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IN THE SUPREME COURT OF MISSISSIPPI

SOUTHERN HEALTHCARE SERVICES, INC., MEDFORCE MANAGEMENT, LLC, d/b/a WILLOWCREEK RETIREMENT CENTER AND DALESON ENTERPRISE, LLC d/b/a JONES COUNTY REST HOME — APPELLANTS

VS. — DOCKET NO. 2011-CA-01833

LLOYD'S OF LONDON, CERTAIN UNDERWRITERS AT LLOYD'S, LONDON, CARONIA CORPORATION — APPELLEES

APPEAL FROM CAUSE NO. 2006-26-CV8
CIRCUIT COURT OF THE FIRST JUDICIAL DISTRICT
JONES COUNTY, MISSISSIPPI

APPELLEES' RESPONSIVE BRIEF

NO ORAL ARGUMENT REQUESTED

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CERTIFICATE OF INTERESTED PARTIES

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the Justices of the Supreme Court and/or the Judges of the Court of Appeals may evaluate possible disqualifications or recusal.

1. Plaintiff-Appellant, Southern Healthcare Services, Inc., Sumrall, Lamar County, Mississippi.
2. Plaintiff-Appellant, Medforce Management, LLC d/b/a Willowcreek Retirement Center, Byram, Hinds County, Mississippi.
3. Plaintiff-Appellant, Daleson Enterprise, LLC d/b/a Jones County Rest Home, Ellisville, Jones County, Mississippi.
4. Attorney for Plaintiffs-Appellants, Derek A. Henderson, Attorney at Law, Jackson, Mississippi.
5. Attorney for Plaintiffs-Appellants, David Mullin, Mullin, Hoard & Brown, LLP, Amarillo, Texas.
6. Defendant-Appellee, Lloyd's of London, Certain Underwriters at Lloyd's of London, London, United Kingdom.
7. Defendant-Appellee, Caronia Corporation, Houston, Texas.

8. Attorneys for Defendants-Appellees, Richard O. Burson, Grayson Lacey and Shirley M. Moore[1], Gholson Burson Entrekin & Orr, PA, 535 North 5th Avenue, P.O. Box 1289, Laurel, MS 39441-1289.

9. Attorney for Defendants-Appellees, Scott D. Braun, Johnson & Bell, Ltd., 33 West Monroe Street, Suite 2700, Chicago, IL 60603-5404.

10. Honorable Joe N. Pigott, Special Circuit Court Judge, Jones County, Mississippi.

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[1] Out of an abundance of caution and in the interest of full disclosure, Defendants disclose that attorney Shirley M. Moore served as a law clerk for Judge Roberts in 2009. While clerking at the Court of Appeals, Ms. Moore was not involved in the first appeal in this matter. She performed no research or writing in the prior appeal and she did not attend oral arguments in the matter. Further, Ms. Moore was not privy to conversations regarding that matter with Judge Roberts or any justice on the court. As stated, Defendants simply wish to disclose Ms. Moore's prior employment at the Court of Appeals to the judges of the Mississippi Supreme Court, the Court of Appeals, and Plaintiffs. Defendants aver no conflict exists.

IN THE SUPREME COURT OF MISSISSIPPI

**SOUTHERN HEALTHCARE SERVICES, INC.
MEDFORCE MANAGEMENT, LLC, d/b/a
WILLOWCREEK RETIREMENT CENTER AND
DALESON ENTERPRISE, LLC d/b/a JONES
COUNTY REST HOME** **APPELLANTS**

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6. Defendant-Appellee, Lloyd's of London, Certain Underwriters at Lloyd's of London, London, United Kingdom.
7. Defendant-Appellee, Caronia Corporation, Houston, Texas.

8. Attorneys for Defendants-Appellees, Richard O. Burson, Grayson Lacey and Shirley M. Moore[1], Gholson Burson Entrekin & Orr, PA, 535 North 5th Avenue, P.O. Box 1289, Laurel, MS 39441-1289.

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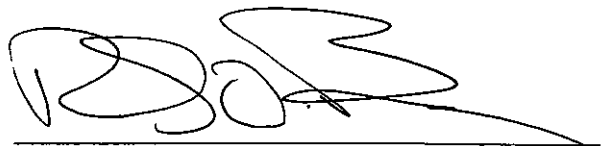

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PRELIMINARY STATEMENT

This simple breach of contract case has had an extensive and serpentine procedural history: Judge Robert Evans granted summary judgment in 2008; the Court of Appeals sent the case back in 2009; and, Judge Joe Pigott, on the same facts, reinstated summary judgment in 2011. Invigorated by the dissent in the prior appeal, Plaintiffs seek to change the landscape of contract law by asking this Court to find that an insurer has an incontrovertible duty to pay for all defense costs, regardless of what a sophisticated party bargained for. Such a holding would rub against the proverbial grain of substantive contract law. Further, to accept Plaintiffs' argument that an insurer must quickly settle a lawsuit based solely on its venue without consideration of its merits, would implicitly overrule *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255, (Miss. 1988) – all without good reason.

Through the procedural journey, Plaintiffs have been amply afforded the opportunity to present their argument and be heard by two of the most seasoned trial judges in the State of Mississippi. Although Plaintiffs have persistently sought to introduce emotional and immaterial facts related to Plaintiffs' voluntary business decisions apart from the contract at issue, the two experienced trial judges have refused to be led astray by these rabbit trails. The two trial judges acknowledged the fact that these sophisticated Plaintiffs made a conscious business decision to retain the first $250,000.00 risk for any claim brought against them. They recognized that the contract unambiguously provided that *any* investigative or defense costs *were included* within that $250,000.00 retained risk. They appreciated that Defendants advanced over $701,153.54 in defense and settlement costs within the Plaintiffs' deductible, without ever denying coverage or refusing any settlement offer or, more importantly, without Plaintiffs suffering *any* judgment – much less an excess judgment. Finally, the two trial judges saw that Plaintiffs, in persistent error, refuse to reimburse Underwriters for monies they advanced within Plaintiffs' deductible.

To escape their contractual obligation, Plaintiffs simply seek to expand Mississippi's duty to defend case law into one of strict liability to insurers, rather than acknowledging sophisticated parties' freedom to contract.

An insurance policy is a contract, pure and simple, and courts apply substantive contract law when considering an insurance contract.[1] "In Mississippi, an insurance company's duty to defend its insureds derives neither from common law nor statute, but rather from the provisions of its policy, that is, its insurance contract with its insured."[2] "It is a matter of contractual agreement. Absent a higher obligation created by statute, an insurance company's duty to defend is neither greater nor broader than the duty to comply with its other contractual obligations."[3]

The instant case tests this Court's mettle to remain true to the long-standing substantive law of contract, as well as the common law related to an insurer's duty to defend claims within, or outside of, a policy's coverage. Applicable authority from Mississippi and other jurisdictions, demonstrate that one does not obviate the other. They must co-exist.

STATEMENT OF THE ISSUES

I. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON PLAINTIFFS' CLAIMS AS DEFENDANTS PERFORMED ALL CONTRACTUAL DUTIES OWED PER THE CONTRACT

II. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THEIR COUNTERCLAIM

III. THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN DENYING PLAINTIFFS' MOTION TO AMEND COMPLAINT

IV. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION TO STRIKE AND DID NOT DENY PLAINTIFFS DUE PROCESS

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[1] *Architex Ass. v. Scottsdale Ins. Co.*, 27 So.3d 1148, 1157 (¶21)(Miss. 2010); *Estate of Bradley v Royal Surplus Lines Ins. Co*,, 2010 U.S.Dist. LEXIS 67466 (N.D.Miss. July 6, 2010).

[2] *Baker, Donelson, Bearman & Caldwell, P.C. v Muirhead*, 920 So. 2d 440, 450-451 (¶¶40, 41, 47)(Miss. 2006)(to sustain a bad faith claim against an insurer, the insurer must have lacked an arguable and reasonable basis for its decision.).

[3] *Id.* at 450 (¶40).

STATEMENT OF THE CASE

A. NATURE OF THE CASE

In 2006, Appellants/Plaintiffs, Southern Healthcare Services, Inc., Medforce Management, LLC d/b/a Willow Creek Retirement Center, and Daleson Enterprises, LLC d/b/a Jones County Rest Home[4] filed a lawsuit in the First Judicial District of Jones County, Mississippi against Those Certain Underwriters at Lloyd's, London, subscribing to Policy No. LNH2003066, and Caronia Corporation[5] for, among other things, breach of contract and breach of the duty of good faith and fair dealing. They also alleged fraud and misrepresentation against Fox-Everett, Inc., their long-time insurance agent. Underwriters counterclaimed for Plaintiffs', via Southern's, failure to reimburse Underwriters for amounts advanced to Plaintiffs under the insurance contract. Specifically, Underwriters advanced certain amounts within the deductibles applicable to a number of underlying claims asserted against Plaintiffs. Plaintiffs appealed from two orders of the Circuit Court for the First Judicial District of Jones County, Mississippi, which granted summary judgment to Defendants on both Plaintiffs' claim and Underwriters' Counterclaim. The Mississippi Court of Appeals found the appeal improperly certified under Rule 54(b) of the Mississippi Rules of Civil Procedure, as Plaintiffs' claims against their agent, Fox-Everett, as to the amount of their deductible, were not resolved; the appeal was dismissed.[6] Plaintiffs have settled all issues with Fox-Everett, and the circuit court reaffirmed the two prior summary judgment orders in favor of Defendants, placing the litigation in the same posture it was in 2008. The Plaintiffs appeal a second time.

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[4] Collectively "Plaintiffs" or individually "Southern," "Daleson," or "Medforce." Southern, Daleson, and Medforce are closely held corporations owned by the same two principals, Larry Fortenberry ("Fortenberry") and Larry Russell. Throughout this litigation, Mr. Fortenberry has been the most involved. Accordingly, any reference to the companies' principals will be limited to Mr. Fortenberry.

[5] Collectively "Defendants" or, sometimes, individually "Underwriters" or "Caronia."

[6] See *Southern Healthcare Services v Lloyd's of London*, 20 So.3d 84 (Miss. Ct. App. 2009).

B. COURSE OF PROCEEDINGS AND DISPOSITION IN THE COURT BELOW

While this case was on appeal in 2008-2009, Judge Evans passed away.[7] The Honorable Joe Pigott was appointed to hear the remaining issues between Plaintiffs and Fox-Everett.[8] Plaintiffs filed their Motion to Reconsider Summary Judgment Motions, or in the Alternative, to Lift the Abeyance on Plaintiffs' Pending Discovery, and the motion was heard in conjunction with a status conference on March 10, 2011.[9] The court vacated, without denying, the final judgments and orders granting Defendants' motions for summary judgment.[10] The circuit court also vacated the order staying discovery.[11] At Plaintiffs' insistence, the case was placed on an accelerated and aggressive discovery track, and ultimately, the case was set for trial to begin on December 5, 2011.[12] Between March and October 2011, the parties conducted extensive discovery and filed multiple motions.[13] On September 29, 2011, a hearing was held on Plaintiffs' Motion to Amend their Complaint.[14] The trial court reinstated its prior rulings on Defendants' Motions for Summary Judgment; accordingly, Underwriters were awarded the sum of $701,153.54.[15] In the Order regarding the same, the trial judge addressed the prior March 10, 2011 hearing, and stated, in part, as follows:

> At the conclusion of the hearing on Plaintiffs' Motion to Reconsider Summary Judgment Motions . . . this Court vacated the final judgments and orders . . . but did not deny either motion for summary judgment . . . . this Court effectively took both motions for summary judgment under advisement.

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[7] Defendants refer this Court to their Response to Plaintiffs' Motion to Reconsider Summary Judgment Motions, Or in the Alternative to Lift the Abeyance on Plaintiffs' Pending Discovery. (R.1338-43).
[8] (R.1334).
[9] (R.1338, 1344).
[10] The court entered the order related to the March 10, 2011, hearing on August 16, 2011, with a handwritten note indicating the order related back to March 10, 2011. (R. 1958).
[11] *Id.*
[12] Initially, and at Plaintiffs' insistence, trial was scheduled to begin on September 6, 2011, and thereafter on December 5, 2011. (R. 1367, 1913).
[13] See e.g., (R.1851 - 1916).
[14] (R. 37-40; Hg. Tr. pp. 69-117).
[15] Hg. Tr. 112; (R. 2271-74).

> Having reviewed the Court file . . . well over one thousand (1,000) pages . . . and [the] parties' extensive briefing of all issues raised in both motions for summary judgment[,] as well as the transcript of the hearings on the same, this Court finds that Defendants' *Motion for Summary Judgment* . . . on Multiple Claims and Underwriters' *Motion for Partial Summary Judgment on Their Counterclaim . . . Against Southern* are well taken and should be granted. As the bases for its decision . . . the Court adopts and incorporates . . . Judge Evans' March 26, 2008 . . . and July 8, 2008, *Findings of Fact and Conclusions of Law*.[16]

After the trial court reinstated Judge Evans' grant of summary judgment, Plaintiffs quickly and unbeknownst to Defendants mediated and settled all claims with Fox Everett. Fox-Everett was dismissed from the lawsuit with prejudice on October 29, 2011.[17] Plaintiffs also filed a flurry of responses and motions after the trial court's reinstatement of Judge Evans' grant of summary judgment on September 29, 2011, which included the following:

- **October 13, 2011**: Plaintiffs' Motion for New Trial, and In the Alternative, to Alter and Amend Judgments;[18]
- **October 14, 2011**: Plaintiffs' Supplemental Response to Underwriters Motion for Partial Summary Judgment on Their Counterclaim, and Plaintiffs' Supplemental Response to Defendants' Motion for Summary Judgment;[19]
- **October 17, 2011**: Plaintiffs' Motion for Partial Summary Judgment on Count I [Breach of Contract] Against Lloyds' of London and Certain Underwriters Subscribing to Policy No. LNH2003066, and its supporting memorandum;[20] and
- **October 21, 2011**: Plaintiffs' Amended Motion for New Trial, And In The Alternative, To Alter and Amend Judgments.[21]

In response, Defendants' filed their Combined Motion to Strike, or in the Alternative to Dismiss as Moot on October 31, 2011; their Response to Plaintiffs' Motion for Partial Summary Judgment on Count I; and their Response to Plaintiffs' Motion for a New Trial.[22] The trial court granted Defendants' Combined Motion to Strike on November 11, 2011, and Plaintiffs' filed

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[16] R. 4819-22;Hg. Tr. 106-112 (emphasis in original). The Final Judgment Dismissing Plaintiffs' Claims against Defendants and granting Defendants' Counterclaim was entered on October 14, 2011. (R. 4817-18, 3317).
[17] (R. 4817-18, 3317).
[18] (R. 2301 with exhibits).
[19] (R. 2365, 2602 with exhibits).
[20] (R. 3317, 3321).
[21] (R. 4601).
[22] (R. 4777, 4969, 4882).

their notice of the instant appeal on December 7, 2011.[23]

C. STATEMENT OF FACTS

1. The Insurance Policy

Policy No. LNH2003066 (the "Policy") was a combined healthcare and general liability policy underwritten by Underwriters and administered through Caronia, a third-party administrator.[24] The parties agreed on a deductible of "$250,000.00 each claim, Defense Costs included," paid via Southern as the First-Named Insured.[25] Medforce and Daleson were insured, along with other facilities throughout Mississippi.

2. The Underlying Lawsuits

During the Policy's coverage period, Plaintiffs notified Defendants of five (5) medical negligence claims against them. Caronia issued standard reservation of rights ("ROR") letters to Plaintiffs,[26] and Defendants appointed Nurse Anne Everrett to investigate the underlying claims and provided a defense to Plaintiffs by retaining Plaintiffs' chosen counsel: Massey, Higginbotham & Vise; Robert Hammond of Ramsey & Hammond; and Lisa McKay ("McKay"), of Currie, Johnson, Griffin, Gaines & Myers.[27] Defendants investigated and monitored the evolvement of the underlying lawsuits via Nurse Everett, Plaintiffs' counsel, the attorneys at Sedgewick, Detert, Moran & Arnold, LLP ("SDMA"), and Caronia.[28]

Without any adverse judgment or ruling against Plaintiffs, Underwriters settled the underlying claims of *Huffmaster, Arrington, Christoffer*, and *Landrum*[29] between December

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[23] (R. 4978-4979, 4980.).
[24] (R. 136-217, 544).
[25] (R.3360, 142-144).
[26] (R.234-246).
[27] (R.3569-3570, 3554-3555).
[28] (R.3540-3550).
[29] For a complete statement of the style of the five (5) underlying lawsuits, please see Defendants' Answer and Counterclaim filed in the trial court. (R.134-135).

2006 and August 2007.[30] In October 2006, the *Owens* plaintiffs voluntarily dismissed that lawsuit, thereby requiring Plaintiffs to reimburse Underwriters for only defense costs advanced in that matter. Underwriters advanced the following amounts within the per-claim deductibles to defend and resolve all of the underlying claims asserted against Plaintiffs, but Plaintiffs have not reimbursed Underwriters for those costs:

Underlying Claim (Plaintiff)	**Underlying Defendant(s)**	**Amount Underwriters Paid Within Deductibles**
Arrington	Southern, Daleson	$ 154,741.08
Christoffer	Southern, Daleson	$ 122,409.29
Huffmaster	Medforce (d/b/a WCRC)	$ 172,640.64
Landrum[31]	Daleson (d/b/a JCRH)	$ 248,650.00
Owens	Southern (d/b/a/WCRC)	$ 2,712.53
Total		**$ 701,153.54**

3. Plaintiffs' Bankruptcy, the Jones County Rest Home, and *Zumwalt*

The issue in this lawsuit is Judge Evans' grant of summary judgment in Defendants' favor, based upon the unambiguous Policy at issue and Southern's deductible obligation under the same. However, Plaintiffs discuss peripheral, immaterial facts –namely Daleson's and Medforce's voluntary petition for bankruptcy and the non-renewal of the Jones County Rest Home lease. As such, Defendants are compelled to briefly respond to same.

a. Plaintiffs' voluntary bankruptcy petition and Defendants' settlement of the underlying lawsuit.

The *Huffmaster* lawsuit was related to Medforce (d/b/a/ Willow Creek Retirement Center), and it was filed in Hinds County, Mississippi.[32] Plaintiffs' attorney, McKay, believed it

[30] (See Pl.s' Br. P.23).
[31] Only the *Landrum* claim was settled above the Policy's $250,000.00 deductible amount. It exceeded the Policy's deductible by $65,852.83, which Underwriters paid and, obviously, have not sought from Plaintiffs, as amounts paid above the deductible are Underwriters' obligation. Further, for *Landrum*, Plaintiffs initially paid defense counsel directly in the amount of $1,350. This initial payment explains why the amount Underwriters paid within the deductible is $248,650 rather than $250,000 – the Policy's full deductible.
[32] Pl.'s Br. p.7.

had little, if any, merit, but she was concerned about the venue, which had awarded large verdicts against nursing home defendants in the past.[33] Over several months, McKay corresponded with Christopher Sabella ("Sabella") of Caronia, and voiced her venue concerns; Sabella, in turn, conveyed those concerns to SDMA attorney Jenna Buda ("Buda").[34] McKay believed *Huffmaster* could be settled, but no formal settlement offer was tendered to Defendants prior to January 2005.[35]

In late 2004, McKay recommended that Defendants make a settlement offer within the policy limits in the *Huffmaster* case, and she stated that Fortenberry, the principal of Southern, was contemplating bankruptcy because he was not prepared to pay the Policy's deductible obligation in the underlying lawsuits.[36] On December 29, 2004, Fortenberry offered $5,000.00 to each claimant in the underlying lawsuits, purportedly to spur negotiations.[37] On January 3, 2005, the *Huffmaster* Claimant extended the first formal settlement offer of $435,000.00, agreeing to a ten (10) year promissory note for Southern to pay its $250,000.00 deductible.[38] McKay then forwarded the offer to Defendants.[39] Medforce and Daleson voluntarily petitioned for bankruptcy less than a week later without further communication with Defendants or allowing Defendants a reasonable opportunity to respond to the *Huffmaster* offer.[40] Litigation in the underlying lawsuits ceased pursuant to the automatic stay. Believing it to be the best strategy, McKay removed the underlying lawsuits to federal court.[41] In accordance with the law and common practice, the bankruptcy court restricted recovery in the underlying lawsuits to the

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[33] (R 2851).
[34] (R.3166-80).
[35] (R.3177-78, 3180).
[36] (R. 3180, 3805, 3810, 3902).
[37] (R. 3908-17).
[38] (R. 3921).
[39] (R. 3180).
[40] (R. 3947).
[41] (R.4524, 4529).

Policy's limits, which included Plaintiffs' deductible and Defendants' limits of liability, and remanded the underlying lawsuits to state court. Once the automatic stay was lifted, Underwriters settled the *Huffmaster, Arrington, Christoffer,* and *Landrum* claims on behalf of Plaintiffs between 2006-2007.[42] As noted, the *Owens*' lawsuit was voluntarily dismissed by the underlying plaintiff.

b. The Jones County Rest Home and Zumwalt

In the instant case, Plaintiffs claim Defendants caused Daleson to lose its lease on the Jones County Rest Home by "forcing" it into bankruptcy and, as a result, Daleson allegedly lost the value of the "$7.2 million nursing home business in Jones County."[43] Contemporaneous with the prior appeal in this matter, the Mississippi Supreme Court was deciding *Zumwalt, Inc., v. Jones County Board of Supervisors*, 19 So. 3d 672 (Miss. 2009), which detailed Plaintiffs' procurement of the lease for the Jones County Rest Home through a complete assignment of Donna Zumwalt's lease with the Jones County Board of Supervisors ("Board"), as well as the Board's nonrenewal of the lease. [44] The facts and parties of the *Zumwalt* litigation are directly related to Plaintiffs and Plaintiffs' claims in the instant litigation.

In 2000, Ms. Zumwalt acquired the lease for the Jones County Rest Home.[45] In February 2002, she sought Board approval to assign her lease to Fortenberry, as principal of Daleson; the

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[42] (R. 4816).

[43] (Pl.'s Br. pp. 21, 23). Daleson remained as debtor-in-possession of Jones County Rest Home for a year between January 2005, when it voluntarily filed for bankruptcy, through December 2005 until the lease expired on its own terms and was not renewed by the Board. (R. 3892, 3996-98). Also, Plaintiffs conspicuously attempt to convolute the *Huffmaster* case with the Jones County Rest Home, but it is undisputed that the Jones County Rest Home lease was held by Daleson and was not associated with Medforce d/b/a Willowcreek Nursing Home –the nursing home involved in the *Huffmaster* case.

[44] This Court may take judicial notice of these facts pursuant to long-standing authority. *See e.g., Vaughn v. State Farm Mut. Auto. Ins. Co.*, 445 So. 2d 224, 225 (Miss. 1984)(court may take judicial notice of its ***opinions and mandates***).

[45] *Zumwalt,* 19 So. 3d at 676, 678-79, (¶¶ 9-24).

Board consented on February 25, 2002.[46] Between 2003 and 2005, the Board decided to allow the lease to expire upon its terms.[47] The *Zumwalt* opinion detailed the events leading to the Board's decision, thus:

> **By May of 2003**, the Board of Supervisors had begun receiving complaints from members of the community regarding Daleson's management of the Home, and the Board sent a letter to Daleson regarding its concerns. The complaints concerned Daleson's requiring residents to purchase medications from businesses outside Jones County, poor upkeep and lack of cleanliness of the facility, and a general state of disrepair. Eventually, the Board of Supervisors resolved not to renew the lease with Daleson. Instead, the Board decided to lease the Home to South Central Regional Medical Center ("SCRMC") when the lease with Daleson expired on its own terms on December 31, 2005.
> . . . .
>
> The seeds of [] controversy were sown in early 2005, when Daleson met informally with some members of the Board of Supervisors, demanding that the Board build a new structure for the Home. At that meeting, Daleson made claims of ownership to the Home and threatened to remove the Home from the county if a new building was not erected.[48]

SUMMARY OF THE ARGUMENT

Not once, but twice, Plaintiffs' claims have been heard and flatly rejected by ***two*** of the most experienced trial judges in the state – who had the advantage of reviewing the contract, a mountain of documents produced in discovery and pleadings, and oral arguments presented by counsel. The Policy plainly required Southern to pay the first $250,000.00 in expenses, whether or not those expenses were for a defense, investigation, settlement, or judgment related to any covered claim against *any* of the Plaintiffs. Underwriters paid $701,153.54 to defend and settle the underlying lawsuits against Plaintiffs. Defendants never denied coverage or rejected a settlement offer. And, "[i]mportantly," as noted by the Court of Appeals, there was "no adverse judgment or ruling against the [Plaintiffs] from the time the underlying tort suits were originally

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[46] *Id.* at (¶25).
[47] *Id.* at 679-80 (¶¶27-29).
[48] *Id.* at 679-680 (¶¶27-29, 35)(emphasis added).

filed until their settlement."[49]

The heart of this entire litigation is simply Southern's dogged avoidance of its contractual obligation to reimburse Underwriters for monies they advanced within the deductible of "$250,000.00 each claim, Defense Costs included." [50] Plaintiffs' excuses for their avoidance of their contractual obligation are unsupported by authority and the unambiguous terms of the contract. The "[P]olicy clearly give[s] the [Defendants] the right to reimbursement of any defense costs, including settlement costs, incurred within the deductible amount."[51]

STANDARD OF REVIEW

The Court employs a de novo standard of review for summary judgments and decides whether material facts are in dispute.[52] All evidentiary matters, including admissions in pleadings, answers to interrogatories, depositions, and affidavits will be considered.[53] The evidence is viewed in a light most favorable to the nonmoving party.[54] The mere "presence of fact issues . . . . does not *per se* entitle a party to avoid summary judgment."[55] "[A] hundred contested issues of fact will not thwart summary judgment where there is no genuine dispute regarding the material issues of fact."[56] To avoid summary judgment, the non-moving party must show sufficient evidence to establish the existence of ***all*** essential elements of his case.[57]

ARGUMENT

In 2011, Judge Pigott, reaffirmed Judge Evans' grant of summary judgment in favor of

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[49] *Southern*, 20 So. 3d at 87 (¶7).
[50] (R.142).
[51] *Southern*, 20 So. 3d at 95 (¶46)(Griffis, J., dissenting).
[52] *Mid-Delta Home Health, Inc. v. Miss. Ass'n for Home Care*, 822 So. 2d 336, 339-340 (¶11) (Miss. Ct. App. 2002)(citation omitted).
[53] *Gullege v. Shaw*, 880 So. 2d 288, 292 (¶9)(Miss. 2004)(citation omitted).
[54] *Mid-Delta*. At 339-340 (¶11)(citation omitted).
[55] *Shaw v. Burchfield*, 481 So. 2d 247, 252 (Miss. 1985)(emphasis in original).
[56] *Id.* (emphasis in original).
[57] *Sligh v. The First National Bank of Holmes County*, 735 So. 2d 963, 965-66 (¶7)(Miss. 1999)(citation omitted).

the Defendants, on both Plaintiffs' claims and Defendants' counterclaim. Further, he fully adopted Judge Evans' Findings of Fact and Conclusions of Law in support of his decision. Both seasoned trial judges found that no issues of material fact existed because the unambiguous contract clearly required Plaintiffs to reimburse Defendants for any monies advanced within the per claim deductible, and Defendants had indeed advanced $701,153.54 within Plaintiffs' deductible to successfully defend and settle the underlying lawsuits. Both trial judges refused to be led astray by Plaintiffs' attempt to muddy the contractual waters by their self-serving account of voluntary decisions or events unrelated to the contract at issue or its attendant obligations. The experienced trial judges were precisely accurate in their assessment of the contract, applicable authority, and unique facts of this case.

I. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON PLAINTIFFS' CLAIMS AS DEFENDANTS PERFORMED ALL CONTRACTUAL DUTIES OWED PER THE CONTRACT

A. The Unambiguous Policy Did Not Require Defendants To Advance Defense Costs Within Plaintiffs' Deductible

1. The lens through which the policy should be viewed

Although Plaintiffs acknowledge that the Policy's terms and conditions are unambiguous, throughout their brief they encourage this Court to rewrite the insurance contract to provide for an interpretation more favorable to their current position. However, this case is about enforcement of the Policy's unambiguous terms and conditions in a manner that gives effect to the intent of the parties.[58] After all, the words utilized by the parties are the best resources for ascertaining intent and assigning meaning with fairness and accuracy.[59] Accordingly, the contract should be read as a whole to give effect to all of its clauses in a manner that

[58] *Herring Gas Co. v. Pine Belt Gas, Inc.* 2 So.3d 636, 639 (¶17)(Miss. 2009)(citations and quotations omitted).
[59] *Id.*

"harmonize[s] the provisions in accord with the parties' apparent intent."[60]

2. The deductible or self-insured retention

Before objectively reviewing the Policy as a whole, Defendants address the similarities, yet distinctive nuances, of deductibles and self-insured retentions – a primer of sorts. Research has revealed a dearth of Mississippi cases addressing excess insurance policies and the exact issue at hand, which may account for the dissents' erroneous contract interpretation in the prior appeal, but Mississippi jurisprudence is not without guidance.

New York State Thruway Auth. v. KTA-Tator Eng'g Servs., P.C., 78 A.D.3d 1566 (N.Y. App. Div. 4th Dep't 2010) is a case analogous to the one at bar.[61] In *Thruway*, the primary insurer, appealed from a judgment wherein the lower court declared that the primary insurer was responsible for the defense of KTA-Tator Engineering Services, P.C. in the underlying lawsuit, up to the $100,000 deductible/SIR in the insurance policy issued by the excess insurer.[62] The *Thruway* court determined the policy contained an SIR in the amount of $100,000, rather than a deductible.[63] The *Thruway* court explained the distinction as follows:

> A SIR differs from a deductible in that a SIR is an amount that an insured retains and covers before insurance coverage begins to apply. Once a SIR is satisfied, the insurer is then liable for amounts exceeding the retention. In contrast, a deductible is an amount that an insurer subtracts from a policy amount, reducing the amount of insurance.[64]

The court then discussed contract interpretation and the unique characteristics of the policy, which was similar to the subject Policy in the instant case, and stated:

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[60] *One South, Inc. v. Hollowell*, 963 So.2d 1156, 1162 (¶10) (Miss. 2007)(citation omitted).
[61] (In *Thruway*, court affirmed trial court that found primary insurer was to bear defense costs incurred within the SIR/Deductible which included defense costs.) Defendants state that it is proper for this Court to consider decisions of courts of other jurisdictions on similar questions and it may follow them if satisfied of the soundness of the reasoning by which they are supported. *Griffith v. Gulf Refining Co.*, 215 Miss. 15, 36, 61 So.2d 306, 307 (1952)(citation omitted). Defendants note that the jurisdictions of the persuasive authority provided employs contract interpretation law virtually identical to Mississippi's.
[62] *Thruway*, 78 A.D. at 1566.
[63] *Id.* at 1567.
[64] *Id.* (citation omitted).

> It is well settled that a contract must be read as a whole to give effect and meaning to every term. Indeed, a contract should be interpreted in a way that reconciles all of its provisions, if possible. Here, the [] policy provided that the policy limit and $100,000 "deductible" included claim expenses, which were defined to include defense costs. The policy further provided that the policy limit "applies as excess over any deductible amount." Inasmuch as the policy explicitly provided that the $100,000 would not reduce the policy limit, it cannot be said that the policy contained a deductible that would be subtracted from the policy limits. We thus conclude that the [] policy contained a SIR and that [the primary insurer] was obligated to provide . . . for [] defense costs up to $100,000.00.[65]

In addition to *Thruway*, Defendants present *Beloit Liquidating Trust v. Century Indem. Co.*,[66] which is also analogous to the instant case. After considering the contract as a whole, the *Beloit* court explained:

> Plaintiff claims [the] policy [] is primary not excess insurance[,] and [] defendant [insurer] had a duty to defend plaintiff in the underlying litigation. However, a ***review of the contract*** language ***shows it is an excess policy***. The self-insured endorsement expressly limits defendant's liability to ultimate net loss in excess of plaintiff's retained limit. The contract clearly contemplates that defendant's liability will only arise after plaintiff has exhausted its SIR . . . and that legal expenses will be paid as part of the ultimate net loss. These are characteristics of excess rather than primary insurance . . . . While the printed form language creates a duty to defend, the SIR endorsement overrides it by its language limiting defendant's liability "under all coverages" to ultimate net loss, including legal expenses, in excess of the SIR.
>
> Plaintiff contends the SIR is simply a deductible that must be satisfied before the indemnity provisions of the policy are triggered. However, ***a deductible generally reduces the coverage limit while an SIR does not*** . . . .[67]

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[65] *Id.* at 1567-68 (emphasis added).

[66] 2002 U.S. Dist. LEXIS 24535, 5-7 (N.D. Ill. Dec. 20, 2002)(emphasis added).

[67] *Beloit*, 2002 U.S. Dist. LEXIS 24535, 5-7(citing Seaman & Kittredge, "Excess Liability Insurance: Law & Litigation," 32 Tort & Ins., L.J. 653, 655 (Spring 1997)); *See also*, *Cont'l Cas. Co. v. N. Am. Capacity Ins. Co*, 2012 U.S. App. LEXIS 10877 (5th Cir. May 30, 2012)(court held three primary insurers would share equally in defense costs and excess insurer could seek reimbursement for defense costs incurred within primary policy limits and insured's self-insured retention); *Schneider Nat'l Transp v. Ford Motor Co.*, 280 F.3d 532, 534, 538-39 and n.7 (5th Cir. 2002)(insured had policy with SIR; court stated there were two underlying insurance policies: one written by primary insurer and the other was the insured's self-insured retention. Court noted that the majority rule is excess insurer is not obligated to participate in defense until all primary limits are exhausted.); *Ware v. Carrom Health Care Products, Inc.*, 727 Supp. 300, 305 (N.D. Miss. 1989)(excess insurer not required to "drop down" and pay defense costs because primary insurer was insolvent; the court stated: "A drop down defense is no more warranted than drop down coverage," finding it would "stretch the meaning and purpose of the excess policy"); *But see*, *Admiral Ins. Co. v. FF Acquisition Corp.*, (In re FF Acquisition Corp.) 422 B.R. 64 (Bankr. 2009)(excess

The Massachusetts Supreme Court has explained that "[a] self-insured retention bears some resemblance to a deductible . . . . [But] [t]he difference between a self-insured retention and a deductible is usually that, under policies containing a self-insured retention, the insured assumes the obligation of providing itself a defense until the retention is exhausted."[68] Secondary authority also explains that "[m]ost commercial insurance policies provide for an amount which the insured must pay out of pocket before the insurer's duty to pay is triggered."[69] This is done to allot a portion of the risk to the insured.[70] "SIRs and deductibles serve the same purpose, allotting a portion of the risk to the insured."[71] "An, SIR, a form of 'self-insurance,' must be exhausted before the liability of the insurer arises . . . . A deductible on the other hand, does not prevent the triggering of coverage by the policy."[72] Simply put, an SIR, or "self-insurance" is defined as "setting aside a fund to meet losses instead of insuring against such through insurance."[73]

There can be no question that Southern, as the first-named insured, was obligated to "meet losses" for any and all investigative, defense, or settlement costs incurred within the first $250,000.00 per claim. Further, the deductible did not erode the policy limits, and as in *Thruway* and *Beloit*, the Policy clearly stated defense costs were included in the deductible, which

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insurer required to "drop down" and pay defense costs when debtor was insolvent); *Keenan Hopkins Schmidt and Stowell Contractors, Inc. v. Continental Casualty Co.*, 653 F. Supp. 1255, 1263, 1267-68 (M.D. Fla. 2009)(Florida law looks solely to policy language to discern whether it provides primary or excess insurance; excess insurer of policy that had a $250,000 ***deductible*** had no duty to provide insured a defense in underlying case within the policy's deductible).

[68] *Boston Gas Co. 1 v. Century Indem. Co.*, 454 Mass. 337, 341 n.8 (Mass. 2009). (citing 2 A.D. Windt, Insurance Claims and Disputes § 11:31, 11-495 (5th ed. 2007))(internal citations and quotations omitted)(emphasis added).

[69] 83 Am. Bankr. L.J. 495, 511-512 (citation omitted).

[70] *Id.*

[71] 24-3 ABIJ 18, 55.

[72] 83 Am. Bankr. L.J. 495, 511-512 (citation omitted).

[73] 24-9 ABIJ 24 (citing *In re Amatex Corp.*, 107 B.R. 856, 871 (E.D. Pa. 1989)(quoting Black's Law Dictionary 1482 (9th ed. 2009).

Plaintiffs do not deny. Plaintiffs were required to pay all defense and settlement costs within the first $250,000.00 for each claim, whether Plaintiffs' self-reserved obligation was referred to as a "deductible" or "SIR."[74] Indeed, the sophisticated Plaintiffs acknowledged this obligation as evidenced by the fact they paid investigative and/or defense expenses, as they were incurred, without question or objection until they voluntarily chose to file for bankruptcy.[75]

3. The Policy as a whole

A copy of the Policy may be found in the record on pages 136 – 217. As mentioned, it was a combined healthcare general and professional liability policy.[76] The Plaintiffs were to read the Policy and return it immediately to Excess Specialty Placement, Inc., for appropriate alteration if its terms contradicted the parties' understanding.[77] The words employed by the parties demonstrate that the Policy functions such that Plaintiffs, via Southern as the first-named insured, agreed to retain the first $250,000.00 each claim, defense costs included. A detailed review of the Policy and its provisions fully supports Defendants' position.

a. The Deductible and Endorsement No. 1

It is undisputed that the Policy contained a deductible for both the general and professional liability coverage. The Declaration Page provided that the deductible for each type

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[74] "***What's in a name? That which we call a rose by any other name would smell as sweet.***" http://www.enotes.com/shakespeare-quotes/what-s-name-that-which-we-call-rose (last accessed May 29, 2012.). Many courts, various legal authorities, and treatises have recognized this truth. A person, place or thing may be called various names, but the identifying characteristics are defining. The subject Policy's characteristics clearly demonstrate that Southern's self-reserved contractual obligation served as an SIR. Nonetheless, for consistency, Defendants will primarily refer to Plaintiffs obligation to pay the first "$250,000.00 each claim, Defense Costs included," as a deductible.

[75] *Memphis & C. R. Co. v. Neighbors*, 51 Miss. 412, 422-423 (Miss. 1875)(The right to rescind may be lost by acquiescence; a party intending to rescind a contract claiming breach by the other party must do it promptly, on the first information of such breach. He must promptly have protested . . . if he intended to rely upon these acts as a violation of the contract. He would not be permitted to remain silent whilst money was thus being spent and then object and claim a rescission or setting aside of the contract.").

[76] (R.142).The underlying lawsuits solely implicated the policy's professional liability coverage.

[77] (R.139, 144).

of coverage was "$250,000.00 each claim, Defense Costs included."[78] Endorsement No. 1 pertained to Plaintiffs' deductible obligation, and it was distinctly noted as "attaching to and forming part of [the] policy."[79] Indeed, "[a] complete Policy include[d] the Declarations, General Policy Provisions and Conditions, and the applicable Coverage Parts."[80] Both the Healthcare General and Professional Liability coverage sections included a deductible provision or clause,[81] and Endorsement No. 1 replaced those provisions in their entirety, stating that the deductible did not erode the policy limits, thereby, effectively operating as an SIR.[82] Endorsement No. 1 stated, in relevant part, as follows:

> The First Named Insured shall be responsible for the amount shown in the Declarations, WHICH DEDUCTIBLE AMOUNT SHALL BE IN ADDITION TO AND SHALL NOT ERODE THE APPLICABLE LIMITS OF INSURANCE SHOWN IN THE DECLARAIONS. Expenses we incur in investigating and defending claims and suits are included in the deductible. The deductible applies to each medical incident and the First Named Insured shall not insure against it without our written consent . . . .
>
> We may pay all or part of the deductible to settle a claim or suit. The First Named Insured agrees to repay us promptly after we notify the First Named Insured of the Settlement.[83]

In practical application, considering the Policy as a whole, Endorsement No. 1 provided that (1) Southern, as the First Named Insured was responsible to pay the deductible amount of $250,000.00 per claim for every insured covered under the policy; (2) Any expenses incurred by Defendants in investigating or defending the claims or suits were included in the deductible;[84] (3)

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[78] (R.142).
[79] (R.136, 143).
[80] (R.145).
[81] (R.159, 170).
[82] (R.136, 137).
[83] (R.137, 170)(emphasis in original).
[84] The Policy obligates Southern to pay investigative and defense expenses "incur[red]" by the Defendants, not only costs "paid" by Defendants. As such, all that was needed for Southern to become obligated to pay for the defense costs within the Policy's deductible provision was that Defendants brought that expense upon themselves. See Black's Law, 836 (9th ed. 2009). ("To suffer or bring on oneself"). The record clearly reflects that Defendants *incurred* investigative and defense expenses in the

The deductible applied to each incident, and ***Southern was prohibited from insuring against the deductible*** without Defendants' written permission; (4) Defendants had the discretion to advance funds to settle claims within the deductible, but if so, Southern agreed to promptly reimburse Underwriters upon notification; (5) Endorsement No. 1 discussed "reimbursement" of costs in relation to the settlement of a claim within the deductible – not for defense costs incurred without settlement; and (6) As the deductible did not erode the applicable Policy limits, Defendants were to pay up to $500,000.00 per claim with a $1 Million aggregate ***after*** Southern met its deductible obligation. As supported by *Thruway* and *Beloit*, Endorsement No. 1 clearly made Plaintiffs, via Southern as the first-named insured, responsible for any costs incurred within the first $250,000.00.

b. Healthcare Professional Liability Claims Made Coverage

This section of the Policy included the "insuring agreement" for the professional liability coverage, as well as "conditions" for the coverage. [85] It provided in relevant part, as follows:

> Insuring Agreement
>
> We will pay those amounts that you are legally required to pay others as damages resulting from a medical incident arising out of professional services provided by any Insured ....
>
> In addition to our Limit of Insurance we will also pay defense costs. We have the right and duty to defend and appoint an attorney to defend any suit against an Insured for a covered claim, and we will:
>
> 1. Do so even if any of the charges of the claim are groundless, false or fraudulent;
> And

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underlying lawsuits following their designation of Nurse Everett, Plaintiffs' chosen counsel, and other investigative expense in the defense of those suits. *See e.g.* (R. 4276 – invoice from Mr. Hammond to Defendants for legal fees and R.3790-95 Currie Griffin Invoices to Defendants.)

[85] (R.163, 170). As noted by the dissent in the prior appeal, these conditions were in addition to the policy section titled "General Policy Provisions and Conditions – Section III. Conditions Applicable to All Coverage Parts." *Southern*, 20 So.3d at 94 (¶43); (R. at 170-71.).

2. Investigate and settle any claim or suit to the extent we believe is appropriate.

Our duty to defend any suit ends, and we may withdraw from the defense, after the applicable Limit of Insurance has been exhausted by settlements, judgments, awards and interest accruing thereon prior to entry of judgment or issuance of award.[86]

This provision neither altered nor diminished Endorsement No. 1 and the Declaration Page. Plaintiffs' agreement to retain the risk and pay the first $250,000.00 in investigative, defense, or settlement costs remained the same. Harmonized with the rest of the Policy's provisions, the parties clearly agreed that Defendants would pay for defense costs "[i]n addition to [their] Limit of Insurance," ***when*** Plaintiff met their deductible amount of $250,000.00 per claim, which included defense costs. This section also punctuated Defendants' discretion to evaluate the merits and surrounding events of a claim and only then settle claims "to the extent" they thought appropriate.

Conditions

This provision simply imposed certain notice requirements upon the first-named insured, and it stated, in part, as follows:

1. If . . . the First Named Insured shall become aware of any medical incident which may reasonably be expected to give rise to a claim being made against any Insured, the First Named Insured must notify us in writing as soon as practicable.

. . . .

1. Cooperate with us in the investigation, settlement, or defense of the claim or suit; and

2. Assist us, upon request, in the enforcement of any right against any person or organization which may be liable to the Insured....

. . . .

The dissent in the prior appeal (hereinafter "dissent") erroneously believed this section

[86] (R.163).

required Defendants to advance defense costs incurred within Plaintiffs' deductible obligation. Rather than look to the actual words employed by the parties, the dissent looked at the absence of words that specifically stated Plaintiffs were to pay their deductible before Defendants were required to advance defense costs for claims.[87] In essence, the dissent used a negative to create a positive in contravention of the well-known rules of construction requiring courts to enforce the words of a contract as approved by the parties.

Just because this clause "does not condition the contractual duty to defend on prepayment of the insurance deductible," it does not override the Policy's Declaration Page and Endorsement No. 1, as well as other provisions, which clearly anticipated Plaintiffs self-insuring for all investigative and defense costs incurred within the deductible before Defendants' monetary obligations arose. While extending the utmost respect to the honorable judges in the dissent, Defendants assert that it is error to construe the unambiguous contract by considering its sections in isolation– as opposed to its entirety – while relying on the absence of words the parties might have employed, to arrive at an interpretation that renders complete sections of the contract moot.[88]

c. Deductible Liability Insurance Endorsement

In addition to Endorsement No. 1, the policy contained a Deductible Liability Insurance Endorsement.[89] The endorsement applied to both the healthcare general and professional liability coverage, and it elucidated that the schedule, or type basis and amount, of the Policy's deductible was to be on a "per claim," as opposed to a "per occurrence," basis. It did not replace or modify Endorsement No. 1, so Endorsement No. 1 remained part of the complete policy. Therefore, Plaintiffs were still required to pay the deductible per claim, which included any

[87] *Southern,* 20 So. 3d at 94 (¶43).
[88] *One South*, 963 So.2d at 1162 (¶10)(Citation omitted)("When construing a contract, we will read the contract as a whole, so as to give effect to all of its clauses.").
[89] (R. 198-200).

investigation and defense costs incurred within the first $250,000.00.[90] The endorsement, in relevant part, stated:

> A. Our obligation...to pay damages on your behalf applies only to... damages in excess of any deductible amounts stated in the Schedule above....
>
> B. You may select a deductible amount on either a "per claim" or "per occurrence" basis . . . .The deductible amount . . . applies as follows:
>
> 1. []If the deductible amount indicated in the Schedule above is on a per claim basis, that deductible applies as follows:
>
> . . . .
>
> e. Under medical Incident to all damages sustained by any one person resulting from any one "medical incident" arising out of professional services.
>
> ...a separate deductible amount will be applied to each person making a claim for such damages.
>
> . . . .
>
> C. The terms of the insurance, including those with respect to:
>
> 1. Our right and duty to defend the Insured against "any Suits" see[k]ing those damages; and
>
> 2. Your duties in the event of [a] ... "claim" ...apply irrespective of the application [i.e., "per claim" versus "per occurrence"] of the deductible amount.
>
> D. We may pay any part or all of the deductible amount to effect settlement . . . you shall promptly reimburse us for such part of the deductible amount.... All other terms and conditions of the policy remain unchanged.

This provision simply clarified that Plaintiffs elected a "per claim" versus a "per occurrence" basis of deductible. The "per claim" application of the deductible did not alter Plaintiffs' obligation under Endorsement No. 1 – wherein Plaintiffs were required to pay defense costs incurred within the deductible amount. Further, it reiterated that Defendants' obligation to

[90] (R.136, 198).

pay damages did not arise until the deductible amount was exhausted. Again, the Policy restated that Defendants retained the option to pay all or part of the deductible to ***settle*** a claim, and if so, Plaintiffs agreed to "promptly reimburse" Defendants for same.

Plaintiffs' concede the Policy is unambiguous.[91] Adopting argument presented by the dissent, however, they claim Plaintiffs were still not obligated to pay defense costs up front because Policy sections such as this do not define "defense costs" as damages; therefore, they claim Plaintiffs only had to reimburse Underwriters after Underwriters advanced defense costs within Plaintiffs' deductible obligation.[92] Defendants respectfully disagree as such an interpretation is in direct contradiction to the clear dictates of the Declarations page and Endorsement No. 1, and it effectively renders Underwriters a bank providing Southern, as the first-named insured, with a no-interest, long-term loan.

The instant case is an excellent example of how harmful and erroneous such an interpretation would be, as Plaintiffs have refused to honor their contractual obligation to reimburse Underwriters for many years and still, today, seek to avoid their obligations through spurious and false allegations, despite the fact they were afforded the full benefits of their insurance coverage and suffered no adverse judgment or verdict. Moreover, it goes against common sense to believe that a contract that unambiguously required the insured to pay the first $250,000.00 in ***investigative*** and ***defense costs***, presumed that those costs could only be recovered ***after*** all of the investigation and defense occurred and the underlying matter was resolved via dismissal, settlement, or trial.[93]

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[91] (Pl.'s Br. 13, 34, 37)(E.g., see respectively, "The unambiguous language of the policy . . . ."; ". . . the unambiguous terms of the contract . . . ."; "The unambiguous language of the policy . . .").

[92] (Pl.'s Br. 12) *Southern*, 20 So.3d at 95 (¶46)).

[93] Again, Defendants assert that Plaintiffs were fully cognizant that they were to pay their deductible, *with investigative and defense costs included therein*, as they admitted such in their original Complaint. See Pl.'s Original Com. pp 7-8 (¶18) and (R.7-8)(Plaintiffs acknowledging that the deductible "stood between them and protection for their businesses.").

Further any legal lexicon, along with the Policy's internal definitions, demonstrates the futility of Plaintiffs' argument related to this erroneous interpretation. The most basic definition of damages "relate to monetary compensation for loss or injury to a person or property."[94] Certainly, the sophisticated parties to the subject contract intended to attribute the common term its familiar and accepted meaning.[95] As such, this section simply stated that Southern, on behalf of itself or any other insured, was to pay the first $250,000.00 in monetary compensation for any loss or injury to a person or property, in the event of a claim covered under the Policy. Underwriters were only obligated to pay amounts in excess of $250,000 for any one claim.

In addition, the Policy defined "defense costs," in relevant part, as (1) fees charged by an attorney *designated* by us; and (2) other fees, costs and expenses *incurred* by us in the investigation, adjustment defense and appeal of a claim.[96] Plaintiffs' chosen attorneys were undisputedly "designated" by the Defendants to defend the Plaintiffs in the underlying lawsuits. For that legal representation, Defendants *incurred* defense expenses. Accordingly, those expenses came within the Policy's definition of "defense costs," which unambiguously were included within the Policy's deductible of "$250,000.00 each claim, Defense Costs included."

d. Supplementary Payments and Defense Costs Within the Limits of Liability

This section followed the endorsement discussed above. In relevant part, it provided:

> ***Subject to the Deductible Liability Insurance Endorsement provisions of this policy,*** it is agreed that we will pay the following Supplementary Payments and Defense Costs, which will be included within, not it addition to and will erode, the Limits of Liability of the policy.

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[94] Black's Law Dictionary, 445 (9th ed. 2009).

[95] A court must give terms used in a policy their plain, ordinary meaning unless the policy itself shows the parties intended the terms to have a different, technical meaning, and it must "consider the policy as a whole and interpret it to fulfill the reasonable expectations of the parties in light of customs and uses of the industry." *Lexington Ins. Co. v. Educare Cmty. Living Corp.-Gulf Coast*, 149 Fed. Appx. 326, 328 (5th Cir. 2005)(citation omitted).[95]

[96] (R.174-75, 181-82).

A. all expenses incurred by us, all costs taxed against you in any suit defended by us and all interest on the entire amount of any judgment therein ***which accrues after entry of the judgment and before we have paid*** or tendered or deposited in court that part of the judgment which does not exceed the limit of our liability thereon;

...

D. reasonable expenses incurred by you at our request...

E. all defense costs...costs of investigation . . . provided such [] expenses are incurred by or with our prior written permission.

All other terms and conditions of this policy remain unchanged.[97]

As a bases for relieving Plaintiffs of their obligation to "prepay"[98] defense costs incurred within the deductible, the dissent opined: "This endorsement contains no provision requiring prepayment of the deductible as a condition for providing a defense to the Appellants . . . ."[99] Again, Defendants respectfully disagree with the dissent's contract interpretation: That view does not construe the policy as a whole, while harmonizing all sections to give effect to each one. The dissent's piecemeal construction lays waste to entire policy sections and Plaintiffs' correlating obligations under the same. The provision's section title alone demonstrates that it related to supplementary payments and defense expenses incurred within Defendants' limit of liability, which was not implicated until Plaintiffs paid their deductible obligation. Neither this section nor any other Policy provision states it deletes Endorsement No. 1 or the Declarations

[97] (R.201)(Emphasis added).

[98] Defendants emphasize, again, the record reflects that Plaintiffs were never required to "prepay" any amount of their deductible obligation: The contract simply obligated them to pay for expenses within the deductible, as they were incurred. Plaintiffs' conduct demonstrated their understanding of this, as they initially paid investigative and defense invoices as they were incurred. See, e.g. (R. 3737-83). Plaintiffs chose to voluntarily file for bankruptcy, after four lawsuits, in addition to *Huffmaster*, were filed against Plaintiffs, claiming they were not financially able to defend them. See (R.3175-76; Pl.s' Br. 20). To the extent Plaintiffs attempt to portray that Defendants required them to pay a lump sum of $250,000.00, it is simply another example of Plaintiffs' mischaracterization of facts in an attempt to inflame emotions and create non-existent damage claims.

[99] *Southern*, 20 So. 3d at 95 (¶44).

Page, which unambiguously required Plaintiffs to pay defense costs incurred within the deductible.

e. General Policy Provisions and Conditions

This policy section provided, in relevant part, as follows:[100] "Except with respect to the Limits of Insurance and deductibles...this insurance applies [] [a]s if each Insured were the only Insured . . . We have issued this Policy in reliance upon your representation."[101] Plaintiffs' argument has been fluid throughout this litigation. Instead of claiming misrepresentation of the amount of their deductible ($25,000 v. $250,000),[102] Plaintiffs now argue misrepresentation and material breach by Defendants because Caronia notified Plaintiffs of their deductible obligation in the ROR letters rather than Underwriters immediately advancing Daleson's and Medforce's defense costs incurred within the deductible, while hoping that Southern would later reimburse them. Plaintiffs, as well as the dissent, attempt to support this position by claiming that Medforce and Daleson were never obligated for the deductible – only Southern was.[103] Per the unambiguous Policy, this argument fails.

To begin, Plaintiffs barely acknowledge that Southern was a named party in three of the five underlying lawsuits, and Southern's principals Larry Fortenberry and Larry Russell were named individually in the *Huffmaster* case.[104] To accept Plaintiffs' argument, Southern would have been obligated to pay for defense costs incurred within the deductible for its own expenses,

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[100] This provision's treatment of other insurance further indicates the Policy acted, in essence, as an excess policy. As noted, Plaintiffs could not insure against their deductible without Defendants' written permission. This section also required Plaintiffs to fully access all other insurance before looking to Defendants, in the event Plaintiffs had insurance in addition to their deductible or self-insured retention.
[101] (R.184-86).
[102] E.g. (R.6-9).
[103] The dissent mistakenly stated that Defendants "did not seek payment of the deductible from Southern until after Daleson and Medforce were forced into bankruptcy." *Southern*, 20, So. 3d at 98 (¶54). Apparently, the dissent inadvertently overlooked specific language in the ROR letters, which plainly stated that the deductible was to be paid "directly by Southern Healthcare Services, Inc., d/b/a . . . ." See R. 542,545,548, 550, 553.
[104] Appellants' Br. pp. 6-7; (R. 8-9).

and undoubtedly Fortenberry and Russell's, as principals of Southern, but not Medforce and Daleson's defense expenses. Such a position is incongruous. This provision clearly defined that all insureds were considered the same, except with respect to the Policy's limit of insurance and deductible. The distinction simply meant that in certain matters Southern, as the managing entity of the closely-held nursing homes, acted on behalf of other insureds by submitting premiums and deductible payments, giving Defendants notice of claims, etc.[105] All insureds were considered the same under the Policy, and they were all subject to the deductible of "$250,000.00 each claim, Defense Costs included." Southern simply agreed to be the conduit for the deductible payments, just as it did for the insurance premium payments.

B. Defendants Performed All of Their Contractual and Common Law Duties Owed Under the Policy

1. Duty to Defend

Plaintiffs rely upon *Moeller v. American Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1068-69 (Miss. 1996) to claim that Defendants breached a duty to defend.[106] The *Moeller* court opined that a "liability insurance company has an absolute duty to defend a complaint which contains allegations covered by the language of the policy; [but] it clearly has no duty to defend a claim outside the coverage of the policy."[107] *Moeller* recognized that an insured can be accused of acts or omissions that further investigation may prove not to be within the policy's coverage.[108] In those cases, the insurer has the right to inform the insured of the coverage available for the claims of a complaint, and to offer its insured a defense, while reserving its right to deny coverage for a judgment rendered against its insured. (i.e., ROR letter).[109] However, when an insurer chooses to provide a defense under a reservation of rights, "a special obligation

[105] (R.185-86).
[106] Appellants' Br. pp. 33-37.
[107] *Moeller*, 707 So. 2d at 1069.
[108] *Id.*
[109] *Id.* (citation omitted).

is imposed upon the insurance carrier" and it must offer an insured the opportunity to select his own counsel to defend the claims and pay the insureds' selected counsel.[110]

Plaintiffs use this to assert that Defendants were in breach of contract from the moment they sent reservation of rights letters that also informed the Plaintiffs that Plaintiffs, via Southern as the first-named insured, were to pay the first "$250,000.00 each claim, Defense Costs included," as the contract required. To accept such a myopic view of the holding in *Moeller* would impose a duty similar to a strict liability standard, thereby obliterating parties' abilities to contract for insureds to pay their investigative, defense, settlement, or judgment costs up to a certain dollar amount. It would also implicitly hold that Mississippi does not recognize insurance contracts with self-insured retentions (or deductibles functioning as same), which would be inconsistent with Mississippi substantive contract law and authority from other jurisdictions. A thorough reading and understanding of the unique facts of *Moeller*, as well as other more applicable cases, reveals that such an extreme result is not mandated by *Moeller*, nor does *Moeller* limit a party's freedom to contract.[111]

First, the facts of *Moeller* are easily distinguishable from the instant case. For example, in *Moeller*, the insurance company initially denied coverage, but after further review, it chose to defend the insured law firm on all claims even though only a defamation claim was actually covered within the policy.[112] Even more distinguishing is the fact that by extending a defense for non-covered claims, the insurer not only created a conflict between the insurance company and the insured law firm, it created a conflict between the insured firm and another insured attorney –

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[110] *Id.* (citation omitted).
[111] Without diverting into a lengthy policy argument, such an extreme interpretation of *Moeller* would certainly offend public policy as it would adversely affect the insurability of high-risk businesses, like the nursing home industry was on the eve of tort reform.
[112] *Moeller*, 707 So. 2d at 1066.

Armin J. Moeller.[113] Moreover, the insurance company even pursued a claim against the firms' employee – who was also an insured under the contract – without providing a defense for that employee.[114] Finally, and most important, **nothing** in *Moeller* indicates that the policy at issue had a deductible, or self-insured retention, which conspicuously stated the insured was to bear defense costs within the deductible amount. To the contrary, the *Moeller* opinion clearly indicates that the insurance company in *Moeller* was the firm's primary insurer, not an insurer, whose policy functioned as an excess policy as in this case.[115]

Acknowledging the authority and duty to defend principles of *Moeller*, Defendants assert that *Moeller* is not controlling in this case, as the policy at issue and unique facts are distinctly dissimilar. Authority which explains the function of the type policies as the one at issue, such as *Thruway* and *Beloit*, discussed above (and *Lexington* discussed infra), are on all fours with the instant case and should govern this Court's decision. Defendants afforded Plaintiffs all the indemnification benefits provided under the Policy. They promptly designated independent counsel for Plaintiffs, did not deny coverage for covered claims, and successfully resolved all underlying lawsuits by advancing costs incurred within Plaintiffs' deductible, although the unambiguous Policy did not require them to do so. Defendants met their duty to defend in accordance with the parties' contract.

2. The Reservation of Rights Letters

Plaintiffs and the dissent acknowledge Defendants' right to send the ROR letters, but they claim the letters triggered a breach by Defendants because the Policy was a duty to defend Policy.[116] An objective construction of the Policy and review of the ROR letters and applicable

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[113] *Id.* at 1067, 1070-72.
[114] *Id.* at 1070-72.
[115] *Id.* at 1066. (The insurer in *Moeller* notified its insured that it wished to afford the insured the "opportunity to notify any excess insurance carrier . . . .").
[116] (Pl's Br. 34-37); *Southern*, 20 So. 3d at 33 (¶49)(Defendants "acted within their contractual rights in

case law demonstrates that Defendants were within their contractual and judicial rights to notify Defendants of claims that may not have been covered under the Policy, and they were prudent to not begin advancing defense costs until Defendants discerned the Policy's coverage of all underlying claims and Plaintiffs fulfilled their deductible obligation.

In *Twin City Fire Insurance Co. v. City of Madison*, 309 F. 3d 901, 906 (5th Cir. 2002), the Court stated: "When the alleged misconduct of the insurer concerns the duty to defend, the insurer may be liable despite an exclusion otherwise applicable .... [and] may be estopped from denying liability under the policy, if its conduct results in prejudice to the insured."[117] "Even if the insurer would not have been liable had it not assumed the defense in the first instance, it may become liable for withdrawing, because the assumption of the defense may give rise to a duty to continue with the defense."[118]

Defendants heeded this warning, and as such appropriately informed Plaintiffs of the Policy's coverage and Plaintiffs' duty per the contract. Defendants' ROR letters clearly stated that they would not defend or indemnify claims excluded in the Policy, and that independent counsel of Plaintiffs' choosing had been designated.[119] The ROR letters also clearly stated the Policy's requirement that Southern, as the first-named insured, was to pay the all costs, including defense, incurred within the $250,000.00 deductible. Defendants at all times acted in accordance

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reserving the right to later deny coverage . . . with respect to non-covered claims . . . ."). An aside: Plaintiffs, and the dissent state that Defendants denied coverage to Plaintiffs in a letter dated November 9, 2004. ; 20 So.3d at 98(¶56);(Pl.'s Br. p. 37). This is incorrect, as demonstrated in the record and ROR letters. As correctly observed by Judges Evans and Pigott, Defendants never denied coverage for any claims that were covered within the policy.

[117] *Twin City*, 309 F.3d at 906(citation omitted).

[118] *Id.* (internal citations omitted)(emphasis added).

[119] Defendants can only surmise that Plaintiffs' new claim that their independent counsel was "selected by Lloyd's" is simply an attempt to create the illusion of a conflict where none existed. It is undisputed that Defendants retained independent counsel of Plaintiffs' choosing. Plaintiffs have not complained of ineffective assistance of counsel by Hammond or McKay. Rather, they rely heavily on McKay's opinion related to the venue of the *Huffmaster* case and her opinion that *Huffmaster* was a case better settled than tried.

with the unambiguous contract terms and within their judicial rights. As such, Defendants reservation of rights letters did not result in a material breach of contract.

3. Defendants Acted Responsibly and In Good Faith

Plaintiffs expend a glut of words attempting to fabricate a scenario wherein Defendants "fail[ed] to settle," and therefore, "forc[ed] [their] own insured into bankruptcy." However, Plaintiffs' allegations come down to nothing more than claiming Defendants should have made the first settlement offer based upon informal discussions between McKay and the *Huffmaster* attorney and McKay's "plaintiff-friendly" venue concerns. Record evidence demonstrates that Defendants did not "fail to settle" the underlying claims and that McKay and Defendants were correct in their assessment of the merits, or lack thereof, of the *Huffmaster* lawsuit. Further, it is evident Plaintiffs would have filed bankruptcy despite a settlement offer within policy limits.

a. Plaintiffs' voluntary bankruptcy

The *Huffmaster* claimants extended their first formal settlement offer on January 3, 2005, in response to Plaintiffs' December 29, 2004, $5,000.00 settlement offer.[120] The *Huffmaster* offer was within policy limits **and** allowed Plaintiffs to pay the deductible amount over a ten (10) year period.[121] Less than a week later, Medforce and Daleson filed a voluntary petition for bankruptcy without comment to Defendants or allowing Defendants a reasonable opportunity to accept, reject, or respond to the offer. Plaintiffs do not acknowledge whether they waited for an acceptance or rejection of the other four offers before filing for bankruptcy – or even whether they waited for a response, as those underlying plaintiffs had been given until January 6, 2005 to respond.[122] An objective consideration of Plaintiffs' claims and the observable record facts

[120] (R.3177, 3180).
[121] (R.3177-78).
[122] See, e.g. (R. 3166-75).

demonstrate that Plaintiffs' decision to voluntarily file for bankruptcy was not caused or dependent upon Defendants extending a first settlement offer prior to January 2005.

b. Defendants did not "fail to settle" Huffmaster.

Plaintiffs have waived a "failure to settle" claim, as it was not raised in their original Complaint in this matter.[123] Without waiving any objection, however, Defendants address this baseless claim to demonstrate it still fails as a matter of law.

The threshold that must be crossed before a party can prevail on a bad faith/duty to settle claim is that an offer within policy limits be rejected, and next, the insured actually suffer an excess judgment. Neither thing happened. As noted, no settlement offer was made by the *Huffmaster* claimant prior to January 2005.[124] Rather, McKay made reports such as the *Huffmaster* attorneys "*intimated*" they were "interested in talking to their clients about taking the policy limits, if offered;" Or, that the *Huffmaster* plaintiff's attorney told her that it was "still a good window of opportunity to get th[e] case settled, as his client would like to put this behind her and move on. . . ."; Or, that she had "been led to believe that [the *Huffmaster* plaintiff] would be interested in settling the case of the policy limits at this time[,] [but] [w]hile they have not made a formal demand for the same . . . ."[125] Defendants did not disregard the *Huffmaster* case, McKay's venue concerns, or a potential settlement of *Huffmaster* prior to the Plaintiffs exhausting their deductible. The record reflects that all matters were considered and evaluated.

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[123] *Fowler v. White*, 85 So. 3d 287, 293 (¶22) (Miss. 2012)(waiver argument procedurally barred because it was raised for the first time on appeal); See also *Havard v. State*, 2012 Miss. LEXIS 231 *10 (¶18) (Miss. May 10, 2012)(citing *McBride v. State*, 61 So. 3d 138, 148 (Miss. 2011)(waived statutory claim by failing to raise it with the trial court)). See Pl.'s Original Com. (R.3-17).

[124] From McKay's communications with Defendants and Fortenberry, she apparently had some discussions with the *Huffmaster* plaintiff's attorney. However, such discussions did not equate to the submission of a formal settlement offer or denial of same by Defendants. Further, case law and the [P]olicy at issue demonstrate that Defendants were not bound to accept such, even if the informal discussions could be construed as a formal offer. To the contrary, case law demonstrates that Defendants had the contractual and legal right to assess the merits of the underlying lawsuits, which had little merit, before quickly settling the underlying claim for policy limits.

[125] (R.3610, 3709-10)(emphasis added).

Between June and December 2004, numerous communications occurred between McKay and Christopher Sabella ("Sabella") of Caronia, as well as between Sabella and Jenna Buda ("Buda"), an attorney at SDMA. Plaintiffs attempt to minimize the number and/or timing of the communications, but that does not overcome the fact that Defendants actively monitored the underlying lawsuits through the designation of at least four entities and/or persons or attorneys to investigate, evaluate, defend and monitor the underlying claims and represent Plaintiffs' interests.[126]

Most importantly, when considering Plaintiffs' crescendo of "the sky was falling because of a bad venue," it should be noted that Plaintiffs do not even give a nod to the fact that McKay, their independent counsel, believed the *Huffmaster* claim had little, if any, merit.[127] Plaintiffs attempt to leap over a mountain of record evidence demonstrating Defendants' active, reasonable evaluation and handling of the *Huffmaster* lawsuit – as well as the successful resolution of all the underlying claims – simply to shift their deductible obligation to Defendants. Their only springboard for that leap, however, is the venue where *Huffmaster* was pending. To accept Plaintiffs' argument and grant the relief they request would implicitly overrule *Hartford Accident & Indem. Co. v. Foster*, 528 So. 2d 255, 265 (Miss. 1988)[128] and other cases addressing plaintiffs' failure-to-settle claims, effectively setting new precedent that requires insurers to quickly settle simply because the underlying matter is pending in a "plaintiff-friendly" venue or,

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[126] E.g. (R. 2857)(Sabella stating that "other than the bad venue and Judge, I still do not see what the insured has allegedly done to warrant the payment of the policy limits."); (R. 2859)(Buda replying to Sabella asking whether the venue can be changed because McKay was relying heavily on the venue in making her settlement recommendation).

[127] Plaintiffs quote a considerable portion of McKay's August 25, 2004 letter to Sabella, but notably they omit the most significant information. McKay began the letter by addressing the merits of the *Huffmaster* case, stating the nursing home resident was combative and the injuries were self-inflicted. (R.2851).

[128] *Hartford*, 528 So. 2d at 265 ("[I]nsurer has a fiduciary duty to look after the insured's interest at least to the same extent as its own, ***and*** also ***to make a knowledgeable, honest and intelligent evaluation of the claim*** commensurate with its ability to do so.)(emphasis added).

otherwise, risk liability.

For their meritless "failure to settle" claim, Plaintiffs rely upon *Lexington Ins. Co. v. Hattiesburg Med. Park Mgmt.*, 2007 U.S. Dist. LEXIS 49598 (S.D. Miss. July 6, 2007). However, *Lexington* provides no support for Plaintiffs. To the contrary, *Lexington* supports Defendants' position. *Lexington* involved a nursing home with an insurance policy that included a self-insured retention, *which included defense costs.*[129] The *Lexington* plaintiff claimed the insurer failed to properly settle the underlying litigation because the insurer's representative refused to offer more than $200,000.00 during mediation, "despite [its] defense counsel's recommendations."[130] The *Lexington* nursing home's officer swore he believed the underlying litigation could have been settled earlier, if the insurer had "negotiated in good faith."[131] Relying upon *Hartford*, the district court rejected the "failure to settle" claim, finding no evidence that a settlement offer was made to the insurer and that there was no evidence the insurer failed "to make a knowledgeable, honest and intelligent evaluation of the claim."[132] The situation is the same in the instant case.

The record evidence (including McKay's letters and the final settlements of each underlying claim) clearly demonstrates that Defendants made a knowledgeable, honest, and intelligent evaluation and accurately assessed the merits of the underlying lawsuits. Also, as noted, no formal settlement offer was made to Defendants prior to January 2005, and Defendants did not – at any point – reject any settlement offer. Further, Defendants settled all but one of the

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[129] *Lexington*, 2007 U.S. Dist. LEXIS 49598 at *23, 24 and n.8 . Similar to the instant case, the nursing home in *Lexington* also had an insurance policy with a deductible, or self-insured retention, which included defense costs. The court noted: "Under the...policies, the Insureds [we]re obligated to pay the first $25,000 of any 'occurrence,' including defense costs . . . ." *Id.* Dissimilar to the instant case, however, the nursing home plaintiff in *Lexington* actually paid its SIR obligation and then sought an accounting. *Id.* at *23, 24.

[130] *Id.* at *27-28.

[131] *Id.* at *28.

[132] *Id.* at *29-30(citing *Hartford*, 528 So. 2d at 265).

underlying claims within the Plaintiffs' deductible amount and one underlying lawsuit was voluntarily dismissed without any settlement. Plaintiffs' self-serving and unsupported claim that this was only due to their bankruptcy is not supported by the objective record facts. The settlements reached, particularly in *Huffmaster* and *Owens*, fully support McKay's and Defendants' evaluation of the case, which was that they had little, if any, merit.

Plaintiffs' appeal for this Court to overlook the objective facts and accept their argument that the "plaintiff-friendly" venue of *Huffmaster* required Defendants to extend the first settlement offer and settle quickly should be rejected. As the *Hartford* court stated:

> No insurance company should be faulted [], *regardless of the plaintiff's injuries*, for not paying a claim when it has every reason to believe its insured was not at fault. In doing so it may upon occasion lose [], but [it] is a far more salutary practice than encouraging insurance companies to pay off every dubious claim in which the injuries happen to be serious.[133]

To accept Plaintiffs' argument, would serve to hold insurers and their insureds hostage when cunning plaintiffs file a lawsuit in a "plaintiff-friendly" forum, and it would deny the insurer the right to consider the merits of a claim and objectively evaluate what was best for both the insured and the insurer. Such is not the law. Based upon *Hartford* and *Lexington*, Defendants were not required to quickly settle without fully considering the merits of the *Huffmaster* lawsuit, regardless of its venue. Plaintiff has offered no authority to the contrary.

c. Plaintiffs' meritless "bad faith" claim

Defendants cautiously address Plaintiffs' meritless bad faith arguments as all parties agree the Policy is unambiguous.[134] As such, the parties' obligations under the Policy, including any duty to defend or settle, must be construed from the four corners of the document.[135]

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[133] *Hartford*, 528 So. 2d at 266. (emphasis added).
[134] See footnote 96 of this brief.
[135] When a contract is unambiguous, "intent should [] be sought in an objective reading of . . . the contract to the exclusion of parol or extrinsic evidence." *A&F Props., LLC v Madison County Bd. Of Supervisors*, 933 So. 2d 296, 301 (¶12)(Miss. 2006)(internal citations and quotations omitted).

Nonetheless, Plaintiffs make blatant mischaracterizations of Defendants' statements or actions, and through their improper population of the trial court record, they have introduced documents that were properly stricken by the trial court and should not be considered by this Court.[136] Without waiving their objection to this Court and in their Motion to Strike filed in the trial court, Defendants address Plaintiffs' false statements out of an abundance of caution.

In an obvious ploy to inflame the emotions of the Court to aid in escaping their contractual obligations, Plaintiffs pepper their briefing with invective accusations of bad faith, fraud, and deception. For example, they spew Defendants "concealed" documents; misrepresented Southern's policy obligations; "obscure[d] the truth"; "fraudulently billed and received payments from plaintiffs"; have "been intentionally deceptive"; "refuse[d] to provide coverage"; "forc[ed] its own insureds into bankruptcy [and then] ... exploited" the situation; engaged in "gamesmanship"; and most disturbingly Plaintiffs make the defamatory statement that Defendants have "been intentionally deceptive in [their] pleadings and arguments to the ... court for the last six years, [and have prevailed through] duplicity."[137] An objective view of the record and Policy demonstrates that these statements are patently untrue.

Plaintiffs also claim that Defendants have now "admitted in discovery that [they] were wrong in representing to plaintiffs that the $250,000 deductible had to be paid before Lloyd's

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[136] As clearly demonstrated supra and infra, Judge Pigott simply reaffirmed Judge Evans' ruling. Therefore, the procedural posture of this case should be as it was on the first appeal, and this Court should consider only the evidence that was before Judge Evans. Also, as discussed below, much of what Plaintiffs have introduced into the record was through untimely filings in the trial court.

[137] (Pl.'s Br. 1, 20, 21, 22, 24). It appears that Plaintiffs are inferring Defendants have committed fraud on the court. Defendants vigorously deny and dispute the veracity of such a baseless assertion. Not one judge has suggested that Defendants have acted inappropriately before any court. Fraud on the court involves "'the most egregious misconduct,' a showing of 'an unconscionable plan or scheme which is designed to improperly influence the court in its decision.'" *Tirouda v. State*, 919 So.2d 211, 216 (¶11)(Miss. Ct. App. 2005)(citation omitted). The instant case is a simple breach of contract dispute, involving differing opinions about the time when Plaintiffs were required to pay the defense costs unquestionably included in their deductible, as well as the reasonable and arguable basis for the Defendants' decisions – nothing more.

paid any indemnity or defense costs . . . ."[138] In support of this erroneous claim, Plaintiffs rely on a July 6, 2006, letter from one of the Defendants' attorneys.[139] At Defendants' request, their lawyers, SDMA, provided an update on the underlying litigation, Plaintiffs' bankruptcy, and surrounding events. From a lengthy email, Plaintiffs spotlight the following excerpt from SDMA's letter: "Based upon the Policy language, we believe that Underwriters are obligated to provide a defense in connection with the underlying lawsuits, regardless of the application of the deductible . . . . We do not believe that provision of such defense should be made 'subject to' repayment by Southern, since the Policy language provides the duty to defend applies regardless of the deductible amount."[140] Of SDMA's two (2)-page letter, Plaintiffs wholly ignore Southern's obligations which permeate the entire letter; instead, they excise two (2) sentences to craft their meritless claim of bad faith and conspiracy. This manipulative endeavor should be rejected, as the letter, *if erroneously considered at all*, should be considered *in toto* and in context.

First, SDMA's July 6, 2006, letter provided a differing opinion than had been provided to Defendants earlier. Second, nothing in SDMA's opinion letter indicated that Defendants were prohibited from seeking payment from Southern for defense expenses incurred within the deductible, *while* advancing the defense costs, incurred within the deductible, under a reservation of rights. Also, Plaintiffs fail to acknowledge that on June 22, 2006, SDMA provided a report about the underlying lawsuits and Plaintiffs and bankruptcy, wherein he discussed Plaintiffs' new bad faith allegations, but he did not recommend that Defendants advance defense costs in Southern's stead.[141] Underwriters' agreement to advance defense costs, per SDMA's July 6, 2006, letter, while actively seeking reimbursement from Southern, was solely out of an

[138] (Pl.'s Br. 28).
[139] (R.3309, 4052).
[140] (Pl,'s Br. 23)(R.3308, 4052).
[141] (R.3540-50).

abundance of caution. Underwriters did not admit they were wrong in their understanding of the unambiguous contract, nor do they believe so today. They simply agreed to SDMA's authority request on various issues.[142] Such reasonable actions were not tantamount to a confession that Defendants had been incorrect in their interpretation of the policy or misrepresented anything; it was simply a decision to follow their counsel's new and differing advice, as any company or person is entitled to do. Plaintiffs' claim that there was "misconduct," by which Defendants have "avoided a day of reckoning" is spurious and false.[143]

Plaintiffs' claim that Defendants "concealed" documents from them is beyond reason. Certainly Plaintiffs would acknowledge that any confidential memorandum, opinion letter, or communication between Defendants and their counselors was protected by the attorney-client privilege or attorney work product pursuant to the Mississippi Rules of Civil Procedure and decades of jurisprudence and, as such, should not have been given to Plaintiffs. As noted by the Supreme Court in *Upjohn Co. v. United States*, attorneys have rightly depended on the sacrosanct nature of the attorney work-product doctrine; otherwise, "much of what is now put down in writing would remain unwritten. [And his] thoughts, *heretofore inviolate*, would not be his own."[144] Reiterating that it is an immaterial fact to the issue at hand, Defendants note that the protected attorney work product was only produced in discovery related to Defendants' Amended Answer asserting the affirmative defense of advice of counsel.[145]

It should be remembered that Judge Evans stayed discovery because he agreed the Policy was unambiguous, as did the dissent and now do Plaintiffs. Accordingly, extrinsic evidence was rightly not considered. Following the prior appeal in this matter when Judge Pigott allowed discovery while he familiarized himself with the case, Defendants ***voluntarily*** produced the

[142] (R. 4255).
[143] (Pl.'s Br. 24).
[144] *Upjohn*, 449 U.S. 383, 397-398 (1981)(citation omitted)(emphasis added).
[145] (R.1577).

document Plaintiffs claim Defendants "concealed." Plaintiffs' two-sentence basis for their bad faith argument shows only that Defendants prudently relied upon their counsel's advice. Because Defendants' counsel's advice changed through the course of the underlying litigation does not equate to an admission that Defendants believed their contract interpretation inaccurate, liability in this matter, or anything else. As stated, the record reflects that Defendants simply agreed to grant the authority SDMA requested, and while doing so, Defendants maintained that Southern was to continue to pay investigative and defense costs – per the contract.

In their briefing, Plaintiffs make the ludicrous statement that "Lloyd's must be laughing about this case."[146] Assuredly, Defendants do not find anything about this case or Plaintiffs' false and defamatory allegations laughable. Defendants have addressed the underlying lawsuits and this litigation with prompt attention and a knowledgeable, honest, and intelligent assessment of the contract at issue, the merits of the underlying lawsuits, and the settlement negotiations related to same. Further, Underwriters have advanced $701,153.54, incurred within the deductible obligation in Southern's stead, successfully resolving of all the underlying claims. Indeed, Underwriters' actions in resolving the underlying claims prevented Plaintiffs from liability, given that had all suits been settled for more than the per claim deductibles, as Plaintiffs contend, Plaintiffs' deductible liability would have been as much as $1,250,000 (five claims x $250,000 each claim). The unambiguous contract, the undisputed objective record facts, and Mississippi law demonstrate Plaintiffs cannot meet the heavy burden in establishing that Defendants acted in bad faith and/or lacked a reasonable, or arguable, basis for their decisions.[147]

II. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION FOR SUMMARY JUDGMENT ON THEIR COUNTERCLAIM

[146] (Pl's. Br. 23).

[147] *Windom v. Marshall*, 926 So. 2d 867, 872 (¶22) (Miss. 2006)(The insured bears a heavy burden in establishing that the insurer had no reasonably arguable basis to deny the claim.); *Snug Harbor, Ltd. v. Zurich Ins.*, 968 F.2d 538, 546-547 (5th Cir. 1992)("A finding of bad faith cannot be premised solely on the breach of contractual duty, such as a duty to defend.")(citation omitted).

Plaintiffs clearly acknowledge their $250,000.00 deductible obligation.[148] They also admit Underwriters paid $701,153.54 to defend and settle all underlying claims.[149] Plaintiffs ***do not*** claim they ever notified Defendants they believed Underwriters were in breach of contract prior to Daleson and Medforce voluntarily filing for bankruptcy in January 2005. Despite full acknowledgment of their unambiguous contractual deductible obligation, Plaintiffs inexplicably assert they can accept the contract's full benefits, and then refuse to reimburse Underwriters by simply claiming material breach by Defendants. For this argument, Plaintiffs cite to *Gulf South Capital Corp. v. Brown*, 183 So. 2d 802, 804-05 (Miss. 1966). However, the facts of *Gulf South* and the law addressed, therein, do not support Plaintiffs' claim.

In *Gulf South*, a buyer sought to purchase a hotel.[150] The buyer presented an earnest money check, requiring a materialman's lien to be cured.[151] Disagreeing that was part of the agreement, the seller instructed his attorney to return the check, which he did.[152] Despite clear termination of contract, the buyer later sued; the lower court found the seller not liable, and dismissed the suit.[153] Affirming, the supreme court stated:

> The materiality of the breach is the decisive factor. Repudiation of a material part of the contract excuses the other party . . . . Thus the repudiation of his duty by one of the parties terminates the duty of the other, giving the latter the legal privilege of refusing to render the return performance . . . .
>
> As to the character or kind of breach or default warranting re[s]cission, there may be a re[s]cission if there is a failure to perform a substantial part of the contract or one or more of its essential terms or conditions, or if there is such a breach as substantially defeats its purpose.[154]

Plaintiffs are like the buyers in *Gulf South* – the breaching party.

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[148] See *e.g.* (Pl.'s Br. 20).
[149] (Pl.'s Br. 23).
[150] *Gulf south*. 183 So. 2d at 802-03.
[151] *Id.* at 803.
[152] *Id.* at 804.
[153] *Id.*
[154] *Id.* at 804-05.

First, Plaintiffs acknowledge the Policy is unambiguous.[155] Second, as stated, Plaintiffs have not claimed or produced any evidence they notified Underwriters they believed Underwriters were to advance defense costs and only then seek reimbursement from Plaintiffs prior to Medforce's and Daleson's decision to voluntarily file bankruptcy. Plaintiffs offer no evidence they believed the Underwriters repudiated the contract, or that Plaintiffs were rescinding the same. Third, it was Southern not Underwriters that ceased paying Plaintiffs' chosen counsel, McKay. The Policy unambiguously required Plaintiffs, via Southern, to pay the first $250,000.00, each claim – *including defense costs*. As such, Southern materially breached the contract – not Underwriters. Nonetheless, Underwriters fully performed under the contract successfully resolving the claims against all Plaintiffs and advancing $701,154.53, most of which was within the Policy's deductible. Fourth, Underwriters never denied coverage for claims within the Policy's coverage.

Plaintiffs' have provided no authority for their claim that they can simply refuse to reimburse Underwriters for the $701, 153.54 advanced within Plaintiffs' deductible obligation after having received the full benefits thereof. They cannot. For generations, Mississippi law has recognized that Plaintiffs cannot accept the benefits of the contract and then claim that they have been damaged by an alleged breach of contract to the same extent as if nothing had been done.[156]

As stated above, the Policy "clearly give[s] [] [Underwriters] the right to reimbursement of any defense costs, including settlement costs, incurred within the deductible."[157] Judges Evans and Pigott correctly granted summary judgment in favor of Underwriters on their Counterclaim and correctly awarded them $701,154.53 in reimbursement of monies they

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[155] (Pl.'s Br. 34).
[156] *Marsh v. McPherson*, 105 U.S. 709, 716 (1882)(" [I]f he permitted repairs to be made or supplies to be furnished, and accepted the benefit of them, he certainly cannot claim that he has been damaged by a breach of the contract to the same extent as if nothing had been done to make good his loss.").
[157] *Southern Healthcare*, 20 So. 3d at 95 (¶46).

expended in reliance upon the contract with Plaintiffs.

III. THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN DENYING PLAINTIFFS' MOTION TO AMEND COMPLAINT

"Motions for leave to amend [a] complaint are left to the sound discretion of the trial court; the Supreme Court reviews such determinations under an abuse of discretion standard; [] unless convinced that the trial judge abused his/her discretion, the Supreme Court is without authority to reverse."[158] There is no absolute right to amend.[159]

Judge Pigott vacated the stay on discovery during the March 2011, hearing following the dismissal of the prior appeal by the Mississippi Court of Appeals. On or about July 14, 2011, Plaintiffs filed a Motion to Amend their Complaint.[160] At the hearing on September 29, 2011, after reading the prior pleadings, briefing, and evidence presented ("over 1,000 pages"), Judge Pigott stated he had determined to reinstate the summary judgments granted by Judge Evans and he adopted Judge Evans' Findings of Fact and Conclusions of Law in support of same. He also addressed Plaintiffs' Motion to Amend Their Complaint, and found that Plaintiffs were simply attempting to bring new time-barred causes of action and add new categories of damages.[161] Those new causes of action and categories of damages were such that Plaintiffs knew, or reasonably should have known, about when they filed this lawsuit.

For example, Plaintiffs sought to amend their Complaint to add new causes of action and damages. In their amended complaint, Plaintiffs sought to no longer limit their "lost profits" damages to Daleson, but rather, sought to add damages for lost profits of Medforce and Southern and also damages related to the sale of the Jones County Rest Home personalty.[162] They also

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[158] *Webb v. Braswell*, 930 So. 2d 387, 392 (¶8)(Miss. 2006) (citation omitted).
[159] *Id.* at 394 (¶11)(citation omitted).
[160] (R. 1868).
[161] (Hg. Tr. 110-11).
[162] (R. 1916-25).

sought to add new claims of bad faith and Breach of Fiduciary Duty against Lloyd's.[163] To have allowed the amended complaint, would not only have allowed Plaintiffs to bring time barred claims, it would have required Defendants to procure additional expert evaluation, discovery, and testimony to address those claims, with the expert designation deadline having already past, only two weeks remaining in the discovery period, and the trial only two months away.[164] Without a doubt, Defendants would have been prejudiced by an amended complaint raising new causes of action and categories of damages so close to the end of discovery and trial.

The record reflects that Judge Pigott made a thorough review of the extensive record when making his decision. Indeed, the record evidence clearly demonstrates that Plaintiffs simply sought to inflate their damage claims by adding new causes of action and categories of damages on the eve of trial, despite being fully aware of their claimed damages prior to filing the instant lawsuit. The trial court did not abuse his discretion in denying Plaintiffs' Motion to Amend their Complaint.[165]

IV. THE TRIAL COURT PROPERLY GRANTED DEFENDANTS' MOTION TO STRIKE AND DID NOT DENY PLAINTIFFS DUE PROCESS

A. Plaintiffs' Untimely Filed Dispositive Motion(s) and Pleadings

Once the trial court issued its final rulings, Plaintiffs' new motion for summary judgment or other pleadings and responses (other than Plaintiffs' motion for a new trial) were untimely and improperly filed pursuant to Rules 6 and 56 of the Mississippi Rules of Civil Procedure. Neither rule permits a party opposing summary judgment to file opposing affidavits nor supplemental arguments ***after*** the moving party's motion for summary judgment has been heard and ruled

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[163] (R. 1916-1925).

[164] Defendants further rely upon argument articulated in their Response to Plaintiffs' Motion to Amend Complaint in further support of their position related to this issue. (R.1916-25).

[165] *See e.g., Webb*, 930 So.2d at 394-95 (¶11)(supreme court affirmed trial court's denial of plaintiffs' motion to amend, finding plaintiffs could have reasonably known and amended much earlier and amending would have required the non-moving party to engage in more discovery and present new evidence, namely expert testimony.).

upon. Rather, when responding to a motion for summary judgment, the adverse party may serve affidavits and present evidence, "prior to the day of the hearing."[166]

As stated, Judge Pigott simply reinstated Judge Evans' prior rulings on the summary judgment motions. Effectively, he placed the case in the same procedural posture as before the first appeal in this matter. Therefore, the time period for Plaintiffs to have filed affidavits or other evidence in opposition to the motions was prior to Judge Evans' rulings. Nonetheless, they were given a second opportunity to file such evidence at any time between the March 3 and September 29, 2011, hearings before Judge Pigott – which they did not do.

Plaintiffs' attempt to file a profusion of pre-trial filings after the trial court's entry of judgment on its final ruling on Defendants' motion for summary judgment was wholly inappropriate. As noted by the supreme court in *Richardson v APAC-Mississippi*, 631 So. 2d 143, 146 (Miss. 1994), a motion to strike was the appropriate response to Plaintiffs' motions for and against summary judgment. [167] The trial court correctly granted Defendants' Combined Motion to Strike Plaintiffs' post-judgment supplemental responses in opposition to Defendants' motion for summary judgment, as well as Plaintiffs' separate motion for summary judgment.

B. Plaintiffs' Due Process Argument

"Procedural due process requires that parties who have rights that will be affected are entitled to be heard."[168] Plaintiffs have been provided two opportunities to be heard. Defendants filed their Motions for Summary Judgment on Plaintiffs' claims and Underwriters' counterclaim

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[166] Miss. R. Civ. P. 56(c)(emphasis added); See also Miss. R. Civ. P. 6(d)(opposing affidavits may be served not later than one day before the hearing).
[167] *Richardson*, 631 So. 2d at 146(Affirming the trial court's decision to strike the opposing party's affidavits, the Court stated: "Rule 6(b) prohibits a trial judge from receiving documents filed after the specified period unless the 'failure to act was the result of excusable neglect.'").
[168] *TXG Intrastate Pipeline Co. v. Grossnickle*, 716 So. 2d 991, 1024 (¶127)(Miss. 1997)(citation omitted).

on or about August 17, 2007.[169] Plaintiffs responded in September 2007.[170] Per Rule 56(c) of the Mississippi Rules of Civil Procedure, it was incumbent upon Plaintiffs to come forward with sufficient evidence to show a genuine issue of material fact existed, in order to defeat Defendants' motion for summary judgment. In March 2008, having reviewed the parties' briefing and conducted a hearing on all issues, Judge Evans found that no genuine issue of material fact existed because Defendants had fulfilled their obligations per the contract; had never denied coverage; and Underwriters paid to settle all of the underlying claims within the Policy's limits.[171] Final judgment was entered July 2008.[172] This was Plaintiffs' first opportunity to be heard.

After the court of appeals dismissed the prior appeal in this matter as untimely certified under Rule 54(b), the trial court vacated the stay on discovery and the prior summary judgment rulings until the trial judge had opportunity to get up to speed on the case.[173] During that time, the Court entered a scheduling order that had a discovery deadline of October 17, 2011, a dispositive deadline of October 31, 2011, and a trial date of December 5, 2011.[174] A flurry of discovery transpired between March 10 and September 29, 2011.

On September 29, 2011, at a motion hearing, the trial judge stated that since the March 2011 hearing, he had read the voluminous amount of pleadings and documents produced; that he had never denied the motion for summary judgment; that the Mississippi Court of Appeals had not reversed the summary judgment motions granted in favor of Defendants by Judge Evans; and that he found the rulings should be "reinstated." Judge Pigott adopted Judge Evans' ruling, along with Judge Evans' Findings of Fact and Conclusions of Law, effectively placing the

[169] (R.130).
[170] (R.758).
[171] (R.1170-82).
[172] (R.1181-82).
[173] (R.111).
[174] (R.1913).

litigation in the same position that it was prior to the Plaintiffs' first appeal in this matter. The opportunity to conduct discovery and present arguments against summary judgment while Judge Pigott studied the evidence and pleadings, and hear oral arguments regarding the same, was Plaintiffs' second opportunity to be heard.[175]

Despite Plaintiffs' claim that they "were thrown out of court," with a judgment against them, they cannot claim surprise, as they were surely aware Defendants had not abandoned their belief summary judgment in their favor was appropriate, nor had Judge Pigott reversed Judge Evans' prior ruling. In other words, Defendants' motions for summary judgment were never denied by the trial court or reversed by the court of appeals. At all times prior to the September 29, 2011, both parties were acutely aware that Judge Pigott retained the right to reinstate the motions for summary judgment in favor of Defendants. On March 3, 2011, Judge Pigott stated that the case would go forward as if there had been no summary judgment, but that he "did not need to warn" the parties that, if it developed that there were no genuine issues of fact as to Defendants, he could still remedy the matter and he was "not-forejudging it."[176]

Judge Pigott reinstated Judge Evans' grant of summary judgment in favor of Defendants only two (2) weeks before the discovery deadline. Plaintiffs have offered no authority, or even suggested the trial court was bound to allow the arbitrarily-designated discovery deadline to expire prior to ruling on the motions. Indeed, they cannot, as Rule 56 of the Mississippi Rules of Procedure does not require such. Rather, the rule and an abundance of case law confirms that a motion for summary judgment may be made at any time and mandates that a non-moving party

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[175] Defendants assert that Plaintiffs have actually had three opportunities to be heard, as they have been given the opportunity to fully brief and argue this matter in the prior appeal. As recognized by Plaintiffs, Defendants, the two experienced trial judges, and at a minimum, the four judges of the dissent, the insurance contract is unambiguous and its interpretation is a matter of law, not of fact. Further, even Plaintiffs acknowledged before Judge Pigott during opposition to Defendants' discovery requests, that this case presented "a unique situation because [it had] already been [] on . . . [a]ppeal[]." Hg. Tr. 33:13-13.

[176] (Hg Tr. 9:8-13).

must promptly come forward with credible evidence to rebut evidence brought forward by the moving party.

Furthermore, Plaintiffs acknowledged to Judge Pigott that they had nothing more to add to their argument against Judge Evans' grant of summary judgment. During oral argument on June 16, 2011, Plaintiffs' stated they had nothing to add to the dissent's statements in the prior appeal in this matter.[177] Plaintiffs' affirmed that the dissent fully covered what they would say.[178] As such, Plaintiffs cannot claim prejudice by Judge Pigott reinstating Judge Evans' grant of summary judgment motions in favor of Defendants, nor can they claim they were denied due process, as they have been afforded at least two opportunities to present their argument in opposition to Defendants' motions for summary judgment.

It is true, "[j]ustice is served when a fair opportunity to oppose a motion [for summary judgment] is provided."[179] It is equally true that a trial court may grant a summary judgment if the pleadings, depositions, answers to interrogatories and admissions on file together with the affidavits, if any, show no genuine issue of material fact exists; if so, the moving party is entitled to a judgment as a matter of law.[180] Plaintiffs were provided two – *yea arguably three* – fair opportunities to oppose Defendants' summary judgment motions, and Judge Pigott was within his authority and discretion to reinstate Judge Evans' rulings after thoroughly reviewing the voluminous pleadings and documents in the court record.

CONCLUSION

"It is the duty of every contracting party to learn and know [the contract's] content . . . . because the [other party] may, and probably will, pay his money and shape his action in reliance

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[177] (Hg. Tr. 53:1-29; 54: 1-17)
[178] (Hg Tr. 54:5-17).
[179] *Erby v. N. Mississippi Med. Ctr.*, 654 So. 2d 495, 502 (Miss. 1995).
[180] *Collier v. Trustmark Nat'l Bank*, 678 So.2d 693, 695 (Miss. 1996)(citing M.R.C.P. 56).

upon the agreement."[181] "To permit a party ...to admit[] he signed it but to deny that it expresses the agreement he made...would absolutely destroy the value of all contracts."[182] Defendants shaped their actions in reliance of the parties' contract. Now, Plaintiffs want to deny the unambiguous contract expresses the agreement they made.

Plaintiffs acknowledge the unambiguous contract required them, via Southern, to pay their deductible, or self-insured retention, of $250,000.00 each claim, Defense Costs included. Underwriters defended and paid $701,153.54, to resolve the five (5) underlying lawsuits: costs clearly within Southern's deductible obligation, without Plaintiffs suffering any trial or adverse judgment. Plaintiffs, in persistent error, have refused to reimburse Underwriters, as the parties' agreement clearly mandates. To grant Plaintiffs' request would *absolutely destroy the value* of the contract at issue *and* establish precedent such that insureds may reap the benefit of insurance contracts and then disavow them by simply crying bad faith to escape their contractual obligations. Such a ruling would diminish and serve to "destroy the value of all contracts."

WHEREFORE, PREMISES CONSIDERED, Defendants, Those Certain Underwriters at Lloyd's of London, subscribing to Policy No. LNH2003066, and Caronia Corporation respectfully requests that this Court affirm the following: (1) the trial court's grant of summary judgment in favor of Defendants on Plaintiffs' claims, as well as its grant of summary judgment in favor of Underwriters on their Counterclaim and Final Judgment Dismissing Plaintiffs' Claims Against Defendants; (2) the trial court's grant of Defendants' Motion to Strike, Or In The Alternative Dismiss as Moot, filed on or about October 31, 2011; (3) the trial court's denial of Plaintiffs' Motion for Leave to Amend Plaintiffs' Complaint; and (4) the trial court's denial of Plaintiffs' Motion for Partial Summary Judgment on Count I (Breach of Contract) Against

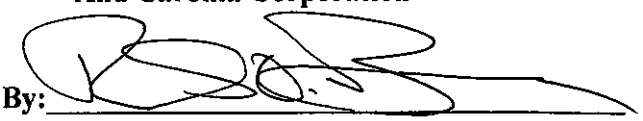
[181] *Alliance Trust Co. v. Armstrong*, 185 Miss. 148, 163-164 (Miss. 1939).
[182] *Id.*

Lloyd's of London and Certain Lloyd's Underwriters Subscribing to Policy No. LNH2003066.

Defendants request that this Court assess all costs of this appeal to Plaintiffs.

Respectfully submitted, this the 2nd day of July, 2012.

Certain London Underwriters
Subscribing to Policy No. LNH2003066
And Caronia Corporation



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CERTIFICATE OF SERVICE

I, Richard O. Burson, do hereby certify that I have this day served provided, via United States Mail, postage prepaid, a copy of the preceding document to the following:

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This the 2nd day of July, 2012.

Richard O. Burson