Supreme Judicial Court.

FOR THE COMMONWEALTH OF MASSACHUSETTS.

No. SJC-10911.

APPEALS COURT NO. 2009-P-0619.

SUFFOLK COUNTY.

MARCIA RHODES, HAROLD RHODES
AND REBECCA RHODES,
PLAINTIFFS-APPELLANTS,

v.

AIG DOMESTIC CLAIMS, INC. F/K/A AIG TECHNICAL SERVICES, INC.,
NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA,
AND ZURICH AMERICAN INSURANCE COMPANY,
DEFENDANTS-APPELLEES.

ON APPEAL FROM A JUDGMENT OF THE SUPERIOR COURT.

**BRIEF FOR THE PLAINTIFFS-APPELLANTS,
MARCIA RHODES, HAROLD RHODES AND REBECCA RHODES.**

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STATEMENT OF THE CASE

On January 9, 2002, a tractor-tanker slammed into the back of Marcia Rhodes' stopped car, instantly paralyzing her. Marcia Rhodes, her husband Harold and their daughter Rebecca filed suit against the driver, his employer, and the lessor and lessee of the truck. On September 15, 2004, a jury awarded the Rhodes family a total of $9.412 million. After credit for a settlement with a third-party defendant, with interest, the judgment was $11.365 million (the "Underlying Action"). The judgment was appealed. A satisfaction of judgment was ultimately filed in the Underlying Action in September 2005.

A. Course of Proceedings

This action was filed during the pendency of the appeal in the Underlying Action. The Rhodes family filed suit in April 2005 against the primary and excess insurers (Zurich and National Union, respectively), and National Union's claims administrator, AIGDC, for failure to effectuate prompt settlement after liability was reasonably clear. Between February 5 and March 31, 2007, the court (Gants, J.) conducted a 16-day bench trial. Fifteen months later, the Trial Court issued Findings of Fact, Conclusions of Law, and Order ("Order"), containing the following rulings:

- Despite failing to make any settlement offer or tender its policy for more than

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two years after the crash in which the driver's fault and insured status was never in question, Zurich did not violate chs. 176D/93A;

- National Union and AIGDC willfully and knowingly violated chs. 176D/93A by refusing to make a reasonable settlement offer until one month before trial, but the Court excused the violations because the Rhodes family would not have accepted a prompt hypothetical offer that was never made;
- National Union and AIGDC willfully violated chs. 176D/93A by pursuing an appeal and thereafter making unreasonably low settlement offers "in an attempt to bully plaintiffs into accepting an unreasonably low settlement";
- Contrary to the express language of c. 93A requiring the doubling of the underlying judgment, the Trial Court doubled post-judgment lost use of money damages, which were, in any event, incorrectly calculated based on a five month delay that might have occurred if NU/AIGDC complied with the statute,

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rather than on the actual twelve month payment delay.

B. Statement of Facts[1]

On January 9, 2002, Marcia Rhodes was stopped by a patrolman on Route 109 in Medway because Professional Tree Service ("Professional Tree") was working on the side of the road. An 18-wheel tractor-tanker driven by Carlo Zalewski slammed into her stopped car, instantly paralyzing her. Zalewski was employed by Driver Logistic Services ("DLS") and was assigned to drive for GAF Building Corp. ("GAF"). Appendix, Volume I, pp. 17-18 ("App., Vol. _"). GAF leased the tractor-tanker from Penske Truck Leasing Co. ("Penske"). GAF had a $2 million primary automobile policy with Zurich and a $50 million excess policy with National Union. GAF and Zurich retained Crawford & Company ("Crawford") as their Third Party Administrator ("TPA") on claims. Id. at 18. AIGDC was National Union's claim administrator. Id. at 20.

Crawford received notice of Marcia Rhodes' claim on the day of the crash. Three weeks later, on January 30, 2002, John Chaney, a Crawford adjustor, issued his First Full Formal Report. He classified the claim as "catastrophic," reportable to both GAF and Zurich, and stated it was clear it would "carry a high value." Id.

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[1] Unless otherwise stated, all of the facts below are findings of fact contained in pages 1-27 of the Order, set forth in the Appendix at 17-43.

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at 18-19. Crawford's report was sent to Zurich's corporate headquarters. Zurich, however, did not act on or process the report. Id. at 20.

On April 8, 2002, three months after the crash, Chaney sent a second transmittal to GAF, Zurich and AIGDC stating that Zalewski was clearly liable for Ms. Rhodes' injuries and his liability may be imputed to GAF. Chaney noted the possibility of contribution from Professional Tree, and recommended that Zurich's $2 million policy limits be placed in reserve. Id. at 20-21. Zurich, however, still did nothing.

On July 3, 2002, six months after the crash, the law firm of Nixon Peabody, which represented GAF, informed Penske that it was an additional insured under GAF's liability policies. By this time, it was clear that GAF's policies with Zurich and National Union covered Zalewski, GAF, DLS and Penske. Id. at 22. On July 12, 2002, Marcia, Harold and Rebecca Rhodes filed suit against Zalewski, DLS, Penske and GAF. Id. Though Chaney sent a copy of the complaint to Zurich on August 1, 2002, it still did nothing to process the claim. Id. at 23.

Chaney then called David McIntosh, a Zurich claims director, to inform him of a dispute between GAF and Penske. As a result, on August 21, 2002, over seven months after the crash, McIntosh finally opened a Rhodes file. Id. Other than referring the Penske

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matter to coverage counsel, McIntosh took no action on the claim. Id.

The Rhodes family served discovery in the Underlying Action in September 2002. Id. at 23-24. Crawford continued to report to Zurich and AIGDC on September 25, 2002 and May 6, 2003, estimating the potential case value as $5-$10 million and continuing to recommend that the reserve be increased to the $2 million policy limits. In June 2003, seventeen months after the crash, McIntosh requested a formal report from Jody Mills at Crawford, who replaced Chaney on the claim. She sent the report on June 4, 2003, noting that Marcia Rhodes' medical records had been produced in discovery. Id. at 24.

On August 13, 2003, the Rhodes family sent a detailed demand to GAF's counsel, which included a "day in the life" video, medical bills and records, a life care plan, and an economist's report. Id. at 25-26. The demand summarized medical expenses of $413,977.68, a present value of combined future medical costs of $2,027,078, loss of household services worth $292,379 and $83,984.74 in out-of-pocket expenses. The $2,817,419.30 in special damages were the basis for a demand of $16.5 million. Id.

In September 2003, twenty months after the crash, Crawford sent the demand package to Zurich. Id. at 27. McIntosh, Zurich's claims director, however, was, no longer on the claim. Zurich reassigned the Rhodes

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claim to Kathleen Fuell. Id. at 26. In October 2003, Fuell asked Nixon Peabody to give her a case evaluation. Id. at 28.

Crawford continued to report to Zurich and AIGDC in September and November 2003. Its November transmittal noted that the demand was not unreasonable in light of nearly $3 million in special damages. Crawford strongly suggested that Zurich surrender its policy limits as a good faith position prior to mediation. Id. at 28-29. Fuell also received the case evaluation from defense counsel, who clearly wanted to mediate the case. Id. at 29-30.

On November 19, 2003, 22 months after the crash, Fuell arranged a conference call with defense counsel, Crawford, and AIGDC. On the call, defense counsel reviewed the theories of liability, defenses and likely damages. Id. Fuell said she would seek authority to tender Zurich's policy limits. All agreed that $2 million would not settle the case and defense counsel advocated that a $5 million offer be made before mediation. Id. at 30-31. However, Nicholas Satriano, the fifth AIGDC claims director on the Rhodes file, rejected counsel's recommendation and refused to contribute money from the excess policy before mediation. Id.

Fuell finally requested authority to tender the Zurich policy limits in December 2003, twenty-three months after the crash. She estimated the value of the

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case as considerably more than $10 million. Id. at 32-33. Another month passed before Zurich approved the tender. On January 23, 2004, more than two years after the crash, Fuell tendered Zurich's policy limits to AIGDC. Id. at 33.[2]

To delay matters further, a dispute ensued between Zurich and AIGDC about the validity of the tender and whether the tender transferred the duty to defend. Id. at 33-34. Nonetheless, by January 2004, AIGDC knew it had Zurich's $2 million available for settlement. In March 2004, the Rhodes family amended their complaint. Id. at 35. To date, no one had responded to the Rhodes' August 2003 $16.5 million settlement demand, or a December 2003 $19.5 million amended demand, which included accrued interest. Id.

AIGDC refused to make any offer outside of mediation. Frustrated by AIGDC's obstinacy, on March 18, 2004, GAF's coverage counsel sent a letter stating that the failure to respond to the settlement demands violated chs. 176D/93A. Despite this "smoking gun" admonition, NU/AIGDC still took no action on settlement. Id. at 36. Without NU/AIGDC's involvement, however, GAF's defense counsel offered $2 million (Zurich's policy limits) to settle the case. Id. at 38. The Rhodes family rejected the March 31, 2004 settlement offer but agreed to mediation.

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[2] The Trial Court found NU/AIGDC's obligations under c. 176D were triggered by the January 2004 tender.

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NU/AIGDC refused to participate in mediation in April 2004, claiming that they needed more discovery to value the case. Id. Marcia Rhodes had an independent medical exam in July and was deposed in early August 2004. Id. at 39.

National Union finally agreed to mediation, which was scheduled for August 11, 2004, thirty months after the crash and just a few weeks before the September 7, 2004 trial date. Warren Nitti, the sixth AIGDC adjuster on the Rhodes claim, thought the case was worth $6 million, and requested authority to make such an offer. Id.

Instead, AIGDC provided Nitti with settlement authority of $3.75 million (of which only $1.75 million would have come from the National Union coverage, since $2 million would come from Zurich). AIGDC also assumed that Professional Tree's insurer would offer its full $1 million policy limits. Accordingly, AIGDC valued the claim at $4.75 million. Id. Nitti's first offer at mediation was $2.75 million. His final offer of $3.5 million was also rejected. Id. at 40. At mediation, the Rhodes family settled with the third-party defendant, Professional Tree, for $550,000. Id.

Just before trial, Zalewski, DLS, and GAF stipulated to liability. Id. at 40-41. On the first day of trial, AIGDC repeated the $3.5 million offer.[3] This, however, effectively decreased National Union's

[3] Harold Rhodes, App., Vol. IV, pp. 1541-42.

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offer since Professional Tree's contribution was less than the $1 million AIGDC assumed would have been part of a global settlement.[4]

Nitti attended trial and communicated that it was progressing more favorably for the Rhodes family than anticipated. After the close of evidence, Nitti made an offer of $6 million, which was rejected. Id. at 41. On September 15, 2004, the jury returned verdicts totaling $9.412 million.[5] Nitti sought approval to appeal. Post-trial motions were denied and defendants filed a notice of appeal on November 10, 2004. Id. at 41-42.

On November 19, 2004, the Rhodes family sent c. 93A demand letters to the insurers. National Union responded by offering $7 million in exchange for a release of not only the personal injury claims, but also of the 93A claims. Id. at 42. Zurich paid its policy limits and post-judgment interest in December 2004 without requiring a release of the 93A claims. Id.

The Rhodes family filed this action on April 8, 2005. In May, NU/AIGDC offered to settle for $5.75

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[4] This offer is not in dispute but is not referenced in the Order. The Rhodes family contends that it represents yet another willful violation of c. 176D. NU/AIGDC would have had to increase Nitti's settlement authority from $3.75 to $4.2 million to account for the $450,000 decrease in Professional Tree's contribution.

[5] Reduced by $550,000, and with interest, the judgments totaled $11,365,334. Marcia Rhodes' verdict of $7.412 million was reduced by the Professional Tree settlement; Harold Rhodes' verdict was $1.5 million and Rebecca Rhodes' verdict was $500,000.

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million (recognizing that Zurich already paid $2.3 million). In June 2005, AIGDC agreed to withdraw the appeal and pay the Rhodes family $8.965 million, albeit in three installments, without requiring dismissal of the Chapter 93A action. Id.

SUMMARY OF THE ARGUMENT

1. The Trial Court ignored the plain language and unambiguous intent of c. 93A by refusing to double the underlying judgment in calculating punitive damages even though it found 1) pre- and post judgment willful and knowing violations of c. 93A and 2) the latter violation caused injury and damages to the Rhodes family. Chapter 93A explicitly requires that "the amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence." Therefore, it was clear legal error to not enter a punitive damage award against NU/AIGDC of at least $22,730,668. Pages 16-24.

2. The Trial Court committed clear legal error by failing to hold NU/AIGDC liable for their pre-judgment knowing and willful refusal to make a prompt settlement offer. Contrary to the Trial Court's ruling, plaintiffs are not required to prove the case would have settled if a prior hypothetical offer had been made. The finding that NU/AIGDC tried to strong-arm the Rhodes family by intentionally refusing to make an

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offer when liability was reasonably clear is all that was required to establish liability and impose punitive damages. Pages 24-27.

3. The Trial Court committed clear legal error in finding the Rhodes family suffered no injury from NU/AIGDC's knowing and willful failure to make a prompt settlement offer. The Trial Court's factual findings support an award of damages in favor of the Rhodes family for emotional distress and for being forced to endure the "frustrations of litigation" in having to pursue claims under chs. 176D/93A in order to collect their judgment. If a court cannot calculate compensatory damages under c. 93A, nominal damages of $25 must be awarded. An award of nominal damages does not void the statutory requirement that punitive damages must be based on the underlying judgment for willful or knowing violations. Pages 27-34.

4. The Trial Court improperly calculated compensatory damages for NU/AIGDC's post-judgment violation of c. 176D. The Trial Court should have measured lost use of money damages from the entry of judgment on September 28, 2004 through the September 6, 2005 date of final payment on the judgment, rather than creating a hypothetical scenario based on when payments may have been made if NU/AIGDC had complied with their statutory obligations. Pages 34-36.

5. The Trial Court committed clear legal error in holding Zurich complied with c. 176D. The Trial

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Court's findings of facts establish, as a matter of law, that Zurich's inaction and deliberate delay from January 2002 through March 2004 constitute a willful and knowing violation of c. 176D/93A. The Trial Court erred in not entering a joint compensatory and separate punitive damages award against Zurich. Pages 36-47.

ARGUMENT

Marcia Rhodes, her husband Harold, and their daughter Rebecca are like every Massachusetts consumer who relies on insurance as a safety net, especially when catastrophic injury changes their lives and needs. Chapters 176D/93A were enacted to protect this and every other Massachusetts family by providing them with financial security in the event of covered losses.

Here, in an order issued 15 months after closing arguments, the Trial Court ignored the clear mandate of c. 93A to double the underlying judgment upon finding willful violations of c. 176D by NU/AIGDC. In addition, the Trial Court recognized that it was undisputed that the insured driver, Zalewski, was at fault and that Zurich and its agents knew its $2 million policy limits would never settle the claim. Yet the Trial Court somehow held Zurich's 24 month process to tender its policy limits, which violated its own internal standards, was a fair settlement practice.

In order to encourage settlement of claims, and deter insurers from forcing claimants into unnecessary

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litigation to obtain relief, chs. 176D/93A "together require an insurer ... promptly to put a fair and reasonable settlement offer on the table when liability and damages become clear." Hopkins v. Liberty Mut. Ins. Co., 434 Mass. 556, 566 (2001).

As this case abundantly demonstrates, injured claimants and plaintiffs remain at the mercy of insurance companies who delay and ignore them month after month and year after year even when liability is reasonably clear, despite the enhanced punitive damages enacted by the Massachusetts Legislature in 1989. Every Massachusetts resident, from those with "routine" workers compensation injuries and "simple" slip and fall cases, to those with catastrophic injuries like Marcia Rhodes, remain in need of the protections offered by chs. 176D/93A.[6] The reported cases

[6] Brandley v. United States Fid. & Guar. Co., 819 F. Supp. 101 (D. Mass. 1993) (liability under 176D/93A where Paul and Gayle Brandley's car was struck by truck that ran red light and insurer did not agree to settle until first day of trial, two and one-half years after injury); Miller v. Risk Mgmt. Found. of the Harvard Med. Inst., Inc., 36 Mass. App. Ct. 411 (1994) (liability under 176D/93A where Malcolm Miller suffered 2d and 3d degree burns, and insurer waited nineteen months after liability was reasonably clear to make offer); Clegg v. Butler, 424 Mass. 413 (1997) (liability under 176D/93A where James Clegg injured in 1991 collision and insurer should have known by 1992 that he was totally disabled, but did not offer $250,000 policy limits until 1994); Hopkins v. Liberty Mutual, 434 Mass. 556 (2001) (liability under 176D/93A where insurer aware of liability in August 1992, yet made no settlement offer until 1995); Metropolitan Prop. and Cas. Ins. Co. v. Choukas, 47 Mass. App. Ct. 196 (1999) (liability under 93A/176D where James Choukas was totally disabled for 28 weeks and partially disabled for 8 more weeks after auto accident; his own

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represent the tip of the iceberg. The insurance industry knows that the overwhelming majority of injured claimants do not have the financial ability or stamina to litigate for years to vindicate their rights. The Trial Court's findings show that Massachusetts families remain at risk - critical risk - of being subjected to physical suffering, financial ruin and emotional upheaval at the hands of insurers. Indeed, both National Union and AIGDC have engaged in insurance practices scorned by judges at every level of our judicial system.[7]

Nevertheless, the Trial Court purposely avoided awarding punitive damages measured by the $11.3 million judgment, as required under c. 93A, because it believed

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insurer failed to make offer on underinsured coverage and dispute went to arbitration more than one year after accident); Hauptman v. St. Paul Insurance Companies, No. 02-557 (Barnstable Super. Ct. April 6, 2006) (Quinlan, J.), (liability under 93A/176D where Carmela Hauptman fell in 1999, but insurer made no reasonable settlement offer until 2004); Tallent v. Liberty Mutual Ins. Co., No. 1997-1777-H, 2005 WL 1239284 (Mass. Super. Ct. April 22, 2005) (liability under 176D/93A where ironworker Raymond Tallent fell and was permanently disabled; insurer appealed rather than paying $2 million judgment).

[7] Murphy v. National Union Fire Ins. Co., 438 Mass. 529 (2003)(Kenneth Murphy was seriously injured when his stopped car was struck by another vehicle; insurer disputed damages for almost six years until arbitration award of $1.6 million); Maxwell v. AIG Domestic Claims, Inc., 72 Mass. App. Ct. 685, 693 (2008) (affirming denial of AIGDC's motion to dismiss where Maxwell became homeless after workers compensation benefits were denied; he filed suit for malicious prosecution based on AIGDC's pursuit of fraud and criminal charges, and its refusal to pay for surgery despite judge's ruling that "failure to provide employee with reasonable and necessary medical care . . . is simply inexcusable.").

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the "actual damages" caused by the insurers' willful violations were insufficient to merit the "extraordinarily punitive damages" dictated by c. 93A. App., Vol. I, p. 71. This result is far beyond the Trial Court's discretion. Having found a willful violation, the statute unambiguously required the Trial Court to double the $11.3 million judgment. Chapter 93A must be applied as written and the Trial Court's damage award must be corrected.

I. Standard of Review.

This Court reviews questions of law, including interpretation and application of chs. 176D/93A, "de novo." R.W. Granger & Sons v. J&S Insulation, 435 Mass. 66, 73 (2001); Zabin v. Picciotto, 73 Mass. App. Ct. 141, 170 (2008). The Trial Court's findings of fact will only be set aside if clearly erroneous. Mass. R. Civ. P. 52(a).

II. The Trial Court's Rulings with Respect to the Scope and Extent of National Union and AIGDC's Liability Are Erroneous as a Matter of Law.

The Rhodes family obtained a judgment in the Underlying Action and the Trial Court found that National Union and its agent willfully violated their duty to effectuate prompt settlement of claims in which liability had become reasonably clear. The law is explicit that under such circumstances, "'actual damages' shall be taken to be the amount of the judgment for the purpose of bad faith multiplication

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...." Yeagle v. Aetna Cas. & Surety Co., 42 Mass. App. Ct. 650, 653-54 (1997).

The Trial Court ignored that clear mandate. It improperly refused to award punitive damages of double the $11.3 million judgment because it found National Union's pre-judgment violation of c. 176D did not cause economic harm, and the post-judgment violation did not "cause" judgment to enter in the Underlying Action - it caused "only" lost use of money damages. App., Vol. I, pp. 73, 76.

However, the Supreme Judicial Court has already held that under c. 93A, whether the knowing and willful violation occurred before or after trial (or both, as the Trial Court found in this case) the amount of the underlying judgment must be multiplied. R.W. Granger, 435 Mass. at 80-83 (affirming doubling of underlying judgment for post-judgment unfair settlement practices). The only inquiries relevant to the imposition of punitive damages are: (1) was there a violation that caused injury; (2) was the violation knowing or willful; (3) if so, was there a judgment; and (4) if so, should the underlying judgment be doubled or trebled. Id.

The Trial Court improperly parsed NU/AIGDC's continuing willful breach of its statutory duty into separate pre- and post judgment violations. The Trial Court should have evaluated its conduct as a whole. A continuing breach of c. 176D is a single violation, not

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a series of separate violations. Hopkins, 434 Mass. at 562-63 (citing Darmetko v. Boston Hous. Auth., 378 Mass. 758, 761-62 (1979)). The Trial Court essentially held that National Union's deliberate decision to delay an offer until just a few weeks before trial to increase its leverage, although a willful violation of c. 176D, was "cured" when it finally made a reasonable offer. The Trial Court improperly used this novel analysis to avoid the imposition of punitive damages against NU/AIGDC for its pre-judgment violation of c. 176D.

A. Chapter 93A Mandates that the Underlying Judgment is the Basis for Punitive Damages.

If an insurer engages in unfair settlement practices in violation of c. 176D, then under c. 93A:

> [R]ecovery shall be in the amount of actual damages or twenty-five dollars, whichever is greater; or up to three but not less than two times such amount if the court finds that the use or employment of the act or practice was a willful or knowing violation of said section two... For the purposes of this chapter, the amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence...

G.L. c. 93A, § 9(3). The Legislature determined that damages for the lost use of money was an insufficient deterrent of unfair settlement practices. See Clegg, 424 Mass. at 424; R.W. Granger, 435 Mass. at 83 n.21 (2001). Accordingly, in 1989, the Legislature increased the deterrent effect of the statute by making

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the underlying judgment the basis for multiple damages, thereby effectively punishing and deterring these powerful insurance companies. Id. at 81; Kapp v. Arbella Mut. Ins. Co., 426 Mass. 683, 686 (1998) (insurer faces "exposure to punitive damages many times greater than multiplication of the lost money alone").

Judgment entered in favor of the Rhodes family in September 2004. The Trial Court specifically found that, in appealing the judgment, National Union knowingly and willfully did "precisely what Chapter 176D was intended to prevent - attempt to bully the plaintiffs into accepting an unreasonably low settlement rather than wait the roughly two years for their appeal to conclude and the judgment to be paid." App., Vol. I, p. 76.

The Trial Court further found that the repeated lowball offers and delay in paying the judgment caused harm to the Rhodes family, both emotional distress and lost use of money. Id. at 77. Unfortunately, in an error of extraordinary proportions, the Trial Court refused to apply the plain language of c. 93A, § 9, which unequivocally mandates that the underlying judgment be doubled when calculating punitive damages, regardless of when the willful violation occurred. R.W. Granger, 435 Mass. at 80-83; Yeagle, 42 Mass. App. Ct. at 653-54; Cohen v. Liberty Mut. Ins. Co., 41 Mass. App. Ct. 748, 756 (1996).

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The Trial Court rationalized its refusal to apply the statute as written by speculating that where a post-trial violation does not "cause" an underlying judgment to enter, the legislature could not have intended that the judgment would be used to calculate punitive damages. That speculation must be rejected. In R.W. Granger, the Supreme Judicial Court affirmed an award of double the judgment based solely on post-judgment violations where the "unreasonable settlement practices after the jury verdict . . . denied J&S prompt recovery of the sums owed to it." 435 Mass. at 81.

> By awarding to J&S double "the amount of the judgment" . . . the judge did precisely what the language of the 1989 amendment requires.
>
> While an award to J&S of $845,653.42 may appear excessive in light of the fact that USF&G's postverdict bad faith conduct caused J&S to lose only the use of the money to which it was entitled, the award is consistent with the legislative intent that led to the 1989 amendment.

R.W. Granger, 435 Mass. at 82. The Trial Court's order amends the statute by judicial fiat.

B. The Trial Court's Ruling is Contrary to the Remedial Purpose of the Statutes.

Limiting statutory punitive damages to cases where a willful violation "causes" judgment to enter defeats the purpose of the statute "to encourage settlement of insurance claims . . . and discourage insurers from forcing claimants into unnecessary litigation to obtain relief." Hopkins, 434 Mass. at 567-68. Unnecessary

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litigation is not limited to preparing for and trying a case to verdict. This case provides a perfect example of post-trial litigation that the Rhodes family would have avoided if NU/AIGDC complied with c. 176D, including: (1) filing a motion to dismiss the appeal for lack of prosecution; (2) serving Chapter 93A demand letters; (3) filing this lawsuit; and (4) engaging in discovery in this action before National Union paid the judgment. This "litigation activity" was forced upon the Rhodes family. R.W. Granger, 435 Mass. at 78 (describing litigation to include post-verdict activities and pursuit of 93A claim).

The Trial Court believed that the judgment in the Underlying Action should not have been used to calculate punitive damages simply because it was a multi-million dollar judgment. Given the language of the statute and their knowledge of the severity of Marcia Rhodes' injuries, that is the risk the insurers chose to take. After the $11.3 million judgment entered, the insurers knowingly assumed the risk of a multimillion dollar punitive damage award.

Moreover, it is not the Trial Court's role to make public policy decisions - the policy decision was made by the Legislature in 1989, and it was clear error for the Trial Court to ignore the statute's mandate. See Board of Appeals of Woburn v. Housing Appeals Comm., 451 Mass. 581, 590 (2008) (reversing decision that "brushed aside the language of the governing statute,"

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even though HAC believed it acted in accord with legislative intent; decision contrary to express statutory language could not stand); Bronstein v. Prudential Ins. Co., 390 Mass. 701, 708 (1984) ("To stretch the meaning of a statute so as to adjust an alleged injustice, inequity or hardship could cause a multiplicity of interpretations as each alleged injustice, inequity or hardship arose.").

In refusing to apply the statute as written, the Trial Court suggests that "[t]o allow a plaintiff to obtain actual and punitive damages when it would not have settled the case even with a reasonable settlement offer would actually discourage plaintiffs to settle . . . ." App., Vol. I, p. 72. This unrealistic risk assessment is not what motivated the Legislature to amend the punitive damage provision of c. 93A. Doubling or trebling the underlying judgment is intended to deter powerful insurance companies from unfairly delaying payment and forcing deserving claimants into accepting unreasonably low settlements.

The Trial Court's concern that following the statutory mandate would somehow entice plaintiffs to not settle claims is more than far-fetched. It assumes that wily claimants with the time, money, and emotional fortitude to endure years of discovery, a trial on the merits, post-trial motions and an appeal, will do so in order to preserve a right to pursue a 93A action and rely on the underlying judgment for a punitive damages

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award. Injured plaintiffs generally do not play "Gotcha" with insurance companies - the dynamic is the reverse (as the entire c. 176D statutory scheme implicitly recognizes). Even if the Trial Court were correct in its assessment of the risk, that risk cannot justify the result the Trial Court plainly sought to reach by not following the statute as written. See Board of Appeals of Woburn, 451 Mass. at 590; Bronstein, 390 Mass. at 708.

The real risk of the Trial Court's decision is the fact that it gives insurers a green light to engage in unfair settlement practices with little fear of punitive damages, and a roadmap of how to do it. Unless Superior Court judges apply c. 93A as written to enforce c. 176D, insurers are free to do precisely what NU/AIGDC did: intentionally delay making any offer for months before deliberately making the lowest possible reasonable offer shortly before trial; then, if the low offer is rejected, take a calculated risk that the jury will be stingy; if the jury is not, appeal the verdict as excessive and try to bully plaintiffs into accepting an unreasonably low offer rather than wait for the appellate process to conclude before receiving restitution for their injuries. App., Vol. I, pp. 58-60, 76.

The Trial Court improperly ignored the legislative mandate to double the underlying judgment in awarding punitive damages for NU/AIGDC's willful and knowing

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violations of chs. 176D/93A. That award must be set aside and the underlying judgment must be doubled for the entry of a punitive award of $22,730,668 in favor of the Rhodes family. R.W. Granger, 435 Mass. at 82-83 ("It would be contrary to the language of the statute, as well as to the punitive purpose of the 1989 amendment, to reduce the 'amount of the judgment' (in the language of the statute)"); Cohen, 41 Mass. App. Ct. at 756 (where interest is a component of underlying judgment 'actual damages' to be multiplied include both base recovery and interest).

C. Trial Court Erred in Making Inquiry of Whether Plaintiffs Would Have Accepted a Hypothetical Offer.

The Trial Court found liability was reasonably clear as to NU/AIGDC on December 5, 2003, but that it refused to make any offer until August 11, 2004. Furthermore:

> This Court does find that AIGDC's failure to provide a prompt settlement offer was willful and knowing . . . . In short . . . AIGDC did not delay its settlement offer to conduct the investigation needed to make liability reasonably clear; it delayed because it thought it would be in a better strategic posture if the offer were postponed until the mediation and it did not wish the mediation to occur until trial was nearly imminent.

App., Vol. I, pp. 70-71, n.15; see also id. at 57.

Yet, the Trial Court excused NU/AIGDC's egregious violation because the Rhodes family did not accept the lowest possible (late) reasonable offer, and the Trial Court found they would not have accepted an earlier

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reasonable offer, had one been extended. The Trial Court erroneously held that the Rhodes family had to prove "not only that the insurer failed to make a prompt or reasonable settlement offer, but also that, if it had, the plaintiff would have accepted that offer and settled the actual or threatened litigation." Id. at 69. This ruling represents clear legal error.

The law does not require the Rhodes family to prove the case would have settled before a verdict was returned or judgment entered in order to recover under c. 176D. The Trial Court's supposition that the Legislature intended to limit actual and punitive damages to "cases that would have settled (or settled earlier) had the insurer performed its duty to provide a prompt and reasonable settlement offer," App., Vol. I, pp. 71-72, is not supported by the statute, any precedent or legislative history.

The duty to promptly effectuate a fair and reasonable settlement falls squarely on insurers and does not require plaintiffs to prove that but for the insurer's statutory violation, the case would have settled. Hopkins, 434 Mass. at 569 (imposing punitive damages and rejecting argument that since plaintiff did not prove she would have accepted earlier offer, insurer did not "cause" any harm); Bobick v. United States Fid. & Guar. Co., 439 Mass. 652, 662-63 (2003) (reaffirming that plaintiffs need not prove they would have accepted hypothetical offer).

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The Trial Court refused to follow the Hopkins holding, claiming (erroneously) that Hopkins, a c. 176D case, was "effectively overruled" by a subsequent c. 93A decision, Hershenow v. Enterprise Rent-A-Car, 445 Mass. 790 (2006). App., Vol. I, pp. 68-69. This finding demonstrates the lengths to which the Trial Court was prepared to go to avoid the clear import of Hopkins:

> An insurer's statutory duty to make a prompt and fair settlement offer does not depend on the willingness of a claimant to accept such an offer. Accordingly, quantifying the damages for the injury incurred by the plaintiff as a result of the defendant's failure under G.L. c. 176D, §3(9)(f), does not turn on whether the plaintiff can show that she would have taken advantage of an earlier settlement opportunity."
>
> [W]hen the defendant failed to make any offer at all, the plaintiff should not be required to show that she would have accepted a hypothetical settlement offer, had one been forthcoming. . . ."

Hopkins, 434 Mass. at 567, 569 (internal citation omitted).

Contrary to the remedial purpose of the statute, the Trial Court's holding shifts to the plaintiff the risk of uncertainty of what would have happened if only the insurer had complied with its statutory mandate. Clegg, 424 Mass. at 422, n.8 ("insurers cannot avoid liability for their unfair practices under G.L. c. 176D, § 3(9), by pointing to the uncertainty surrounding a claim . . . when that uncertainty stems from the primary insurer's own behavior and delay.").

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Also, the factual underpinning for the Court's ruling, i.e. that the Rhodes family would never have accepted a settlement offer less than $8 million, is clearly erroneous.[8] Indeed, the Trial Court penalized the Rhodes family for being honest in testifying that the only time they discussed a settlement figure was in August 2004 in connection with mediation, when they knew unequivocally they would have settled for $8 million. Neither Marcia nor Harold Rhodes could guess how they would have responded to a specific offer in 2002, 2003 or earlier in 2004. The type of guesswork that would be required is precisely why plaintiffs are not required to prove hypotheticals, and exactly why the Trial Court's findings should be reversed.

D. The Trial Court Erred in Ruling that Plaintiffs Suffered no Pretrial Injury.

The Hopkins Court noted that it was not deciding whether the same measure of damages would apply where a late offer was made and rejected. 434 Mass. at 567 n.16. This footnote suggests that an insurer may stop the accrual of damages by making a reasonable

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[8] As Harold Rhodes testified - "Before mediation we really never thought about [what settlement offer we would have accepted] or talked about it." App., Vol., VI, p. 1636. "You know, again, there was never an offer made of $6 million, so we never considered it." Id. at 1657. At mediation, the Rhodes family was willing to negotiate in a range of $6-$10 million. Id. at 1537. Marcia Rhodes did not know if she would have agreed to accept less than $8 million in 2002 or 2003: "I don't know because there was no offer forthcoming, so how would I know how I would have reacted?" App., Vol. III, p. 1129.

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settlement offer (albeit late). It does not suggest that a late offer nullifies a previous violation such that a plaintiff suffered no injury, as the Trial Court found here.

The Trial Court's Order conflates "injury" and "damages," which is why it incorrectly believed that Hershenow controlled its decision rather than Hopkins. However, the two are entirely consistent. Hopkins essentially held that a c. 176D plaintiff establishes injury where an insurer delays making an offer, regardless of whether the case would have settled had an offer been made earlier. Hershenow simply holds that a c. 93A plaintiff must prove she was injured as the result of the defendant's wrongful conduct.

Injury is the "invasion of any legally protected interest of another." Leardi v. Brown, 394 Mass. 151, 159-60 (1985) (injury may occur without actual economic damage, which is why c. 93A allows for nominal damages). Whether a plaintiff has established an injury is a question separate from the amount of damages flowing from the injury. "[T]o the extent that the plaintiff is able to prevail on the issue of liability but is unable to prove actual damages, the Legislature has decided that she is entitled to a specified remedy." Hershenow, 445 Mass. at 790 n.18.[9]

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[9] In holding plaintiffs must show injury to recover under c. 93A, the Court emphasized it was not overruling the expansive definition of "loss" or "injury" in Leardi. Hershenow, 445 Mass. at 800. In

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The specified remedy is $25 in nominal damages - yet the Trial Court did not even consider awarding nominal damages to the Rhodes family because it wanted to avoid imposing punitive damages based on the underlying judgment:

> [I]f this Court, under Hopkins, were required to find that the plaintiffs suffered even nominal damages from being denied a prompt settlement offer that they certainly would have rejected, and if this court were to find the violation willful or knowing(which it does), the plaintiffs would be entitled to receive not merely those nominal damages . . . but also double or triple the amount of the judgment they received in the underlying personal injury case - that is, $22.6 million or $33.9 million.

App., Vol I., pp. 70-71.

Hershenow rejected the Trial Court's rationale. The "Legislature intended to permit recovery when an unfair or deceptive act caused a personal injury loss such as emotional distress, even if the consumer lost no 'money' or 'property.'" Hershenow at 798; see also First Agric. Bank. v. Cappuccino of the Berkshires, Inc., 1986 Mass. App. Div. 110, 114 (1986) (finding emotional distress resulting from malicious abuse of process can be recovered under c. 93A).

Once liability was reasonably clear, NU/AIGDC had a statutory obligation to make a prompt and reasonable settlement offer, but refused to do so until August 2004. The Trial Court held that the failure to not

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discussing Leardi, the Hershenow Court used the terms "injury" and "loss" interchangeably. Whichever term is used, however, the concept remains distinct from the concept of "damages."

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make an offer by May 2004 violated c. 176D. That violation invaded the Rhodes' legally protected interests, and caused them cognizable injury for purposes of chs. 176D/93A.

Suffering through the "frustrations of litigation" is a foreseeable non-economic injury and is precisely the harm that chs. 176D/93A are intended to prevent. Hershenow, 445 Mass. at 798-800, 802 (plaintiffs entitled to recover economic and non-economic losses, including emotional distress resulting from invasion of their interests); Hopkins, 434 Mass. at 566-67; Clegg, 424 Mass. at 419 ("[U]njust delay subjects the claimant to many of the costs and frustrations that are encountered when litigation must be instituted and no settlement is reached."). Indeed, such injury is not just foreseeable; when there is a willful or knowing violation of c. 176D, it is precisely what the insurer intends in order to coerce claimants into accepting low settlements.

Settlement negotiations require the participation of two parties. As Harold Rhodes testified, the December 2003 increased demand was made because it was "nearly 2 years since Marcia's crash and we hadn't heard anything from any of the defendants . . . and . . . what we wanted to do is get a wake-up call to say pay attention to us, talk to us. You know, this has gone on an awfully long time now." Harold Rhodes, App., Vol. IV, p. 1534.

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The Trial Court properly found that the Rhodes family suffered emotional distress as a result of the prolonged litigation and the failure of the defendants to make a timely, reasonable offer. However, the Trial Court decided to disregard this harm because their "emotional distress would not have materially diminished had the defendants made an earlier settlement offer that [plaintiffs'] attorney would promptly have rejected." App., Vol. I, p. 64 (emphasis added). Contrary to the Trial Court's ruling, this finding establishes that the defendants' knowing and willful violations of chs. 176D/93A resulted in "injury" to the Rhodes family. Having found injury, liability and causation were established. Whether their distress would have "materially diminished" before trial goes to the amount of damages to be awarded, not the existence of an injury.

The emotional distress presented to the Trial Court from both Zurich and National Union's combined failures included distress and anxiety caused by the defendants' violations. While their expenses mounted, they depleted their life's savings by $470,000 to pay expenses relating to Marcia's catastrophic injuries, and went into debt. They were forced to get on with their lives while wondering, worrying, and waiting for the defense or insurers to raise or respond to a settlement offer.

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After August 2003, Mr. Rhodes suffered increasingly more stress because the defendants did not respond to their first demand, and the family's assets were being depleted. He was terrified that the family would run out of money, since by July 2004 they had not received a reasonable settlement offer. Harold Rhodes, App., Vol. IV, pp. 1557-59. The effect of the financial pressures and litigation on Mr. Rhodes was quite evident to his family. [10] As more time passed without a response or overture toward settlement, his anger turned to outrage. Id. at 1551.[11]

Nonetheless, the Trial Court ignored its own findings of injury and improperly held that the Rhodes family could not recover for pre-judgment willful violations of Chapters 93A/176D. It did so after finding that the only way the Rhodes family could have been harmed was if they would have accepted a prompt

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[10] Steven Rhodes Testimony, App., Vol. III, pp. 779-783, 793-94, 803; Rebecca Rhodes Testimony, Id., pp. 879-80; Marcia Rhodes Testimony, Id., pp. 1052-53.

[11] Mr. Rhodes was insulted, and very angry that the first settlement offer of $2 million was so low, and was not made until more than two years after the crash. App., Vol. IV, pp. 1535-36. Marcia Rhodes viewed the July 2004 independent medical exam as something she had to do to "prove" she was paralyzed. She thought it was "ludicrous" for the defendants to have waited "so late in the game" to make her submit to an IME. Nonetheless, she agreed to it because she thought it would be "a definitive closing point" to the litigation. App., Vol. III, pp. 1039, 1943-44. Harold Rhodes was outraged that the first offer at the mediation, $2.75 million, didn't even cover Marcia's past and future medical expenses - it was "ridiculous." App., Vol. III, p. 1536.

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reasonable offer and therefore would have been spared the "frustrations of litigation." App., Vol. I, p. 69.

In addition to ignoring its finding of pre-judgment injury, the Trial Court also failed to recognize or address the frustrations of litigation suffered by the Rhodes family because of NU/AIGDC's willful violations after judgment entered.[12] The Trial Court committed legal error in both analyses.

E. Emotional Distress Damages are Recoverable under c. 93A.

The Trial Court erroneously held that a c. 93A plaintiff must prove the elements of intentional infliction of emotional distress in order to recover emotional distress damages. This is a clear legal error. The Trial Court misconstrued Haddad v. Gonzalez, 410 Mass. 855 (1991) as requiring proof of intentional infliction of emotional distress under c. 93A. App., Vol. I, p. 77. Haddad, however, held only that intentional infliction of emotional distress provides a basis for liability under c. 93A.

The statute is intended to permit recovery where the unfair act "caused a personal injury loss such as

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[12] Marcia Rhodes experienced "total disbelief" and a sense of "horror" when she learned of the appeal because the case was not over and would drag on. App., Vol. III, pp. 1069-70. Harold Rhodes described an emotional rollercoaster of feelings from relief after the verdict to the realization that the appeal would take two years, and that the family would be in dire financial straits and forced to take whatever the insurance companies offered. App., Vol. IV, pp. 1563-64.

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emotional distress, even if the consumer lost no 'money' or 'property.'" Hershenow, 445 Mass. at 798.[13] Emotional distress damages can be awarded in chs. 176D/93A cases without pleading or proving intentional infliction of emotional distress. Accordingly, the Trial Court's holding requiring the Rhodes family to prove intentional infliction of emotional distress must be overturned.

F. The Calculation of Post-Judgment Compensatory Damages Is Clearly Erroneous.

The Trial Court was correct in finding that the Rhodes' were damaged by NU/AIGDC's failure to make prompt settlement of the claim after judgment entered. "[W]hen an insurer wrongfully withholds funds from a claimant, it is depriving that claimant of the use of those funds" and such harm is compensable under c. 93A. Clegg, 424 Mass. at 419.

As of September 28, 2004, the judgments in favor of the Rhodes family totaled $11,365,334.[14] From September 28, 2004 until September 6, 2005, the Rhodes family did not have use of the full value of the judgments. Yet, rather than begin to calculate interest from the date judgment entered (or even

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[13] Similarly, another remedial statute, c. 151B, also provides for the recovery of emotional distress damages. See, e.g., Buckley Nursing Home Inc. v. MCAD, 20 Mass. App Ct. 172, 182, review denied, 395 Mass. 1103 (1985); Stonehill College v. MCAD, 441 Mass. 549 (2004) (confirming emotional distress awards can be made under c. 151B).

[14] App., Vol. VIII, pp. 5196-97, Docket Entries 97-99.

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starting with the December 17, 2004 response to the Rhodes family's 93A letter), the Trial Court assumed that if NU/AIGDC made a reasonable offer on December 17, 2004, settlement might have been reached by January 2, 2005 and the first of three installments might have been paid on February 5, 2005. Based on this conjecture, the Trial Court awarded five months of interest as compensatory damages. App., Vol. I, pp. 76-77. In reality, NU/AIGDC made installment payments on July 5, August 5, and September 6, 2005.[15] The compensatory damages award is wrong because interest is properly calculated from the time an offer should have been made (i.e. the date of the judgment) to when payment was actually made. Hopkins, 434 Mass. at 560.

The Rhodes family should not be required to forego post-judgment interest because NU/AIGDC waited until June 2005 to make a reasonable settlement offer and then wanted to spread the payments over three months. As payments on the judgment were made in December 2004 by Zurich, and then by National Union over the summer of 2005, the Rhodes family did not have use of the entire judgment in the year it took to collect it. When the $11,365,334 judgment is reduced by the payments, and interest is calculated for the twelve

[15] App., Vol. XI, pp. 6692-93.

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month period, the lost use of funds totals $991,645.71.[16]

Unless the Rhodes family recovers for the lost use of money from the entry of judgment through the date of final payment, NU/AIGDC will have been rewarded with a bonus of almost $550,000, representing the difference between the $448,250.00 awarded by the Trial Court and the full measure of interest over a twelve month period. The statute is intended to penalize and deter unfair settlement practices, not reward them.

III. The Trial Court Erred in Finding no Violation of Chapters 176D or 93A By Zurich.

As a matter of law, Zurich violated chs. 176D/93A. The Trial Court recognized that the settlement analysis Zurich needed to perform was more straightforward than that required of National Union:

> In a catastrophic injury [case] where negligence is not materially disputed, damages are reasonably clear to the primary insurer with modest policy limits once it is reasonably clear that the amount of damages will exceed those policy limits, even if the total scope of damages is not yet reasonably clear…. Consequently, damages may be reasonably clear to the primary insurer before they are reasonably clear to the excess insurer.

App., Vol. I, p. 29 (citation omitted).

Chapters 176D/93A prohibit unreasonable delay and/or indifference on the part of a primary insurer in

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[16] The Chart found at Addendum page 91, is based on a trial exhibit found at App., Vol. VIII, pp. 5196-97. The Chart provides a breakdown of the judgment amount, payment dates and amounts, and accrued interest.

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investigating and settling claims. Clegg, 424 Mass. at 422-23 (finding violation where damages exceeded policy limits, yet insurer did not tender or make offer until 2 years after demand); R.W. Granger, 435 Mass. at 71 (imposing punitive damages for inexplicable delay of four months between demand and inadequate settlement offer and other "cavalier" conduct); Miller, 36 Mass. App. Ct. at 419 (imposing treble damages for insurer's "studied indifference" where liability was reasonably clear, yet insurer took six months to respond to demand with unreasonably low offer); Mongeon v. Arbella, 17 Mass. L. Rep. 631, 636-39 (Mass. Super. Ct. April 23, 2004) (finding violation where insurer failed to investigate or address causation and damages until six months after accident and did not offer policy limits for two years). The Trial Court misapplied the law in holding that Zurich's claims practices complied with c. 176D. Under established precedent and the Trial Court's findings of fact, Zurich knowingly and willfully violated chs. 176D/93A.

A. The Facts Demonstrate Zurich Violated its Statutory Obligations as Early as 2002.

Zurich had to answer four questions to decide whether, and when, to tender its policy limits:

> (1)Was it reasonably clear that at least one of the insureds would be found liable? (2) Did any of its insureds have other primary insurance that covered this loss? (3) How much could it expect the third party defendant, Professional Tree . . . to contribute? (4) Was it reasonably clear that

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> the damages suffered by [the Rhodes Family] exceeded the $2 million policy limits, plus any reasonably expected contribution from Professional Tree or its insurer?

App., Vol. I, p. 55. All of the facts necessary to answer these questions were in existence in 2002. Zurich, however, never bothered to do the investigation necessary to answer them. Had Zurich paid any attention to the claim in 2002, it was obvious Zalewski was covered by its policy and that he would be found negligent. Id. at 27.[17]

Although Crawford was immediately involved in the Rhodes claim and sent multiple updates from January through July of 2002, Zurich failed to even open a claim file until August 2002, eight months after the crash, due to its internal "paperwork limbo." Id. at 20, n.2. In contrast to Zurich's indifference, by July 2002, the insured, GAF, had reviewed the primary and excess policies and understood that Zalewski, DLS, Penske, and GAF were all covered. Id. at 22.

Had Zurich investigated the status of other policies available to DLS and Zalewski, it would have learned in 2002 what it was told in November 2003 - they had no other coverage. Had Zurich investigated policies available to Professional Tree, it would have learned the actual amount of Professional Tree's coverage was $1 million, not $3 million as Zurich was

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[17] If there were any doubt as to Zalewski's liability, it was laid to rest in November 2002 when he admitted to sufficient facts to support a guilty finding on charges of driving to endanger. Id. at 24.

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told in November 2003.[18] Lastly, had Zurich assessed damages in a prompt and timely manner in 2002, it was obvious that the Rhodes claim exceeded the policy limits and any possible contribution from other primary insurers. Indeed, Crawford valued the claim at $5-$10 million in September 2002 and repeatedly recommended that the claim be reserved at the $2 million policy limits. App., Vol. VIII, pp. 3675-3712.

Other than asking outside counsel to determine whether Penske was covered, Zurich took no action on the Rhodes claim in 2002. Zurich waited until May 29, 2003, over 16 months after the crash, for GAF's coverage counsel to ask for any other policies covering Zalewski and DLS. Id. at 27-28. Zurich waited until September 2003, almost 19 months after the crash, for defense counsel to depose Professional Tree's owner and ask about liability coverage.[19] Zurich waited to assess damages until it received the Rhodes family's demand package in September 2003.

Zurich's inaction violated its own policies, evidence that is highly probative of a willful and

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[18] In finding that AIGDC violated Chapters 176D and 93A, the Trial Court held "it should not have taken long [] to ascertain from Professional Tree Service that its policy limits were only $1 million rather than $3 million." Id. at 59. Just as AIGDC "made no reasonable effort to promptly resolve the outstanding coverage issues," neither did Zurich. Id.

[19] App., Vol. VIII, pp. 3699-3702. Zurich relied on the initial report that Professional Tree had $3 million in coverage, which Crawford indicated needed to be confirmed. In fact, Professional Tree only had $1 million in coverage for the crash. App., Vol. I, p. 59.

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knowing violation of c. 176D. See Choukas, 47 Mass. App. Ct. at 198 n.2 (finding willful and knowing violation for failing to follow internal guidelines). The Trial Court, however, did not address these facts. Zurich's Best Practices Policy required that "all applicable coverage issues are recognized immediately upon receipt of information . . . [and] are proactively resolved in a timely manner." App., Vol. VIII, p. 3655. Zurich did not even confirm coverage for the Rhodes claim to GAF, Penske and DLS until January 21, 2003, more than a year after the crash. Id. at 3773. Zurich's policy also required the prompt identification and resolution of issues of subrogation and contribution. Id. at 3663-64. Nonetheless, as summarized above, Zurich did nothing to address, much less resolve, these issues. Zurich's policy required its case manager to make initial contact with plaintiff's counsel and obtain information to assess exposure within 30 days of receiving the necessary information. Id. at 3657-58. David McIntosh, Zurich's case manager, never contacted counsel for the Rhodes family.

Had Zurich followed its own policies and shown respect for its obligations under c. 176D, it would have performed an investigation and asked for factual information in 2002. Or, it would have instructed Crawford and defense counsel to collect medical records and bills well before February 2003, when GAF first

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served discovery requests. Instead, McIntosh who was assigned to the claim in August 2002, waited until June 2003 to ask Crawford for a detailed analysis of the claim. While McIntosh complained that Crawford caused delay by failing to provide the requested information, blaming Crawford does more to damn Zurich than absolve it. Crawford was Zurich's agent,[20] so any mishandling of the claim by Crawford is legally imputed to Zurich. Douglas v. Holyoke Mach. Co., 233 Mass. 573, 576 (1919) (agent's negligence attributable to principal).

Zurich's reckless indifference toward the Rhodes claim is strikingly similar to the insurer's conduct in Mongeon, 17 Mass. L. Rep. at 636-38. Arbella was found to have willfully violated c. 176D where it "made no effort to confirm if the driver was uninsured and did not focus on damages until Mongeon's attorney did an investigation proving the uninsured status of the driver." Contrary to its statutory obligations, Arbella - like Zurich - chose not to address causation and damages until several months after the accident, and belatedly offered its policy limits two years after the accident. Id.

Here, the Trial Court's analysis of Zurich's conduct did not even start until August 2003, eighteen

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[20] "Crawford provided various adjustment services, including accepting and acknowledging proofs of loss, maintaining claims files, investigating all reported claims and evaluating their merits, proposing Claim Reserve guidelines, and retaining attorneys." App., Vol. I, p. 18.

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months after the crash, when the Rhodes family served its demand package. Departing from well-established precedent, the Trial Court held an insurer has no obligation to investigate a claim or assess damages until it receives a demand. That is not the law. Promptness under c. 176D is a function of when liability is reasonably clear, not whether or when a demand is made:

> If liability is reasonably obvious and the injuries serious, an insurer is not excused from making an offer... even without a firm demand from the claimant. In this instance, an insurer may not wait until a settlement offer has been made, but has an obligation to respond to the claim without a demand.

Eric Mills Holmes, Holmes Appelman on Insurance 2d: Law of Liability Insurance, §137.4(C), p.163 (2003) (cases cited). This Court should not condone Zurich's unfair insurance practice of sitting on its hands waiting for the Rhodes family to do an investigation for it and then make a demand in order to trigger its attention to the claim.

Though it received the Rhodes' demand in September 2003, Zurich did not pay attention to the claim in earnest until November 2003 after Crawford belatedly confirmed there were no other policies covering Zalewski or DLS. App., Vol. I, pp. 12-13. By November, Zurich also knew defense counsel wanted to make an offer of $5 million. Id. at 30. Zurich itself estimated the value of a pain and suffering award to Marcia Rhodes in the range of $11 million - $13.75

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million.[21] Marcia Rhodes' pain and suffering alone, apart from any past and future medical expenses, was well in excess of Zurich's policy limits. There was no reason why Zurich could not have assessed damages, including pain and suffering, in 2002.

Though it controlled the defense, Zurich did not respond to the Rhodes' August or December 2003 demands.[22] Zurich's first effort toward achieving settlement - the tender of its policy limits - was two years after the crash, and it waited until March 31, 2004 to extend a settlement offer. Zurich's efforts came months, if not years, too late.

B. Exonerating Zurich is Improper Departure from Established Law.

The Trial Court had "no doubt that Zurich could have and should have provided the required authorization for the tender earlier than January 22, 2004." App., Vol. I, p. 51. Inexplicably, however, the Trial Court found Zurich's deliberate indifference to the claim from January 2002 to June 2003, when McIntosh asked for a full report, followed by its extended delay until the January 2004 tender, was not "unfair." Id. Once the Trial Court found Zurich should

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[21] App., Vol. VII, p. 3459 (noting 50% probability of $12.75 million award).

[22] Crawford warned Zurich of the potential for liability under c. 93A if no good faith offer was made in response to the August 2003 demand letter. App., Vol. VIII, pp. 3710-12.

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have taken steps to effectuate settlement, but did not, a breach of its statutory obligation was established.

It was reasonably clear "by October 2, 2003 that the total damages incurred from the accident would far exceed the Zurich policy limits of $2 million." Id. at 46.[23] In fact, it was reasonably clear much earlier than October 2003 that damages exceeded Zurich's policy limits, such that Zurich should have tendered its limits in 2002. Damages were reasonably clear to Zurich even without knowing the precise dollar value of every element of damages. The Trial Court found that all Zurich had to do was determine if damages exceeded its policy limits, and both Crawford and Zurich readily made that determination without reference to medical expenses.[24] But even under the October 2003 date identified by the Trial Court, Zurich should have taken steps toward settlement much earlier than it did. The tender did not take place until more than three months

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[23] As argued above, had Zurich complied with its own guidelines and policies, or listened to its agent, Crawford, it would have realized by September 2002 that the claim was worth at least $5 million.

[24] The Trial Court's finding that the amount of medical expenses "could not have been reasonably clear at least until August 13, 2003 when the Rhodes made their written settlement demand" is clearly erroneous. App., Vol. I, p. 45. Had Zurich or its agents requested or subpoenaed Marcia Rhodes' billing records, the calculation of medical expenses would have been straightforward. Indeed, the UMass Medical Center bills and records were readily available in April 2002. Patten App., Vol. III, p. 1015. The only confusion on medical expenses resulted from the Rhodes' health insurer's tally of charges, which overstated expenses. App., Vol. I, p. 25 n.5.

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later, and Zurich did not make a settlement offer until almost six months later.

The Trial Court bent over backwards to make excuses for Zurich's delays. First, it found that the Rhodes' demand was sent and McIntosh was taken off the claim in "August, the slowest summer month of the year." Id. at 46. Next, Kathleen Fuell sought approval to tender the policy limits in "the busy holiday season between Thanksgiving and New Year's Day." Id. at 51. The statute provides no leeway for these feeble excuses, which are trivial and insulting in light of the catastrophic injuries for which the Rhodes family was awaiting fair compensation.

The Trial Court also adopted a "blame the victim" rationale to shift responsibility for Zurich's sluggishness to the Rhodes family. Under the Order, for plaintiffs to really be protected by c. 176D, they must first comply with an affirmative obligation to make a c. 93A demand: The "Rhodes' attorney chose not to characterize their . . . August 13, 2003 [demand] as a demand . . . under G.L. c. 176D/[93A] . . . [Zurich] was under no statutory deadline ... and lacked the urgency that would have been stimulated by such a deadline." Id. at 50. This ruling eviscerates the legislative intent and represents yet another clear legal error - Chapter 176D, § 3(9)(f) mandates "prompt" settlement efforts - that imposes both statutory "urgency" and a deadline.

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Even under the facts found by the Trial Court, Zurich "had reason to know of its liability for [the Rhodes] claim under its insurance policy with [GAF] several months prior to its receipt of [Plaintiffs'] demand letter, yet it failed to settle [the] claim or tender its policy at that time or for more than a year thereafter." Cohen, 41 Mass. App. Ct. at 756. Accordingly, Zurich must be found to have willfully and knowingly violated c. 176D and punitive damages must be awarded under c. 93A. Id.

C. Zurich Cannot Hide Behind National Union to Avoid Liability.

The Trial Court found Zurich was not liable because even if it had acted sooner, the case would not have settled. App., Vol. I, pp. 36-37. This reasoning has already been rejected: "Whether a settlement is eventually reached or not, unjust delay subjects the claimant to many of the costs and frustrations that are encountered when litigation must be instituted and no settlement is reached." Clegg, 424 Mass. at 419. Because "injury" is broader than simply causing a trial on the merits, and includes the frustrations involved in making a claim, filing suit, depleting assets to pay expenses resulting from injuries, waiting for insurers to investigate, making a demand, and being ignored for two years, Zurich is liable for its violation of c. 176D, irrespective of the independently unlawful actions of NU/AIGDC.

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In addition, Zurich and NU/AIGDC's wrongful conduct overlapped from January to March 2004 when they sparred over who would pay the defense lawyers going forward. App., Vol. I, 33-36. Just as the Trial Court found AIGDC could not rely on the ambiguity of who would pay for the defense to delay its obligation to comply with c. 176D, neither can Zurich. Id. at 49. The Trial Court recognized that the insurers must place plaintiffs' interests before their own and focus on settling the claim first, and resolving their own disputes later.[25]

Zurich's statutory violations caused both injury and damages to the Rhodes family. While Zurich and NU/AIGDC are jointly and severally liable to the Rhodes family for compensatory damages, Kattar v. Demoulas, 433 Mass. 1, 15 (2000), Zurich is independently liable to the Rhodes family for $22.7 million in punitive damages. Int'l Fid. Ins. Co. v. Wilson, 387 Mass. 841, 857-58 (1983) (plaintiff not limited to single punitive award; punitive damages are imposed separately to fulfill legislative intent).

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[25] See, e.g., Premier Ins. Co. of Massachusetts v. Jean E. Furtado, 428 Mass. 507, 510 (1998) (insurer filed declaratory judgment action to resolve dispute, and therefore did not violate c. 176D); National Union Fire Ins. Co. v. American Motorists Ins. Co., 504 S.E.2d 673, 675 (Ga. 1998) (noting "the better policy is to encourage insurers to promptly protect their insureds' interests and to hold disputes among themselves in abeyance"); Zurich American Ins. Co. v. Pennsylvania Mfrs. Ass'n Ins. Co., No. A-4260-01T1, 2003 WL 23095605 (N.J. Super. Ct. App. Div. May 7, 2003) (Zurich sought declaratory judgment regarding liability for defense costs).

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CONCLUSION

The Rhodes family hereby requests that this Court reverse the Superior Court's decision, in part, and order that the Superior Court:

1. Enter judgment in favor of Plaintiffs and against NU/AIGDC, awarding double the amount of the underlying judgment, $22,730,668, as required by G.L. c. 93A, § 9;

2. Amend judgment in favor of Plaintiffs and against NU/AIGDC, awarding lost use of money damages to total $991,645.71;

3. Enter judgment in favor of Plaintiffs and against NU/AIGDC, awarding compensatory damages for pre- and post-judgment "frustrations of litigation" including emotional distress;

4. Issue findings and enter judgment in favor of Plaintiffs and against Zurich, awarding compensatory damages for "frustrations of litigation" including emotional distress;

5. Enter a separate judgment against Zurich for a knowing and willful violation of G.L. c. 176D and awarding double the amount of the underlying judgment, $22,730,668, as required by G.L. c. 93A, § 9; and

6. Remand this matter to the Trial Court to determine the reasonable costs and attorneys' fees the Plaintiffs shall recover for pursuing claims against Zurich.

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Respectfully submitted,

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ADDENDUM.

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ADDENDUM

MASSACHUSETTS GENERAL LAWS

Chapter 93A: Section 2. Unfair practices; legislative intent; rules and regulations

Section 2. (a) Unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful.

(b) It is the intent of the legislature that in construing paragraph (a) of this section in actions brought under sections four, nine and eleven, the courts will be guided by the interpretations given by the Federal Trade Commission and the Federal Courts to section 5(a)(1) of the Federal Trade Commission Act (15 U.S.C. 45(a)(1)), as from time to time amended.

(c) The attorney general may make rules and regulations interpreting the provisions of subsection 2(a) of this chapter. Such rules and regulations shall not be inconsistent with the rules, regulations and decisions of the Federal Trade Commission and the Federal Courts interpreting the provisions of 15 U.S.C. 45(a)(1) (The Federal Trade Commission Act), as from time to time amended.

Chapter 93A: Section 9. Civil actions and remedies; class action; demand for relief; damages; costs; exhausting administrative remedies

Section 9. (1) Any person, other than a person entitled to bring action under section eleven of this chapter, who has been injured by another person's use or employment of any method, act or practice declared to be unlawful by section two or any rule or regulation issued thereunder or any person whose rights are affected by another person violating the provisions of clause (9) of section three of chapter one hundred and seventy-six D may bring an action in the superior court, or in the housing court as provided in section three of chapter one hundred and eighty-five C whether by way of original complaint, counterclaim, cross-claim or third party action, for damages and such equitable relief, including an injunction, as the court deems to be necessary and proper.

(2) Any persons entitled to bring such action may, if the use or employment of the unfair or deceptive act or practice has caused similar injury to numerous other persons similarly situated and if the court finds in a preliminary hearing that he adequately and fairly represents such other persons, bring the action on

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behalf of himself and such other similarly injured and situated persons; the court shall require that notice of such action be given to unnamed petitioners in the most effective practicable manner. Such action shall not be dismissed, settled or compromised without the approval of the court, and notice of any proposed dismissal, settlement or compromise shall be given to all members of the class of petitioners in such manner as the court directs.

(3) At least thirty days prior to the filing of any such action, a written demand for relief, identifying the claimant and reasonably describing the unfair or deceptive act or practice relied upon and the injury suffered, shall be mailed or delivered to any prospective respondent. Any person receiving such a demand for relief who, within thirty days of the mailing or delivery of the demand for relief, makes a written tender of settlement which is rejected by the claimant may, in any subsequent action, file the written tender and an affidavit concerning its rejection and thereby limit any recovery to the relief tendered if the court finds that the relief tendered was reasonable in relation to the injury actually suffered by the petitioner. In all other cases, if the court finds for the petitioner, recovery shall be in the amount of actual damages or twenty-five dollars, whichever is greater; or up to three but not less than two times such amount if the court finds that the use or employment of the act or practice was a willful or knowing violation of said section two or that the refusal to grant relief upon demand was made in bad faith with knowledge or reason to know that the act or practice complained of violated said section two. For the purposes of this chapter, the amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence, regardless of the existence or nonexistence of insurance coverage available in payment of the claim. In addition, the court shall award such other equitable relief, including an injunction, as it deems to be necessary and proper. The demand requirements of this paragraph shall not apply if the claim is asserted by way of counterclaim or cross-claim, or if the prospective respondent does not maintain a place of business or does not keep assets within the commonwealth, but such respondent may otherwise employ the provisions of this section by making a written offer of relief and paying the rejected tender into court as soon as practicable after receiving notice of an action commenced under this section. Notwithstanding any other provision to the contrary, if the court finds any method, act or practice unlawful with regard to any security or any contract of sale of a commodity for

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future delivery as defined in section two, and if the court finds for the petitioner, recovery shall be in the amount of actual damages.

(3A) A person may assert a claim under this section in a district court, whether by way of original complaint, counterclaim, cross-claim or third-party action, for money damages only. Said damages may include double or treble damages, attorneys' fees and costs, as herein provided. The demand requirements and provision for tender of offer of settlement provided in paragraph (3) shall also be applicable under this paragraph, except that no rights to equitable relief shall be created under this paragraph, nor shall a person asserting a claim hereunder be able to assert any claim on behalf of other similarly injured and situated persons as provided in paragraph (2).

(4) If the court finds in any action commenced hereunder that there has been a violation of section two, the petitioner shall, in addition to other relief provided for by this section and irrespective of the amount in controversy, be awarded reasonable attorney's fees and costs incurred in connection with said action; provided, however, the court shall deny recovery of attorney's fees and costs which are incurred after the rejection of a reasonable written offer of settlement made within thirty days of the mailing or delivery of the written demand for relief required by this section.

[There is no paragraph (5).]

(6) Any person entitled to bring an action under this section shall not be required to initiate, pursue or exhaust any remedy established by any regulation, administrative procedure, local, state or federal law or statute or the common law in order to bring an action under this section or to obtain injunctive relief or recover damages or attorney's fees or costs or other relief as provided in this section. Failure to exhaust administrative remedies shall not be a defense to any proceeding under this section, except as provided in paragraph seven.

(7) The court may upon motion by the respondent before the time for answering and after a hearing suspend proceedings brought under this section to permit the respondent to initiate action in which the petitioner shall be named a party before any appropriate regulatory board or officer providing adjudicatory hearings to complainants if the respondent's evidence indicates that:

(a) there is a substantial likelihood that final action by the court favorable to the petitioner would require

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of the respondent conduct or practices that would disrupt or be inconsistent with a regulatory scheme that regulates or covers the actions or transactions complained of by the petitioner established and administered under law by any state or federal regulatory board or officer acting under statutory authority of the commonwealth or of the United States; or

(b) that said regulatory board or officer has a substantial interest in reviewing said transactions or actions prior to judicial action under this chapter and that the said regulatory board or officer has the power to provide substantially the relief sought by the petitioner and the class, if any, which the petitioner represents, under this section.

Upon suspending proceedings under this section the court may enter any interlocutory or temporary orders it deems necessary and proper pending final action by the regulatory board or officer and trial, if any, in the court, including issuance of injunctions, certification of a class, and orders concerning the presentation of the matter to the regulatory board or officer. The court shall issue appropriate interlocutory orders, decrees and injunctions to preserve the status quo between the parties pending final action by the regulatory board or officer and trial and shall stay all proceedings in any court or before any regulatory board or officer in which petitioner and respondent are necessarily involved. The court may issue further orders, injunctions or other relief while the matter is before the regulatory board or officer and shall terminate the suspension and bring the matter forward for trial if it finds (a) that proceedings before the regulatory board or officer are unreasonably delayed or otherwise unreasonably prejudicial to the interests of a party before the court, or (b) that the regulatory board or officer has not taken final action within six months of the beginning of the order suspending proceedings under this chapter.

(8) Except as provided in section ten, recovering or failing to recover an award of damages or other relief in any administrative or judicial proceeding, except proceedings authorized by this section, by any person entitled to bring an action under this section, shall not constitute a bar to, or limitation upon relief authorized by this section.

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Chapter 176D: Section 3. Unfair methods of competition and unfair or deceptive acts or practices

Section 3. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:—

(1) Misrepresentations and false advertising of insurance policies: making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement which:—

(a) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(b) Misrepresents the dividends or shares of the surplus to be received on any insurance policy;

(c) Makes any false or misleading statements as to the dividends or share or surplus previously paid on any insurance policy;

(d) Misleads or misrepresents the financial condition of any person or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) Misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally: making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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(3) Defamation: making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) Boycott, coercion and intimidation: entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; any refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility's or provider's contracts or affiliations with any other nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or any nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to any health care facility or provider at a level equal to the lowest price paid to such facility or provider under a contract with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or government payor.

(5) False statements and entries: (a) knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person; or (b) knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Stock operations and advisory board contracts: issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

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(7) Unfair discrimination: (a) making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or (b) making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(8) Rebates: Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any insurance contract, including but not limited to a contract for life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract, or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in clauses (7) or (8) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:—(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payment directly to an office of the insurer in the amount which fairly represents the saving in collection expenses; (iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense

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experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices: An unfair claim settlement practice shall consist of any of the following acts or omissions:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) Failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) Making claims payments to insured or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) Making known to insured or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements of compromises less than the amount awarded in arbitration;

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(l) Delaying the investigation or payment of claims by requiring that an insured or claimant, or the physician of either, submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) Failing to settle claims promptly, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) Failing to provide promptly a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failure to maintain complaint handling procedures; failure of any person to maintain a complete record of all of the complaints which it has received since the date of its last examination, which record shall indicate in such form and detail as the commissioner may from time to time prescribe, the total number of complaints, their classification by line of insurance, and the nature, disposition, and time of processing of each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance. Agents, brokers and adjusters shall maintain any written communications received by them which express a grievance for a period of two years from receipt, with a record of their disposition, which shall be available for examination by the commissioner at any time.

(11) Misrepresentation in insurance applications: making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurers, agent, broker, or individual.

(12) Any violation of sections ninety-five, two B, one hundred eighty-one, one hundred eighty-two, one hundred eighty-three, one hundred eighty-seven B, one hundred eighty-seven C, one hundred eighty-seven D, one hundred eighty-nine, one hundred ninety-three E, or one hundred ninety-three K of chapter one hundred seventy-five.

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COMMONWEALTH OF MASSACHUSETTS

BARNSTABLE, SS. SUPERIOR COURT
C.A. NO. 02-557

CARMELA HAUPTMAN
PLAINTIFF

VS.

ST. PAUL INSURANCE COMPANIES & OTHERS[1]
DEFENDANTS

FINDINGS OF FACT, RULINGS OF LAW, AND ORDER FOR JUDGMENT

This action arises out of a negligence claim brought by the plaintiff, Carmela Hauptman ("Hauptman"), against the defendant, St. Paul Insurance Fire & Marine Companies ("St. Paul"). At all times relevant, St. Paul was the general liability insurer of the lodging facility known as the Flagship Motor Inn ("Flagship"), located in West Yarmouth, Massachusetts. Hauptman was injured when she tripped and fell at the Flagship in September of 1999. Nearly five years after the plaintiff was injured, the parties settled her claim for $95,000. Hauptman now brings this action under G. L. c. 93A and G. L. c. 176D, alleging that the defendant engaged in unfair and deceptive claim settlement practices.

Based upon all of the credible evidence presented at the trail of this action, the Court makes the following findings of fact and rulings of law.

FINDINGS OF FACT

Carmela Hauptman resides in Garnersville, New York. St. Paul is a corporation organized under the laws of the state of Minnesota and is engaged in the business of insurance in Massachusetts and is an insurer within the meaning of G. L. c. 93A and G. L. c.

[1] Flagship Motor Inn, Ltd., Flagship Hotel Investors, LLC, Bellevue Properties, Inc.

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176D. St. Paul's insured, the Flagship Motor Inn, is a resort motel located at 343 Main Street in West Yarmouth, Massachusetts. On September 9, 1999, Hauptman was a member of a senior citizen tour group visiting Cape Cod and staying at the Flagship. Around 9 PM on this date, Hauptman's group arrived at the Flagship. Hauptman got off the charter bus and was the first member of the group to enter the rear entrance of the Flagship. As Hauptman entered the Flagship, she tripped, lost her balance, and fell, striking the door jam with her left shoulder. She recalls that the rear entrance was completely dark when she entered. Flagship became aware of Hauptman's fall within minutes of its occurrence.

Shortly after the plaintiff's fall, Flagship presented Hauptman's claim to St. Paul. In September of 1999, St. Paul forwarded the claim to its third-party claims administrator, Carl Warren & Co. ("Carl Warren"), an entity authorized by St. Paul to negotiate, adjust, and settle claims against St. Paul's insureds. Carl Warren assigned the claim to an adjuster named Richard McAbee ("McAbee"). McAbee engaged a local investigatory firm, Norfield Associates ("Norfield") to investigate the claim. On September 23, 1999, Norfield sent its report to McAbee. (Exhibit 4). Attached to the report were nine photographs, two handwritten reports discussing the September 9, 1999 incident, and a blank "PM Maintenance Nightly Checklist." The report stated in part that:

> At the time of our investigation, we were informed by Mr. Forte that these are light sensitive lights and come on when light is no longer sufficient. He indicated that these lights come on at approximately 7:00 PM and are checked by the PM maintenance staff daily. (Ex. 4, p. 2).

The first handwritten note, signed by Angela Donegan, a front desk employee, and the general manager of the property, Philip Forte ("Forte") states:

> On September 9, 1999 Mrs. Hauptman fell in the walkway of

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> the hotel entrance when she fell she hit her head off of the metal door frame. One of the other members from the bus called the front desk to let me know about the accident. I ask if she needed medical treatment and she refused at first. About 10 minutes later another member from the bus tour came down to the front desk and ask for 911 to be called. The time of the accident report was 9:14 p.m. (Exhibit 4).

The second handwritten statement, given by Neil Sullivan ("Sullivan"), security at the Flagship the night Hauptman fell, and signed by Forte, states:

> On September 9, 1999, I was informed by a Mrs. Carmela Hauptman that she injured herself upon entering the back entrance of the Flagship Inn. She stated, she tripped upon entering the building. After carefully, looking where she tripped there were no signs of any loose debris or any foreign objects. The area was lite [sic] well at the time and there were no other incidents of this kind. (Ex. 4, last 3 pp.)

The "PM Maintenance Nightly Checklist" had "checklist" items, but it was blank, without any indication that such tasks had been completed. Carl Warren also received a typed and handwritten document that stated, in part:

> WE THE UNDERSIGNED ATTEST TO THE ABSENCE OF LIGHTING IN THE ENTRANCE WAY TO THE FLAGSHIP MOTOR INN AT APPROXIMATELY 9:00 PM. ON SEPTEMBER 9, 1999 WHICH RESULTED IN THE FALL AND INJURY TO CARMELA HAUPTMAN.

This document was signed by other members of the tour group, who were also staying at the Flagship at the time of Hauptman's fall. (Ex. 18).

In January 2000, Hauptman engaged Attorney David W. Krumsiek ("Krumsiek ") to prosecute her claim. On February 4, 2000, Krumsiek sent a letter of representation to Carl Warren (Ex. 22). By letter dated March 2, 2000, Richard McAbee informed David W. Krumsiek that:

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> We have completed our investigation into the above captioned matter and have determined that the light bulb in question had burned out. The light bulb had been inspected by the maintenance staff on the previous day. Your client's accident was our first notice that the light bulb was not working. It has been verified that the light bulb was out at the time that your 79-year-old client sustained her injury. I shall await your client's medical package at your convenience. (Exhibit 2).

McAbee later admitted that he had no factual basis for his representation that the "light bulb had been inspected by the maintenance staff on the previous day . . . [and Plaintiff's] accident was our first notice that the light bulb was not working." McAbee's claim file note from August 22, 2000 indicates that Sullivan told McAbee that there was never any indication that the light was out and that "[Sullivan] made his rounds and all the lights were working." In the August 22, 2000 note, McAbee also mentioned that "[t]he hotel does not have any maintenance records on the lights involved" and that "Sullivan is no longer employed with [Flagship]. Left on bad terms." (Exhibit 1, p. 18).

Based on McAbee's claim file notes, Carl Warren believed that it had a two pronged defense based on causation of the injuries and the notice issue on the light. Sullivan was considered a critical witness to a defense predicated on notice. Between November 2000 and February 2001, McAbee continued to try to track down Sullivan and obtain a signed statement from him. On February 27, 2001, Norfield forwarded a "Final Report" to McAbee indicating that Sullivan stated that the lights were not working on the evening of the claimant's accident and that the manager, Forte, was aware of the fact as he had the lights repaired the day following the accident. The attorney retained by Flagship, Roger Donahue ("Donahue") informed the defendant of his view that Sullivan's change in position about the light was not credible. In addition, there was some suggestion in McAbee's claim notes that

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Sullivan was being uncooperative because he had been terminated from his position at the Flagship.

In January 2002, St. Paul transferred the claim file to another third-party claims administrator, Certus Claims Administration, LLC ("Certus"), and Rose Mary Jiminez ("Jiminez") was assigned to the file. On April 18, 2002, Jiminez received a settlement demand package from Krumsiek, containing documentation evidencing medical damages exceeding $28,000.00. The demand package also included medical notes and reports, a narrative report from Hauptman's orthopedic surgeon (Peter McCann, M.D.) causally relating a full thickness tear of the plaintiff's left rotator cuff to the fall on September 9, 1999. Based upon all of this, Krumsiek made a demand for settlement in the amount of $250,000.

On July 1, 2002, Jiminez requested settlement authority for $25,000. On July 17, 2002, she offered Krumsiek $5,000 in settlement of the claim. Krumsiek rejected the offer. On August 23, 2002, Krumsiek sent a demand letter to St. Paul and to Certus, pursuant to G. L. c. 93A, alleging unfair and deceptive insurance claims practices in violation of G. L. c. 176D and G. L. c. 93A. In November 2002, the defendant's "Staff Attorney Assessment Report" indicated a most likely verdict of $90,000. (Exhibit 7, p. 187). In January 2003, the defendant's staff attorney sent a letter to Jiminez indicating potential liability of $200,000 in the event of a negligence finding against St. Paul. (Exhibit 6, p. 61). In March 2003, based on this letter, Jiminez recommended increasing the reserve to $100,000. St. Paul then increased the reserve amount from $24,500 to $100,000.

Despite the increase in the reserve, Jiminez did not increase the $5,000 offer because she believed that liability and damages were "questionable." (Exhibit 13, p. 73). She

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believed that liability was questionable because of the possible "notice" defense. (Exhibit 13, p. 73). Jiminez thought that damages were questionable because Hauptman was elderly and had "various complaints of injury." (Exhibit 13, p. 74). The defendant believed that a subsequent accident suffered by the plaintiff in August of 2000 might be the cause of some of the injury to her shoulder. However, in her deposition testimony, taken June 6, 2003, Hauptman indicated that the August 2000 injury did not involve a fall; rather, she twisted her ankle. On October 1, 2003, the defendant's Staff Attorney continued to indicate a most likely verdict (client's share) of $90,000 and recommended suit disposition of $45,000. During this time, Jiminez never increased the settlement offer above $5,000. On October 6, 2003, Jiminez noted in the claim file that "if judge pushes us to settle we have $25,000 in settlement authority that should be sufficient to resolve claim." (Exhibit 6, p. 115). It appears that as of late 2003-early 2004, the defendant began taking the claim seriously and during this time deposed both Forte and Dr. McCann.

On January 19, 2004, the defendant's Staff Attorney's assessment suggested that it had verified medical expenses in the amount of $31,955 and indicated a most likely verdict (client's share) of $150,000 and recommended suit disposition of $60,000. (Exhibit 10, p. 211, 222). On January 20, 2004, Jiminez noted in the claim file that "we will start negotiations by offering specials claimed of $28,912 . . . and go up slowly from there." It was in this January 2004 Assessment that the defendant first mentioned having a settlement strategy. Jiminez admitted in her deposition that she hoped to settle the claim well short of the amount at which counsel had valued Hauptman's claim. (Exhibit 13, p. 99).

In January 2004, Hauptman successfully moved the Court for a spoliation order pertaining to the Flagship's failure to maintain the alleged inspection records. (Moses, J.).

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In addition, her motion for leave to amend the complaint to allege violations of G. L. c. 93A and G. L. c. 176D was allowed. The allowance of the plaintiff's motions led Jiminez to request an increase in settlement authority to $75,000. On February 19, 2004, Jiminez offered Krumsiek $28, 372 in settlement of the claim. The plaintiff rejected this offer. On March 8, 2004, plaintiff's co-counsel reduced the plaintiff's demand to $225,000, and Jiminez countered with a $35,000 settlement offer. Again, Hauptman rejected this offer. Five months later, on August 29, 2004, Jiminez offered $95,000 to settle the claim. Hauptman accepted this offer. Hauptman would have accepted a $95,000 settlement offer at any point during the claim settlement process. (Exhibit 19).

Based on all of the foregoing, Hauptman maintains that St. Paul engaged in unfair and deceptive claims settlement practice in violation of G. L. c. 93A and G. L. c. 176D. The plaintiff specifically cites the following as evidence of the defendant's unfair and deceptive conduct: (1) the defendant's lack of investigative materials supporting its notice defense; (2) the lack of factual basis to support any causality defense; (3) the fact that the defendant did not increase the settlement offer, in spite of increase in reserves, increases in settlement authority, and the opinions of defendant's counsel indicating substantial exposure; (4) Dr. McCann's narrative report establishing a causal connection between Hauptman's accident and the injury; and (5) the defendant's desire, evidenced through the actions of its third-party claim administrators, to drag out the settlement process by low balling the settlement amount and to settle well-below the amount at which the claim had been assessed.

RULINGS OF LAW

A. Standard of Review

Chapter 93A, § 2(a) states that "[u]nfair methods of competition and unfair or

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deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful." Chapter 176D, § 3, relating to the insurance industry, prohibits "unfair or deceptive acts or practices in the business of insurance," including in subsection (9)(f) the failure "to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." The prohibitions set forth in G. L. c. 176D, § 3 (9) "were enacted to encourage settlement of insurance claims . . . and discourage insurers from forcing claimants into unnecessary litigation to obtain relief." Hopkins v. Liberty Mut. Ins. Co., 434 Mass. 556, 567-568 (2001), quoting Clegg v. Butler, 424 Mass. 413, 419 (1997). They specifically were "designed to remedy a host of possible violations in the insurance industry and [were imported to G. L. c. 93A by virtue of St. 1979, c. 406, § 1, amending G. L. c. 93A, § 9 (1),] to subject insurers committing violations to the remedies available to an injured party under G. L. c. 93A." Hopkins v. Liberty Mut. Ins. Co., 434 Mass. at 562. See Bobick v. United States Fid. & Guar. Co., 439 Mass. 652, 659 (2003); Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. 115, 121 (1994).

An insurance company is held to the duty of good faith and fair dealing as defined under G. L. c. 176D § 3(9), whether it is dealing with its insured or third-party claimants. Bobick v. U.S. Fidelity and Guar. Co., 439 Mass. at 658-659. An insurer breaches this duty by "failing to effectuate prompt, fair, and equitable settlements of claims when liability has become reasonably clear." G. L. c. 176D, § 3(9)(f). See Hopkins v. Liberty Mut. Ins. Co., 434 Mass. at 564. Liability for the purposes of G. L. c. 176D § 3(9)(f) encompasses both fault and damages. Clegg v. Butler, 424 Mass. at 421. Whether a defendant's liability is "reasonably clear" calls for an objective standard of inquiry into the facts and the applicable law. See Van Dyke v. St. Paul Fire & Marine Ins. Co., 388 Mass. 671, 677 n. 8 (1983). The

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reasonably clear standard is invoked when liability becomes objectively clear, not when liability becomes certain. See Demeo v. State Farm Mutual Auto Insurance Co., 38 Mass. App. Ct. at 955-957 (objective test calls upon the fact finder to determine whether a reasonable person, with knowledge of the relevant facts and law, would probably have concluded, for good reason, that the insurer was liable to the plaintiff).

Where liability is not reasonably clear, an insurer need not make any offer in settlement. Id. at 956-957. Furthermore, the obligations of an insurer under §3 (9)(f) do not require it simply to "accede to the amount of plaintiff's demand even if liability has become reasonably clear." Forcucci v. U.S. Fidelity & Guar. Co., 817 F. Supp. 195, 202 (D. Mass. 1993). Rather, an insurer may seek the "best bargain." Id., quoting Curtis v. Duffy, 742 F. Supp. 34, 38 (D. Mass. 1990).

B. Was liability "reasonably clear"?

Hauptman argues that liability in this case became "reasonably clear" when Attorney Krumsiek submitted the demand letter dated April 15, 2002. According to the plaintiff, the demand letter outlined the plaintiff's theory of liability and damages, including copies of Hauptman's medical bills in excess of $28,000 and support from Dr. McCann that Hauptman's injuries were causally related to her fall on September 9, 1999. St. Paul disagrees and suggests that liability was not "reasonably clear" because even if it was proven that the light bulb was out, the plaintiff still had to prove that Flagship had notice of it. St. Paul believed that because there was no evidence that Flagship had advance notice of the lighting defect, it acted appropriately when offering only $5,000 to settle the claim.

Together, the two statutes require an insurer, such as St. Paul, "promptly to put a fair and reasonable offer on the table when liability and damages become clear, either within the

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thirty-day period set forth in G. L. c. 93A, § 9(3), or as soon thereafter as liability and damages make themselves apparent." Hopkins v. Liberty Mut. Ins. Co., 434 Mass. at 566. The standard for examining the adequacy of an insurer's response to a demand for relief under G. L. c. 93A, § 9(3) is "whether, in the circumstances, and in light of the complainant's demands, the offer is reasonable." Clegg v. Butler, 424 Mass. at 420, quoting Calimlim v. Foreign Car Ctr., Inc., 392 Mass. 228, 234 (1984).

Looking at the facts in this case, St. Paul should have made a reasonable offer within thirty days of April 18, 2002, or as soon after that date as liability and damages became apparent. Hopkins v. Liberty Mut. Ins. Co., 434 Mass. at 566. When Krumsiek sent the demand letter to St. Paul, he also sent medical records and evidence of medical expenses. The first settlement offer was made three months later, on July 17, 2002. Although the medical damages were estimated to be $28,000, the initial settlement offer was only $5,000. Giving St. Paul the benefit of the doubt, it is assumed that at this point in time, the defendant did not believe that liability was reasonably clear.

However, as of March 2003, there were quite a few notations in the claim file indicating that liability on the part of the insured was in the range of $90,000. In fact, at this time, Jiminez had asked to increase the reserve from $25,000 to $100,000 and the defendant's staff attorney had listed the gross exposure of the claim at $250,000 with liability at 50/50 with a potential jury verdict against the insured at $90,000. Even so, Jiminez never increased the settlement offer above $5,000. It was not until over a year later, in August of 2004 that Jiminez offered the plaintiff $95,000.

Throughout the rest of 2003, the defendant continued to gather discovery by deposing Hauptman, Forte, and Dr. McCann. By the time the defendant's staff attorney updated the

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assessment report in January 2004, investigation of the claim had concluded. The plaintiff's medical expenses had been verified in the amount of nearly $32,000 and liability was assessed at $150,000, with settlement recommended as a viable option. These facts suggest that at least as early as January 2004, liability in the amount of $90,000 was "reasonably clear." All of these facts suggest that the defendant's repeated offer to settle for $5,000 was not reasonable. The court notes that, on January 20, 2004, Jiminez noted in the claim file that "we will start negotiations by offering specials claimed of $28,912 . . . and go up slowly from there." Liability was not only reasonably clear as of that date, but the proposed offer was intentionally low and the negotiation process was to be intentionally prolonged.

By comparing the instant case to Bobick v. United States Fid. & Guar. Co., it becomes very clear that St. Paul's offer of $5,000 was unreasonable. 439 Mass. at 662. The plaintiff in Bobick argued that the defendant's $50,000 offer of settlement was neither fair nor equitable. Id. The court however found that this offer was "reasonable as a matter of law" and also found it significant that the offer extended by the insurer (and rejected by the plaintiff) was only $10,000 less than the principal amount assessed by the jury. Id. While Hauptman's claim did not get to a jury, the amount offered by St. Paul ($5,000) was dramatically lower than both the amount authorized for settlement (ranging between $25,000 and $100,000) and the $95,000 eventually offered to Hauptman. Unlike the $50,000 offered in Bobick, the offer made by St. Paul in this case was not reasonable as a matter of law.

Given the unreasonableness of St. Paul's offer, as well as the nearly five year period between Hauptman's injury and the $95,000 offer eventually made by St. Paul, this court finds that the defendant failed to promptly put a fair and reasonable offer on the table after liability and damages had become reasonably clear. The evidence indicates that the

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defendant dragged its feet throughout the entire claims process, hoping to settle Hauptman's claim for far less than it was estimated to be. Objective bad faith may be found where a potential defendant offers "much less than a case is worth in a situation where liability is either clear or highly likely." See Guity v. Commerce Ins. Co., 36 Mass. App. Ct. 339, 343 (1994). Here, the claim file notes and the deposition testimony from Jiminez suggest that St. Paul was not acting in good faith in settling Hauptman's claim. The cause of the Chapter 93A damages in this case was St. Paul's delay in making a reasonable settlement offer until August 24, 2004. Liability was reasonably clear as of January 19, 2004; therefore damages will be assessed as of that date.

C. Damages and Attorney Fees and Costs

In an action brought under G. L. c. 93 against an insurer for unfair settlement practices, in which the parties settled and thus no judgment entered, the damages are to be calculated based on the lost interest on the money unlawfully withheld. Clegg v. Butler, 424 Mass. at 423-425. A plaintiff is entitled to recover, as damages under 93A and 176D, the value of the loss of use of monies, at a fair rate of interest. See Clegg v. Butler, 424 Mass. at 425; Bertassi v. Allstate Ins. Co., 402 Mass. 366 (1988). A fair rate of interest is the judgment rate of twelve (12%) per cent. Patry v. Liberty Mobilehome Sales, Inc., 394 Mass. 270, 273 (1985), citing G. L. c. 231, § 6B.

Hauptman's Chapter 93A damages arise from the loss of the use of the $95,000 settlement amount from January 19, 2004, until St. Paul made the offer on August 24, 2004. Hopkins v. Liberty Mut. Ins. Co., 434 Mass. at 567; Clegg v. Butler, 424 Mass. at 424-425. Twelve percent of $95,000 for eight months (January – August) is $7,467. Because St. Paul's violation was willful and knowing, the Court may double or treble the interest. See

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Bertassi v. Allstate Ins. Co., 402 Mass. at 372-373. The history of the settlement, the delay and inadequate offers warrants imposition of triple damages. Accordingly, after tripling Hauptman's loss of use of the money, her damages are $22,401.00.

The plaintiff is also entitled under G. L. c. 93A § 9(4) to recover her reasonable attorneys fees and costs that are fairly attributable to the Chapter 93A claim and proportionate to the Chapter 93A damages. Lane v. Commerce Ins. Co., Civil No. 01-0385 (Plymouth Super. Ct. May 8, 2003) (Hely, J.), citing Linthicum v. Archambault, 379 Mass. 381, 388-389 (1979).

ORDER

A judgment shall enter for the plaintiff with damages in the amount of $22,401.00. Plaintiff's counsel may submit an affidavit of reasonable attorney fees and costs attributable to a successful Chapter 93A claim within thirty days of notice of this order. Defense counsel shall have fourteen days to respond to the plaintiffs' submission.

By the court (Quinlan, J.)

1st Assistant Clerk

Date: April 6, 2006

A true copy, Attest:

Clerk

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Tallent v. Liberty Mut. Ins. Co.Mass.Super.,2005.Only the Westlaw citation is currently available.Raymond TALLENT, and another,[FN1] Plaintiffs

FN1. Alice Tallent

v.

LIBERTY MUTUAL INSURANCE COMPANY, Defendant

No. Civ.A.1997-1777H.

April 22, 2005.

FINDINGS OF FACT, RULINGS OF LAW AND ORDER FOR JUDGMENT

HAGGERTY, J.

INTRODUCTION

*1 The plaintiffs, Raymond and Alice Tallent ("the Tallents"), bring this G.L. c. 93A claim against the defendant, Liberty Mutual Insurance Company ("Liberty Mutual"), for violations of G.L. c. 176D. In the underlying action, the Tallents sued Turner Construction Company, Inc., ("Turner"), an insured of Liberty Mutual, for negligently erecting scaffolding that collapsed and caused permanent injuries to Mr. Tallent. The Tallents allege that Liberty Mutual violated G.L. c. 176D by refusing to settle without conducting a reasonable investigation and failing to settle their claim despite the fact that Turner's liability was reasonably clear. After a trial, without a jury, and based upon all the credible evidence, the court makes the following findings of fact and rulings of law.

FINDINGS OF FACT

I make the following factual findings based on the exhibits and testimony produced at trial.

A. *The Trial, The Post-Trial Motions And The Appellate Proceedings.*

On April 9, 1986, Raymond Tallent, an iron worker was injured at a construction site for a new office building at 150 Federal Street, Boston, Massachusetts. Raymond Tallent crashed to the ground from unsecured scaffolding which ultimately rendered him permanently disabled and unable to work. Turner was the general contractor and was responsible for ensuring safety at the construction site. Turner was insured by the defendant, Liberty Mutual.

Raymond Tallent and his wife Alice Tallent filed suit against Turner in November 1986 seeking damages for Mr. Tallent's injuries and Mrs. Tallent's loss of consortium, resulting from Turner's negligent construction and maintenance of the scaffolding and planking which Raymond Tallent was using at the time of the accident. Turner filed third party claims against Raymond Tallent's employer, Dorel Steel Erection Corporation ("Dorel") and Owen Steel Company, Inc. ("Owen"), the steel fabricator for the project on claims for contractual indemnification. Dorel was a sub-contractor to Owen and Owen was a sub-contractor to Turner. Prior to trial, Turner admitted in its answers to interrogatories that it had erected the scaffolding. At trial, Turner's defense was three-fold: Raymond Tallent was negligent, which the jury rejected; the planking for the scaffolding did not belong to Turner, despite the fact that there was testimony that Turner employees erected the scaffolding, there were admissions in answers to interrogatories that Turner erected the scaffolding, and there was testimony that Turner employees worked on the scaffolding in the area where the plaintiff fell shortly before his fall; and the damages claimed by Tallent were excessive, despite the fact that there was uncontroverted evidence that Raymond Tallent's past and future loss of earning capacity was in excess of $700,000 and Turner conceded that Raymond Tallent was permanently disabled from employment as an iron worker.

In addition to the negligence and consortium claims against Turner, the trial judge submitted special questions concerning the negligence of Dorel and Owen for a future determination by the court of contractual indemnification obligations. On October, 8, 1993, the jury returned a verdict against Turner for Raymond Tallent in the amount of $1,000,000 and for Alice Tallent in the amount of $100,000. The jury found negligence but no causation against Dorel and no negligence against Owen. The value of the verdict in October, 1993, including pre-judgment interest

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was $2,006,340.

*2 Prior to trial, Turner filed a motion in limine to preclude the introduction of evidence relating to insurance coverage. The motion was allowed. Turner also filed a motion in limine to exclude hearsay testimony that prior to the accident, an employee told Turner that the scaffolding was faulty. This motion was likewise allowed.

At trial, Raymond Tallent testified to the hearsay statement which was the subject matter of the motion in limine. Both parties objected, the objection was sustained and the jury were instructed to disregard the testimony. Turner moved for a mistrial which was denied. During the course of the testimony of an expert for the Tallents, the expert volunteered that he had done work for Liberty Mutual. Turner moved for a mistrial which was denied.

Turner filed post-trial motions raising, *inter alia*, the denial of the motions for a mistrial based upon the evidentiary issues, a motion for new trial on a claim that the verdict was against the weight of the evidence, and a request for judgment notwithstanding the verdict relating to the indemnification claims against Dorel and Owen. The trial judge heard the motions in November 1993 and denied the motions in a Memorandum of Decision and Order which was docketed on January 27, 1994. In his Memorandum of Decision, the trial judge concluded that "the prejudicial effect of the violations [of the court's orders on the motions in limine] was not such that declaration of a mistrial is warranted in view of the substantial evidence supporting the verdict." Turner filed a notice of appeal in February, 1994, after judgment issued on February 7, 1994.

The transcripts of the trial were completed in May, 1995. The Appeals Court heard oral argument on December 5, 1996. The centerpiece of Turner's appeal was the issue of contractual indemnity as evidenced by the allocation of more than the first two-thirds of the argument section of the brief to the topic. The final argument in the brief was a claim that the trial judge abused his discretion in failing to give a curative instruction upon mention by the witness of "Liberty Mutual," despite the absence of such a request at trial. Turner also claimed that the judge abused his discretion in failing to declare a mistrial when Raymond Tallent testified to a hearsay statement. Turner additionally claimed that the combined effect of the missteps warranted a new trial, as Turner did in its motion for a new trial before the trial judge.

The judgments of the Superior Court and the denial of Turner's motion for a new trial were affirmed in a Memorandum and Order Pursuant to Rule 1:28, entered on May 1, 1997. The Supreme Judicial Court denied Turner's Application for Further Appellate Review on July 3, 1997. On August 20, 1997, Liberty Mutual paid the Tallents $2,924,665, which included the judgment, and pre-judgment and post-judgment interest.

B. *The Relationship Between The Attorneys, The In-House Activities At Liberty Mutual, And The Negotiations To Settle.*

*3 At trial, during the pre-trial proceedings, and in post-trial motions, Attorney Ann Marie Maguire ("Maguire") represented the Tallents. Attorneys Henry DuLaurence ("DuLaurence") and Charles Mahanor ("Mahanor") of Liberty Mutual represented Turner. The relationship between Maguire and DuLaurence was acrimonious, at best, and somewhat less so between Maguire and Mahanor. Maguire and DuLaurence did not speak to each other. The "bad blood" between Maguire and DuLaurence found its source in two prior cases in which the attorneys represented opposing parties: Maguire for the plaintiffs and DuLaurence for Liberty Mutual. The intensity of the hostility in the Tallent case led to Maguire's filing an application for a temporary restraining order against DuLaurence sometime following the Tallent trial. The application was subsequently withdrawn. The hostile relationship between Maguire and DuLaurence, and to a lessor extent between Maguire and Mahanor infected some of Liberty Mutual's decisions during the pendency of the appeal.

The events between the filing of the notice of appeal in February, 1994, and the payment of the judgment in August, 1997, are the basis for the Tallents' claim against Liberty Mutual that it violated the provisions of G.L. c. 176D, § 3(9)(d) and (f). During the trial and up to some time in the fall of 1995, Philip McCarthy ("McCarthy") was employed by Liberty Mutual as a Regional Property Specialist who handled large claims against Turner. Since 1966, McCarthy had occupied a variety of positions with Liberty Mutual, including claims adjuster, claims manager and claims supervisor for the home office. McCarthy's responsibilities in the Tallent case included daily attendance at the trial to provide his independent observation and evaluation of the trial developments. At the end of each day, McCarthy

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entered his daily summary in Liberty Mutual's electronic claims log, the ACES system which was accessible to all Liberty Mutual employees involved in the case, including its attorneys. The summaries were written to Julien Savoie ("Savoie"), who was Liberty Mutual's Home Office Examiner. As early as September 29, 1993, McCarthy opined that there was little chance of a defense verdict. By the end of the trial, McCarthy and the defense attorneys believed that the Tallents would prevail against Turner. McCarthy was not surprised by the amount of the verdict but he was surprised by the defense verdicts for the sub-contractors, Dorel and Owen.

Turner filed post-trial motions relating to the evidentiary issues and a request for judgment notwithstanding the verdict relating to the indemnification and contribution claims against Dorel and Owen. The trial judge heard the motions in November 1993, and denied the motions in a Memorandum of Decision and Order which was docketed on January 27, 1994. McCarthy agreed with the trial judge's assessment of the effect of the evidentiary issues: despite the violation of the court's orders there was no prejudicial impact on the jury.

*4 In a memo to McCarthy from Mahanor dated February 2, 1994, Mahanor outlined what he believed were the grounds for appeal. In the memo, Mahanor stated that "[b]y taking an appeal of the denial of these [post-trial] motions, it may make counsel for the plaintiffs more amenable towards any potential settlement negotiations." In McCarthy's view, this latter statement was not a valid reason for pursuing an appeal.

Savoie, the Home Office Examiner became involved in the Tallent case at least as early as January 18, 1993. He was responsible for reviewing the work of the employees at the branch level of Liberty Mutual and for obtaining authorization for settlement of the cases, if appropriate. In his capacity as Home Office Examiner, Savoie reviewed and wrote ACES notes. Prior to trial, on January 18, 1993, Savoie admitted that "liability doesn't look very good for us since it appears the insured [Turner] may have set up and maintained the staging in question."

Following the denial of Turner's post-trial motions, Maguire began the campaign to be paid the amount of the judgment or, in the alternative, to settle the case for less than the judgment. Maguire first dealt with McCarthy approximately one to two weeks following the post-trial motions. She learned that Turner would appeal. Once the notice of appeal was filed, Maguire contacted Jerry Cook ("Cook"), an adjuster for Liberty Mutual and a troubleshooter for difficult cases. In the first round of telephone calls to Cook in the Spring of 1994, Maguire gave him a summary of the case and the trial, described the animosity with DuLaurence in the Tallent case and the history leading to the acrimony, and emphasized that the weakness of the issues on appeal would result in the affirmance of the judgment for the Tallents. Cook learned from Maguire that her demand prior to trial was $900,000 and that she was not willing to accept that amount post-trial. A summary of these discussions between Cook and Maguire were documented in the ACES log for viewing by Liberty Mutual employees. DuLaurence expressed some concern that the case might be settled during the pendency of the appeal. Savoie increased the reserves to $1 million.

In the second round of conversations in the Fall of 1994, Maguire told Cook of the bleak situation of her client: the Tallents had no money and Raymond Tallent was unemployable. Cook told Maguire that DuLaurence had a very different view of the likely outcome of the appeal. In October, 1994, the value of the judgment with interest was in excess of $2.16 million. Maguire made a demand of $2 million. She emphasized that the record of the trial would support her view that the Tallents would prevail on appeal. She further argued to Cook that even if the Appeals Court granted a new trial the Tallents would nonetheless prevail. Cook said that the demand would not be acceptable to Liberty Mutual. He opined in an ACES note that he thought Maguire would settle for $1.5 million and recommended that the reserves be increased to $1.5 million.

*5 During this period, McCarthy had no confidence that Turner would prevail in the appeal and emphasized that the case should be settled before the appeal. His views, as well as those of Cook were expressed in the ACES notes. McCarthy, who had reviewed Cook's ACES notes thought that an offer of $1.5 million might settle the case. In a subsequent ACES note, Cook then asked for $1.5 million to settle the case in the event that $1 million was rejected. He also expressed the view that Liberty Mutual should "get on with" the settlement. Savoie responded in an ACES note that he had consulted with Mahanor who thought that Turner's appellate issues were strong. This was Mahanor's first appellate case. Based on Savoie's conversation with Mahanor, Savoie described Maguire as "arrogant and intractible [sic]" in a December 5, 1994 ACES note. After Savoie consulted with the claims management

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personnel of Liberty Mutual he withheld from Cook the authority to settle. As there was no scheduled hearing date at that time in the Appeals Court, Savoie indicated that there was no reason for Liberty Mutual to make an offer to settle the case. Cook responded that he disagreed with Savoie's decision to make no offer to the Tallents and with Mahanor's description of Maguire.

When Cook called Maguire on December 7, 1994 to tell her that there would be no offer to settle Maguire suggested that the case be presented by a panel of plaintiff and defendant representatives to personnel at Liberty Mutual for their valuation of the case. Cook conveyed this information in the ACES log. He also noted that a new trial might well be a pyrrhic victory even if the jury awards the Tallents less because there would be additional legal fees and additional interest added to the judgment. This communication led to Savoie's inquiry in an ACES note whether Liberty Mutual could settle with Turner and continue to maintain the appeal against Dorel and Owen on the indemnification issue. On December 14, 1994, Cook responded that Savoie should get an opinion from Liberty Mutual's legal department.

It was not until May 11, 1995 that Savoie made a request of the home office legal department of Liberty Mutual for an assessment of Turner's "chances for a new trial." On August 18, 1995, Attorney Michael Skeary ("Skeary"), another employee of Liberty Mutual answered the request in a memo to Savoie addressing four specific inquiries of Savoie and he did so without reviewing the transcript of the trial which was available as early as May or June, 1995. Skeary was not an "independent" voice in this matter. He had worked for Liberty Mutual for approximately six years and reviewed cases for potential appeals. Skeary rarely assessed cases for the viability of the appeal after the filing of the notice of appeal, as he did in this case. However, Skeary rightly concluded that the verdict was not against the weight of the evidence and that appeal on the issues underling Dorel and Owen could proceed even if Liberty Mutual settled with the Tallents. Conversely, he mistakenly opined that there was a "strong possibility of obtaining a new trial on appeal" based upon violations of the orders on the motions in limine.

*6 Prior to the third round of discussions between Cook and Maguire, DuLaurence entered a rather free-ranging note in the ACES log on April 24 and 25, 1995. Not only did DuLaurence forcefully discourage settlement, he assumed that the appeal would find its way to the Supreme Judicial Court and in that forum, the evidentiary violations of the court's rulings on motions in limine would not be tolerated. He also mentioned tort reform and a prior case he had handled in the Appeals Court regarding a trial judge's absence from the trial during the playing of a video-taped deposition.

In early May 1995, Cook and Maguire resumed their discussions. On May 2, 1995, Maguire told Cook that she had heard that Liberty Mutual had fired DuLaurence and she wondered if that changed Liberty Mutual's position on settlement. In his ACES note reflecting his conversation with Maguire, Cook again mentioned that "this is decision time," that McCarthy feels that the case should be settled and that the opportunity for settlement is "unlikely to ever be better." Cook also noted that the last demand was for $2 million.

Maguire called Cook on May 10, 1995. She offered to do a mock trial for the decision makers at Liberty Mutual. She reaffirmed her demand of $2 million and pointed out that the value of the verdict was then $2.25 million. No offer was forthcoming. During these conversations the trial transcript was still unavailable although it was completed in late May, 1995.

In October, 1995, Turner filed its appellate brief and the Tallents filed their brief in January, 1996. On January 23, 1996, Maguire wrote a demand letter to Liberty Mutual pursuant to G.L. c. 93A, § 9 and G.L. 176D, § 3(9)(b), (c), and (f). In the letter, Maguire detailed the facts and summarized the verdict and post-trial motions. She described Raymond Tallent's condition of disability and unemployability, as well as the basis for the jury's award of $ 1 million to Raymond Tallent. Maguire also pointed out that Turner's appellate brief did not raise the issue of liability or damages but rather Turner argued primarily the indemnification issue and the two evidentiary issues. Maguire concluded that "liability and damages are more than reasonably clear" and demanded the jury award plus interest.

Attorney Marc L. LaCasse ("LaCasse") of McCormack and Epstein responded to Maguire's demand letter on February 23, 1996 and indicated in his response that his firm had been retained by Liberty Mutual for the purpose of responding to Maguire's January 23, 1996 letter. From the response, it is clear that LaCasse viewed the basis of Maguire's demand pursuant to G.L. c. 93A and c. 176 D to be Turner's alleged frivolous appeal of the jury verdict

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and the post-trial motions. He pointed out that if the Appeals Court granted a new trial on the basis of the evidentiary issues the "liability and damages will once again be at issue." In the letter, LaCasse responded to each of the provisions of G.L. c. 176D, § 3(9) which were allegedly violated. He claimed that the Tallents failed to allege any injuries suffered at the hands of Liberty Mutual. Finally, LaCasse offered to mediate the case through the Appeals Court mediation program. On March 19, 1996, Maguire responded that liability was "nearly indisputable" prior to trial since Turner conceded that it was responsible for ensuring a safe workplace, it had erected the scaffolding, and Raymond Tallent was injured when an unsecured plank slipped out from the scaffolding. As for the responsibility of Liberty Mutual, Maguire wrote that the insurance carrier has a duty to effectuate a prompt, fair and equitable settlement once liability becomes reasonably clear. She concluded that the damages consisted of the verdict, interest and attorney's fees and that the Tallents wanted an offer and not mediation.

*7 There was additional correspondence between Maguire and LaCasse relative to the Tallents' demand. Finally, on May 13, 1996, LaCasse offered a structured settlement to Raymond Tallent, consisting of an immediate cash payment of $300,000 to include attorney's fees and liens, monthly payments of $1,191 to the then fifty-five year old Raymond Tallent, and an immediate cash payment of $45,000 to Alice Tallent. On June 7, 1996, Maguire responded that the offer was unacceptable and noted that the then present day value of Liberty Mutual's offer was between $500,000 and $600,000, less than one half of the interest that had accrued on the jury award. Maguire and the Tallents viewed the offer as "yet another example of Liberty Mutual's continued unfair settlement practices."

Following the failed settlement attempt, the parties agreed to mediate and selected William Dailey as the mediator. On September 6, 1996, Mahanor wrote to counsel for Dorel and Owen inviting their participation in the mediation. He made clear in the letter that the appeal against Dorel and Owen would proceed even if a settlement could be reached between the Tallents and Turner. Dorel and Owen did not attend the mediation.

Maguire, Mahanor and LaCasse participated in the mediation in the Fall of 1996. During the pendency of the mediation, the case was argued in the Appeals Court. Just prior to the oral arguments, the demand of the Tallents was $1.8 million and the value of the verdict was $2.8 million. Following the oral arguments, the Tallents raised their demand to $2.2 million due to their assessment of the strength of their oral argument. At this time, Liberty Mutual's offer was $1.4 million. On February 10, 1997, Debi Hopkins ("Hopkins"), who had replaced McCarthy in the Tallent case, asked Savoie if Liberty Mutual might reconsider its position. On March 20, 1997, Savoie responded that Liberty Mutual would stand by its position.

On April 4, 1997, the Tallents filed a complaint alleging violations of G.L. c. 93A and c. 176D. On May 1, 1997, in a Memorandum and Order pursuant to Rule 1:28, the Appeals Court affirmed the judgment of the trial court. On May 21, 1997, Turner filed an application for further appellate review which was denied by the Supreme Judicial Court on July 3, 1997. Final judgment entered in the Superior Court on July 17, 1997. On August 20, 1997, Liberty Mutual paid the Tallents a total of $2,924,665, which included $918,325 in post-judgment interest. Upon receipt of the money from Liberty Mutual, the net to the Tallents after payment of attorney's fees and costs was approximately $1.6 million. The Tallents invested $1.1 million in a conservative portfolio investing 50% in stocks and 50% in bonds.

During the pendency of this case, Attorney Kathy Jo Cook, the successor counsel in this suit wrote a "Supplemental Demand Letter" on February 2, 2000, to LaCasse, in which she demanded $150,000 for the severe emotional distress of the Tallents and $12,993 in legal expenses for the appeal. LaCasse responded that there is no provision in the law for a supplemental demand letter, the supplemental letter was untimely, and there was no bad faith on the part of Liberty Mutual.

C. *The Duty of Liberty Mutual*

*8 I credit the testimony of Arthur A. Kiriakos ("Kiriakos"), an independent adjuster who provides services to insurance companies and individual claimants. Kiriakos conducts field investigations, performs claims evaluations and provides expert testimony for c. 176D and c. 93A claims. He has worked in the insurance industry in many capacities, including as a claims supervisor and director of claims litigation for in excess of twenty years. Based upon the discrepancies in the points of view of McCarthy and Mahanor on the likely success of an appeal, Liberty Mutual had a duty to get a second

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independent opinion on the viability of the appeal. Liberty Mutual's knowledge of the hostility between DuLaurence, Mahanor and Maguire further underscored the need for an independent opinion on the merits of the appeal.

I also find persuasive the testimony of Alice Olsen Mann ("Mann"), an attorney with many year of appellate and insurance defense experience. From 1981 to 1998, she was an associate and then a partner at the firm of Morris, Mahoney and Miller, LLP an insurance defense firm. In 1981, Mann started an appellate department at her firm and she handled all appeals for the insurance companies represented by the firm. Since 1998, Mann has been a solo practitioner who continues to deal with insurance coverage issues and continues to do appellate litigation as well. A substantial part of Mann's practice deals with c. 176D and c. 93A claims for insurance companies.

I also credit Mann's testimony that the obligation of an insurance company post-verdict is to evaluate objectively the appellate issues, if any, and the reasonable likelihood of success on those issues. Further, if there is no reasonable likelihood of prevailing on appeal then the jury verdict establishes that the liability of the insurance company is reasonably clear. I also credit Mann's testimony that the likelihood of success on the two evidentiary issues on the appeal involving the Tallents and Turner was virtually non-existent and this is something that a reasonably experienced appellate attorney would know simply by reading the trial judge's decision on Turner's post-trial motions.

D. *The Loss of Use of the Judgment Amount*

I accept as credible the deposition testimony of Sherwood Small ("Small"), who at the time of his testimony was the president of Boston Private Value Investors, an investment management company. As an investment advisor, Small conducts an historical analysis for a given period of time and measures the performance of an investment against indices for common stock, value stock, bonds and a mix of stocks and bonds.

Small performed numerous calculations concerning the investment of an amount of money equivalent to the following: 1) to the value of the judgment on the day of the verdict (October 8, 1993); 2) the value of the judgment on the date of the verdict (October 7, 1993), minus 40% in attorney's fees and $35,000 in expenses; 3) the value of the judgment on the date that judgment on issued following the post-trial motions (February 7, 1994); and, 5) the value of the judgment on the date that the judgment issued (February 7, 1994), minus 40% in attorney's fees and $35,000 in expenses.[FN2] The end date for the calculations was August 20, 1997, the date that Liberty Mutual paid the Tallents. Small applied to the foregoing sums and periods of time the compound rates of return of the S & P 500, the Dow Jones Industrial, and the Russell indices, and government bonds. He further calculated the rate of return on a mixed portfolio of stocks and bonds. A conservative portfolio for a person in his 50's, as Tallent was in 1994, in the relevant time period was 50% in stocks and 50% in bonds. The rates of return using a blended portfolio of 50% in stocks and 50% in bonds were as follows for the time period from February 7, 1994 [FN3] to August 20, 1997 were as follows: 15.9% for the S & P 500 and government bonds; 12.74% for the Russell 1000 value and government bonds; and 15.98% for the Dow Jones industrial and government bonds.

FN2. As to this latter figure, Small provided all of the necessary figures to perform the calculation but did not actually do the final math on the essential figures.

FN3. For reasons which follow herein, I find that February 7, 1994, was the outside date on which liability was reasonably clear.

RULINGS OF LAW

*9 Chapter 93A was implemented to prevent unfair and deceptive practices in trade or commerce and to provide a cause of action for consumers to recover for damages that result from these practices. G .L. c. 93A, § 2. Similarly, the purpose of G.L. c. 176D is to deter unfair and deceptive acts or practices in the business of insurance. G.L. c. 176D, § 2. Section 3(9) of G.L. c. 176D defines the unfair or deceptive acts or practices that are considered a violation of G.L. c. 176D. However, G.L. c. 176D does not provide a cause of action for an individual who suffers damages as a result of an insurer's violation of the statute. Instead, "[a]ny person whose rights have been affected by an insurance practice that violates G.L. c. 176D, § 3(9), may sue under G.L. c. 93A." *Murphy v. National Union Fire Ins. Co.*, 438 Mass. 529, 532 n. 5, 781 N.E.2d 1232 (2003). The injured party is entitled to recover for all losses which were the foreseeable consequence of the insurer's unfair or

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deceptive act or practice. *Hopkins v. Liberty Mut. Ins. Co.*, 434 Mass. 556, 566, 750 N.E.2d 943 (2001).

In the present case, the Tallents brought a.c. 93A claim against the defendants for alleged violations of G.L. c. 176D, § 3(9). The plaintiffs claim that Liberty Mutual violated subsections (d) and (f) [FN4] of 176D, § 3(9) by failing to conduct a thorough investigation which resulted in Liberty Mutual's failure to settle the case once liability became reasonably clear. Liberty Mutual argues that the Tallents c. 93A claims are barred because they failed to send a demand letter that complied with the statutory requirements. In the alternative, Liberty Mutual argues that it did not violate G.L. c. 176D, § 3(9)(d) or (f) because liability was not reasonably clear until the appellate process was fully exhausted and that it conducted a reasonable investigation into the viability of the appellate issues after the denial of its post-trial motions..

FN4. Although the Tallents' first demand letter states that Liberty Mutual's failure to pay the judgment on the underlying claim was a violation of G.L. c.176D, § 3(a)(b)(c) and (f), the case was based on alleged violations of (d) and (f) only. The reference to the failure to investigate was addressed in Maguire's letter of March 19, 1996 although not by specific statutory reference. See *Cohen v. Liberty Mutual Insurance Co.*, 41 Mass.App.Ct. 748, 756, 673 N.E.2d 84 (1996); *Piccuirro v. Gaitenby*, 20 Mass.App.Ct. 286, 292, 480 N.E.2d 30 (1985). Moreover, the plaintiffs' proposed request for rulings addresses only violations of (d) and (f). Consequently, alleged violations of (a)(b) and (c) are waived.

A. *The Sufficiency of the Demand Letter*

Chapter 93A requires that the plaintiffs set out their demands in a letter which must be sent at least thirty days before the filing of a claim. G.L. c. 93A, § 9(3). A demand letter listing the specific unfair and deceptive practices alleged is a prerequisite to filing a c. 93A complaint. *Spring v. Geriatric Authority of Holyoke*, 394 Mass. 274, 287, 475 N.E.2d 727 (1985). Any relief that is not set out in the demand letter can not be granted. *Clegg v. Butler*, 424 Mass. 413, 423, 676 N.E.2d 1134 (1997). "The purposes of the demand letter are twofold: (1) 'to encourage negotiation and settlement by notifying prospective defendants of claims arising from allegedly unlawful conduct' and (2) 'to operate as a control on the amount of damages which the complainant can ultimately recover if he proves his case." ' *Spring v. Geriatric Authority of Holyoke*, 394 Mass. at 288, 475 N.E.2d 727, quoting *Slaney v. Westwood Auto, Inc.*, 366 Mass. 688, 704, 322 N.E.2d 768 (1975). A demand letter must reasonably describe the unfair practice alleged and the injury suffered in a manner which provides the prospective defendant with an opportunity to review the facts and law involved to see if the requested relief should be granted or denied. *Id.* Where a demand letter is statutorily insufficient, the c. 93A the claim must be dismissed. *Bressel, v. Jolicoeur*, 34 Mass.App.Ct. 205, 211, 609 N.E.2d 94 (1993).

*10 The appellate courts have upheld the sufficiency of a demand letter in various situations. In *Williams v. Gulf Insurance Co.*, the plaintiffs suffered property damage to buildings insured by the defendant. 39 Mass.App.Ct. 432, 432-433, 657 N.E.2d 240 (1995). After extensive correspondence concerning the amount of damage to be covered, the insurer decided to execute its option to repair the damage itself instead of issuing an insurance award. *Id.* at 433, 657 N.E.2d 240. However, the insurer never repaired the building. *Id.* The plaintiff brought a c. 93A complaint against the insurer for violating c. 176D, § 3(9)(f), and the trial court found for the plaintiff. *Id.* at 433, 657 N.E.2d 240. On appeal, the defendant argued that the Tallents' c. 93A demand was insufficient because it only alleged that the defendant had failed "to effectuate a prompt, fair and equitable settlement." *Id.* at 435-436, 657 N.E.2d 240. The court held this language sufficient in the context where the insurance company did not contest liability and it was well aware of the facts surrounding the claim before it received the demand letter. *Id.* at 436, 657 N.E.2d 240.

In *Fredericks v. Rosenblatt*, the trial court dismissed the plaintiff's c. 93A claim because it found that the demand letter failed to state an injury. 40 Mass.App.Ct. 713, 714, 667 N.E.2d 287 (1996). However, the Appeals Court reversed this decision holding that the demand letter was sufficient because it "[c]oncretely described the purported injury-the loss of the plaintiff's property damage claim against the MBTA resulting from his having executed the first general release at the urging of the defendants-and that the amount of damages claimed was reasonably ascertainable." *Id.* at 717, 667 N.E.2d 287. *Fredericks* indicates that a c.93A demand letter is sufficient as long as the content of the letter allows the recipient to understand what injury the plaintiff

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has suffered.

The appellate courts have also held the contents of a c. 93A demand letter to be sufficient when the information provided the defendant with " 'an opportunity to review the facts and the law involved to see if the requested relief should be granted or denied' and to enable [it] to make 'a reasonable tender of settlement' in order to limit the recoverable damages." *Brandt v. Olympic Construction Inc.*, 16 Mass.App.Ct. 913, 915, 449 N.E.2d 1231 (1983), citing *York v. Sullivan*, 396 Mass. 157, 162 (1975). In *Brandt* the court held that a demand letter that did not list the specific money or property loss was sufficient because it "reasonably described the deceptive acts relied on and was sufficient to give the defendant an opportunity to review the facts and the law involved to see if the requested relief should be granted or denied and to enable [the defendant] to make a reasonable tender of settlement in order to limit the recoverable damages." 16 Mass.App.Ct. at 915, 449 N.E.2d 1231. The court further stated that a c. 93A letter should not be held to the same standard as a c. 93A complaint. *Id.*; see also *Tarpey v. Crescent Ridge Dairy, Inc.*, 47 Mass.App.Ct. 380, 713 N.E.2d 975 (1999) (where a demand letter that failed to specify the dollar amount requested was not fatal to the c. 93A claim since the letter was otherwise comprehensive and detailed).

*11 In this case, the original c. 93A demand letter dated January 23, 1996, and the supplemental correspondence through July 3, 1996, provided the defendant with sufficient information to review the facts and law surrounding the allegations and adequately described the Tallents' injuries.[FN5] The first demand letter specifically stated that Liberty Mutual had failed to pay the Tallents the judgment to which they were entitled as a result of Turner's negligence and the supplemental correspondence during the six month period informed Liberty Mutual of its failure to adequately investigate the merit of the issues on appeal and to effectuate a prompt, fair and equitable settlement. The original letter also stated that Raymond Tallent was not working, that he would not be able to work in the future, and described his specific physical injuries that prevented him from working. This language clearly indicates that the Tallents were suffering financially because the defendants failed to pay the judgment. In addition, the correspondence by the attorney to the defense attorney during this six month period asserts that the Tallents were continuing to pay legal fees. The correspondence provided sufficient information for Liberty Mutual to identify the Tallents' injuries.

FN5. The Tallents also sent the defendant a second demand letter on February 2, 2000, which asserted a new injury of emotional distress and the legal fees for the appeal. However, a c. 93A demand letter cannot be supplemented after the plaintiff has filed the claim, without amending the complaint. *Medeiros v. Woburn Nursing Center, Inc.*, 2001 WL 1174141 (Mass.Super.2001); see also *Hobbs v. Carroll*, 34 Mass.App.Ct. 951, 952, 614 N.E.2d 695 (1993). The c. 93A claim in this case was filed on April 4, 1997. The second demand letter was mailed on February 2, 2000, and there is no record of a motion to amend or allowance of such a motion to amend the original complaint. Thus, the second letter of February 2, 2000 does not legally supplement the original demand of the plaintiff.

Furthermore, this was not correspondence that Liberty Mutual received without having any background of the underlying claim. Liberty Mutual had an advisor at the trial every day who made daily reports. It knew that a jury had assessed damages against its insured and that the Tallents were suffering physically and financially as a result of its insured's negligence, Given the specific language of the original and supplemental demand letters, and the depth of Liberty Mutual's knowledge of the underlying claim, this Court concludes that the c. 93A demand letter and the supplemental correspondence in 1996 meet the statutory requirements.

B. *Violations of G.L. c. 176D*

An insurance company is held to the duty of good faith and fair dealing as defined under G.L. c. 176D, § 3(9) whether it is dealing with its insured or third-party claimants. *Bobick v. United States Fid. & Guar. Co.*, 439 Mass. 652, 658-659, 790 N.E.2d 653 (2003). These duties apply not only to pre-trial and trial process, but also to appellate procedures. *Davis v. Allstate Insurance Co.*, 434 Mass. 174, 187 n. 13, 747 N.E.2d 141 (2001).

The Tallents allege that Liberty Mutual breached its duty to them, as a third-party claimants, by failing to settle the case promptly once liability became reasonably clear. They also allege that Liberty Mutual breached its duty when it failed to conduct an

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adequate investigation of the appellate issues. This Court addresses each allegation in turn.

1. *Chapter 176D, § 3(9)(f); When Liability Became Reasonably Clear*

One manner in which an insurer can breach its duty of good faith and fair dealing to a third party is by failing to effectuate prompt, fair, and equitable settlements of claims when liability has become reasonably clear, G.L. c. 176D, § 3(9)(f). See *Hopkins*, 434 Mass. at 562, 750 N.E.2d 943. Liability for the purposes of G.L. c. 176D, § 3(9)(f) encompasses both fault and damages. *Clegg*, 424 Mass. at 421, 676 N.E.2d 1134 (1997). In determining whether liability is reasonably clear, "[t]he test is not whether a reasonable insurer might have settled the case within the policy limits, but whether no reasonable insurer would have failed to settle the case within the policy limits." *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 121, 628 N.E.2d 14 (1994).

*12 Liberty Mutual contends that it did not violate G.L. c. 176D, § 3(9)(f) because it relied on trial counsel's advice that there were reasonable grounds upon which to file an appeal. After considering all the relevant factors, this Court concludes that the defendant's argument is unsupported by the relevant facts and law, and that no reasonable insurer would have failed to recognize its liability at least by February of 1994, when judgment entered following the denial of the post-trial motions.

a. *Advice of Counsel*

Liberty Mutual argues that because it relied on its trial counsel's opinion that reasonable grounds existed for appeal, it did not violate G.L. c. 176D, § 3(9)(f). While reliance on the advice of counsel constitutes "some evidence" of good faith, the cases that have upheld an advice of counsel defense are factually distinguishable from the case at hand. *Hartford Cas. Ins. Co.*, 417 Mass. at 122, n. 5, 628 N.E.2d 14. Insurers have successfully used the reliance on counsel defense in cases where the insurers either based a decision on independent legal advice or, legal advice of its own counsel that was supported by an independent expert opinion. See *Van Dyke v. St. Paul Fire & Marine Ins. Co.*, 388 Mass. 671, 673-74, 448 N.E.2d 357 (1983) (where the insurer reasonably relied upon the opinion of an experienced trial counsel and a former chief of surgery that liability was not clear); *Mayer v. Medical Malpractice Joint Underwriting Ass'n*, 40 Mass.App.Ct. 266, 274, 663 N.E.2d 274 (1996) (where insurance company's decision not to settle was reasonably based on the information and advice it received from its counsel, which was grounded in the opinions of three medical experts).

Liberty Mutual's reliance on advice from Mahanor was unreasonable for a number of reasons. First, Mahanor had no practical appellate experience, as this was his first appellate case. In cases where the courts have found reliance on trial counsel reasonable, the counsel was experienced and was supported by expert opinions or independent legal advice, which is not the case here. Second, Liberty Mutual, in relying on the legal advice of Mahanor, failed to recognize his lack of objectivity in the case. The fact that Mahanor was being paid by Liberty Mutual and had invested a substantial amount of time and energy into the trial should have raised questions about his ability to objectively assess the appellate issues. In addition, Liberty Mutual was well aware of the animosity between opposing counsel during trial and that Mahanor also harbored ill feelings toward Maguire. Any reasonable insurer would recognize that these factors, taken together, indicate that Mahanor had questionable judgment and a personal motive to appeal the case, and any reliance on his unverified and inexperienced advice would be unreasonable. Liberty Mutual's contention that it reasonably relied on the advice of its home office counsel is also without merit. Skeary's neutrality concerning the case is called into question because he was an employee of Liberty Mutual. Any insurer would know that it is not reasonable to rely on legal advice provided by an unobjective attorney. Liberty Mutual argues that all Skeary needed in order to provide an objective review was the claims file and the trial judge's post-trial order. I agree. Although in other contexts, a trial transcript would be necessary to effectively evaluate the merits of an appeal here, the only pertinent issue on appeal [FN6] was whether the trial judge abused his discretion in failing to grant a mistrial on the basis of the evidentiary issues. However, no reasonable insurer relying on the advice of reasonably knowledgeable counsel would have thought there was any chance of prevailing on appeal. The trial judge, in a very thoughtful opinion, explained why these missteps were not overly prejudicial.

FN6. At trial and his written comments in a written memo to Savoie, Skeary conceded

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that, in his opinion, the verdict was not against the weight of the evidence.

*13 Liberty Mutual failed to recognize that Mahanor's inexperience and lack of objectivity, and Skeary's lack of objectivity and unknown experience on appellate issues, prevented them from giving reliable legal advice. Without supporting legal advice from outside counsel or factual support from experts, Liberty Mutual was unreasonable in relying on the advice of these two attorneys. In these circumstances, reliance on counsel's advice does not help Liberty Mutual.

b. *The Viability of Turner's Issues on Appeal.*

The defendant argues that liability does not become reasonably clear when a jury finds for plaintiff or when there is still a good faith disagreement about liability. Clegg, 424 Mass. at 418, 676 N.E.2d 1134. While an insurer has a duty to defend an adverse judgment against its insured, it only must do so if reasonable grounds exist that the insured's interest might be served by the appeal. Davis, 434 Mass. at 180, 747 N.E.2d 141. However, whether there are reasonable grounds to appeal depends upon a reasoned legal assessment of what occurred at trial, including: 1) the rulings and instructions to the jury by the trial judge; 2) the objections and motions by trial counsel; and 3) the state of the law on the points in issue.

In reviewing Liberty Mutual's decision to appeal, it is important to consider all the relevant factors to determine if it had any reasonable grounds on which to appeal. A consideration is Turner's admission in its interrogatories that it was responsible for setting up the failed scaffolding that led to Mr. Tallent's injuries. The importance of this admission is evidence in Liberty Mutual's failure to appeal the amount of damages or fault. As to Turner, on appeal Liberty Mutual only argued that error in the two evidentiary matters should have resulted in a mistrial. It is "relatively rare for evidentiary errors to result in a reversal in a civil action." Bowlen v. O'Connor Café of Worcester, Inc., 50 Mass.App.Ct. 56, 67, 734 N.E.2d 726 (2000). Liberty Mutual's allotment of only a few pages of its thirty-three page appellate brief to the evidentiary issues indicates the lack of importance and strength Liberty Mutual assigned to these issues.

Liberty Mutual's decision to pursue an appeal was not only based upon unreliable and biased advice, but also it was in contradiction to the advice of its own seasoned employees. One such employee was McCarthy, a Regional Property Specialist who had worked for Liberty Mutual since 1966 and attended the trial for the sole purpose of providing his independent observation and evaluation of the trial developments to Liberty Mutual. As early as September 29, 1993, he stated that there was little chance of a verdict for Turner. McCarthy also agreed with the trial judge's rulings on the post-trial motions concerning the effect of the evidentiary issues: despite the violation of the court's orders; there was no prejudicial impact on the jury. In addition, upon review of the case file on July 19, 1993, Savoie, the Home Office Examiner in charge of obtaining authorization for the settlement of cases, wrote that liability did not look good for Liberty Mutual since Turner may have set up and maintained the staging in question.[FN7] Furthermore, Cook, an adjuster for Liberty Mutual and a troubleshooter for difficult cases, who became involved in the case after the jury verdict, advised that Liberty Mutual should get on with the settlement negotiations and disagreed with Savoie's decision to forego a settlement offer to the plaintiffs and to pursue the appeal.

FN7. In fact, Turner made this admission in its answer to interrogatories.

*14 Moreover, Liberty Mutual should have calculated into its assessment of its appellate issues the considerable deference that appellate courts grant to a judge's disposition of a motion for a new trial, especially where the motion judge was also the trial judge. Gath v. M/A-Com, Inc., 440 Mass. 482, 492, 802 N.E.2d 521 (2003). An appellate court will only reverse such a ruling for an abuse of discretion. *Id.* This deference was evidence when the Appeals Court issued its memorandum and order for Liberty Mutual's appeal pursuant to Appeals Court's Appellate Practice Rule 1:28, which is done when the appeal is either lacking any substantial questions of law or presenting an error so clear as to warrant summary disposition.[FN8] Finally, despite the Rule 1:28 opinion by the Appeals Court, Liberty Mutual forged ahead with its request for further appellate review to the Supreme Judicial Court and the request was appropriately denied.

FN8. Appeals Court's Appellate Practice Rule 1:28. "[A] panel of the justices of this court may determine that no substantial question of law is presented by the appeal or

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> that some clear error of law has been committed which has injuriously affected the substantial rights of an appellant and may, by its written order, affirm, modify or reverse the action of the court below."

Liberty Mutual based its decision to pursue an appeal on the unsupported advice of inexperienced and unobjective legal counsel. This, taken in conjunction with: 1) Turner's admission to liability; 2) Liberty Mutual's failure to appeal liability; 3) the advice from its seasoned employees to settle the case; and 4) the deference appellate courts give to trial judges in their trial rulings leads me to the conclusion that there were no reasonable grounds on which Liberty Mutual could pursue an appeal and that liability was reasonably clear when the trial court denied the post-trial motions.[FN9]

> FN9. This Court recognizes the need to balance the desirability of settlement post-verdict with the danger of stifling the appellate process. In some cases there is a fine line between the two. However, given the lack of merit to the appellate issues here, no reasonable insurers would have failed to offer a fair, prompt and equitable settlement or to pay the amount of the judgment. Moreover, c. 176D imposes duties on insurance companies that are not applicable to individual defendants. Thus, where an individual defendant may be subject to a claim that his appeal is frivolous, the standard and the duties are heightened for insurance companies because of c. 176D.

2. *Chapter 176D, § 3(9)(d); Duty to Investigate*

An insurer may breach its duty of good faith and fair dealing by refusing to pay claims without conducting a reasonable investigation based upon all available information. G.L. c. 176D, § 3(9)(d). This provision or G.L. c. 176D addresses situations where the insurer refuses to pay a claim without attempting to verify its legitimacy. *Id.*

Liberty Mutual contends that it did not violate G.L. c. 176D, § 3(9)(d) because it conducted a reasonable post-trial investigation regarding the viability of its appellate issues. After considering all of the following relevant factors, I conclude that the defendant's argument is unsupported by the relevant facts and law, and that a reasonable insurance company would have conducted a more thorough investigation into the viability of its appellate issues.

In evaluating whether or not Liberty Mutual conducted a reasonable investigation into the likelihood of success of its appellate arguments, its actions should be measured against the standard in the insurance industry, as explained by expert testimony. I find persuasive Mann's testimony and opinion, that Liberty Mutual was required to analyze the legal issues objectively to determine if liability and damages were reasonably clear before proceeding with the appeal, and that obtaining the advice of objective appellate counsel for that analysis was a frequent practice in the insurance industry. This is further supported by the credible testimony of Kiriakos, who testified that in supervising and overseeing the claim, the home office should have been concerned about its counsel's motivation for the appeal and investigated the matter carefully. He further opined that Liberty Mutual did not purse a reasonable investigation of the merits of its appeal and did not act reasonably in evaluating its legal position on whether liability to the Tallents was reasonably clear.

*15 Liberty Mutual, when presented with contradicting advice about the potential success of its appeal, choose to rely on advice from its unobjective and inexperienced trial counsel rather than seeking a second opinion from an objective and informed counsel. It did seek out the opinion of Skeary but he was also in-house counsel and it was unclear how familiar he was with appellate practice. Moreover, this consultation with Skeary, more than two and one half years post-verdict, was too little and too late. In sum, Liberty Mutual breached its duty to the Tallents because it failed to conduct an adequate investigation based upon all available information in determining if it had reasonable grounds for an appeal.

C. *Damages*

When a plaintiff brings an action under G.L. c. 93A, § 9 for a violation of G.L. c. 176D, § 3(9), a plaintiff is entitled to recover for all losses that were the foreseeable consequence of the defendant's unfair or deceptive act or practice. *Hopkins*, 434 Mass. at 566-567, 750 N.E.2d 943. Under G.L. c. 93A, § 9(3) "[R]ecovery shall be in the amount of actual damages or twenty-five dollars, whichever is greater; or up to three but no less than two times such amount if the court finds that the use or employment of the act or practice was a willful or knowing violation of said section two or that the refusal to grant relief upon

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demand was made in bad faith with knowledge or reason to know that the act or practice complained of violated said section two. For the purpose of this chapter, the amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence, regardless of the existence or nonexistence of insurance coverage available in payment of the claim ."

Chapter 93A, § 9(3) "distinguishes between those cases in which a judgment has entered on the underlying claim and those in which no judgment has entered: if the amount of 'actual damages' is to be doubled or trebled, and where there has been no judgment on an underlying claim, the base damages are calculated according to the interest lost on the money wrongfully withheld by the insurer, compensating claimants for 'the costs and expenses directly resulting from the insurer's conduct." *R.W. Granger & Sons, Inc. v. J & S Insulation, Inc.*, 435 Mass. 66, 82, 754 N.E.2d 668 (2001), citing *Kapp v. Arbella Mut. Ins. Co.*, 426 Mass. 683, 686, 689 N.E.2d 1347 (1998); *Clegg*, 424 Mass. at 425, 676 N.E.2d 1134. "If, however, the defendant is subject to multiple damages and the plaintiff has recovered a judgment on the underlying claim, actual damages shall be taken to be the amount of the judgment for the purpose of bad faith multiplication." *Id.* (internal citations omitted)

The Appeals Court specifically examined the language in G.L. c. 93A, § 9(3) that allows the court to double or treble the underlying judgment if bad faith is found. *Cohen v. Liberty Mutual Ins. Co.*, 41 Mass.App.Ct. 748, 753-756, 673 N.E.2d 84 (1996). This provision of c. 93A was added by the Legislature in 1989 in response to the Appeals Court decision, *Wallace v. American Mfrs. Mut. Ins. Co.*, 22 Mass.App.Ct. 938, 494 N.E.2d 35 (1986). *Id.* In *Wallace*, the court held that when bad faith was found, and there was an underlying judgment, the plaintiff could only recover doubled or trebled damages on the interest of the judgment from the date when the insurer should have settled until the actual date of judgment. *Id.* The amendment to c. 93A in 1989 responded to this decision and directs the courts to double or treble the underlying judgment, and not simply the lost interest. *Id.* at 755, 494 N.E.2d 35. However, the court in *Cohen* further opined that while the amendment changed the amount which was to be multiplied, "[it] did not abolish the need for a plaintiff under c. 93A to show a causal connection between a defendant's wrongful conduct and the resulting damages." *Id.* at 755, 673 N.E.2d 84. The court concludes that in a case where an underlying judgment exceeded a policy limit, the insurer could not be held liable for more than the limits of its policy. *Id.* at 756, 673 N.E.2d 84.

*16 The Supreme Judicial Court in *R.W. Granger* also discussed what amount was to by multiplied in a case where there was an underlying judgment and post-verdict bad faith conduct. The court stated that while doubling the underlying verdict may seem excessive in light of the fact that the defendants' post-verdict conduct only caused the plaintiff to lose the use of the money to which it was entitled, the award is consistent with the intent of the legislature. *R.W. Granger*, 435 Mass. at 82, 754 N.E.2d 668. "The Legislature directed that where ... a plaintiff obtains a judgment against an insurer subject to multiple damages because it acted in bad faith in denying reasonable settlement of the plaintiff's underlying claim, the defendant insurer 'shall be' subject to 'multiplication of the judgment secured by the plaintiff on the underlying claim, thereby risking exposure to punitive damages many times greater than multiplication of the lose of use of money alone." ' *Id.*, citing *Kapp* 426 Mass. at 686, 689 N.E.2d 1347.

In this case, Liberty Mutual violated G.L. c. 176D, § 3(9)(d) and (f). In addition, there is a judgment in the underlying case. Therefore, the only remaining question is whether the defendant acted in bad faith in making its decision to pursue an appeal rather than pay the judgment once liability became reasonably clear.[FN10] If the defendants decision was made in good faith, then the Tallents are entitled to the interest on the judgment for the period from February 7, 1994 to August 20, 1997. However, if Liberty Mutual's decision was made in bad faith, the plaintiffs are entitled to double or treble the underlying judgment, plus attorneys fees and costs in pursuing the c. 93A claim.

FN10. I note that Liberty Mutual never made a prompt, fair and equitable offer to settle for less than the judgment. Since no such offer was forthcoming, I do not address the question whether a prompt, fair and equitable settlement offer in these circumstances could have been something less than the amount of the judgment on February 7, 1994.

1. *Good Faith or Bad Faith*

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Whether Liberty Mutual's failure to offer the Tallents a reasonable settlement proposal after liability was made in bad faith is a question of fact. *Parker v. D'Avolio*, 40 Mass.App.Ct. 394, 395, 664 N.E.2d 858 (1996). Liberty Mutual has the burden of proving that its refusal to settle was reasonable and made in good faith in light of the demand and attendant circumstances. *Kohl v. Silver Lake Motors, Inc.*, 369 Mass. 795, 799, 343 N.E.2d 375 (1976). Liberty Mutual must show that it did not act deliberately to derail the settlement process and that it did not intend to "wear out the claimant by unduly delaying settlement when liability, including causation and damages is clear or highly likely." *Parker*, 40 Mass.App.Ct. at 396, 664 N.E.2d 858, citing *Miller v. Risk Mgmt. Foundation of Harvard Med. Insts., Inc.*, 36 Mass.App.Ct. 411, 418, 632 N.E.2d 841 (1994); *Guity v. Commerce Ins. Co.*, 36 Mass.App.Ct. 339, 343, 631 N.E.2d 75 (1994).

"An absence of good faith and the presence of extortionate tactics generally characterize the basis for a c. 93A-176D action based on unfair settlement practice." *Guity*, 36 Mass.App.Ct. at 344, 631 N.E.2d 75, citing *Forucci v. United States Fid. & Guar. Co.*, 817 F.Supp. 195, 202 (D.Mass.), *aff'd*, 11 F.3d 1 (1st Cir.1993). "Good faith" for purposes of G.L. c. 93A is defined as "the insurer making settlement decisions without regard to the policy limits and the insurer's 'exercise of common prudence to discover the facts as to the liability and damages upon which an intelligent decision may be based.' " *Bolden v. O'Connor Café of Worcester, Inc.*, 50 Mass.App.Ct. 56, 59 n. 9, 734 N.E.2d 726 (2000), quoting *Hartford Cas. Ins. Co.*, 417 Mass. at 119, 628 N.E.2d 14.

*17 Bad faith in the context of a Chapter 93A action may be either objective or subjective. *Parker*, 40 Mass.App.Ct. at 396, 664 N.E.2d 858. "Objective bad faith may be found where a potential defendant offers 'much less than a case is worth in a situation where liability is either clear or highly likely.' " *Id.* quoting *Guity*, 36 Mass.App.Ct. at 343, 631 N.E.2d 75. Under the objective bad faith analysis, the key inquiry is whether a reasonable person, with knowledge of the relevant facts and law, would probably have concluded, for good reason, that the insurer was liable to the plaintiff. *Demeo v. State Farm Mut. Auto. Ins. Co.*, 38 Mass.App.Ct. 955, 956-957, 649 N.E.2d 803 (1995).

Even when an insurer can satisfy the test for objective reasonableness, it may still be liable under c. 93A if the plaintiff can establish that the insurer was motivated by subjective bad faith. *Parker*, 40 Mass.App.Ct. at 396, 664 N.E.2d 858. "Subjective bad faith may be established by direct evidence that a defendant was 'motivated by subjective bad faith' even where 'on an objective standard of reasonableness' he 'would have been warranted in not settling a case.' " *Parker*, 40 Mass.App.Ct. at 396, 664 N.E.2d 858, citing *Hartford Cas. Ins. Co.*, 417 Mass. at 123, 628 N.E.2d 14. A good faith reasonable position by an insurer, even if incorrect, is not a c. 93A/ c.176D violation. *Peckham v. Continental Casualty*, 895 F.2d 830, 833 (1st. Cir.1990). "An insurer is not held to standards or omniscience or perfection; it has leeway to use and should consistently employ its honest business judgment." *Id.* at 835.

As stated previously, I find that liability was reasonably clear after the trial judge denied the defendant's post-trial motions. Therefore, in determining whether Liberty Mutual objectively acted in bad faith, this court must consider if its post-trial settlement offers were much less than the case was worth. *Parker*, 40 Mass.App.Ct. at 396, 664 N.E.2d 858. The post-trial motions were decided in February 1994, and the first post-trial settlement negotiations began in the spring of 1994. At the time Maguire was attempting to negotiate a settlement agreement, McCarthy informed Liberty Mutual that he had no confidence that Turner would prevail in the appeal and advised a settlement. However, Liberty Mutual made no settlement offer at that time.

In the fall of 1994, Maguire attempted to negotiate another round of settlement talks. At this time, the value of the judgment was $2.16 million. Cook recommended that Liberty Mutual should settle the case and that a new trial might well be a pyrrhic victory. Even if the jury awarded the Tallents less, there would be additional legal fees, and additional interest added to the judgment. Despite the advice from McCarthy and Cook, Savoie denied Cook the authority to settle the claim. He based this decision on advice he received from Mahanor whose advice, as previously discussed, was unreliable because of his inexperience and lack of objectivity. On December 7, 1994 Cook let Maguire know that there would be no offer to settle.

*18 Both parties filed appellate briefs by January of 1996. On January 26, 1996, Maguire wrote a demand letter to Liberty Mutual pursuant to G.L. c. 93A, § 9 and G.L. c. 176D, § 3(9)(b), (c), and (f). Liberty Mutual responded through LaCasse that there had been no violations of Chapter 93A and the original demand letter was insufficient because it failed to

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state injuries. No settlement offer was made at this time.

Finally, on May 13, 1996, more than two years after liability had become clear, Liberty Mutual made the Tallents a settlement offer that had a then present day value between $500,000 and $600,000, which was less than one half of the interest that had accrued on the jury award. The Tallents rightfully rejected this offer. After the oral arguments in the Appeals Court, Liberty Mutual had a standing offer of $1.4 million. Considering the strength of their oral arguments, and the fact that the jury award was now worth $2.8 million, the Tallents did not consider this a reasonable offer and refused it. At this time, Hopkins, the person who replaced McCarthy in the case, advised Liberty Mutual to increase its offer, however, Liberty Mutual refused.

I conclude that Liberty Mutual objectively acted in bad faith when it failed to offer the Tallents the judgment amount after liability became clear. The defendants withheld all settlement offers for two years after liability became clear. The only explanation the defendants offer this Court is that they relied on counsel's advice that it had viable appellate issues. I have already determined that no reasonable insurance company would have relied upon an inexperienced trial counsel's advice without further investigation and support of his opinion. In addition, considering the growing value of the judgment and the weakness of Liberty Mutual's appellate issues, the settlement offers that were eventually made to the Tallents were well below the value of the case. Therefore, Liberty Mutual's failure to offer the Tallents the amount of the judgment or at least a timely and reasonable settlement offer was done in bad faith. In my view, Liberty Mutual used the appellate process in an attempt to extort the Tallents into a settlement for far less then they were owed.

Liberty Mutual's argument that it made a subjective good faith decision to pursue an appeal after post-trial motions is equally unpersuasive. In order to prove that it made a subjective good faith decision to appeal, Liberty Mutual must show that it made an honest business judgment. *Peckham*, 895 F.2d at 835. However, there is no evidence that Liberty Mutual made a honest business judgment to appeal.

The animosity between opposing counsel in the underlying action was evident and permeated the appellate decisions. The hostility was so severe that DuLaurence and Maguire did not speak to each other, and at one point Maguire filed an application for a temporary restraining order against DuLaurence. As stated earlier, Liberty Mutual was also aware that Mahanor harbored feelings of hostility toward Maguire. In addition, in a memo from Mahanor to McCarthy, dated February 2, 1994, Mahanor outlined what he believed to be the grounds for appeal stating. "[b]y taking an appeal of the denial of these [post-trial] motions, it may make counsel for the plaintiffs more amenable towards any potential settlement negotiations."

*19 As previously discussed, McCarthy and Cook advised Liberty Mutual to settle the case with the Tallents. This advice lead Savoie to ask Liberty Mutual's legal office if it could settle with the Tallents and still appeal indemnification issues. However, he never requested this advice until May 11, 1995, over a year after liability was clear. Savoie even testified that the principal motivation for the appeal was to get the subcontractors to pay all or part of the Tallents' damages. This is supported by the limited number of pages Liberty Mutual allotted in its appellate brief to the evidentiary issues.

Liberty Mutual was incapable of making an honest business judgment because it blatantly ignored, and failed to address, the facts indicating that Mahanor and DuLaurence had bad faith motives for pursuing an appeal. It is clear that part of the purpose of the appeal was to put the Tallents in a position where they would be more likely to settle for much less than the verdict with interest, as evident by the subsequent "low-ball" offers. In addition, it appears that Liberty Mutual's primary concern on appeal was to secure contribution toward the judgment from other companies that were involved in the accident, and it was not protecting the intorests of its client, Turner. Liberty Mutual failed to pursue a reasonable and timely investigation of the merits of its appeal and ignored essential factors that were necessary in making an honest business judgment. Its consultation with Skeary presented Liberty Mutual with another opportunity to make a fair and equitable offer (albeit not prompt) to settle or to pay the judgment. This consultation lacked the requisite independence and it was incomplete and too late. Liberty Mutual has presented no evidence that it attempted to act in a manner consistent with making an honest business judgment. Even under a subjective analysis, Liberty Mutual's decision to pursue an appeal was done in bad faith.

2. *Calculating Damages*

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I do not conclude that the conduct of Liberty Mutual was sufficiently egregious to warrant treble damages. However, since I have concluded that Liberty Mutual acted in bad faith in pursuing the appeal the amount of the judgment issued on February 7, 1994, $2,050,344 shall be doubled for a total of $4,100,688. I note that had Liberty Mutual not acted in bad faith the Tallents' damages would be the loss of use of the February 7, 1994 judgment from that date until they were paid on August 20, 1997. See *Yeagle v. Aetria Casualty & Surety Company*, 42 Mass.App.Ct. 650, 653-656, 679 N.E.2d 248 (1997). Under single c. 93A damages, the total amount of the Tallents' loss of the use of the money would have been $111,237.00.[FN11]

FN11. The Tallents were awarded interest for this period of time at the statutory rate of 12%. As a base for the amount that would have been invested by the Tallents I have utilized what they actually invested, $1.1 million. To this figure, I have calculated interest for the applicable period at a rate of 14.87% which represents an average return on the most conservative portfolio investment of 50% in stocks and 50% in government bonds. I then subtracted what they were paid at the 12% statutory interest from 14.87% interest.

ORDER FOR JUDGMENT

It is therefore *ORDERED* that judgment enter for the plaintiff in the amount of $4,100,688.00 [FN12] against the defendant Liberty Mutual. Counsel for the Tallents shall submit an itemized bill of attorneys' fees in pursuing the c. 93A action. Defense counsel shall have fourteen days to respond to the plaintiffs' submission.

FN12. Since the complaint was filed on April 4, 1997, the Tallents are entitled to interest on the judgment at a rate of 12%. G.L. c.231, § 6B. The Clerk is directed to calculate the interest on the judgment at this rate of 12% through March 10, 2003. Since the matter has been under advisement beyond the one hundred and twenty days permitted for matters under advisement. G.L. c. 220, § 14A, the interest rate to be applied from March 11, 2000 through the date judgment issues is 5.41%, which is 1% above the average prime rate for the period of time. See The Wall Street Journal (where the prime rate is calculated on an historical basis.) A summary of the historical date is attached as Addendum A, [Ed. Note: [Addendum omitted for publication purposes.] The defendant] should not be penalized with 12% interest for this period nor should the plaintiffs be deprived of the loss of use of the money due to the delay in rendering the opinion.

Mass.Super.,2005.
Tallent v. Liberty Mut. Ins. Co.
Not Reported in N.E.2d, 2005 WL 1239284 (Mass.Super.)

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Findings of Fact, Conclusions of Law, and Order (App. 17-81)

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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

NOTIFY

SUPERIOR COURT
CIVIL ACTION
NO. 05-1360-BLS1

MARCIA RHODES, HAROLD RHODES, and REBECCA RHODES,
Plaintiffs

vs.

AIG DOMESTIC CLAIMS, INC. f/k/a AIG Technical Services, NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA, and ZURICH AMERICAN INSURANCE COMPANY,
Defendants

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The plaintiffs, Marcia Rhodes, Harold Rhodes, and Rebecca Rhodes (collectively, "the Rhodes"), have filed this action against the defendants AIG Domestic Claims, Inc., formerly known as AIG Technical Services ("AIGDC"), National Union Fire Insurance Company of Pittsburgh, PA ("National Union"), and Zurich American Insurance Company ("Zurich"), alleging that these insurers violated G.L. c. 176D,§ 3(9)(f) (and, in turn, G.L. c. 93A) by failing to effectuate a prompt, fair, and equitable settlement of a tort claim in which liability was reasonably clear. This Court conducted a 16-day bench trial between February 5, 2007 and March 31, 2007, followed by extensive briefing. Based on the testimony at trial and the exhibits admitted into evidence, viewed in light of the governing law, this Court makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

In the early afternoon of January 9, 2002, Professional Tree Service was grinding tree stumps off Route 109 in Medway and had retained a Medway patrolman on paid detail to stop one lane of traffic at a time to protect the safety of its tree service truck and employee. The police officer stopped a Toyota driven by Marcia Rhodes, then 46 years old. After she came to a

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full stop, an 18-wheel trailer truck driven by Carlo Zalewski struck the rear of Ms. Rhodes car and pushed it off the road down an embankment. The tractor-trailer had struck her car with such force that the trunk had been pushed into the back seat of the vehicle. Ms. Rhodes was conscious when the police officer ran over to her aid, but she had lost all feeling below her waist. As a result of the traffic accident, she suffered, among other injuries, a fractured spinal cord at T-12 and broken ribs. The accident left her a paraplegic, unable to walk.

Zalewski at the time of the accident was employed by Driver Logistic Services ("DLS"), and had been assigned by DLS to drive the truck for GAF Building Corp. ("GAF"). GAF had leased the truck from its owner, Penske Truck Leasing Co. ("Penske").

At the time of the accident, GAF had a $2 million primary automobile insurance policy with Zurich, and a $50 million excess umbrella policy with National Union. Under the Zurich Policy, GAF had a self-insured retention of $250,000 per claim, including defense costs, and retained the authority to approve payments up to that amount. Zurich had to approve any settlement of a claim that involved payment of more than $100,000. GAF had retained Crawford & Company ("Crawford") as its Third Party Administrator ("TPA") to adjust its claims and Zurich also entered into a Third Party Administrator Agreement with Crawford to adjust its GAF claims. As Zurich's TPA for GAF claims, Crawford provided various adjustment services, including accepting and acknowledging proofs of loss, maintaining claims files, investigating all reported claims and evaluating their merits, proposing Claim Reserve guidelines, and retaining attorneys approved by Zurich to defend claims.

Crawford received notice of the claim arising from the January 9, 2002 accident involving Ms. Rhodes that same day. On January 30, 2002, John Chaney, a Senior Liability Adjuster for

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Crawford, issued what he characterized as his First Full Formal Report regarding the accident. Chaney classified the claim as "catastrophic," and therefore declared that it will be reportable to both GAF and Zurich. Chaney had interviewed Zalewski by telephone on January 10, 2002, and reported that Zalewski said that he was descending a long gradual hill on Route 109, traveling roughly at the speed limit of 35 miles per hour when a car "popped out" of an intersecting street, causing him to go to his brake "vigorously." When he saw that this car had passed, he put his foot to the gas pedal, returned his eyes from that car to the road ahead, and saw Rhodes' car only 20-30 feet ahead. He put on his brakes, but they locked and he had too little space to stop. He said he saw no warning signs of work being done near the area of the accident. He was cited criminally for Operating Negligently to Endanger, and taken for drug and alcohol tests. The alcohol test was negative. The drug test had yet to be processed, but Zalewski denied that drugs or alcohol played any role in the accident. He said he was unaware of any defects in his truck. The police report confirmed his account, but noted that a truck traveling downhill in Zalewski's direction on Route 109 to the accident scene would have had 800 feet of straight, clear visibility. The police report also noted that the truck had one inoperative brake, but this was not deemed a factor in the accident.

As to damages, Chaney wrote that he was not fully aware of the extent of Ms. Rhodes' injuries, "except that we know she remains in life threatening condition at UMass Medical Center, is paralyzed, [and] suffers currently from pneumonia and pancreatic infection." He opined that the case "will carry a high value" but that it was premature to estimate the ultimate exposure.

Chaney noted that Ms. Rhodes had retained counsel, attorney Frederick Pritzker of the

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law firm of Brown Rudnick Freed & Gesmer, PC. At GAF's suggestion, Crawford retained the law firm of Nixon Peabody, LLP to represent GAF. Chaney asked GAF to notify the excess carrier (National Union), which it did. Chaney provided a copy of this report to the Vice President for Risk Management at GAF, the attorney at Nixon Peabody representing GAF, and Zurich at its corporate headquarters in Shaumberg, Illinois.

While this Court has no doubt that Chaney indeed did send his First Full Formal Report to Zurich's headquarters, the Report appears not to have found its way to any of Zurich's claims representatives, probably because Zurich had not earlier been notified of the claim and had established no claims file to which it could be sent. AIGDC, which served as the claims administrator for National Union and, for all practical purposes, managed National Union's excess insurance claims, received a copy of this Report on February 4, 2002 because GAF's broker gave written notice to AIGDC of the claim on that date, enclosing both the Report and the police report.[1]

Chaney's next transmittal to GAF was on April 8, 2002, with copies sent to AIGDC and Zurich's postal box.[2] Chaney noted that Zalewski was clearly liable for Ms. Rhodes' injuries due to his lack of attention and he opined that Zalewski's liability may be imputed to GAF.[3] He

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[1] Since AIGDC served as National Union's claims administrator and managed the Rhodes' excess insurance claim, this Court will simply refer to AIGDC when speaking of the excess insurer. There is no dispute that, if AIGDC is liable here, National Union is equally liable.

[2] Since AIGDC had earlier been notified of the claim and established a claim number, it received this transmittal; Zurich still had no claim number so this transmittal, too, was lost in its paperwork limbo.

[3] Chaney apparently mistakenly believed that Zalewski was employed by GAF; Zalewski was actually employed by DLS. GAF had retained DLS as an independent contractor to provide drivers for the trucks GAF leased from Penske.

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foresaw the possibility of contribution from Penske for faulty maintenance (although he noted that this did not cause the accident), and from Professional Tree Service and the Town of Medway for not having placed warning signs and for poorly managing traffic. He awaited the legal opinion of defense counsel as to the potential for contribution from other possible tortfeasors. He recommended that the policy limits of $2 million be put in reserve. However, no reserve was yet put in place because only Zurich had the authority to set a reserve of greater than $100,000, and no one at Zurich yet knew of this claim.

The next day, on April 9, 2002, Tracey Kelley, whose unusual title at AIGDC was "Complex Director" (which at AIGDC effectively meant that she was assigned complex claims, defined as claims with a potential value of more then one million dollars), wrote Chaney to inform him that she was handling the excess claim on behalf of AIGDC. She asked for copies of "all pleadings, investigative materials regarding the accident and/or damages claimed, a synopsis of any medical records received and reviewed, deposition summaries, dispositive motions and all analysis of liability and/or damages prepared by defense counsel."

On April 16, 2002, Ms. Rhodes, for the first time since the accident, returned home. She had undergone spinal fusion surgery at the University of Massachusetts Medical Center following the accident and remained there for a month. She was then released to Fairlawn Rehabilitation Hospital, where she had remained for two months before being allowed to return home. At home, she was confined to a wheelchair and dependent on others to move her from her wheelchair to her bed or to the toilet. In May 2002, she was hospitalized again, this time at Milford-Whitinsville Regional Hospital, for emergency surgery to remove a gangrenous gall bladder. After a week of recovery, she was transferred to Whittier Rehabilitation Hospital, where

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she remained for two weeks before coming home in June 2002. Shortly thereafter, because of her intensive physical therapy, she developed tendonitis and bursitis in her arms and shoulders and had to stop all physical therapy to allow them time to heal.

On July 3, 2002, GAF's law firm -- Nixon Peabody– informed Penske by letter that, under their Lease & Service Agreement dated May 18, 1992, Penske was an additional insured on the GAF liability policies. Consequently, by this time, GAF understood that its liability policies with Zurich and National Union covered Zalewski, GAF, DLS, and Penske with respect to the Rhodes accident.

On July 12, 2002, Ms. Rhodes, Mr. Rhodes, and their daughter, Rebecca Rhodes, who was then 14 years old, filed a civil complaint in Norfolk County Superior Court against Zalewski, DLS, Penske, and GAF. Ms. Rhodes sought damages for her injuries; Mr. Rhodes and Rebecca sought loss of consortium damages. The claim against Zalewski was premised on his negligence in causing the accident. The claim against DLS was premised on its vicarious liability for Zalewski's negligence, since he was a DLS employee acting within the scope of his employment at the time. The claim against GAF alleged that it was negligent in failing to exercise control over the independent contractor to whom it entrusted its leased trucks. The claims against Penske alleged two distinct legal theories: (1) that it was negligent in failing to exercise control over the the independent contractor to whom it entrusted the trucks it owned and (2) that it was legally responsible under G.L. c. 231, § 85A for the conduct of the driver who drove the truck it owned.[4]

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[4] Under G.L. c. 231, § 85A, once the plaintiffs prove that the truck was registered in the name of Penske as owner at the time of the accident, it is "presumed" that the truck was "operated, maintained, controlled or used by and under the control of a person for whose conduct

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Although Chaney's notes reflect that he sent a copy of the Rhodes complaint to Zurich at its Illinois headquarters on or about August 1, 2002, Zurich only learned of the case when it was asked to resolve a dispute that had arisen between GAF and Penske. Although GAF's attorney had informed Penske by letter on July 3 that Penske was an additional insured on GAF's policies, GAF changed its position after suit was brought and told Penske that it would neither defend nor indemnify Penske as to the claim. GAF also contended that there would be a conflict if Nixon Peabody were to represent Penske, and that Penske needed to retain separate counsel. On August 7, 2002, Chaney sent a "formal letter of notification" to Zurich and, perhaps most importantly, telephoned David McIntosh, a claims director at Zurich, to inform him of the coverage dispute with Penske. With personal contact finally having been made with a Zurich claims director, Chaney faxed to McIntosh various papers in his claim file (but omitted his First Full Formal Report and April 8, 2002 transmittal) and Zurich belatedly opened a claim file on August 21, 2002.

Zurich did not immediately take any action as to the Rhodes claim apart from resolving questions of coverage. McIntosh referred the matter to Zurich's coverage counsel to determine who was covered under the GAF policy. Zurich agreed to pay for Penske's separate counsel under a reservation of rights.

On August 30, 2002, the Rhodes filed an amended complaint which added a negligent maintenance claim against Penske. On September 27, 2002, the Rhodes served their first set of

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[Penske] was legally responsible, and absence of such responsibility shall be an affirmative defence to be set up in the answer and proved by the defendant." G.L. c. 231, § 85A. This means that ownership of the truck is prima facie evidence of control, sufficient to defeat any motion for summary judgement or directed verdict, but rebuttable with evidence to the contrary.

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requests for the production of documents to all defendants. Little new transpired as discovery proceeded. Although Crawford appears to have obtained no new information of consequence and had not received any of Rhodes' medical records, its view of the value of the case appeared to solidify. Chaney's transmittal letter of September 25, 2002, which was sent directly to McIntosh at Zurich, estimated the potential case value as between $5 million and $10 million. He also continued to recommend that the case be reserved at the policy limits of $2 million.

On November 21, 2002, Zalewski admitted to sufficient facts to support a finding of guilt as to his criminal charge in District Court and apologized for what he had done. Ms. Rhodes prepared a detailed written victim impact statement for his sentencing.

On May 6, 2003, Jody Mills, who had taken over as adjuster of the Rhodes file at Crawford, prepared a transmittal letter which noted that GAF's attorney in the Rhodes case had said that he did not expect the case to run its usual litigation course because of the severity of Ms. Rhodes' injuries. Counsel said that Ms. Rhodes' medical expenses would approach $1 million, but no demand had yet been made by Rhodes' counsel. Mills, like Chaney before her, continued to estimate the potential case value as between $5 million and $10 million.

In early June 2003, McIntosh of Zurich asked Mills for a full formal report, which she provided to him on June 4, 2003. Her report noted that Rhodes' attorney had yet to submit a demand or provide medical records. She also noted that she did not yet have a copy of Rhodes' medical records, although she understood that they had been provided in discovery to GAF's counsel.

In a transmittal letter dated July 22, 2003, Mills wrote that she had been advised by GAF's counsel that Rhodes' attorney had made an oral settlement demand of $18.5 million, with

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incurred medical expenses estimated at $1.3 million and future medical expenses estimated at $2 million. He also told her that Rhodes' attorney would be providing a more detailed written demand, along with a "day in the life" videotape. Mills at this time had yet to obtain the medical records from GAF's counsel, even though Zurich had asked for a copy, but she hoped they would be included with the written demand.

The written demand, along with the "day in the life" videotape, was provided to GAF's counsel on August 13, 2003, but the amount of incurred medical expenses ($413,977.68) was less than half of what orally had been represented.[5] Perhaps as a consequence, the amount of the written demand ($16.5 million) was below the oral demand. This demand included special damages totaling $2,817,419.42, comprised of:

- incurred medical expenses of $413,977.68;
- the present value of combined future medical costs arising from her paraplegia of $2,027,078;[6]

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[5] Carlotta Patten, the Brown, Rudnick associate who handled various discovery matters for the Rhodes litigation, acknowledged that Rhodes' April 2003 answers to interrogatories declared that her medical expenses exceeded $1 million. This figure was largely based on a tally provided by United Health Care, Rhodes' health insurer. However, when Patten obtained the various certified medical bills later in the spring of 2003, she observed discrepancies between these bills and the United Health Care totals, which she later learned arose from widespread duplication that reduced by more than half the actual amount of medical expenses. Rhodes' attorneys postponed completion of the written demand until they could resolve these discrepancies.

[6] The medical amounts were projected by Adele Pollard, a registered nurse with Case Management Associates, Inc, who first estimated Ms. Rhodes lifetime medical expenses assuming that she lived 34.7 more years (based on normal life expectancy) and then estimated those lifetime expenses assuming she lived only 24.4 more years (based on a lower than normal life expectancy arising from her injuries). The total relied upon was the average of these two estimates, reduced by present value calculations prepared by an economist.

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- the loss of household services of $292,379; and
- out-of-pocket expenses of $83,984.74.

The demand was carefully documented and included all Rhodes' medical records, along with Pollard's life care plan and an expert economist's report regarding the value of lost household services and present value calculations. The "day in the life" videotape chronicled what was described as a typical day for Ms. Rhodes, which depicted the enormous time and effort needed to move her from her bed to her wheelchair, to bathe her, to feed her, and to prepare her for bed, as well as the nursing care and home assistance needed to assist her with these mundane, everyday needs.

McIntosh changed his duties at Zurich in late August or early September 2003, so Rhodes claim file was reassigned to Katherine Fuell. McIntosh did not brief her on the claim or provide her with any background; she was left to get up to speed on the claim based solely on the contents of the claims file at Zurich and her review of McIntosh's contemporaneous typed notes, which every claims director was required to make and which were referred to as "Z notes." The last two Z notes McIntosh wrote before the transfer to Fuell reflected his frustration with the paucity of investigation conducted and the information provided by Crawford. Under Zurich's TPA agreement with Crawford, it was Crawford's job to serve as the case manager, to manage the litigation, and to ensure that the insureds had an effective and strategically sound legal defense, but Zurich ultimately had to resolve the claim. His June 11, 2003 "Z note" observed that he needed a "complete damage picture" – "full injury information, the medical costs both past and future, likewise we need the same for earnings." He also wanted defense counsel to conduct verdict research regarding the likely verdict in the case, and a litigation plan setting forth the

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current status of the case and the plan for moving forward. His last "Z note," dated August 25, 2003, said simply, "I have heard nothing from the TPA."

On September 11, 2003, Mills sent a letter to McIntosh (apparently still believing he was handling the claims file at Zurich) regarding the status of the case. She enclosed a copy of Rhodes' written demand, as well as a copy of the "day in the life" videotape. It is useful to summarize what information Fuell had in her possession once she received this letter and its attachments in mid-September 2003:

- Based on the medical records included by Rhodes' counsel in the written demand, it was plain that Ms. Rhodes had been rendered a paraplegic as a result of the accident and that she would remain a paraplegic until she died.

- Based on the medical records and the day in the life videotape, it was plain that Ms. Rhodes' life after the accident had become very confined, with a large share of her waking hours devoted to performing the mundane tasks that used to take her only minutes. It was less plain what the long-term prognosis was for her to lead a more normal life, albeit limited by her paraplegia, if she could lift herself onto a wheelchair, operate a motorized wheelchair, and learn to drive a minivan accommodated to her limitations.

- The documented medical expenses already incurred had reached more than $410,000, and there were likely to be substantial future medical and everyday expenses arising from her paraplegia.

- Zalewski was nearly certain to be found negligent in the accident. While Zurich was paying for his defense under a reservation of rights, there should have been little question that he was covered by GAF's Zurich policy, since the policy covered anyone occupying a covered automobile, and a covered automobile included any vehicle leased for a term of six months or more, which included the tractor-trailer that GAF leased from Penske which was driven by Zalewski.

- There was no evidence that Zalewski was separately covered by his own automobile accident policy, but there was no verification yet that he had no other primary insurance. DLS, as Zalewski's employer, was nearly certain to be found vicariously liable for Zalewski's negligence. As with Zalewski, there was yet no evidence that DLS had its own primary insurance but there was also no verification that it had no primary insurance. GAF's coverage counsel on May 29, 2003 had asked in writing for the defense attorney jointly representing Zalewski

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and DLS to furnish all relevant insurance policies, but the defense attorney had so far ignored the letter and provided no response.

- There was some possibility that Penske would be found negligent for its failure to maintain the brakes, but it did not appear that flawless brakes would have prevented the accident.

- Professional Tree Service had been deposed and defense counsel intended to seek leave to add it as a third-party defendant in the action because of its alleged failure to provide adequate warning signs around its work area. At the time, Crawford understood that it had a $3 million policy. In fact, it had two policies, each with a $1 million limit, only one of which would provide coverage.

- Crawford was consistently recommending that the reserve be established at the $2 million policy limits.

- With respect to the litigation, Zalewski had been deposed but none of the three Rhodes had yet been deposed. Nor had anyone asked Ms. Rhodes to undergo an Independent Medical Examination. Defense counsel had agreed that a defense life care planner should be retained to prepare a life care plan, which could then be compared with the plan devised by Rhodes' life care planner.

On September 24, 2003, Mills prepared another transmittal letter that dropped the potential case value from $5-10 million to $5-7 million because the incurred medical expenses were less than half of the amount that she had been told. The letter reflects that mediation had begun to be discussed among counsel, because it notes that Rhodes' attorney had asked for a good faith offer before he would agree to mediation.

Early in October 2003, Fuell sent forms to Crawford asking GAF's defense counsel, Greg Deschenes of Nixon Peabody, to provide a case evaluation regarding the strength of the Rhodes' case and of any legal defenses. In the second week of November 2003, Fuell received two documents that triggered her request for a conference call with defense counsel, Crawford, and AIGDC, which occurred on November 19, 2003.

The first triggering document was a transmittal letter from Mills dated November 13,

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2003 that used stronger language than any she had used before. Although Crawford had repeatedly requested that the reserve be increased to the policy limits, Zurich had yet to take any action, which left the reserve at $50,000 – the limit of the reserve that Crawford alone could authorize. Mills noted that the inadequate reserve could be seen as improper if a regulatory agency examined Zurich's financials, and urged that the reserve be increased to $2 million "at once to keep on the correct side of regulators." For the first time, Mills reported that, according to DLS's attorney, DLS had no insurance coverage of its own due to an error by its insurance agency. Therefore, there was no indication that any defendant likely to be found liable, apart from the third-party defendant Professional Tree Service, held any primary insurance that could share in the liability. Mills reported that it was unproductive to continue the infighting among the defendants and that attention should instead be focused on moving to a good settlement posture. She noted that Rhodes' attorney was a "successful big case lawyer," that his demand was not unreasonable in light of the special damages of nearly $3 million, and that he was "attempting to set up defendants for a 93A violation by making an early demand, asking for a good faith offer before submitting to non-binding arbitration." She "strongly" endorsed surrendering Zurich's policy limits of $2 million as a good faith position prior to mediation. She also noted that it would be better if only one insurer managed the mediation and that this could be accomplished by tendering the policy limits, essentially leaving it to AIGDC to mediate the case.

The second triggering document was Deschenes' case evaluation, which was sent to Crawford and received by Fuell at or around the same time as Mills' transmittal letter. Zurich did not waive its attorney-client privilege, so the content of this document remains unknown to

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this Court. However, based on Deschenes' testimony at trial, it is plain that Deschenes was eager to move the case to mediation. In June 2003, before receiving Rhodes' written demand, he had suggested to Rhodes' attorney that they stay discovery and proceed straight to mediation, but Rhodes' attorney refused to agree to a stay. However, he and Rhodes' attorney had agreed to proceed to mediation without first deposing Marcia and Rebecca Rhodes, sparing them the burden of being deposed unless the mediation failed. Late in October 2003, Deschenes telephoned Mills to ask for the authority to make an offer, since Rhodes' attorney had insisted upon an offer as a precondition to mediation.

The participants in the conference call on November 19 were GAF's insurance broker, GAF's inside counsel and risk management vice president, Fuell from Zurich, Deschenes, and Nick Satriano, AIGDC's Complex Director. Satriano had taken over the Rhodes excess claims file at AIGDC in June 2003.[7] Deschenes reviewed with the others the status of the case, the theories of liability, the defenses, and the likely damages. Deschenes informed them that Rhodes' attorney had asked for a good faith offer as a precondition to entering into mediation. Fuell said that she did not personally have the authority at Zurich to tender the $2 million policy limits, but she intended to ask her superiors for approval of such a tender. The conferees agreed that $2 million was not going to cover the settlement and that AIGDC would have to put up money for the case to settle. Deschenes pressed for a preliminary offer of $5 million prior to mediation.

Satriano was unhappy about being pressed to put up money before he was up-to-speed on

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[7] Satriano was the fifth claims director at AIGDC to take responsibility for this file, following four others who had responsibility for the file for roughly three months apiece.

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the case. He had only passively reviewed the claims file at AIGDC, and it only contained the Crawford reports, which he felt to be conclusory and unreliable. The conference call was the first time he had spoken to Deschenes about the case. He told the conferees that he was new to the file and did not have much of the information that was being discussed at the conference. He asked Deschenes to send him a copy of his file and all the information he had. He said he would study that information and become fully involved in the case. He also said he wanted to bring in associate counsel, that is, he wanted to add to the GAF defense team Attorney William Conroy from the law firm of Campbell & Campbell to jointly represent GAF and AIGDC in the lawsuit. He was challenged by others as to the need for associate counsel, but Satriano did not back down, since he did not have confidence in Deschenes and did not think he was sensitive to the needs of an excess insurer.

Satriano vigorously disagreed with the recommendation that they should offer $5 million prior to the mediation, and refused to commit at that time to putting up any AIGDC money towards a settlement offer. Both Satriano and Fuell understood from Deschenes that Rhodes' attorney had demanded $5 million as "the price of admission" to mediation. In fact, Rhodes' attorney had never stated this or any other number; he had simply insisted upon a good faith offer prior to mediation to ensure that the mediation would not be a waste of time. Rather, Deschenes believed the $5 million to be a good faith preliminary offer and pressed the insurers to offer it, and they conflated his recommendation with Rhodes' attorney insistence upon a good faith offer. This misunderstanding was never corrected; Satriano and Fuell left the conference with the understanding that Rhodes' attorney had refused to enter into mediation unless the insurers first made an offer of no less than $5 million.

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The conference ended with Fuell committing to request authority within Zurich to tender the $2 million policy limits, and asking Deschenes to provide her with the information she needed to make that request. Satriano committed to read the case materials that Deschenes was to provide him but did not commit to any offer.

On November 24, 2003, Deschenes sent Satriano the demand letter, medical records, preliminary defense life care planner report, pleadings, case evaluations, and various reports. Satriano did bring in Conroy as associate counsel in December, and Conroy on December 24 asked Deschenes to send him all "correspondence, pleadings, depositions, and all discoverable documentation" for his review, but asked him to hold off on sending him the 10 boxes of discovery materials.

Following the meeting, Fuell went to work to prepare the BI Claim Report, which was a prerequisite to her obtaining authority at Zurich to tender an amount as large as $2 million. On or about December 5, 2003, she had received the final version of the defense life care plan, prepared by Jane Mattson, which determined that Ms. Rhodes life care costs would total $1,239,763, which was $787,315 less than the present value of Ms. Rhodes' combined future needs in her demand letter.[8] The primary differences between the plaintiff and defense life care plans were that the defense life care plan assumed a shorter life span for Ms. Rhodes (24 years vs. 28.9 years), provided fewer hours per week for home care aides, and assumed that she could reside in the Rhodes' living room rather than in her own modified bedroom.

On December 19, 2003, Fuell submitted her BI Claim Report, which asked for approval

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[8] Mattson's preliminary life care plan, issued on October 2, 2003, had estimated the total life care costs as $1,487,827.

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before the end of the year to tender the $2 million policy limits to AIGDC. She stated that the probability of a plaintiff's verdict was 100 percent, and that there was no possibility of a finding of comparative negligence. She estimated, with respect to the damage award for pain and suffering, a 10 percent risk of an award of $11 million, a 50 percent risk of an award of $12.25 million, and a 10 percent risk of an award as high as $13.75 million damage. She gave an estimated value of the total damage award as nearly $17.88 million. Fuell, however, badly misstated the amount of past medical bills in her Report, describing them as $2.817 million, which was the total amount of special damages in the demand letter; the past medical bills were $413,977.68. As a result, her special damages, even with her low end estimate, was $4.317 million, which was $1.5 million more than the special damages estimate in Rhodes' demand letter. Even eliminating this error, however, it is plain that Fuell in her Report anticipated a total damage award of considerably more than $10 million.

Fuell had sent her Report to Kathy Langley at Zurich, not realizing that Langley was leaving Zurich at the end of that month. Langley told her between Christmas and New Year's Day that she had recommended approval of the full tender to Thomas Lysaught of Zurich, who was to make the decision, but had yet to hear from him. On January 21, 2004, Fuell emailed Lysaught directly and asked if he had reviewed her request for authority to tender the $2 million policy limits. Lysaught gave his approval on January 22.

On January 23, 2004, Fuell telephoned Satriano at AIGDC and verbally tendered to AIGDC the policy limits. Satriano said he would not accept a verbal tender and needed it in writing. He added that the writing needed to address whether Zurich was simply tendering its policy limits and would continue to pay for the defense of the case, or whether it was also

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tendering the defense obligation, i.e. whether it would refuse to pay any longer for the defense upon the tender. She told him she would need to review the policy to determine Zurich's defense obligation upon tender and would send him a letter incorporating the correct policy language. She added that, while she would get him a written confirmation, Zurich intended to tender its policy limits and has already advised both the client and the broker of the tender. Satriano admits that, as a result of this telephone call, he knew that he had Zurich's $2 million available for any settlement.

Fuell had not responded to Satriano in writing by February 13, 2004, and Satriano grew concerned about the risk of confusion as to whether Zurich was seeking to tender its defense obligations along with its policy limits. That day, he emailed Fuell that AIGDC had not yet received any formal offer of tender, that any formal offer must be in writing, and any written offer may not be communicated by email. He added that "my current understanding is that the primary insurer has NOT relinquished their duty to defend the insured in this litigation" and that he expected Zurich, as primary insurer, to continue its obligation to defend regardless of any tender. Fuell replied that day by email that she had never stated that Zurich was "in any way relinquishing our defense obligations to the insured ...." She said that she expected to have access to the policy when she returned to the office on Monday so that she can provide written notification to him. She ended by reiterating that, even without a formal writing, Zurich has offered the full limits of its policy to AIGDC, and AIGDC can rely upon that tender in communicating a response to plaintiffs' demand.

Although he did not yet have a formal writing from Zurich memorializing the tender, Satriano certainly understood that he had Zurich's tender because he attended a meeting on

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March 4, 2004 at GAF's home office in New Jersey to discuss the case without inviting Zurich. On March 1, a few days before this meeting, the Rhodes had moved to amend their complaint against GAF to add a count under a federal motor carrier's statute which would plainly have made GAF vicariously liable for Zalewski's negligence. The motion to amend, over GAF's objection, was allowed on March 16. As a result, GAF, which before was defending a claim that it had negligently failed to supervise an independent contractor, was now defending a vicarious liability claim based on Zalewski's negligence, and consequently had essentially no chance of escaping liability.

Present at the March 4 meeting, apart from Satriano, were various GAF representatives, Deschenes, Conroy, and GAF's insurance broker. At this meeting, Deschenes presented the results of the jury verdict and settlement research he had conducted, which focused on automobile accident cases, mostly in Massachusetts, in which liability was probable or reasonably clear and which involved severe damages, many of them resulting in paraplegia. The average settlement among these comparable cases was $6,647,333; the average verdict was $9,696,437. GAF wanted to respond to Rhodes' demand, which had increased in December 2003 to $19.5 million. All thought that Rhodes' demand was too high, but no one suggested that it was unworthy of a response. Satriano, however, was adamantly opposed to making a $5 million offer prior to mediation or to making any offer in order to cause Rhodes' attorney to agree to mediation. He said he was willing to go to mediation but did not want to set an improper artificial starting point for the mediation. Since AIGDC was not willing to make an offer prior to mediation and Pritzker had earlier said that an offer was a precondition to mediation, this meeting accomplished little towards agreeing upon a settlement posture. At the

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close of the meeting, Satriano simply told Conroy to tell Pritzker that they were still working on a response to his settlement demand and would get back to him.

The meeting, however, did provide some guidance regarding litigation strategy. Conroy said he had identified a physiatrist (an expert in physical medicine) to conduct an Independent Medical Examination ("IME") of Ms. Rhodes to determine the severity of her present condition and her ability to recover some functioning through rehabilitation. There was also some discussion of deposing Ms. Rhodes and her daughter, but no decision was made as to whether to proceed with their depositions before any mediation.

For all practical purposes, the failure to develop a settlement position at this March 4 meeting meant that no reasonable settlement offer would be presented before the pretrial conference on April 1, 2004, since Satriano knew at the meeting that he had been called to active military duty in Iraq and that responsibility for the Rhodes excess claim file at AIGDC was to be transferred in his absence to Richard Mastronardo, who did not attend the meeting.

GAF's coverage attorney, Anthony Bartell, was so frustrated by AIGDC's unwillingness to agree upon a settlement offer that he wrote Satriano on March 18 that AIGDC's failure to commence settlement negotiations with Rhodes' attorney despite his settlement demand more than seven months ago violated its obligation under G.L. c. 176D, § 3(9)(f) "to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." He also informed Satriano that, once Zurich formalized its tender, GAF would offer Zurich's $2 million to the Rhodes to settle their claims.

Zurich did not resolve the question of its defense obligations upon tender until March 29, 2004. Fuell wrote Mastronardo a formal letter stating that Zurich was tendering its $2 million

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policy limits and that its duty to defend the insured and additional insureds under the Policy ended with the tender. The letter quoted the provision of the Zurich Policy that declared:

> Our duty to defend or settle ends ... when we tender, or pay to any claimant or to a court of competent jurisdiction, with the court's permission, the maximum limits provided under this coverage. We may end our duty to defend at any time during the course of the lawsuit by tendering or paying the maximum limits provided under this coverage, without the need for a judgment or settlement of the lawsuit or a release by the claimant.

The letter stated that, effective April 5, 2004, Zurich was transferring all its defense obligations to AIGDC. The letter asked to whom the $2 million check should be made payable to and to whom it should be sent.

Mastronardo orally rejected Zurich's March 29 formal written tender because of its attempt to transfer to AIGDC the defense obligation. He stated that AIGDC had no defense obligation under its excess policy and that the issue of legal fees needed to be resolved between Zurich and GAF. On April 2, 2004, Martin Maturine, AIGDC's Complex Director for Excess Specialty Claims, wrote Zurich to confirm that it had rejected Zurich's tender of primary policy limits. AIGDC's rejection of the tender was spurious. Maturine focused on the provision in the National Union Policy that declared that National Union "shall have the right and duty to defend any claim or suit seeking damages covered by the terms and conditions of this policy" when the limits of all underlying insurance policies providing coverage to the insured "have been exhausted by payment of claims to which this policy applies." (emphasis in Maturine letter but not in Policy). In essence, AIGDC was declaring that its duty to defend commenced only upon payment of policy limits so it was going to reject the tender of those limits in order to prevent such payment from occurring.

On April 2, 2004, Fuell informed GAF and all counsel that, in light of AIGDC's rejection

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of its tender, Zurich had made a "business decision" to continue to pay all defense costs in the Rhodes litigation. Fuell said that Zurich had offered to deposit its $2 million tender in an escrow account and reserved its rights to recover its defense costs from AIGDC.

Soon after the formal tender on March 29, before the April 1 pretrial conference, Deschenes, on behalf of GAF, offered Pritzker $2 million to settle the Rhodes' claims and invited Pritzker to mediate the case. Pritzker considered the offer wholly inadequate, and said he wanted to mull over whether mediation was worth doing in light of that offer. A few weeks later, however, Pritzker agreed to mediate, and invited the defendants to select a mediator.

While the Rhodes were willing by mid-April 2004 to proceed to mediation, AIGDC did not wish to proceed to mediation until it had concluded the additional discovery it now insisted it needed. After Satriano left for Iraq, Maturine took over as the Complex Director of the Rhodes claim file and Tracey Kelly, who had been the Complex Director in charge of the file in April 2002, was promoted to Complex Claims Supervisor and assumed supervisory authority over the case. They did not wish to proceed to mediation until Marcia and Rebecca Rhodes had been deposed, the IME of Marcia Rhodes had been completed, and they had obtained Marcia Rhodes' prior psychological records. They also wanted to explore various insurance coverage issues which they felt had not been adequately resolved – the amount of coverage carried by Professional Tree Service and whether Zalewski was a covered person under the Penske policy.

Pritzker would not agree to hand over Ms. Rhodes' psychological records, so defense counsel filed a motion seeking such discovery, which was denied on June 11, 2004. Since the discovery deadline had passed, defense counsel also filed a motion on June 18, 2004 to extend

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discovery and extend the trial date.[9] On July 8, 2004, Superior Court Judge Elizabeth Donovan denied the motion but permitted the depositions of Marcia and Rebecca Rhodes to proceed, since Pritzker had earlier agreed with defense counsel that they could be postponed beyond the discovery deadline.

The mediation was scheduled for August 11, 2004. The IME of Marcia Rhodes was conducted on July 20, 2004 by the defendants' expert physiatrist. Marcia Rhodes was deposed on August 4, 2004. Rebecca was not deposed until August 25, 2004, after mediation failed.

Maturine left AIGDC in June 2004 so yet another Complex Director, Warren Nitti, was assigned to the Rhodes file. He was asked to compile a narrative report regarding the Rhodes' claim, which he completed on August 3, 2004. Nitti recommended that authority be given to pay a settlement of $6 million, but Kelly overruled him and authorized a settlement of only $4.75 million. She intended to offer a structured settlement with an annuity to pay for Ms. Rhodes' life care plan, because the annuity could be obtained for less than the value of the life care plan and offered tax advantages to the Rhodes. While Kelly, on behalf of AIGDC, gave settlement authority up to $4.75 million, she understood that this would include only $1.75 million of AIGDC's monies, since $2 million of the settlement was to come from Zurich's policy and she assumed that the remaining $1 million would come from Professional Tree Service, who AIGDC had determined had $1 million in coverage and figured would be willing to pay policy limits in order to avoid the risk of far greater exposure at trial.

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[9] A similar motion had been filed on May 17, 2004 but it was withdrawn after GAF objected to the filing of that motion. GAF agreed to the filing of the motion only after Maturine warned GAF in writing that its continued denial of consent to its filing may constitute a breach of the insured's obligation of cooperation and may result in AIGDC disclaiming coverage.

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At the mediation on August 11, which was attended, among others, by Pritzker, Nitti, and Attorney Peter Hermes on behalf of Professional Tree Service, the Rhodes made an initial settlement demand of $15.5 million, plus defense payment of Ms. Rhodes' health insurance premiums for the remainder of her life. Nitti, on behalf of the GAF-insured defendants, counter-offered with $2.75 million. After further discussion, the Rhodes counter-offered with $15.0 million, and Nitti increased the defendants' counter-offer to $3.5 million. Meanwhile, Professional Tree Service reached a separate settlement with the Rhodes, agreeing to pay them $550,000 for a release. Nitti never offered the full amount of his authority of $3.75 million. Nor did AIGDC revisit whether to increase Nitti's authority after it learned that the Tree Service had settled for $450,000 less than AIGDC had anticipated. In retrospect, it is now clear that the mediation was doomed to fail in view of the positions taken by the Rhodes and AIGDC. Mr. Rhodes, who effectively spoke for the family as to settlement, would not have accepted any settlement offer at mediation less than $8 million and no one involved in this case at AIGDC would have agreed at mediation to pay that amount to resolve the case.

After the mediation, defense counsel deposed Rebecca Rhodes and attempted again to persuade the court to grant them access to Ms. Rhodes' prior psychological records, asking the court to conduct an *in camera* review of those records to determine their relevance at trial. This motion, filed on an emergency basis on August 19, was denied on August 23.

No settlement negotiations were conducted or further counter-offers communicated before trial commenced on September 7, 2004. Just prior to the trial, Zalewski, DLS, and GAF stipulated to their liability, meaning that the trial would only decide the questions of Penske's liability and the amount of damages suffered by the Rhodes. During the course of trial, the

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parties stipulated to the dismissal of all claims against Penske, leaving only damages to be decided by the jury.

Nitti attended the trial and reported that it was progressing more favorably to the Rhodes than AIGDC had anticipated. After the close of evidence but before closing arguments, Nitti, having obtained authority from AIGDC, increased its offer to $6 million, which included Zurich's $2 million, but not the Tree Service's $550,000. Pritzker did not communicate that offer to the Rhodes, effectively rejecting it. When the jury returned with its verdict on September 15, it awarded Ms. Rhodes $7,412,000 for her injuries, Mr. Rhodes $1.5 million on his consortium claim, and Rebecca Rhodes $500,000 on her consortium claim, for a total award of $9.412 million, not including the 12 percent simple interest that had accrued in the roughly 2 years and two months since the complaint had been filed, which added roughly another 26 percent to the total. Judgement entered for the Rhodes on September 28, 2004. After deducting the $550,000 settlement with Professional Tree Service, all of which was paid to Ms. Rhodes, the total amount due from the GAF-insured defendants was roughly $11.3 million.

On October 8, 2004, Nitti sought internal approval within AIGDC to prosecute an appeal. The proposed appeal had two grounds: (1) the alleged excessiveness of the verdict, and (2) the court's denial of the defendants' motions to obtain Ms. Rhodes' psychological records in discovery. Nitti declared there was a "possibility" of gaining a new trial based on the denial of the psychological records; he admitted that "[t]he chances of obtaining relief on remittitur are more remote."

On October 18, 2004, the defendants moved for a new trial or, in the alternative, remittitur. On November 10, they filed notice of appeal. Their new trial motions were denied on

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November 17. On November 19, the Rhodes sent a Chapter 93A demand letter to Zurich and AIGDC, alleging that they had engaged in unfair settlement practices in violation of G.L. c. 176D, § 3(9)(f) by failing to effectuate a prompt, fair and equitable settlement. They demanded a reasonable settlement within 30 days.

AIGDC responded to the Chapter 93A demand letter on December 17, 2004 by offering $7.0 million, of which $1.25 million would go towards purchasing a life care plan for Ms. Rhodes. This offer included Zurich's $2 million, but did not include the $550,000 already obtained from Professional Tree Service. This settlement offer required the Rhodes not only to release all defendants as to the personal injury claims but also to release all claims under Chapters 93A and 176D. Zurich responded on December 22, 2004 by paying the Rhodes $2,322.995.75 without obtaining any release, which included its $2 million policy limits plus accrued post-judgment interest on the entirety of the underlying judgment from the date that judgment entered. The Rhodes replied by filing this action on April 8, 2005.

AIGDC increased its structured settlement offer on May 2, 2005 to $5.75 million, which, when one includes the amounts paid by the Tree Service and Zurich, brought the total amount to $8.62 million. Pritzker replied on May 12, insisting that the Rhodes would settle for nothing less than the entirety of the settlement, plus interest. On June 2, 2005, after further negotiations, Pritizker confirmed in writing the terms of the Rhodes' settlement with AIGDC: AIGDC would withdraw the defendants' appeal and pay the Rhodes $8.965 million, with $3 million to be paid on July 5, another $3 million to be paid on August 5, and the $2.965 million balance to be paid on September 5. Adding the amounts paid by Zurich and the Tree Service to this total, the plaintiffs obtained roughly $11.835 million in settlement of their tort action. The Rhodes did not

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promise to dismiss their Chapter 93A action against AIGDC as part of the settlement.

CONCLUSIONS OF LAW

G.L. c. 176D, § 3 sets forth various acts that are defined as "unfair or deceptive acts or practices in the business of insurance," and therefore violations of G.L. c. 93A, § 2. G.L. c. 176D, § 3. Among these forbidden acts are various "unfair claim settlement practices," of which the best known is "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." G.L. c. 176D, § 3(9)(f). As our appellate courts have interpreted this provision, some flesh has been added to the spare bones of this statutory obligation. These interpretations have made clear that:

1. The obligations in G.L. c. 176D, § 3(9)(f) are not simply owed to the insurance company's policyholders, but also to those third parties making claims against its policyholders. See, e.g., Clegg v. Butler, 424 Mass. 413, 419 (1997).

2. To "effectuate" a settlement means to make a settlement offer. See, e.g., Hopkins v. Liberty Mutual Insurance Company, 434 Mass. 556, 567 (2001).

3. The obligation to make a settlement offer is triggered only when "liability has become reasonably clear," and "liability encompasses both fault and damages." Clegg v. Butler, 424 Mass. at 421; Metropolitan Property and Cas. Ins. Co. v. Choukas, 47 Mass. App. Ct. 196, 199 (1999).

   AIGDC argues that, in a tort case such as this where the accident resulted in paraplegia, damages are not reasonably clear until the jury renders its verdict because the damages arising from the pain and suffering of the accident victim and the loss of consortium of her spouse and children are inherently unclear and unquantifiable. The Supreme Judicial Court has plainly rejected this proposition, which would effectively negate the statutory obligation of insurance companies to make a prompt and fair settlement offer in nearly all tort cases. See Clegg v. Butler, 424 Mass. at 421; Hopkins v. Liberty Mutual Insurance Company 434 Mass. 556, 567-578.

   In Clegg, the accident victim's car had been struck in a head-on collision and he suffered serious injuries that certainly would have justified a substantial award for pain and suffering. 424 Mass. at 414-415. The Supreme Judicial Court nonetheless affirmed the trial judge's finding that it was a "100% liability case against the insured," and that the insurance company therefore was obliged to have made a settlement offer within 30 days

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of plaintiff's Chapter 93A letter demanding a settlement offer. Id. at 421. In Hopkins, the accident victim's car was struck from the rear and pushed into the vehicle in front, resulting in a spinal injury that permanently prevented the plaintiff from returning to her work as a plumber. 434 Mass. at 557-558. Even though these injuries would have resulted in substantial pain and suffering, the Supreme Judicial Court still found that liability was reasonably clear and, therefore, that the insurance company had an obligation to make a settlement offer within 30 days of its receipt of the plaintiff's Chapter 93A demand letter. Id. at 560-561, 569. In contrast, in O'Leary-Alison v. Metropolitan Property & Cas. Ins. Co., even though negligence was plain because the plaintiff had been rear-ended by the defendant's car, the Appeals Court found that liability was not reasonably clear in large part because the independent medical examiner found no physical condition warranting treatment. 52 Mass. App. Ct. 214, 217-218 (2001).[10]

Therefore, when the Supreme Judicial Court speaks of damages being reasonably clear, it effectively means that (1) it is reasonably clear that the plaintiff has suffered substantial injury caused by the negligence of the defendant, and (2) the extent of those injuries is reasonably clear. It does not mean that it is reasonably clear how much a jury would award the plaintiffs for pain and suffering or loss of consortium, because juries hearing the same evidence plainly will differ in the amounts they award to compensate plaintiffs for these intangible losses.

4. An insurance company is entitled to delay making a settlement offer until liability – negligence and damages – is reasonably clear and may conduct a diligent investigation to determine whether liability indeed is reasonably clear. As the Supreme Judicial Court declared in Clegg:

> Insurers must be given the time to investigate claims thoroughly to determine their liability. Our decisions interpreting the obligations contained within G.L. c. 176D, § 3(9), in no way penalize insurers who delay in good faith when liability is not clear and requires further investigation.

424 Mass. at 413. A corollary to this principle is that an insurance company may not unreasonably delay making an offer once its investigation has determined that negligence and damages are reasonably clear. Nothing bars an insurance company from continuing its investigation in the hope that it will uncover new information that may pinpoint the precise amount of damages or disprove damages that otherwise appeared reasonably clear, but it may not postpone its settlement offer while it pursues these investigative

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[10] The insurance company, despite the disputed evidence as to whether the plaintiff had been injured in the accident, still made a settlement offer of $20,000 in O'Leary-Alison. Id. at 216. Therefore, the Appeals Court essentially found that the insurance company's offer was reasonable under the circumstances, since it did not need to consider whether the insurance company had an obligation to make an offer.

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possibilities.

5. The reasonable clarity of damages depends on the amount of the policy limits. In a catastrophic injury where negligence is not materially disputed, damages are reasonably clear to the primary insurer with modest policy limits once it is reasonably clear that the amount of damages will exceed those policy limits, even if the total scope of damages is not yet reasonably clear. See Clegg, 424 Mass. at 421-422 (since primary insurer knew or should have known that Clegg was permanently and totally disabled from work, there was no reasonable doubt that the damages exceeded the $250,000 available under the primary policy). Consequently, damages may be reasonably clear to the primary insurer before they are reasonably clear to the excess insurer.

Armed with these interpretations, this Court will now determine whether Zurich and/or AIGDC breached its statutory obligation "to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." G.L. c. 176D, § 3(9)(f).

Did Zurich Breach its Obligations as a Primary Insurer under G.L. c. 176D, § 3(9)(f)?

In the instant case, it was reasonably clear by January 30, 2002, when Crawford, Zurich's TPA, issued its First Full Formal Report, that Zalewski was negligent in causing Ms. Rhodes' injuries in the accident, that Ms. Rhodes was not comparatively negligent, and that Ms. Rhodes suffered catastrophic injuries from the accident. The scope of her damages, however, could not have been reasonably clear at least until August 13, 2003, when the Rhodes made their written settlement demand, which set forth the amount of medical expenses she had incurred. The calculation of the amount of medical expenses had gotten so confused that the Rhodes needed to delay the submission of this settlement demand until their attorneys could sort out this confusion and determine why the totals claimed by Ms. Rhodes' health insurer did not match the amount claimed in her medical bills. This confusion had caused the Rhodes to declare in an answer to an interrogatory that her medical expenses exceeded $1 million when they totaled less than half that amount – $413,977.68 – at the time of their settlement demand. In short, it was not even

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reasonably clear to plaintiffs' counsel how much Ms. Rhodes had incurred in medical bills until August 2002, and that calculation was the necessary starting point for any calculation of total damages.

The life care plan for Ms. Rhodes' future medical needs comprised roughly $2.03 million of the roughly $2.8 million in special damages claimed by the Rhodes in that demand letter. Zurich was not obliged to accept the life care plan estimates made by Rhodes' expert; it was entitled, as part of its due diligence in determining the amount of damages that were reasonably clear, to retain its own life care expert to prepare her own estimates and to analyze Rhodes' expert's life care plan. Since the Rhodes' life care plan was provided to the defense in mid-August, the slowest summer month of the year, Zurich acted with reasonable timeliness in obtaining Mattson's preliminary estimates from her life care plan on October 2, 2003. From that estimate of roughly $1.49 million, it should have been reasonably clear that Ms. Rhodes special damages alone, based solely on medical bills that were now in Zurich's possession and its own life care expert's preliminary estimate, totaled more than $1.9 million. Since there was no doubt that Ms. Rhodes had been rendered a paraplegic and that she and her family were entitled to substantial damages for pain and suffering and loss of consortium, it should have been reasonably clear by October 2, 2003 that the total damages incurred from the accident would far exceed the Zurich policy limits of $2 million.

This does not mean, however, that by October 2, 2003 it was reasonably clear that Zurich should tender its policy limits to AIGDC, GAF's excess insurer. While it was plain by then that Zalewski and DLS would be found negligent (Zalewski for his own negligence and DLS, as his employer, for its vicarious responsibility for his negligence), it had not yet been ascertained

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whether Zurich was the only primary insurer providing coverage for Zalewski's and DLS's negligence. It was certainly reasonable for Zurich to seek to determine whether Zalewski and DLS had their own primary coverage, apart from the coverage GAF provided to them through its policy as additional insureds, and Zurich had retained coverage counsel in part to make this determination. While one would think that this question of coverage could have been resolved sooner, since Zurich was providing a defense for both Zalewski and DLS that was contingent upon their continued reasonable cooperation with Zurich, it was only on November 13, 2003 that Zurich obtained information on which it reasonably could rely – Crawford's transmittal letter reporting a conversation with DLS's attorney who stated that, because of an error by DLS's insurance agency, it had no primary coverage apart from Zurich's.

Once Zurich had this information and reviewed the case evaluation it had sought from GAF's defense counsel, it should have been clear by mid-November 2003 that:

- Zurich was the only primary insurer for the two defendants who certainly would be found liable – DLS and Zalewski;
- Zurich was the only primary insurer for another defendant, GAF;
- Penske may have had another primary insurer apart from Zurich, but it was not reasonably likely to be found liable. While Penske may have been negligent in failing to maintain the brakes of Zalewski's tractor-trailer, there was no evidence that any deficiency in the brakes caused the accident. In addition, while Penske's ownership of the truck provided prima facie evidence under G.L. c. 231, § 85A that Penske was legally responsible for Zalewski's conduct, which would have been sufficient to defeat a motion for summary judgment or directed verdict, the evidence would not likely have been strong enough to win at trial, since Penske simply leased the truck to GAF, who retained DLS to drive it.
- Professional Tree Service, a third-party defendant, may have been liable for failing to post proper warning signs and its alleged negligence may have caused the accident, but its liability was less than reasonably certain. At that time, it was not clear how much insurance coverage Professional Tree Service had, but Zurich could quickly have determined that it held $1 million in primary coverage.

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On November 19, 2003, Fuell, Zurich's Complex Director in the case, declared at the conference call with defense counsel and AIGDC's Satriano that she did not have the authority herself to tender the $2 million policy limits but she was going to seek that authority. While Fuell did not orally inform Satriano at AIGDC that she had obtained the necessary authority and was tendering the full policy limits until her telephone call of January 23, 2004, it is plain that AIGDC understood from the time of the November 19, 2003 conference call that Zurich was going to tender its policy limits and acted accordingly. At the meeting, Satriano asked for all relevant documents so that he could become fully informed regarding the claim and evaluate the $5 million settlement offer recommended by GAF's attorney. He also declared his intention to add an attorney representing AIGDC's interests to the GAF defense team in the litigation.

The Rhodes contend that Zurich's delay in tendering its policy limits violated its statutory obligation to "effectuate prompt ... settlements of claims in which liability has become reasonably clear." G.L. c. 176D, § 3(9)(f). Before considering what "prompt" means under this statute, this Court needs first to determine when Zurich actually tendered its policy limits. As noted earlier, Fuell verbally tendered to AIGDC the full policy limits in her telephone call to Satriano on January 23, 2004, but Satriano rejected the tender on two grounds: (1) he wanted it in writing; and (2) he wanted the writing to address whether Zurich was also tendering its defense obligation. It was the latter ground that delayed the written confirmation of Zurich's tender, since Fuell needed to determine from the policy language whether Zurich was going to continue to pay for the defense of the case. On February 13, 2004, she provided Satriano with written email confirmation that Zurich had tendered its policy limits and that AIGDC can rely upon that tender in making a settlement offer to the Rhodes, but the email also indicated that Fuell had not

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resolved whether the tender meant that Zurich no longer intended to pay for the insureds' defense of the case. Fuell did not send the formal letter of tender until March 29, 2004 and AIGDC rejected the tender because it disclaimed any continued obligation to pay for defense costs. Although this Court is not aware of any written correspondence from AIGDC accepting Zurich's tender after Zurich agreed on April 2, 2004 to continue to pay all defense costs, it is plain that AIGDC's acceptance of the tender commenced upon its receipt of Zurich's April 2 letter.

This Court finds that, for all practical purposes regarding settlement of a civil action, Zurich effectively tendered its policy limits to AIGDC on January 23, 2004 with Fuell's verbal tender. From that telephone call, AIGDC knew that it effectively had Zurich's $2 million policy limits in its pocket to include in any settlement offer and that, from that moment, the obligation to make a settlement offer had shifted to AIGDC. It was reasonable for AIGDC to insist that Zurich clarify whether it was seeking also to tender the defense obligation to AIGDC but AIGDC could not reasonably reject Zurich's tender of policy limits because of that ambiguity. If it could, the insurers' settlement obligation could stagnate in legal limbo, with the primary insurer trying to tender policy limits and the excess insurer rejecting the tender, leaving no insurer to make a reasonable settlement offer to the plaintiffs. Rather, AIGDC was obliged to accept the tender of policy limits and resolve separately the question of which insurer now had the obligation to pay defense costs. As noted earlier, if one looks at what AIGDC did rather than what it said, it is clear that it had accepted the tender of policy limits well before Zurich agreed to continue to pay defense costs on April 2, 2004, because it did not even invite Zurich to the meeting at GAF headquarters on March 4, 2004 to discuss legal strategy and settlement offers.

The question then is whether Zurich's tender on January 23, 2004 was "prompt" within

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the meaning of G.L. c. 176D, § 3(9)(f). To be sure, Zurich had effectively completed its due diligence by the November 19, 2003 meeting and Fuell knew then that she was going to recommend that Zurich tender its full limits. However, in order to obtain authority for so large a tender, Fuell had to prepare a detailed BI Claim Report, which she did not complete until December 19, 2003. That Report then had to be reviewed by the approving officer and authorization given, which did not happen until January 22, 2004, in part because the person to whom the Report was addressed left Zurich at the end of December 2003.

This Court notes that, in Hopkins, the Supreme Judicial Court effectively defined "prompt" to mean 30 days after the plaintiff on December 29, 1994 had sent the Chapter 93A letter demanding a settlement offer as required by G.L. c. 176D, § 3(9)(f), even though the plaintiff had on October 14, 1994 sent a settlement demand letter and liability was reasonably clear by the end of October 1994.. 434 Mass. at 559-560, 568. See G.L. c. 93A, § 9(3) (requiring a plaintiff to make a written demand for relief at least 30 days before filing a Chapter 93A action). Here, Rhodes' attorney chose not to characterize their settlement demand on August 13, 2003 as a demand for a settlement offer under G.L. c. 176D, § 3(9)(f); indeed, no settlement offer was demanded under Chapter 93A until after the jury's verdict. Therefore, Fuell was under no statutory deadline when she sought approval of the tender and, as a result, Zurich lacked the urgency that would have been stimulated by such a deadline.

To be sure, an insurer may breach its obligation to effectuate a prompt settlement of a claim without a Chapter 93A demand letter, but the absence of such a demand may affect the determination of whether the obligation of promptness was breached. For all practical purposes, the meaning of "prompt" must be understood in its context, since the failure to be "prompt"

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under G.L. c. 176D, § 3(9)(f) is itself an unfair act in violation of Chapter 93A. Viewed in that context, this Court does not find that Zurich's delay from November 19, 2003 to January 23, 2004 violated its obligation to make a "prompt" tender. It is reasonable for an insurance company to require a tender as large as $2 million to be authorized at a high level in the company and it is equally reasonable to require that such a request be accompanied by a detailed written justification such as the BI Claim Report. It is reasonable to expect that such a written justification will require a significant amount of time to prepare and for the authorizing officer to consider, and it is reasonable to expect that the time needed will be greater when this work is being performed during the busy holiday season between Thanksgiving and New Year's Day. While this Court has no doubt that Zurich could have and should have provided the required authorization for the tender earlier than January 22, 2004, it does not find it to be an unfair act to have failed to do so. Therefore, this Court finds that Zurich acted with the promptness required under G.L. c. 176D, § 3(9)(f) when it provided AIGDC with its verbal tender of policy limits on January 23, 2004.

This Court further finds that, even if Zurich had violated its duty to provide a prompt tender and was obliged to have furnished it within days of the November 19, 2003 conference call, the earlier tender would not in any way have affected either the timing or the amount of AIGDC's subsequent settlement offer. There is literally nothing that AIGDC would have done differently had Zurich's formal tender been provided during the November 19, 2003 conference call. By the end of that conference call, Satriano understood that he was going to obtain Zurich's full $2 million tender, gathered all the documents he needed to take over the case, and announced his intention to bring in associate counsel. This Court recognizes that AIGDC had no "reason to

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examine or determine the extent of its liability" until Zurich, the primary insurer, "was prepared to address the possibility that the [plaintiffs] were entitled to its policy limits," Clegg, 424 Mass.at 421-422 n. 8, but AIGDC certainly understood from the November 19 conference call that it needed urgently to determine the reasonable extent of its liability. This Court also recognizes that AIGDC, as the excess insurer, had "no obligation or incentive to make an explicit commitment until the primary insurer has acted," id. at 422 n. 8, and that Zurich did not furnish its authorized tender until January 23, 2004. AIGDC, however, after it received Zurich's tender, saw no urgency to make a settlement offer, and ultimately decided not to make a settlement offer until the mediation in August 2004. This Court is certain, based on the strategic posture AIGDC took in this action, that AIGDC would not have made a settlement offer prior to the mediation even if Zurich had made its tender on November 19 itself.[11]

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[11] The Rhodes argue that, if they prove that Zurich failed to make a prompt tender of its policy limits, they are entitled to Chapter 93A damages even if they failed to prove that Zurich's delay in furnishing its tender had any consequence on AIGDC's settlement conduct, citing Clegg.

In Clegg, the primary insurer failed to respond to the plaintiffs' various settlement offers, the earliest coming in September 1991, until July 1992, and that settlement offer, which was less than policy limits, was found to be unreasonably low because it was reasonably clear that damages well exceeded the policy limits. 424 Mass. at 414-423. The primary insurer only offered its policy limits at the mediation in May 1994, just before the scheduled trial, and the excess insurer quickly agreed to add $425,000, allowing the case to settle at or around mediation for $675,000. Id. at 416. The Supreme Judicial Court held that the plaintiffs were entitled to damages equal to "the interest lost on the money wrongfully withheld by the insurer." Id. at 423. Justice O'Connor, in dissent, observed that the plaintiffs had failed to prove that they had been deprived of the use of settlement money for any period of time because they would not have been paid the tender of policy limits to the excess insurer and there was no evidence that the excess insurer would have settled the case earlier than the mediation if the primary insurer had tendered earlier. Id. at 428-429 (Dissent, O'Connor, J.). The majority responded to Justice O'Connor's dissent with two separate and distinct arguments. First, the Court essentially declared that the plaintiff was not required to prove that the primary insurer's delay in providing a full tender delayed the ultimate settlement of the case. The Court wrote:

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Therefore, this Court finds that Zurich did not violate its obligation under G.L. c. 176D, §

If we were to follow the position taken by the dissent, when a primary insurer and an excess insurer both cover a claim, a primary insurer who subjects a party to improper delay would never be liable for the injuries caused by such behavior, because there would always be some uncertainty as to what the excess insurer would have done if the primary insurer had behaved differently. We do not believe such a result comports with the language or intent of G.L. c. 176D, § 3(9), or G.L. c. 93A. The evidence regarding the excess insurer's readiness to pay, both as to timing and amount, must necessarily be indirect and inferential in a case such as this, since the excess insurer has no obligation or incentive to make an explicit commitment until the primary insurer has acted. If, as the dissent suggests, such evidence is insufficient, the injured party would never be able to recover damages in respect to the delay in receiving payment from either the excess insurer or the primary insurer. Primary insurers cannot avoid liability for their unfair settlement practices under G.L. c. 176D, § 3(9), by pointing to the uncertainty surrounding a claim against an excess insurer, when that uncertainty stems from the primary insurer's own behavior and delay.

Id. at 422 n. 8.

Second, the Court essentially declared that the trial judge had found that the primary insurer's delay had caused the excess insurer to delay its final settlement offer, and thereby delayed the effectuation of the settlement. The Court noted, "The promptness of [the excess insurer's] settlement also supports the judge's inference that had [the primary insurer] offered its policy limits earlier, [the excess insurer] would have settled earlier too." Id.

Therefore, it is not clear from Clegg whether the Supreme Judicial Court held that a plaintiff in a G.L. c. 176D action is entitled to the interest on the amount the primary insurer should have tendered from the date the tender should have occurred, even if there is no evidence that the plaintiff would have received the use of the tendered money if it had been timely tendered or whether it simply held that the trial judge had found that the excess insurer would have settled far earlier had the primary insurer promptly tendered, and that the primary insurer's delay thereby caused the plaintiff the loss of use of the tendered money.

This Court need not resolve whether the former or the latter holding was intended by the Supreme Judicial Court in Clegg because the Supreme Judicial Court subsequently made it clear in Hershenow v. Enterprise Rent-A-Car Company of Boston, Inc., that, to establish liability in a Chapter 93A action, the plaintiff must not only prove an unfair and deceptive act or practice but must also prove that the unfair act or practice "caused a loss." 445 Mass. 790, 798 (2006). Therefore, even if the Supreme Judicial Court intended the former holding in Clegg, it repudiated that holding in Hershenow, and required the plaintiff to prove its loss, not merely assume it. Hershenow at 801-802 (finding that there is no per se injury under Chapter 93A).

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3(9) to make a prompt tender of its full policy limits and, if it did, its delay did not cause the Rhodes to suffer any injury or loss because the delay did not affect either the amount or timing of AIGDC's settlement offers. As a result, judgment shall enter for Zurich in this action.

Did AIGDC Breach its Obligations as an Excess Insurer under G.L. c. 176D, § 3(9)(f)?

Before the November 19, 2003 conference call, as this Court earlier noted, AIGDC had no duty to "examine or determine the extent of its liability" because Zurich, the primary insurer, had not yet indicated that it was prepared to tender its policy limits. See Clegg, 424 Mass. at 421-422 n. 8. Despite the absence of such a duty, AIGDC had recognized shortly after it received notice of the claim that, in view of the catastrophic injuries suffered by Ms. Rhodes, the tender would likely occur and AIGDC would then assume responsibility for the claim. Cognizant of that likelihood, it monitored the claim and reviewed the transmittals it received from Crawford.

Once Fuell informed Satriano during that November 19, 2003 conference call that she intended to seek Zurich's authorization to tender the policy limits, AIGDC was placed on notice that the tender was imminent and that it would soon assume responsibility for the Rhodes' claim. Satriano acted appropriately during the conference call by asking for all the relevant documents regarding the claim so that he could knowledgeably examine the extent of AIGDC's liability regarding this claim. He also acted appropriately in retaining Conroy as associate counsel to ensure that there was an attorney on the GAF defense team whose judgment he respected and who would reliably protect AIGDC's interest in the litigation.

As earlier noted, until Satriano obtained Zurich's verbal tender on January 23, 2004, AIGDC, as the excess insurer, had no duty to make any settlement offer to the Rhodes. Id.

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However, once that tender was made, AIGDC assumed responsibility for and control over the Rhodes claim, including the responsibility to make a prompt and fair settlement offer.

The evaluation regarding a fair settlement offer that AIGDC, as the excess insurer, needed to make was somewhat different from the evaluation of Zurich, the primary insurer. Since its policy limits were $2 million, Zurich simply needed to make four determinations:

1. Was it reasonably clear that at least one of its insureds would be found liable?
2. Did any of its insureds have other primary insurance that covered this loss?
3. How much, if any, could the third-party defendant, Professional Tree Service, or its insurer be expected to contribute towards any settlement?
4. Was it reasonably clear that the damages suffered by Ms Rhodes, her husband, and her daughter exceeded the $2 million policy limits, plus any reasonably expected contribution from Professional Tree Service or its insurer?

At the time Fuell made these determinations, it was nearly certain that Zalewski and DLS would be found negligent, and there was no evidence that these additional insureds had any other primary insurance. Fuell recognized that Professional Tree Service could be found liable for failing to provide adequate signage and, at the time, believed that it held $3 million in liability insurance (in fact, it held only $1 million in liability insurance). Fuell had no difficulty finding that, even with a reasonable contribution from Professional Tree Service, the Rhodes' reasonably clear damages far exceeded Zurich's $ 2 million policy limits.

AIGDC, as the excess insurer, also needed to make four determinations regarding a fair settlement offer, but they differed slightly from Zurich's determinations:

1. Was it reasonably clear that at least one of its insureds would be found liable?

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2. Did any of its insureds have other primary or excess insurance that covered this loss?

3. How much, if any, could the third-party defendant, Professional Tree Service, or its insurer be expected to contribute towards any settlement?

4. What amount of damages was relatively clear?

By the time Zurich verbally tendered its limits on January 23, 2004, AIGDC had more than two months to evaluate the case. By this time, AIGDC should have known that no IME had yet been requested of Ms. Rhodes and that neither Ms. Rhodes nor Rebecca Rhodes had yet been deposed. Discovery in the case had closed on September 30, 2003, but Pritzker earlier had orally agreed with GAF's attorney to make Ms. Rhodes and Rebecca Rhodes available for deposition after the discovery deadline if the defendants insisted upon their being deposed. This Court finds (as did the Rhodes' expert at trial) that, as part of AIGDC's due diligence in determining whether damages were reasonably clear, it was appropriate for AIGDC to insist that Ms. Rhodes submit to an IME and that Ms. Rhodes and Rebecca Rhodes be deposed. An excess insurer, until the primary insurer tenders its policy limits, does not have the authority to influence the strategic decisions regarding discovery made by the insured's defense counsel. Therefore, upon Zurich's tender, it was appropriate for AIGDC to revisit those decisions and determine whether there was additional discovery that it believed necessary to determine whether liability (here, the extent of damages) were reasonable clear. However, AIGDC could not delay its arrangements for the IME or these depositions in order to delay its obligation to make a prompt settlement offer, especially since discovery in the case had closed and it was scheduled for trial in September 2004.

It appears that AIGDC had determined, at least by the March 4, 2004 meeting at GAF's headquarters, that it wished an IME, because Conroy before the meeting had looked for and

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found a physiatrist to conduct that IME. Yet, AIGDC demonstrated no apparent urgency to schedule the IME; it was not conducted until July 20, 2004, nearly the latest possible time for the IME to be conducted and for defense counsel to have the benefit of the IME report before the mediation on August 11. It is equally clear that AIGDC had not determined by that meeting that the depositions of Ms. Rhodes and Rebecca Rhodes were necessary to determine whether damages were relatively clear because, although the matter was discussed, no decision was made at that meeting as to whether to depose them. The fact that AIGDC did not know whether it wished to depose these two parties even though more than three months had passed since it knew it would assume responsibility for this catastrophic claim demonstrates that AIGDC did not believe that their depositions were necessary to determine whether liability was reasonably clear. Rather, the reason to depose them was simply to gauge how credible they would be at trial, and this reason was offset by the fear that deposing them would harden the plaintiffs' already tough position as to settlement. Indeed, AIGDC proceeded to mediation without having ever deposed Rebecca Rhodes.

AIGDC also insisted that its attorneys seek discovery of Ms. Rhodes' psychological records, which AIGDC argued was imperative before it could determine whether liability was relatively clear. This Court disagrees. G.L. c. 176D, § 3(9) provides that a settlement offer need not be made until liability becomes "reasonably clear," it does not permit a settlement offer to be postponed until everything that may be relevant to damages has been uncovered. If a settlement offer is allowed to await the completion of any possible discovery that may be admissible at trial on the issue of damages based on the premise that liability is not reasonably clear until every bit of possible evidence has been located and scrutinized, then the obligation to give a prompt

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settlement offer would be rendered toothless. It was reasonably clear that Ms. Rhodes had been permanently rendered a paraplegic by the accident, that her life had been forever transformed, and that she was often depressed by how limited her life had become. While it may be relevant at trial that she had previously been treated by a psychologist for depression, such information could not materially change the extent of the pain and suffering arising from the accident.

The fact of the matter is that AIGDC did not delay its settlement offer in order to conduct the IME or to depose Ms. Rhodes or to obtain Ms. Rhodes' psychological records; it delayed its settlement offer because it did not want to make any offer until mediation and it wanted, for strategic purposes, to wait until nearly the eve of trial to mediate the case. As a result, AIGDC did not make any settlement offer in this case until the mediation on August 11, 2004, almost exactly one year from the date that the Rhodes made their settlement demand. The issue, then, is whether delaying the settlement offer this long satisfied AIGDC's duty under G.L. c. 176D, § 3(9) to make a "prompt" settlement offer.

This Court finds that liability, including the extent of damages, in this case was reasonably clear by December 5, 2003, when the final version of the defense life care plan had been prepared by Mattson. By then, discovery had closed, all medical records had been produced, the plaintiffs had presented their detailed settlement demand, and the defense had their own life care plan to compare with that presented by the Rhodes' life care plan expert. To be sure, more would be learned after that date regarding the progress of Ms. Rhodes' recovery, but that is always the case in a catastrophic injury that does not result in death. If an insurance company is entitled to find that liability is not reasonably clear until an end point has been reached regarding the defendant's recovery, then the obligation to make a prompt settlement

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offer would have no practical consequence in a catastrophic injury case because that end point is rarely reached before trial (unless the defendant dies before trial).[12] Therefore, liability was reasonably clear when Zurich tendered its policy limits to AIGDC on January 23, 2004. As noted earlier, this Court would permit AIGDC to delay its settlement offer if, upon tender, it believed in good faith that an IME and the deposition of all plaintiffs was necessary for liability to be reasonably clear, but only if AIGDC made best efforts to ensure that this additional discovery was completed promptly. As also noted, it is plain that AIGDC made no such effort.

AIGDC, however, contends that the time was not yet ripe to make a settlement offer because there remained coverage issues that had yet to be resolved, including the extent of Professional Tree Service's policy limits. Pragmatically, it should not have taken long for AIGDC to ascertain from Professional Tree Service that its policy limits were only $1 million rather than the $3 million that Zurich understood. This Court finds that, while it was reasonable for AIGDC to examine these coverage issues before making a settlement offer, these efforts, too, need to be made with reasonable promptness, given that discovery had closed and that a substantial amount of time had passed since the plaintiffs' settlement offer. This Court finds that AIGDC made no reasonable effort to resolve promptly the outstanding coverage issues.

This Court concludes that, even allowing a generous amount of time for AIGDC to

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[12] Indeed, because of a variety of complications that Ms. Rhodes suffered in 2003 as a result of the accident that left her bedridden until October 2003 (bed sores and a broken leg), Ms. Rhodes did not begin her rehabilitation until at or around the time of the mediation. Therefore, there was no possibility of any end result from that rehabilitation becoming known until long after the trial had ended. Moreover, as a result of those complications, Ms. Rhodes' medical bills increased and, if anything, her long term prognosis grew worse. Therefore, the passage of time in no way should have diminished AIGDC's estimation of Ms. Rhodes' damages.

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become familiar with the claim, to obtain additional discovery it thought necessary to make liability reasonably clear, to resolve coverage issues, and to obtain internal approval within AIGDC, AIGDC violated its duty to make a prompt settlement offer once liability was reasonably clear by failing to make a settlement offer by May 1, 2004. May 1 was roughly eight months after the plaintiffs' settlement demand, seven months after discovery had closed, more than five months after AIGDC knew that Zurich was to tender its policy limits, more than three months after Zurich's verbal tender of limits, two months after the meeting at GAF headquarters where GAF pressed for a settlement offer, one and a half months after GAF's coverage attorney warned AIGDC that its failure to commence settlement negotiations constituted a breach of its obligations under G.L. c. 176D, § 3(9), one month after the formal written tender and the pretrial conference, and a few weeks after Pritzker agreed to mediation based only on Zurich's settlement offer of policy limits.

AIGDC's delay in making a prompt settlement offer cannot be justified by the magnitude of plaintiffs' settlement demand, which at that time was $19.5 million. "An insurer's statutory duty to make a prompt and fair settlement offer does not depend on the willingness of a claimant to accept such an offer." Hopkins, 434 Mass. at 567. Nor can it be justified by Pritzker's supposed demand for a $5 million offer before entering into mediation. Not only did Pritzker never make such a demand, but AIGDC never even explored with Pritzker whether he would enter into mediation prior to a settlement demand, which he effectively did based upon Zurich's tender to him of its settlement limits. An insurer may delay its settlement offer until mediation only if it promptly arranges for mediation, so that the settlement offer made during mediation satisfies its obligation of promptness.

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Having found that AIGDC breached its duty to make a prompt settlement offer once liability was reasonably clear, this Court now turns to the question of whether the settlement offer it ultimately made at mediation – $3.5 million – was a reasonable settlement offer to effectuate a fair settlement. This Court finds it was at the low end of the reasonable range of settlement offers.

AIGDC's Kelly provided Nitti with settlement authority to offer $3.75 million, which included Zurich's $2 million and assumed that Professional Tree Service would offer its policy limits of $1 million. This Court finds the latter assumption reasonable, even though Professional Tree Service ultimately settled for only $550,000. While Professional Tree certainly had a triable case as to liability, in sharp contrast with Zalewski, DLS, and (with the amendment adding the claim under the federal motor carrier statute) GAF, it faced the likelihood of a judgment well above policy limits if it were found liable. AIGDC reasonably expected that Professional Tree Service, to avoid that possibility, would have pressured its insurer to furnish its policy limits if it needed to do so to settle the action.

Nitti only offered $3.5 million of that $3.75 million in authority, and this Court must evaluate the reasonableness of the offer in light of the amount actually offered, not the amount authorized to be offered. "The statute [G.L. c. 176D, § 3(9)] does not call for [a] defendant's final offer, but only one within the scope of reasonableness." Bobick v. United States Fid. & Guar. Co., 439 Mass. 652, 662 (2003), quoting Forcucci v. United States Fid. & Guar. Co., 11 F.3d 1, 2 (1st Cir.1993).

In determining the reasonableness of that offer, this Court is mindful that it is truly determining whether the offer was so low that it constituted an unfair act under Chapter 93A.

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That is a difficult task when, as here, most of the damages are intangible, compensating Ms. Rhodes for her pain and suffering and her husband and daughter for their loss of consortium. In conducting this analysis, this Court must look to all the circumstances, including the reasonableness of the offer in relation to the injuries suffered by the plaintiffs and the reasonableness of the plaintiffs' demand. See Kohl v. Silver Lake Motors, Inc., 369 Mass. 795, 799-801 (1976) (settlement offer must consider injuries actually suffered by plaintiffs); Bobick, 439 Mass. at 662 ("excessive demands on the part of a claimant .. may be considered as part of the over-all circumstances affecting the amount that would qualify as a reasonable offer in response"). See also Clegg, 424 Mass. at 420 ("Our standard for examining the adequacy of an insurer's response to a demand for relief under G.L. c. 93A, § 9(3), is 'whether, in the circumstances, and in light of the complainant's demands, the offer is reasonable.'"), quoting Calimlim v. Foreign Car Ctr., Inc., 392 Mass. 228, 234 (1984).

This Court examines the reasonableness of AIGDC's final offer at mediation from two separate angles. First, the Court looks to the amount of special damages that would clearly be established at trial even if the jury credited the defense experts rather than the plaintiffs' experts. At the time of the mediation, relying on the outdated calculation of past medical expenses set forth in Rhodes' August 13, 2003 settlement demand, Ms. Rhodes had incurred at least $413,977.68 in medical bills. The defense life care planner's final estimate of the cost of Ms. Rhodes' life care plan was $1,239,763. The defense had not challenged the settlement demand's estimate of $292,379 for the loss in household services or the out-of-pocket expenses incurred of $83,984. Therefore, if the case had proceed to trial as planned in September 2004, the defense could not reasonably have disputed that Ms. Rhodes special damages were at least $2.03 million.

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AIGDC appears to have come to the same conclusion; AIGDC's Kelly, who set the offer, estimated the special damages to be $2 million. If the jury awarded only those special damages and did not pay a penny for pain and suffering or loss of consortium, those special damages alone, with common interest of 12 percent per annum from July 12, 2002 (the date the complaint was filed), would have yielded a verdict of roughly $2.56 million. For that judgment to have reached the settlement offer of $4.5 million (including the $1 million anticipated contribution from Professional Tree Service), the jury would have had to award damages for pain and suffering and loss of consortium of roughly $1.54 million (which, with interest, would total $1.94 million).

This Court then asks whether, if the jury had awarded the plaintiffs at trial $1.54 million in pain and suffering and loss of consortium damages, the trial judge would likely have found that award to be so unreasonably low that the plaintiffs were entitled to additur. While such an award would certainly be stingy, even in a county like Norfolk County which is generally viewed as a favorable venue by defense counsel, this Court cannot say with confidence that a motion for additur in those circumstances would be more likely than not to prevail. Since this Court cannot conclude that such a verdict would be found so unreasonably low as to demand an additur, this Court cannot conclude that a settlement offer of this amount is so low as to be unreasonable.

Alternatively, this Court considers the evidence offered by the insurance experts at trial who testified as to whether this offer fell within the reasonable range of settlement offers. This Court concurs with the defense expert, former Superior Court Judge Owen Todd, who testified that the AIGDC's settlement offer of $3.5 million was within the reasonable range, albeit at the low end of that range. In adopting his opinion, this Court considered the entirety of the

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circumstances, including the plaintiffs' unreasonably high settlement demands, the fact that a life care plan may be purchased at less net cost through a structured settlement with an annuity, and the historically low jury awards in Norfolk County.[13]

The issue the Court must now confront is whether AIGDC's breach of its duty to provide a prompt settlement offer by failing to make any settlement offer until August 11, 2004 caused the plaintiffs to suffer any damages. It is plain to this Court that the delay did not cause the plaintiffs any actual compensable damages. Mr. Rhodes testified that he and his family would not have accepted any offer less than $8 million, which is more than the $6 million their own expert opined would have constituted the low range of a reasonable offer. Therefore, this Court is certain that, had AIGDC made a prompt reasonable settlement offer on or before May 1, 2004, even an offer that their own expert testified would have been reasonable, the Rhodes would have rejected that offer. While all three members of the Rhodes family testified to the emotional distress they suffered from the prolonged litigation and Mr. and Ms. Rhodes testified to their anger at the defendants for failing to make a timely, reasonable offer, it is plain to this Court that their emotional distress would not have materially diminished had the defendants earlier made a settlement offer that their attorney would promptly have rejected. Nor would the costs they incurred from the litigation have been diminished if an earlier offer had been presented and turned down. Nor would the financial problems that the Rhodes family suffered from their savings having been depleted to pay the substantial costs of renovating their home to accommodate Ms. Rhodes' paraplegia and to pay the costs of the litigation in any way have been

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[13] Having so found, this Court also finds that AIGDC's offer at the close of evidence at trial of $6 million which, with Professional Tree's $550,000, would have provided the Rhodes with a total of $6.55 million was also within the range of reasonable offers.

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lessened from an earlier settlement offer that they would have rejected. In short, all of these problems – the emotional distress arising from the frustrations of litigation, the substantial costs of litigation, even in a contingent fee case, and the fear of financial ruin – arose from the fact that the minimum settlement they were prepared to accept was well above the settlement that the defendants were prepared to offer or were required by Chapter 176D to offer.

The plaintiffs respond that they need not prove that they would have accepted the settlement offer to prove that the failure to make a prompt settlement offer caused them damages, citing Hopkins. In Hopkins, the Supreme Judicial Court declared:

> The defendant argues that the judge erred in concluding that the plaintiff met her burden of proving that its unlawful conduct caused her to sustain any damages. The defendant points to the absence of any testimony or evidence from the plaintiff that she would have accepted an offer of $400,000 in January, 1995, combined with her rejection of subsequent offers in the same amount. These events, the defendant argues, demonstrate that there is "no causal nexus between [the defendant's] failure to make the $400,000 offer in January of 1995 and any interest which may have been lost as a result of that failure." The defendant concludes that, "[w]ithout such a nexus, [the plaintiff] may only recover (at most) nominal damages." We disagree.
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> General Laws c. 176D, § 3(9) (f), and G.L. c. 93A, § 9, together require an insurer such as the defendant promptly to put a fair and reasonable offer on the table when liability and damages become clear, either within the thirty-day period set forth in G.L. c. 93A, § 9(3), or as soon thereafter as liability and damages make themselves apparent. The defendant concedes on appeal that its failure to effectuate a prompt and fair settlement of the plaintiff's claim violated G.L. c. 176D, § 3(9) (f). The defendant's violation caused injury to the plaintiff, see Leardi v. Brown, 394 Mass. 151, 159 (1985), quoting Restatement (Second) of Torts § 7 (1965) (injury in context of consumer protection legislation, such as G.L. c. 93A, is the "invasion of any legally protected interest of another"), and, under G.L. c. 93A, § 9, the plaintiff is "entitled to recover for all losses which were the foreseeable consequences of the defendant's unfair or deceptive act or practice." DiMarzo v. American Mut. Ins. Co., 389 Mass. 85, 101 (1983).
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> We reject the defendant's contention that the plaintiff has not shown that she was adversely affected or injured by its conduct. The defendant's deliberate failure to take steps, as required by law, to effectuate a prompt and fair settlement in January, 1995, when the liability of its insureds was clear, forced the plaintiff to institute litigation, and, in so doing, to incur the inevitable "costs and frustrations that are encountered when

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litigation must be instituted and no settlement is reached." Clegg v. Butler, 424 Mass. 413, 419 (1997). An insurer's statutory duty to make a prompt and fair settlement offer does not depend on the willingness of a claimant to accept such an offer. See Metropolitan Prop. & Cas. Ins. Co. v. Choukas, 47 Mass.App.Ct. 196, 200 (1999). Accordingly, quantifying the damages for the injury incurred by the plaintiff as a result of the defendant's failure under G.L. c. 176D, § 3(9) (f), does not turn on whether the plaintiff can show that she would have taken advantage of an earlier settlement opportunity. The so-called causation factor entitles a plaintiff, like the plaintiff here, to recover interest on the loss of use of money that should have been, but was not, offered in accordance with G.L. c. 176D, § 3(9) (f), if that sum is in fact included in the sum finally paid to the plaintiff by the insurer. It is this amount of money that has been wrongfully withheld from the plaintiff, and it is this sum on which the defendant must pay interest to remedy its wrongdoing. "This is precisely the type of damage we have described as appropriate[ ] ... in an action ... under [G.L.] c. 93A." Clegg v. Butler, *supra*, quoting Schwartz v. Rose, 418 Mass. 41, 48 (1994).

"The statutes at issue were enacted to encourage settlement of insurance claims ... and discourage insurers from forcing claimants into unnecessary litigation to obtain relief" (citation omitted). Clegg v. Butler, *supra*. An insurer should not be permitted to benefit from its own bad faith, where, as occurred here, it violated G.L. c. 176D, § 3(9) (f), by intentionally failing to make a prompt, fair offer of settlement. The defendant could have avoided the imposition of damages by making a prompt and fair offer of settlement that complied with G.L. c. 176D, § 3(9) (f), within thirty days of receiving the plaintiff's G.L. c. 93A demand letter, as provided by G.L. c. 93A, § 9(3) ("[a]ny person receiving [a written demand for relief] who, within thirty days ... makes a written tender of settlement which is rejected by the claimant may, in any subsequent action, file the written tender and an affidavit concerning its rejection and thereby limit any recovery to the relief tendered if the court finds that the relief tendered was reasonable in relation to the injury actually suffered by the petitioner"). Had such an offer been made, and rejected by the plaintiff, the burden would have been on the defendant to prove that the offer was reasonable. See Kohl v. Silver Lake Motors, Inc., 369 Mass. 795, 799 (1976). In circumstances such as this, when the defendant failed to make any offer at all, the plaintiff should not be required to show that she would have accepted a hypothetical settlement offer, had one been forthcoming. See Metropolitan Prop. & Cas. Ins. Co. v. Choukas, *supra* at 200. We considered a similar argument when deciding the Clegg case and rejected it. See Clegg v. Butler, *supra* at 428-429 (O'Connor, J., dissenting) (arguing that actual damages had not been proved, because, even though primary insurer [defendant] had unlawfully failed to offer prompt and fair settlement, plaintiffs had not shown that excess insurer subsequently would have made offer that was acceptable to them).

We reject the defendant's contention that the plaintiff has not shown that she was adversely affected or injured by its conduct. The defendant's deliberate failure to take steps, as required by law, to effectuate a prompt and fair settlement in January, 1995,

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> when the liability of its insureds was clear, forced the plaintiff to institute litigation, and, in so doing, to incur the inevitable 'costs and frustrations that are encountered when litigation must be instituted and no settlement is reached.

Hopkins, 434 Mass. at 565-569 (footnotes omitted).

While one can certainly see why the plaintiffs claim that Hopkins is determinative, this Court finds that it is not, for two reasons. First, the facts in Hopkins were materially different from those in the instant case. The Supreme Judicial Court in Hopkins, on those facts, appears to have found that the insurer's conduct caused actual damages because the Court recognized what it characterized as "the obvious rule that, in order to recover actual damages under G.L. c. 93A, § 9, there must be a causal relationship between the alleged act and the claimed loss." Id. at. 567-568, n.17. In Hopkins, after having made her initial settlement offer but before filing suit, the plaintiff sent a Chapter 93A letter to the insurer demanding a settlement offer, and filed suit only after the insurer responded to that demand letter without making an offer of settlement. 434 Mass. at 559. When the insurer, belatedly but prior to trial, made a settlement offer of $400,000, the offer was accepted by the plaintiff. Id. 434 Mass. at 559-560. In finding that "[t]he defendant's deliberate failure to take steps, as required by law, to effectuate a prompt and fair settlement in January, 1995, when the liability of its insureds was clear, forced the plaintiff to institute litigation, and, in so doing, to incur the inevitable 'costs and frustrations that are encountered when litigation must be instituted and no settlement is reached," id. at 567, quoting Clegg, 434 Mass. at 419, the Supreme Judicial Court appears to have found that, if this reasonable offer had been made within 30 days of the Chapter 93A letter, as required, the plaintiff would have settled the case without filing suit. That is why the costs of the litigation can be said to have been caused by the insurer's failure to make a prompt settlement offer. That

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is also why the Court found that the plaintiff had suffered damages in the form of lost interest – if the settlement offer had been made promptly after receipt of the Chapter 93A demand letter, the plaintiff would have accepted the offer and enjoyed the use of the $400,000 promptly thereafter, rather than having to wait, as she did, until the eve of trial to have use of that $400,000. See Hopkins at 567 (interest was wrongfully withheld from plaintiff). Indeed, the Supreme Judicial Court expressly noted in Hopkins, "We need not decide in this case whether the same measure of damages would apply in a case where an insurer, having initially violated G.L. c. 176D, § 3(9)(f), and G.L. c. 93A, §§ 2 and 9, thereafter makes a fair and reasonable (but nevertheless tardy) offer of settlement, which is refused by a claimant." Id. at 567, n. 16. The factual scenario expressly reserved by the Court in Hopkins is precisely the scenario presented to this Court.[14]

Second, to the extent that Hopkins can be understood to hold that a plaintiff is entitled to recover damages from an insurer for its failure to make a prompt settlement offer without proving that the plaintiff suffered any loss arising from that unfair act (because the plaintiff would have rejected the offer had it been timely made), Hopkins was effectively overruled by the Supreme Court's subsequent decision in Hershenow v. Enterprise Rent-A-Car Company of Boston, Inc., 445 Mass. 790 (2006). As observed in note 11 *supra*, the Supreme Judicial Court in Hershenow held that, to establish liability in a Chapter 93A action, the plaintiff must not only

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[14] This Court also recognizes that the Supreme Judicial Court in Bobick v. United States Fid. & Guar. Co. held that it was error for a Superior Court judge to grant summary judgment in a Chapter 176D/93A case based on the plaintiff's failure to prove that he would have been willing to accept a reasonable settlement offer at any time before trial. 439 Mass. at 662-663. The Bobick Court, however, simply cited Hopkins for its ruling, and did not provide any analysis of causation beyond that in Hopkins. Id. at 663. Moreover, this finding of error was dictum because the Court found that the settlement offer was reasonable as a matter of law, and therefore did not need to address the question of causation. Id.

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prove an unfair and deceptive act or practice but must also prove that the unfair act or practice "caused a loss." 445 Mass. at 798 (2006). The Court made clear that there is no such thing as a "per se injury" under Chapter 93A; "a plaintiff seeking a remedy under G.L. c. 93A, § 9, must demonstrate that even a per se deception caused a loss." Id. Since there is a "required causal connection between the deceptive act and an adverse consequence or loss," id. at 800, and since there can be no adverse consequence or loss from the failure of an insurer to make a prompt and reasonable settlement offer if the plaintiff would have rejected that offer, Hershenow, although not an insurance case, must stand for the proposition that a plaintiff, to prevail on a Chapter 93A/Chapter 176D claim, must prove not only that the insurer failed to make a prompt or reasonable settlement offer but also that, if it had, the plaintiff would have accepted that offer and settled the claim or threatened litigation.

The instant case illustrates how foolish it would be to interpret Hopkins as permitting a finding of an insurer's failure to make a prompt or reasonable settlement offer when the evidence decisively demonstrates that the plaintiff would not have accepted a reasonable offer if one had been made when it was offered. Under such an interpretation, the plaintiffs would establish some actual damages even though they suffered none. Those modest actual damages, however, would be only the tip of the iceberg of what the insurer would be required to pay in the Chapter 93A action. In 1989, the Legislature amended G.L. c. 93A, § 9(3) to add the italicized language quoted below:

> [I]f the court finds for the petitioner, recovery shall be in the amount of actual damages or twenty-five dollars, whichever is greater; or up to three but not less than two times such amount if the court finds that the use or employment of the act or practice was a willful or knowing violation of said section two ... *For the purposes of this chapter, the amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence, regardless of*

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the existence or nonexistence of insurance coverage available in payment of the claim.

G.L. c. 93A, § 9(3) (italics added). The Supreme Judicial Court and the Appeals Court have interpreted this amendment to mean that, if the plaintiff went to trial in the underlying case and obtained a judgment, and if the plaintiff proves some actual damages arising from the insurer's violation of Chapter 176D and establishes that the violation was willful or knowing, the amount of damages to be doubled or trebled is not the actual damages but the amount of the underlying judgment. See, e.g., Clegg v. Butler, 424 Mass. at 424; Kapp v. Arbella Mut. Ins. Co., 426 Mass. 683, 685-686 (1998); Yeagle v. Aetna Cas. & Sur. Co., 42 Mass. App. Ct. 650, 655 (1997) (the 1989 amendment "threatened a bad faith defendant with multiplication of the amount of the judgment secured by the plaintiff on his basic claim – a total that might be many times over the interest factor" and that "exceeded the injury caused by the c. 93A violation"). As the Supreme Court declared in Clegg:

> The italicized portion of this statute was inserted by St.1989, c. 580, § 1, which was apparently enacted in response to cases such as Bertassi v. Allstate Ins. Co., 402 Mass. 366 (1988); Trempe v. Aetna Cas. & Sur. Co., 20 Mass. App. Ct. 448 (1985); and Wallace v. American Mfrs. Mut. Ins. Co., 22 Mass. App. Ct. 938 (1986), which limited those damages subject to multiplication under c. 93A to loss of use damages, measured by the interest lost on the amount the insurer wrongfully failed to provide the claimant. ... This amendment greatly increased the potential liability of an insurer who wilfully, knowingly or in bad faith engages in unfair business practices.

424 Mass. at 424. Therefore, in this case, if this Court, under Hopkins, were required to find that the plaintiffs suffered even nominal damages from being denied a prompt settlement offer that they certainly would have rejected, and if this Court were to find the violation willful or knowing (which it does)[15], the plaintiffs would be entitled to receive, not merely those nominal damages

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[15] This Court does find that AIGDC's failure to provide a prompt settlement offer was willful and knowing. AIGDC had been warned for months before May 1, 2004, by GAF,

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and the reasonable attorney's fees they incurred in prevailing upon their Chapter 93A/176D claim, but also double or triple the amount of the judgment they received in the underlying personal injury case – that is, $22.6 million or $33.9 million.

The Legislature made clear, however, that these extraordinarily punitive damages were limited to cases where there was, not only willful or knowing conduct, but also some actual damages. See Kapp, 426 Mass. at 685-686 (1998); Yeagle, 42 Mass. App. Ct. at 652-656. The Legislature could have declared that the underlying judgment should be treated as actual damages, but it did not; it required proof of actual damages and used the amount of the underlying judgment only to calculate punitive damages. See id.[16] Since the plaintiff would suffer actual damages from lost interest only if the plaintiff would have accepted the earlier, reasonable settlement offer, the Legislature effectively limited both actual and the far greater punitive damages to those cases that would have settled (or settled earlier) had the insurer

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GAF's defense counsel, and GAF's coverage counsel, that it should make a settlement offer in response to the plaintiffs' August 13, 2003 settlement demand, but AIGDC failed to heed these warnings and decided to make no settlement offer until the mediation was conducted one month before trial. In short, as this Court earlier found, AIGDC did not delay its settlement offer to conduct the investigation needed to make liability reasonably clear; it delayed it because it thought it would be in a better strategic posture if the offer were postponed until the mediation and it did not wish the mediation to occur until trial was nearly imminent.

[16] In Kapp and Yeagle, the Supreme Judicial Court and the Appeals Court understood that the actual damages would generally be loss of use damages, that is, lost interest. In fact, if the case did not settle because of the absence of a reasonable settlement offer and proceeded to judgment, the plaintiff would have suffered loss of use damages only if the reasonable settlement offer should have been provided before the complaint was filed because the plaintiff would receive 12 percent per annum common interest on the amount of the judgment from the date the complaint was filed. The more likely form of actual damages would be "the costs and frustrations that are encountered when litigation must be instituted and no settlement is reached," including any attorney's fees or costs incurred by the plaintiff from having to proceed to trial. Clegg, 424 Mass. at 419.

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performed its duty to provide a prompt and reasonable settlement offer. See Kapp, 426 Mass. at 686 (1989 amendment "was aimed at the situation where a defendant insurer, acting in bad faith, failed to settle a claim reasonably, obliging the plaintiff to litigate unnecessarily"). In those cases where the plaintiff would have rejected even a reasonable settlement offer, then the insurer's failure to make a prompt and reasonable offer is not the reason why the case proceeded to trial.

To allow a plaintiff to obtain actual and punitive damages when it would not have settled the case even with a reasonable settlement offer would actually discourage plaintiffs to settle, which was the opposite of what the Legislature intended when it enacted the 1989 amendment. The Supreme Judicial Court in Clegg observed:

> The multiple damages provided under c. 93A are punitive damages intended to penalize insurers who unreasonably and unfairly force claimants into litigation by wrongfully withholding insurance proceeds. As part of a statutory scheme meant to encourage out-of-court resolutions, the statute does not punish settling insurers by placing the entire settlement award at risk of multiplication.

424 Mass. at 425. Just as it takes "two to tango," it also takes two to settle a case. The punitive damage provision is plainly meant to pressure insurers to make reasonable settlement offers, lest the plaintiff be forced into a trial that he otherwise would have settled. If the plaintiff, however, could win punitive damages regardless of whether he would have accepted a reasonable offer, then a smart plaintiff (or a plaintiff intelligently represented), once he recognized that the insurer had failed to make a prompt or reasonable offer, would choose not to settle the case and proceed to trial, even if the insurer later made a reasonable settlement offer, because the plaintiff could obtain punitive damages of double or treble the underlying judgment only if he proceeded to judgment and did not settle or arbitrate the case. See Clegg, 424 Mass. at 424-425 (punitive damages of double or treble the underlying judgment are available only when underlying case

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proceeds to judgment, not if it is resolved through settlement or arbitration).

Therefore, this Court finds that, since it is plain that the Rhodes would not have settled this case before trial even if AIGDC had made a prompt and reasonable settlement offer (even the offer its own expert declared reasonable), the Rhodes have failed to prove the required element of causation – that AIGDC's failure to make a prompt settlement offer before trial caused them any actual damages. Since the Rhodes have suffered no actual damages from AIGDC's breach of G.L. c. 176D, § 3(9)(f), they are not entitled to an award of either actual or punitive damages.

The final issue this Court must address is whether AIGDC breached its obligation to provide a reasonable settlement offer after trial. As noted earlier, the total amount due under the September 28, 2004 judgment was roughly $11.3 million, and that amount was increasing at a rate of 12 percent per year as a result of post-judgment interest. An insurer's duty to settle a case does not end with the judgment, unless the insurer promptly pays the judgment. When the insurer, as here, causes a notice of appeal to be filed, the insurer continues to have a duty to settle what is now the appellate litigation. While the standard under G.L. c. 176D, § 3(9)(f) remains the same after judgment – the insurer must still provide a prompt and fair offer of settlement once liability has become reasonably clear – the existence of the judgment should change the insurer's evaluation of what constitutes a fair offer. Pragmatically, assuming the policy limits are sufficient, the insurer will be obliged to pay the judgment, with post-judgment interest, unless the insured defendant prevails in overturning the verdict on appeal. Therefore, the questions that need to be considered in evaluating the fairness of the insurer's offer include:

- What is the likelihood that the appeal will succeed?

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- If it does succeed, is the result likely to be a new trial, dismissal of the claim, or a reduction in the amount of the judgment?
- If the appeal obtains a new trial, what is the likelihood that the defendant will prevail at this new trial? If the plaintiff were to prevail, what is the likelihood that the damages found by the jury will differ greatly from those found by the jury at the first trial?

If AIGDC asked itself these questions, which it should have, it would have been apparent that none of the answers bode well for AIGDC. The appeal rested on unusually feeble arguments – the trial court's denial of the defendants' motion for remittitur and its denial of the defendants' motion for discovery of Ms. Rhodes' psychological records. In light of Ms. Rhodes' paraplegia and the extent to which it irrevocably diminished her life and that of her husband and daughter, the likelihood that an appellate court would find that the trial judge abused her discretion by denying the defendants' motion for remittitur is microscopic. The likelihood that an appellate court would find that the trial judge abused her discretion by denying the defendants' motions for disclosure of Ms. Rhodes' psychological records is less fanciful than with the denial of the remittitur but reasonably should still be recognized as minimal. The defendants' motion for disclosure of these records was filed long after discovery had closed. For that reason alone, its denial was well within the discretion of the trial judge. Moreover, the plaintiffs argued that Ms. Rhodes intended to testify only to "garden variety" emotional distress, and did not intend to offer psychological testimony that the accident caused Ms. Rhodes to suffer from a psychiatric disorder. It was well within the Court's discretion to deny the privileged records based on this representation. AIGDC, according to Nitti's internal request for AIGDC approval to prosecute an appeal, apparently believed that Ms. Rhodes' testimony at trial about her pre-existing bi-polar

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disorder required disclosure of these records. It is not clear from this record whether defense counsel objected to this testimony or argued at trial that it opened the door to disclosure of her psychological records but, assuming the defendants preserved their rights on appeal, there is no reason to believe that this testimony unfairly prejudiced the jury in any way that would have affected its verdict. Nitti acknowledged that this testimony was to her pre-existing bi-polar disorder; he does not contend that she testified that the accident caused her bi-polar disorder.

Moreover, even if the Appeals Court were to have found that the trial judge abused her discretion by denying discovery of Ms. Rhodes' psychological records, the best that AIGDC could do is obtain a new trial as to damages, since the AIGDC-insured defendants had already stipulated to liability. Apart from selecting a different jury, there was no reason for AIGDC to believe that a second trial would go any better for it than the first. However, what is certain is that the pre-judgment interest on any verdict would be considerably greater. It would likely take at least two years for the appeals process to conclude and a new trial to be conducted, so the judgment would likely be increased by 50 percent to account for pre-judgment interest rather than the roughly 25 percent increase for pre-judgment interest in the original judgment.

In view of all these factors, AIGDC's offer of $7.0 million on December 17, 2004 in response to the plaintiffs' Chapter 93A demand letter, which included Zurich's $2 million and was roughly 60 percent of the amount then owed under the judgment, was not only unreasonable, but insulting.[17] No reasonable insurer could have concluded that a 40 percent discount of the judgment was reasonable in view of AIGDC's meager chance of prevailing on appeal. When one

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[17] The roughly $11.3 million judgment issued on September 28, 2004 increased by one percent per month as a result of post-judgment common interest. Therefore, with 2 1/2 months having passed since the judgment, the amount due under the judgment by December 17, 2004 was roughly $11.6 million.

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considers that AIGDC also required release of the plaintiffs' claims under Chapters 93A and 176D, the offer becomes even more ridiculous. This Court finds that AIGDC did precisely what Chapter 176D was intended to prevent – attempt to bully the plaintiffs into accepting an unreasonably low settlement rather than wait the roughly two years for their appeal to conclude and the judgment to be paid. See R.W. Granger & Sons, Inc. v. J & S Insulation, Inc., 435 Mass. 66, 77 (2001) (G.L. c. 176D, § 3(9)(g) "expresses a legislative purpose to penalize the practice of 'low balling,' i.e. offering much less than a case is worth in a situation where liability is either clear or highly likely"), quoting Guity v. Commerce Ins. Co., 36 Mass. App. Ct. 339, 343 (1994).

In contrast with AIGDC's failure before trial to provide a prompt offer of settlement, it is plain from the facts of this case that, if a reasonable offer of settlement had been made on December 17, 2004, it would have resulted in settlement of the case and the voluntary dismissal of the appeal because the case did settle in June 2005 once a reasonable settlement was proffered. At that time, AIGDC finally agreed to pay the Rhodes $8.965 million, in three installments, not including the roughly $2.32 million that Zurich had already paid to the Rhodes on December 22, 2004 and not including any release of the plaintiffs' right to file the instant lawsuit. Since a prompt, reasonable post-judgment offer would have resulted in a settlement, the plaintiffs are able to prove so-called "loss of use" damages arising from AIGDC's post-judgment breach of its obligation under G.L. c. 176D, § 3(9)(g), that is, the interest the plaintiffs would have earned on this money had the settlement been reached in December 2004 rather than June 2005. See Hopkins, 434 Mass. at 567 ("The so-called causation factor entitles a plaintiff ... to recover interest on the loss of use of money that should have been, but was not, offered in accordance with G.L. c. 176D, § 3(9)(f), if that sum is in fact included in the sum finally paid to the plaintiff

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by the insurer."). This Court finds that, if the reasonable offer ultimately made by AIGDC on or about June 2, 2005 had been made on December 17, 2004, it is more likely than not that a settlement would have been reached by January 2, 2005 rather than June 2, 2005, and the first of three installment payments would have been paid five months earlier – on February 5, 2005 rather than July 5. Measuring loss of use damages at the post-judgment rate of interest of one percent per month, AIGDC's unreasonable delay in making a reasonable settlement offer cost the Rhodes $448,250.[18]

This Court does not find that the plaintiffs, on this record, have established any damages beyond "loss of use" damages. There is not sufficient evidence of emotional distress arising from these unreasonably low post-judgment offers to award emotional distress damages. The Supreme Judicial Court requires that a plaintiff satisfy the elements of an intentional infliction of emotional distress claim in order to establish emotional distress damages in a Chapter 93A case. Haddad v. Gonzales 410 Mass. 855 (1991). This Court, while it finds AIGDC's conduct to be knowing and willful, does not find it be "extreme and outrageous." See id. at 871. Nor does this Court find the defendants' emotional distress to be sufficiently "severe" during the post-judgment period to warrant damages, if only because Zurich's payment of $2.32 million on December 22, 2004 alleviated the plaintiffs' immediate financial distress. See id..

The Rhodes argue that, when an insurer breaches its obligation to make a prompt and reasonable offer of settlement, the Supreme Judicial Court has suggested that a plaintiff is entitled to compensation for the "costs and frustrations that are encountered when litigation must

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[18] This Court calculated the interest by multiplying the amount AIGDC ultimately offered ($8.965 million) by .05. This Court did not include the amount paid by Zurich on December 22, 2004 in this calculation, which included all post-judgment interest through that date.

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be instituted and no settlement is reached." Clegg, 424 Mass. at 419. See also Hopkins, 434 Mass. at 567 (insurer, by forcing the plaintiff to institute litigation, forced the plaintiffs "to incur the inevitable 'costs and frustrations that are encountered when litigation must be instituted and no settlement is reached'"), quoting Clegg, 424 Mass. at 419. This Court agrees that the financial costs of litigation that the plaintiff was forced to incur by the insurer's failure to comply with its obligations under G.L. c. 176D are compensable under Chapter 93A. However, the plaintiffs did not offer any evidence as to any costs of litigation the Rhodes incurred after December 2004, so this Court will not award any damages for such costs. This Court does not agree that the emotional costs of litigation – the so-called "frustrations" of litigation – are compensable unless those frustrations rise to the level required for recovery of damages under an intentional infliction of emotional distress claim. While the Supreme Judicial Court in Clegg and Hopkins certainly acknowledged that litigation carries "frustrations" with it, the damages in both cases were limited to "loss of use" damages, not emotional distress damages. Clegg, 424 Mass. at 425; Hopkins, 434 Mass. at 560, 567.

This Court further finds that AIGDC's $7.0 million settlement offer, including Zurich's $2 million and including a release of the plaintiffs' claims under Chapters 176D and 93A, made on December 17, 2004 and repeated in writing on March 18, 2005, was not only unreasonably low but also constituted a willful and knowing violation of G.L. c. 176D, § 3(9)(g). This Court finds that double, rather than treble, damages are appropriate here only because AIGDC later came to its senses and made a reasonable post-judgment offer before the appellate litigation began in earnest.

The final issue this Court needs to confront in this legal odyssey is whether the amount

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doubled is the actual damages or the amount of the judgment. This Court finds that the appropriate amount doubled is the actual damages. This Court understands why the Legislature in enacting the 1989 Amendment to G.L. c. 93A, § 9(3) would wish to punish an insurer who, by its willful or knowing failure to make a prompt and fair settlement offer, forces a litigant to proceed to trial to obtain a reasonable judgment. In such cases, the Legislature authorized the doubling or trebling of the underlying judgment to deter insurers from engaging in such unfair conduct. However, when the insurer's failure to make a prompt and fair settlement offer occurs after the issuance of the judgment, it makes no sense to multiply the judgment because the insurer's conduct did not force the trial that yielded that judgment. It may arguably be appropriate to multiply the post-appeal judgment if the insurer's failure to make a prompt and fair post-judgment settlement offer forces the litigant to litigate the full appellate process but that did not happen here – AIGDC made a fair settlement offer and the case settled before any appellate briefs were filed. Consequently, this post-judgment violation of Chapter 176D is comparable to the pre-trial violation of Chapter 176D in which the insurer belatedly makes a fair settlement offer and the case settles before trial (albeit later than it should have). In such cases, the Supreme Judicial Court has declared that the 1989 Amendment to G.L. c. 93A, § 9(3) does not apply, because it applies only to cases in which the insurer's conduct forces the plaintiff to proceed to trial to obtain a judgment, not to cases resolved by settlement or arbitration. See Clegg, 424 Mass. 424-425.

Consequently, this Court finds that AIGDC is liable only for double the actual "loss of use" damages of $448,250, which totals $896,500, plus the Rhodes' reasonable attorney's fees and costs incurred in prosecuting this Chapter 93A action.

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ORDER

For the reasons detailed above, this Court **ORDERS** that:

1. This Court finds that Zurich did not violate its duty as the primary insurer under G.L. c. 176D, § 3(9)(f) " to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." G.L. c. 176D, § 3(9)(f). When final judgment ultimately enters in this case, judgment shall enter in favor of the defendant Zurich, with statutory costs only.

2. This Court finds that National Union and AIGDC, prior to the issuance of the final judgment, violated their duty as the excess insurer under G.L. c. 176D, § 3(9)(f) "to effectuate prompt ...settlements of claims in which liability has become reasonably clear," G.L. c. 176D, § 3(9)(f), but their violation did not cause the plaintiffs to suffer any actual damages.

3. This Court finds that National Union and AIGDC, after the issuance of the final judgment, violated their duty as the excess insurer under G.L. c. 176D, § 3(9)(f) " to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." G.L. c. 176D, § 3(9)(f). This Court finds that the actual damages caused by this violation are limited to "loss of use" damages in the amount of $448,250.

4. This Court finds that the violation found in paragraph 3 *supra* was willful and knowing, and that doubling the amount of actual damages is an appropriate punitive award for such violation. Therefore, this Court orders that National Union and AIGDC, jointly and severally, shall pay the plaintiffs $896,500 in actual and punitive damages.

5. This Court finds, under G.L. c. 93A, § 9(4), that National Union and AIGDC shall also

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pay to the plaintiffs the reasonable attorney's fees and costs incurred in prosecuting this action against National Union and AIGDC. No later than June 27, 2008, the plaintiffs shall serve their application for reasonable attorney's fees and costs, supported by appropriate affidavits and documentation. No later than July 25, 2008, National Union and AIGDC shall serve any opposition to the plaintiffs' application, and the application and opposition will be filed forthwith. A hearing regarding the application for attorney's fees shall be conducted on July 30, 2008 at 2:00 p.m.[19]

Ralph D. Gants
Justice of the Superior Court

DATE: June 3, 2008

I HEREBY ATTEST AND CERTIFY ON 4-16-09 THAT THIS FOREGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE, AND IN MY LEGAL CUSTODY.

MICHAEL JOSEPH DONOVAN
CLERK / MAGISTRATE
SUFFOLK SUPERIOR CIVIL COURT
DEPARTMENT OF THE TRIAL COURT

BY: Asst Clerk

[19] This Court will change this hearing date if it interferes with any counsel's trial or vacation schedule.

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CERTIFICATE OF COMPLIANCE

This brief complies with the rules of court that pertain to the filing of briefs, including, but not limited to: Mass. R. A. P. 16(a)(6) (pertinent findings or memorandum of decision); Mass. R. A. P. 16(e) (references to the record); Mass. R. A. P. 16(f) (reproduction of statutes, rules, regulations); Mass. R. A. P. 16(h) (length of briefs); Mass. R. A. P. 18 (appendix to the briefs); and Mass. R. A. P. 20 (form of briefs, appendices, and other papers).

/s/ M. FREDERICK PRITZKER
M. FREDERICK PRITZKER

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No. SJC-10911.

Appeals Court No. 2009-P-0619.

MARCIA RHODES, HAROLD RHODES
AND REBECCA RHODES,
PLAINTIFFS-APPELLANTS,

v.

AIG DOMESTIC CLAIMS, INC. F/K/A
AIG TECHNICAL SERVICES, INC., NATIONAL UNION FIRE
INSURANCE COMPANY OF PITTSBURGH, PA, AND
ZURICH AMERICAN INSURANCE COMPANY,
DEFENDANTS-APPELLEES.

ON APPEAL FROM A JUDGMENT OF THE SUPERIOR COURT.

BRIEF FOR THE PLAINTIFFS-APPELLANTS, MARCIA RHODES, HAROLD RHODES AND REBECCA RHODES.

SUFFOLK COUNTY.

BATEMAN & SLADE, INC BOSTON, MASSACHUSETTS

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