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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

THOSE CERTAIN UNDERWRITERS AT LLOYD'S, LONDON et al.,

Plaintiffs and Appellants,

v.

CONNEX RAILROAD LLC et al.,

Defendants and Appellants.

B276373

(Los Angeles County Super. Ct. No. BC493509)

APPEALS from a judgment of the Superior Court of the County of Los Angeles, Elihu M. Berle, Judge. Affirmed.

Vanderford & Ruiz, Ty S. Vanderford, Rodolfo F. Ruiz; and Akin Gump Strauss Hauer & Feld, Rex S. Heinke, Jessica M. Weisel, for Plaintiffs and Appellants.

Munger, Tolles & Olsen, Jeremy A. Lawrence, Cary B Lerman, Daniel P. Collins; Farella Braun & Martel, Mary E. McCutcheon, Dennis M. Cusak; Kiesel Law, Paul R. Kiesel, Jeffrey Koncious, Mariana Aroditis; and Weinberg Wheeler

Hudgins Gunn & Dial, D. Lee Roberts, Jr., M. Alan Holcomb, for Defendants and Appellants.

INTRODUCTION

This litigation is an aftermath of the fatal September 12, 2008 Chatsworth head-on collision between a Metrolink commuter train and a Union Pacific freight train. Plaintiffs are all insurers.[1] They insured Metrolink, Connex Railroad LLC and Connex's parent, Veolia Transportation, Inc.[2] Insurers interpleaded their policy limits and then sued for reimbursement, unjust enrichment and a judicial determination that an express policy exclusion precluded coverage for the accident. Connex and Veolia (collectively, Insureds) cross-complained, alleging breach of contract, bad faith, coverage estoppel, and fraud.

Connex and Veolia moved separately for summary judgment on the first amended complaint, contending the express policy exclusion did not apply as a matter of law. The trial court

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[1] Plaintiffs are Those Certain Underwriters at Lloyd's, London, Severally Subscribing Policy No. 507/N05QA06420; Those Certain Underwriters at Lloyd's, London, Severally Subscribing Policy No. 507/N08QA07560; Those Certain Underwriters at Lloyd's, London, Severally Subscribing Policy No. 507/N08QA07560; Indian Harbor Insurance Company, a North Dakota corporation; Steadfast Insurance Company, a North Dakota corporation; and Aspen Insurance UK Limited, a United Kingdom limited company (collectively, Insurers).

[2] Connex contracted with the Southern California Regional Rail Authority (Metrolink) to operate Metrolink trains in this region. Connex employed the personnel operating Metrolink trains. Metrolink is not a party to this action.

agreed and granted the motions. Insurers moved for summary judgment on the cross-complaint, contending it failed as a matter of law based on Insureds' release of all claims against them. The trial court also agreed and granted the motion. We affirm.

FACTUAL AND PROCEDURAL BACKGROUND

Twenty-four passengers were killed and scores more were injured in the Chatsworth accident. Metrolink engineer Robert Sanchez also died. The wrongful death and personal injury claims and lawsuits (Chatsworth claims) settled for $200 million, the maximum allowable recovery under federal law for a single rail collision.[3]

No lawsuit arising out of the accident went to verdict, so there was no judicial determination as to the cause of the collision. The Metrolink train, however, ran a red light and began traveling on a single set of tracks designated for traffic in both directions. The National Transportation Safety Board (NTSB) investigated the crash and found the Metrolink engineer "was actively, if intermittently, using his wireless device shortly after his train departed Chatsworth station, and his text messaging activity during this time compromised his ability to observe and appropriately respond to the *stop* signal at Control Point Topanga." The NTSB also found "[t]he Metrolink engineer was aware that he was violating company safety rules when he used his cell phone to make calls or to send and receive text messages while on duty, but he continued the practice nonetheless."

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[3] Amtrak Reform and Accountability Act of 1997, 49 U.S.C. § 28103(a)(2).

The NTSB concluded "the probable cause . . . was the failure of the Metrolink engineer to observe and appropriately respond to the red signal aspect at Control Point Topanga because he was engaged in prohibited use of a wireless device, specifically text messaging, that distracted him from his duties. Contributing to the accident was the lack of a positive train control system that would have stopped the Metrolink train short of the red signal and thus prevented the collision."[4]

Insurers interpleaded $146 million for settlement of the Chatsworth claims.[5] In exchange for contributing their aggregate policy limits, Insurers and Insureds entered into a "Policy Release and Agreement" (Agreement). Insurers retained the right, "if any, to seek contribution and/or subrogation, or to assert policy defenses with respect to Connex [and] Veolia . . . ." Except for the right to assert a setoff in the event Insurers did sue, Insureds "release[d] and forever discharge[d]" Insurers for all liability arising out of the Chatsworth collision.

Insurers then initiated this action against Insureds based on exclusion 3, which excluded coverage for "Bodily Injury, Personal Injury, Property Damage and/or Advertising Injury which the Insured intended or expected or reasonably could have

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[4] After the Chatsworth accident, federal laws were enacted mandating the use of a positive train control system and prohibiting railroad employees from using handheld devices while on operating trains. (49 U.S.C. § 20157; 75 Fed.Reg. 59580 (Sept. 27, 2010).)

[5] The remaining $54 million is not involved in this litigation. In this action, Insurers sued to recoup $132.5 million of their contribution.

expected." The operative pleading was the first amended complaint. Insureds countered with the cross-complaint.

Motions for summary judgment followed. Insureds maintained the exclusion precluded coverage only for losses that flowed directly and immediately from Insureds' alleged intentional conduct and asserted that, as a matter of law, the exclusion did not defeat coverage for the Chatsworth accident.

Viewing the evidence and reasonable inferences from the evidence produced in discovery in the light most favorable to Insurers, the trial court concluded there was evidence Metrolink engineers used handheld electronic devices while on duty, in violation of Connex's policies, and Connex executives knew corporate rules were being violated and accidents could result if engineers were distracted by their cell phones. The trial court also concluded this evidence failed to raise a triable issue of material fact and granted Connex's motion for summary judgment on the first amended complaint, finding as a matter of law the policy exclusion did not apply.

Insurers sought reconsideration to present additional evidence. The trial court granted that request, but ruled the additional evidence inadmissible and affirmed the grant of summary judgment. Veolia then successfully moved for summary judgment on the same ground as Connex.

The trial court also granted Insurers' motion for summary judgment on the cross-complaint. Insurers paid the policy limits and expressly reserved the right to seek contribution from Insureds. Insureds expressly released Insurers, inter alia, from "past, present or future claims, whether known or unknown, that were or could have been tendered under the policies for coverage" and from "any claims . . . for breach of the duty of good faith and

fair dealing or any other contractual or extra-contractual duties that existed as of the date of the execution of this agreement."

Final judgment was entered May 3, 2016, in favor of Insureds on the first amended complaint and in favor of Insurers on the cross-complaint.

DISCUSSION

I. Summary Judgment on the First Amended Complaint -- Exclusion Does Not Apply as a Matter of Law

A. New York Law

The insurance provision under review is the exclusion for personal injuries and property damage the Insured "intended or expected or reasonably could have expected." Pursuant to the trial court's unchallenged ruling, the exclusion and insurance policies in question are to be interpreted under the laws of the State of New York.[6]

The Court of Appeals of New York, the state's highest court, recently reaffirmed that insurance provisions "must be given their plain and ordinary meaning, and the interpretation of such provisions is a question of law for the court." (*Burlington Ins. Co. v. NYC Tr. Auth.* (2017) 29 N.Y.3d 313, 321, internal quotation marks omitted.) Moreover, "[t]he law governing the interpretation of exclusionary clauses in insurance policies is highly favorable to insureds." (*Pioneer Tower Owners Ass'n v. State Farm Fire & Cas. Co.* (2009) 12 N.Y.3d 302, 306.) Policy exclusions are enforced only where they "'have a definite and precise meaning, unattended by danger of misconception . . . and

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[6] In all other respects, California law applies in this case.

concerning which there is no reasonable basis for a difference of opinion.'" (*Id.* at p. 307.)

The insurer bears the burden to "establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case." (*Cont'l Cas. Co. v. Rapid-American Corp.* (1993) 80 N.Y.2d 640, 652 (*Rapid-American*).) Finally, policy exclusions "are not to be extended by interpretation or implication, but are to be accorded a strict and narrow construction. [Citations.] Indeed, before an insurance company is permitted to avoid policy coverage, it must satisfy the burden which it bears of establishing that the exclusions or exemptions apply in the particular case [citations], and that they are subject to no other reasonable interpretation." (*Seaboard Surety Co. v. Gillette Co.* (1984) 64 N.Y.2d 304, 311.)

The parties have not cited, nor has this court found, one New York decision interpreting the precise language of the exclusion at issue here.[7] Nonetheless, an unbroken line of

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[7] In fact, we located only three reported decisions in the country that include the identical policy exclusion here, i.e., for bodily injury or property damage the insured "intended or expected or reasonably could have expected."

In *Northland Cas. Co. v. HBE Corp.* (M.D. Fla. 2001) 160 F.Supp.2d 1348, the federal district court held that claims of "intentional racial discrimination that do not allege an occurrence under the policy . . . are further precluded from coverage under the policy's 'intended or expected' exclusion." (*Id.* at p. 1365.) Addressing the "intended or expected" exclusion, the federal district court noted, "In this case, the insurance policy contains what is commonly referred to as an 'intended or expected' exclusion. This type of exclusion excludes from coverage all

authority from the Court of Appeals of New York discussing the "intended or expected" language in insurance policy exclusions establishes that coverage is afforded where "accidental results flow[] from intentional causes, i.e., that the resulting damage was unintended although the original act or acts leading to the damage were intentional." (*McGroarty v. Great American Ins. Co.* (1975) 36 N.Y.2d 358, 364 (*McGroarty*).)[8]

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damages and injuries which the insured intended as a consequence of his or her actions." (*Id.* at p. 1359.)

Neither *Martinez v. State Counties Reciprocal Mgmt. Program* (2000) 134 Idaho 247, 250 (uninsured motorist coverage) nor *Northfield Ins. Co. v. Montana Ass'n of Counties* (2000) 301 Mont. 472 (the insurers' preemptive declaratory relief action dismissed for lack of a justiciable controversy) included substantive discussions of the exclusion.

[8] *McGroarty,* like most of the New York decisions, arose in the context of the reviewing court's question as to whether an insured's conduct resulted in an accident or occurrence, i.e., an unintended or unexpected outcome potentially covered by insurance. A number of these decisions involve the broader duty to defend, rather than the duty to indemnify. To add to the analytical web, while the interpretation of insurance policy language presents an issue of law, the coverage conclusion itself is frequently one of fact under New York law. (See, e.g., *McGroarty, supra,* 36 N.Y.2d at p. 363 ["application of the term accident in such contexts as that before us provides a question of fact and not a question of law"].)

At this point in the analysis, however, it must be remembered that although "Accident" is a defined term in the insurance policies we review, the words "accident" or "accidental" retain their everyday meaning as "happening by chance, unintentionally, or unexpectedly." (Online Oxford Dict., en.oxforddictionaries.com/definition/accidental.) "The

The term "accident" in an insurance policy pertains "'not only to an unintentional or unexpected event which, if it occurs, will foreseeably bring on death, but equally to an intentional or expected event which unintentionally or unexpectedly has that result' [*Miller, supra,* 40 N.Y.2d at p. 678]." (*Automobile Ins. Co. of Hartford v. Cook* (2006) 7 N.Y.3d 131, 137-138.) These decisions further demonstrate that only in those circumstances where the result is "inherent in the nature of the acts alleged to be committed by the insured," will coverage be denied based on the "expected or intended" exclusion. (*Id.* at p. 138; see, e.g., *Allstate Ins. Co. v. Mugavero* (1992) 79 N.Y.2d 153 [child sexual abuse excluded from coverage].) As the Court of Appeals of New York has held, "catastrophic results which are the unintended fruits of willful conduct" may still be covered events. (*McGroarty, supra,* 36 N.Y.2d at p. 363.)

Justice Cardozo's opinion in *Messersmith v. American Fidelity Co.* (1921) 232 N.Y. 161 (*Messersmith*) is generally regarded as the genesis for New York's rule. There, the defendant, in violation of the law, loaned his car to an underage,

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multifaceted term 'accident' is not given a narrow, technical definition by the law. It is construed, rather, in accordance with its understanding by the average man." (*Miller v. Continental Ins. Co.* (1976) 40 N.Y.2d 675, 676-677 (*Miller*).

The Chatsworth collision was unquestionably an "Accident" within the meaning of the policies pursuant to New York law. But once this court interprets the exclusionary clause under New York law, we apply California law to determine if there were triable issues of material fact as to whether the "intended or expected or reasonably could have expected" exclusion applied, i.e., whether the personal injuries or property damage flowed "directly and immediately from the insured's alleged intentional act."

unlicensed driver who then caused an accident. The defendant successfully sued his insurer for indemnity. The New York Court of Appeals affirmed, rejecting the insurer's argument that there could be no indemnity because the insured's decision to loan his car was willful, not negligent: "The plaintiff, in intrusting his car to a youth under eighteen did not desire or intend that there should be an injury to travelers. The act of so intrusting it was willful, but not the ensuing conduct of the custodian, through which injury resulted. . . . [¶] . . . A driver turns for a moment to the wrong side of the road, in the belief that the path is clear and deviation safe. The act of deviation is willful, but not the collision supervening. The occupant of a dwelling leaves a flower pot upon the window sill, and the pot, dislodged by wind, falls upon a passing wayfarer. [Citation.] The position of the flower pot is intended, but not the ensuing impact. The character of the liability is not to be determined by analyzing the constituent acts, which, in combination, make up the transaction, and viewing them distributively. It is determined by the quality and purpose of the transaction as a whole." (*Id.* at pp. 165-166.)

McGroarty, supra, 36 N.Y.2d 358 was decided 50 years later. There, the plaintiff and the defendant were adjacent property owners. Excavations and construction on the defendant's property lasted several months, with the plaintiff repeatedly warning the work was likely to damage his building. The plaintiff's building was damaged, and he sued. The defendant's insurer refused to defend on the basis the insured's excavation and construction activities were willful, not negligent. The New York Court of Appeals affirmed the judgment in favor of the insured: "One often contemplates and envisions a sudden or catastrophic event when considering the term accident—an event

which is unanticipated and the product of thoughtlessness rather than willfulness. But a broader view must be taken of the term for otherwise how could we classify catastrophic results which are the unintended fruits of willful conduct? Certainly one may intend to run a red light, but not intend that the catastrophic result of collision with another car occur. Calculated risks can result in accidents." (*Id.* at p. 363.)

Allstate Ins. Co. v. Zuk (1991) 78 N.Y.2d 41 involved a homeowner's policy that excluded coverage for "'bodily injury or property damage which may *reasonably be expected to result from the intentional or criminal acts* of an insured person or *which are in fact intended* by an insured person' (emphasis supplied)." (*Id.* at p. 44.) Based on the exclusion, the insurer obtained summary judgment in its declaratory relief action to establish it had no duty to defend or indemnify the insured who pleaded guilty to manslaughter after the shotgun he was cleaning and loading accidentally fired, killing his friend who was sitting nearby. The Court of Appeals reversed, finding the criminal conviction did "not establish as a matter of law that [the insured] reasonably expected [the victim's] death to result from his actions. Under the terms of this exclusion clause, whether a result is reasonably expected should be gauged as of the time and circumstances of the conduct engaged in by the particular actors, not attributed in hindsight based on an eventual criminal conviction, if any." (*Id.* at p. 46.)

An opinion from New York's intermediate reviewing court, the Supreme Court Appellate Division, Third District, deserves mention at this point. *Continental Ins. Co. v. Colangione* (N.Y.App.Div. 1985) 484 N.Y.S.2d 929 (*Colangione*) involved a water damage claim arising out of a construction project. In

reversing a judgment for the insurance company and remanding for a new trial, *Colangione* explained, "The insurance policy at issue expressly defines 'occurrence' as 'an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured'. In determining whether damage is a product of an accident, the transaction must be considered as a whole and if, as noted in *McGroarty*[*, supra,* 36 N.Y.2d 358], "the resulting damage could be viewed as unintended by the fact finder the total situation could be found to constitute an accident" [*McGroarty* at pp. 364-365]. This court, interpreting virtually the identical clause at issue herein, namely a definition of an occurrence as an accident which results in property damage neither expected nor intended, has distinguished between damages which flow directly and immediately from an intended act, thereby precluding coverage, and damages which accidentally arise out of a chain of unintended though expected or foreseeable events that occurred after an intentional act [citation]. Ordinary negligence does not constitute an intention to cause damage [citation]; neither does a calculated risk amount to an expectation of damage [*McGroarty* at p. 363]." (*Id.* at pp. 930-931.)

The United States Court of Appeals for the Second Circuit succinctly and aptly described the common thread shared by the New York decisions as follows: "New York courts have generally read 'expect or intend' provisions to exclude only those losses or damages that are not accidental." (*Johnstown v. Bankers Standard Ins. Co.* (2d Cir. 1989) 877 F.2d 1146, 1150 (*Johnstown*).) Based on our survey of New York appellate law, we agree.

The Second Circuit issued its opinion in *Johnstown, supra,* 877 F.2d 1146, upon which the trial court and Insureds rely, shortly after *County of Broome v. Aetna Casualty & Sur. Co.* (N.Y.App.Div. 1989) 540 N.Y.S.2d 620 (*Broome*)—also a New York Appellate Division, Third Department opinion—was decided. Insurers argue *Broome* is the decision "most analogous" to this case. Both *Johnstown* and *Broome* involved toxic dumping by a city and county, respectively. The public entities sought insurance coverage for ensuing losses.

The policy language in each case was similar. The *Johnstown* policy defined "occurrence" as "'an accident, including continuous or repeated exposure to the same event, that results . . . in bodily injury, personal injury or property damage. Such injury or damage must be neither expected nor intended by the insured.'" (*Johnstown, supra,* 877 F.2d at p. 1149.) The *Broome* policy defined "occurrence" as an "'accident, including continual or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.'" (*Broome, supra,* 540 N.Y.S.2d at p. 621.)

In *Broome*, the intermediate reviewing court observed, "it has been stated that personal injuries or property damages are expected if the actor knew or should have known there was a substantial probability that a certain result would take place." (*Broome, supra,* 540 N.Y.S.2d at p. 622.) *Broome* applied this statement to the insuring provisions quoted above and determined as a matter of law the insured's discharge of polluting waste into the environment for more than a decade was not an "accident." Consequently, there was no "occurrence" that triggered the coverage provisions. *Broome* provided no analysis

and did not rely on any New York authority to support this conclusion. *Broome* instead cited *Auto-Owners Ins. Co. v. Jensen* (8th Cir. 1981) 667 F.2d 714, 719-720 (*Auto-Owners*), a federal Court of Appeals decision that applied Minnesota law.[9]

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[9] *Auto-Owners, supra,* 667 F.2d at pages 719-720 involved an insurer that refused to defend its insured, who was sued when the spray paint he used for a bridge project "floated easily on air currents" and damaged nearby cars. (*Id.* at p. 717.) The insured's suit to compel the insurer to defend that action was tried to a jury and he prevailed. The federal appellate panel reversed and ordered a new trial based on instructional error as to the meaning of the exclusion precluding coverage for "'property damage neither expected nor intended from the standpoint of the insured.'" (*Id.* at p. 718, fn. 3.)

Relying on *City of Carter Lake v. Aetna Casualty and Surety Co.* (8th Cir. 1979) 604 F.2d 1052 (*Carter Lake*), which applied Iowa law, the *Auto-Owners* court determined "it does not follow that because some negligent acts are covered by such policies, all negligent acts are covered. There may be instances when, although the insured was negligent in his actions, he knew or should have known that resulting damage was expected. To mandate that damages cannot be expected if the actor is negligent results in a meaning of the term expected that is too narrow." (*Auto-Owners, supra,* 667 F.2d at p. 719, fn. omitted.)

The context for the *Carter Lake* holding was quite a bit different than that in *Auto-Owners.* In *Carter Lake,* although the city did not intend the result, a resident's basement was flooded with raw sewage six times in less than one year when the municipal sewage pump overloaded. The resident sued the city, whose insurer disclaimed coverage. The appellate panel determined there was coverage for the first loss, but the city could not rely on insurance coverage for subsequent losses in lieu of repairing the pump. All the losses after the first one "were not unexpected and thus were not accidents or occurrences as those

Johnstown was another pollution case involving the duty to defend. There, the Second Circuit Court of Appeals, applying New York law, reversed summary judgment in favor of the insurer, holding, "proof of warnings of possible physical damages is not enough to show that as a matter of law the damages ultimately incurred were expected or intended. [¶] In opting to keep the landfill in operation, the City took a calculated risk, much as the insured did in *McGroarty* [where] the insured's construction work had caused a great weight of rocks and water to shift against a neighboring property owner's garage wall. The irate property owner had complained to the insured, and had even pointed out cracks developing in the garage wall. The New York Court of Appeals, however, held that, despite these warnings, the damages that subsequently occurred still could be found to have been accidental. [Citation.] [¶] Here, by analogy, the record suggests that the City was aware of potential contamination, but not that the City *intended* the resulting damage, nor that the City, intending harm, *knew* that the extensive damages alleged in the CERCLA complaint would flow directly and immediately from the City's intentional acts. The evidence relied upon on [insurers'] motion for summary judgment thus failed to show that 'as a matter of law that there is no possible factual or legal basis on which [the insurer] might eventually be held to be obligated to indemnify' the insured." (*Johnstown, supra,* 877 F.2d at p. 1152.)

Insurers complain the insurance policy in *Johnstown* did not include the "'reasonably could have expected'" exclusion language. Neither, of course, did the policies in *Broome* or all but

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terms were used in the insurance policy." (*Carter Lake, supra,* 604 F.2d at p. 1059.)

one of the New York decisions this court and the parties have reviewed.[10] But *Johnstown* had this to say about *Broome*: "If the Third Department's interpretation of the 'expect or intend' exclusion does indeed broaden that exclusion to cover any damage that was, objectively speaking, substantially probable, that interpretation appears to conflict with the New York cases discussed in the text, including *McGroarty*[, *supra*, 36 N.Y.2d 358] and its progeny. [Citation.] To the extent that *County of Broome* does diverge from other New York courts' narrow interpretation of the 'expect or intend' clause, that divergence may be due in part to the *County of Broome* court's almost exclusive reliance on precedent from other than New York courts." (*Johnstown, supra,* 877 F.2d at p. 1151, fn. 1.)

We agree with *Johnstown* that *Broome* is an analytical outlier in terms of its statement that "'[personal injuries or] property damages are expected if the actor knew or should have known there was a substantial probability that a certain result would take place.'" (*Johnstown, supra,* 877 F.2d at p. 1151, fn. 1.) *Broome* is in conflict with an otherwise consistent line of New York authority that "distinguishe[s] between damages which flow directly and immediately from an intended act, thereby precluding coverage, and damages which accidentally arise out of a chain of unintended though expected or foreseeable events that occurred after an intentional act." (*Colangione, supra,* 484 N.Y.S.2d at pp. 930-931.)

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[10] *Allstate Ins. Co. v. Zuk, supra,* 78 N.Y.2d 41 is the exception. But the "reasonably expected by the insured" language there was limited to criminal or intentional acts.

B. Policy Language

We begin our analysis with the policy itself. It is an "excess railroad claims made liability policy"[11] and, as pertinent here, provides coverage for bodily injury, personal injury and property damage "resulting from an Accident." "Accident" is a defined term in the policy. It means "an event which first commences" during the policy period and is reported by the insured "up to 120 days" after the policy expires. The express exclusion Insurers rely on is for personal injury and property damage "which the Insured intended or expected or reasonably could have expected."

Under New York case law, an exclusion for a result the insured intended or expected involves a subjective standard. (*Miller, supra,* 40 N.Y.2d at p. 677 ["'[in] construing whether or not a certain result is accidental, it is customary to look at the causality from the point of view of the insured, to see whether or not, from his point of view, it was unexpected, unusual and unforeseen'"].)

The parties agreed, however, the subjective standard would not apply in this case. In their response to Insureds' Undisputed Material Facts Nos. 19 and 36, Insurers stated, "the exclusion at issue should be referred to as the 'Reasonably Could Have Expected Exclusion.' (Whether Connex/Veolia intended or expected the injuries from the Chatsworth accident to occur is irrelevant to this litigation, and referring to the exclusion as the 'Intended or Expected Exclusion' serves only to confuse the issues.)"

As the trial court recognized, the portion of the exclusion that precluded coverage for acts "the insured . . . reasonably could

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[11] Because the policies provided excess coverage, there was no duty to defend.

have expected" had the effect of applying an objective, reasonable-person standard to the exclusion. Under the objective standard, analyses in the New York cases cited above hold true; the only difference is, instead of analyzing causality from the insured's point of view, we consider it from the point of view of a reasonable person.

Our de novo review of the policy language and New York authorities leads us to the same result as the trial court. The "reasonably could have expected" exclusion does not apply unless a reasonable person would conclude the injury and damage "flow[ed] directly and immediately from an insured's alleged intentional act." This is a reasonable interpretation of the policy's exclusionary language, and Insurers failed to demonstrate otherwise. (*Rapid-American, supra,* 80 N.Y.2d at p. 652.) Instead, they suggest "[t]he 'reasonably could have expected' exclusion should apply when, as here, a reasonably prudent person would believe injuries are substantially likely to occur." That interpretation is based on *Broome* and is not supported by overwhelming New York case authority. We reject it.

C. Standard of Review

We return to California law to determine if summary judgment on the first amended complaint was properly granted. We engage in a de novo review of the record, "considering all the evidence set forth in the moving and opposition papers except that to which objections have been made and sustained. [Citation.] Under California's traditional rules, we determine with respect to each cause of action whether the defendant seeking summary judgment has conclusively negated a necessary

element of the plaintiff's case, or has demonstrated that under no hypothesis is there a material issue of fact that requires the process of trial, such that the defendant is entitled to judgment as a matter of law." (*Guz v. Bechtel National Inc.* (2000) 24 Cal.4th 317, 334.)

D. Analysis

Insureds' summary judgment motion was filed after the trial court interpreted the exclusion under New York law. The motion shifted the burden to Insurers to present evidence that raised a triable issue of material fact that would lead a reasonable person to conclude the losses in the Chatsworth collision flowed directly and immediately from Insureds' conduct. (Code Civ. Proc., § 437c, subd. (p)(2).) Despite Insurers' arguments in this court to the contrary, the trial court repeatedly advised it was evaluating the motion by giving Insurers the "most favorable . . . interpretation of the facts." This included evidence that Insureds knew on-board personnel used cell phones and handheld electronic devices in violation of company policy, did not effectively discipline offending employees, and concealed information concerning these violations from Metrolink. The reasonable inference from this evidence, according to Insurers, was that a reasonable person should have expected the Chatsworth collision.

As the trial court concluded, however, whether a reasonable person should have expected the Chatsworth collision is not the standard. To defeat summary judgment, Insurers had to present evidence that raised a triable issue of material fact as to whether the Chatsworth collision "flow[ed] directly and

immediately from an insured's alleged intentional act." They did not meet their burden.

Summary judgment on the first amended complaint was properly granted.

II. Summary Judgment on the Cross-Complaint

A. Background

Insurers and Insureds (and entities not parties to this action, including Metrolink) entered into the Agreement in October 2010, shortly after Insurers interpleaded their aggregate policy limits in order to settle the Chatsworth claims. The parties acknowledged they were all represented by counsel and all "contributed to the drafting of this Agreement," which was to be construed as a jointly prepared document.

In section 3.4 of the Agreement, Insureds agreed to "release and forever discharge" Insurers from any and all payments exceeding $146 million in connection with, in any way relating to, or arising out the Chatsworth collision; every Chatsworth collision court action; any other claim that might arise during the policy period; "any past, present or future claims, whether known or unknown, that were or could have been tendered under the Policies for coverage;" and "any claims against [Insurers] for breach of the duty of good faith and fair dealing or any other contractual extra-contractual duties, that existed as of the date of execution of this agreement."

Section 3.5 provided that nothing in the Agreement could impair Insurers' rights—if any such rights existed—to sue Insureds for contribution, subrogation or to assert "policy

defenses, with respect to [Insureds]."[12] If Insurers did sue, then "notwithstanding the release provided in Paragraph 3.4 above, if [Insurers] assert such rights, then [Insureds] shall be entitled to raise the Released Matters as an affirmative defense or offset to such rights." Paragraph 4.10 included a waiver of Civil Code section 1542 and the "acknowledge[ment] that they may have sustained damages that are presently unknown and unsuspected, and that unknown damages may arise in the future. Nevertheless, the Parties acknowledge that this Agreement has been negotiated and agreed upon in light of such possible damages and expressly waive any and all rights under California Civil Code Section 1542 with respect to the matters released in this Agreement."

Approximately 17 months after Insurers filed this action, the trial court granted Insureds leave to file the cross-complaint. Insureds sued for breach of the insurance policies, "procedural" and "substantive" bad faith based on breach of the covenant of good faith and fair dealing, insurance coverage by estoppel, and fraud.

Insurers moved for summary judgment and, alternatively, summary adjudication of issues. The trial court determined Insureds could raise their claims "as a setoff or offset in the format of a cross-complaint," in addition to asserting them as affirmative defenses to Insurers' complaint. As noted, the trial court thereafter granted summary judgment in favor of Insurers on the cross-complaint.

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[12] Insurers did not reserve a right to sue any entities other than Insureds.

B. Analysis

Insurers' lawsuit "released" Insureds from the strictures of the Agreement only to extent their claims for breach of contract, breach of the covenant of good faith and fair dealing/bad faith, and fraud would offset any award to Insurers' on the first amended complaint. Once the Insureds obtained judgment in their favor on the Insurers' first amended complaint, there was no potential award to offset. Accordingly, Insureds at that point were bound by the terms of the Agreement.[13]

Insurers had already interpleaded their aggregate policy limits by the time the Agreement was signed, suggesting no claims "against [them] for breach of the duty of good faith and fair dealing or any other contractual extra-contractual duties, [still] existed as of the date of execution of this agreement." Insureds did not present any evidence to raise a triable issue of fact concerning the Insurers' conduct that fell outside the Agreement.

Insureds expressly agreed they were releasing all claims based on contract and breach of the duty of good faith and fair dealing. Fraud was not expressly referenced in the Agreement, but conduct based on the breach of a fiduciary duty, i.e., "extra-contractual duties," was. Virtually all the alleged actionable conduct by Insurers predated the Agreement, except for the filing of the Insurers' complaint. But the initiation of the lawsuit was protected by the litigation privilege (Civ. Code, § 47, subd. (b)(1)) and, in any event, an insurer's "defensive pleading" cannot support a bad faith claim. (*California Physicians' Service v.*

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[13] Insureds forfeited any argument that they are entitled to rescind the Release based on fraud in the inducement as the cross-complaint did not seek rescission.

Superior Court (1992) 9 Cal.App.4th 1321, 1326.) This is particularly so where the insurer has not denied the claim, but has in fact paid it, reserving only the right to seek a judicial determination on a coverage question.

Insureds' claim that they were fraudulently induced to enter into the Agreement was not supported by any evidence and was belied by the language in the Agreement. Insureds contend another indicia of fraud was Insurers' decision to attribute the entire interpleaded sum to Insureds, rather than allocating any to Metrolink. This determination was apparent on the face of the Agreement, however, as Insurers reserved the right to sue Insureds, but not Metrolink. Summary judgment was properly granted on the cross-complaint.

DISPOSITION

The judgment is affirmed. The parties are to bear their own costs on appeal.

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

DUNNING, J.*

We concur:

KRIEGLER, Acting P. J.

BAKER, J.

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* Judge of the Orange Superior Court assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.