

# WASHINGTON INSURANCE LAW LETTER™

A SURVEY OF CURRENT  
INSURANCE LAW AND  
TORT LAW DECISIONS

edited by William R. Hickman

VOLUME XXIII, NO. 1

BETTER LATE THAN NEVER 1999

TAKING A BITE OUT OF INSURANCE FRAUD .....	1
<i>State Farm Fire &amp; Cas. Co. v. Huynh</i> , 92 Wn. App. 454, 962 P.2d 854 (1998)	
A MONSTROUS DUTY .....	2
<i>APA v. Glens Falls Ins. Co.</i> , 94 Wn. App. 556, 972 P.2d 737 (1999)	
I DIDN'T KNOW THE GUN WAS LOADED .....	3
<i>Safeco Ins. Co. v. Robert S.</i> , 70 Cal. App. 4th 757 (1999), <i>rev. granted</i> May 26, 1999	
POLLUTION EXCLUSION—CORRECT .....	4
<i>City of Bremerton v. Harbor Ins. Co.</i> , 92 Wn. App. 17, 963 P.2d 194 (1998)	
POLLUTION EXCLUSION—INCORRECT .....	6
<i>Kent Farms, Inc. v. Zurich Ins. Co.</i> , 93 Wn. App. 414, 989 P.2d 109 (1998), <i>review granted</i> , June 1, 1999	
PREJUDICIAL LATE NOTICE .....	7
<i>Benham v. American States Ins. Co.</i> , ___ Wn. App. ___, 973 P.2d 1088 (1999)	
GRABBING THE WHEEL .....	8
<i>North Pacific Ins. Co. v. Christensen</i> , ___ Wn. App. ___, 975 P.2d 552 (1999)	
QUOTE OF THE MONTH .....	9
<i>FRI Holdings, Inc. v. Hartford Cas. Ins. Co.</i> , 70 Cal. App. 4th 1023, 83 Cal. Rptr. 2d 29 (1999)	
DON'T JUST DO IT ONCE—DO IT TWICE .....	10
<i>PEMCO Mut. Ins. Co. v. Utterback</i> , 91 Wn. App. 764, 960 P.2d 453 (1998), <i>rev. denied</i> , 137 Wn.2d 1089 (1999).	

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CHIPPING AWAY THE DEFAULT .....	11
<i>Boss Logger, Inc. v. Aetna Cas. &amp; Sur. Co.</i> , 93 Wn. App. 682, 970 P.2d 755 (1998)	
MORE ROPE, MORE ROPE .....	12
<i>Albee v. Farmers Ins. Co.</i> , 92 Wn. App. 688, 967 P.2d 1 (1998)	
HONEST! IT WAS 18 ACCIDENTS .....	14
<i>State Farm Fire &amp; Cas. Co. v. Torio</i> , 250 2d 833, 673 N.Y. 2d 696 (1998).	
SEXUAL MOLESTATION COVERAGE .....	14
<i>Manufacturers &amp; Merchants Mut. Ins. Co. v. Harvey</i> , 330 S.C. 152, 498 S.E.2d 222 (Ct. App. 1998)	
AN AUTOMOTIVE SLIP AND FALL .....	15
<i>Tyrrell v. Farmers Ins.</i> , 94 Wn. App. 320, 971 P.2d 960 (1999).	
THE OLYMPIC STEAMSHIP WAKE .....	16
<i>Solnicka v. Safeco Ins. Co.</i> , 93 Wn. App. 531, 969 P.2d 124 (1999).	

THIS NEWSLETTER IS PROVIDED AS A FREE SERVICE for clients and friends of the Reed McClure law firm. It contains information of interest and comments about current legal developments in the area of tort and insurance law. This newsletter is not intended to render legal advice or legal opinion, because such advice or opinion can only be given when related to actual fact situations.

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# INDEX

PAGE

Accidents - 18	14
Accidents - Multiple	10
Attorney's Fees	16
Auto - Operator	8
Cooperation Clause	12
Duty to Defend	2
Exam - Reasonable Basis	12
Exclusion - Illegal Acts	3
Exclusion - Pollution	4
Exclusion - Pollution	6
Insurance Fraud	1
Insurance Policy Construction	5
Insurance Policy Construction	6
Judges - Reasonable	9
Judgment - Default - Vacation	11
Late Notice - Prejudice	7
Molestation - Coverage	15
Olympic Steamship Fees	16
Operator - Auto	8
Secondary Gain	12
Shooting	3
Shooting	14
Slip & Fall - Auto	15





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## WE'RE BACK!

Well, actually, that is a bit misleading. We were never gone. However, an odd combination of professional, personal, and family events got in the way of our following up that exciting "Scorching Summer of 1998" issue.

The most significant of those several events is that I became a grandfather for the second time. On March 24, 1999, William Reilly Ollenbrook was born into this world.

We are now looking at a great high pile of coverage and tort opinions. So, in this issue we will start to whittle that pile down a ways.

For all of you who called, wrote, e-mailed, or faxed me asking if you had been dropped off the mailing list, I apologize for having cut off your supply. And for those of you who did not call, write, e-mail, or fax me because you never noticed anything was missing from your life, well, you need to get your priorities readjusted.

## TAKING A BITE OUT OF INSURANCE FRAUD

### FACTS:

One Sunday evening, an auto accident did not happen. The folks who were in the car involved in the accident which did not happen sought treatment from Dr. K., the chiropractor. In his reports, Dr. K. reported objective findings that he said strongly suggested injuries that appeared to be a direct consequence of the accident which did not happen.

The reports and the bills were sent to State Farm for payment. State Farm investigated and concluded the accident did not happen. State Farm sued Dr. K. for fraud and Consumer Protection Act violations. The jury found fraud and a Consumer Protection Act violation.

The Court of Appeals affirmed.

### HOLDINGS:

(1) The entrepreneurial aspects of medical practice, *i.e.*, acts done for the purpose of increasing profits, are within the sphere of trade, are commerce, and are subject to the Consumer Protection Act. False billings and reports are subject to the Consumer Protection Act.



(2) An insurance company stands in the shoes of its premium-paying consumers who are affected by false billings from doctors, and the company has standing to sue the doctor under the Consumer Protection Act.

(3) Doctors who *falsely* report objective findings and bill for services that were never provided *should* fear liability for fraud under the Consumer Protection Act. But the mere reporting and treatment of subjective symptoms described by a patient does not constitute fraud or a violation of the Consumer Protection Act.

#### COMMENT:

It is difficult to overstate the importance of this opinion. It will have a huge deterrent effect on the insurance fraud operatives who have moved into our state. State Farm is to be commended for affirmatively stepping forward and closing down this operation.

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*State Farm Fire & Cas. Co. v. Huynh*, 92 Wn. App. 454, 962 P.2d 854 (1998).

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## A MONSTROUS DUTY

#### FACTS:

In 1992, Andrew the Hurricane swept through southern Florida. Along the way, he ripped the roofs off many houses. Prudential insured a lot of those houses and ended up paying a lot of money for all those blown away roofs.

Having done that, Prudential looked around for someone to blame. It focused on the American Plywood Association (APA) which had recommended a nailing pattern for fastening plywood to framing. It sued the APA in Florida under an oddball procedure available in Florida called a "pure bill in equity for discovery of facts." All the suit seeks is discovery; there is no damage component.

The APA tendered the defense to its CGL carrier. The carrier pointed out that while the insuring agreement said the company would defend any suit seeking damages, the Prudential suit was seeking discovery, not damages.

After two years of discovery, 200,000 documents and \$400,000 in attorneys' fees, Prudential decided not to sue the APA for damages. So, the APA sued its CGL carrier to recover the attorneys' fees it had incurred in defending itself against the "pure bill."



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The trial court granted summary judgment to the CGL carrier. The Court of Appeals said that the question was whether a suit for discovery, prefatory to seeking damages but not yet seeking damages, should be characterized as a suit "seeking damages." The answer to that question was "Yes."

**HOLDINGS:**

- (1) The Prudential suit seeking discovery was a suit seeking damages.
- (2) To say that the Prudential suit, which did not seek damages, was not a suit seeking damages would accentuate form over substance.

**COMMENT:**

Oh! This is truly a monstrous opinion. The duty to defend was stretched beyond all recognition in *Mt. Airy* when it was said to cover anything "arguably" within the coverage. But this! This says that when the written contract requires a suit "seeking damages," and the suit does not seek damages, the duty to defend is activated anyway.

The CGL carrier is asking the Supreme Court to review.

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*APA v. Glens Falls Ins. Co.*, 94 Wn. App. 556, 972 P.2d 737 (1999).

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## I DIDN'T KNOW THE GUN WAS LOADED

**FACTS:**

Sixteen-year-old Kelly had been trained by his father how to use a 9mm Beretta. One day, Kelly had several friends over to his house. He found his mother's .22 caliber Beretta in her coat in a closet. He removed the clip and pulled the slide back. Then he cocked the hammer. He thought the gun was unloaded. He pointed the gun toward his friends and pulled the trigger. He killed Christopher.

Christopher's parents sued. Safeco, the homeowner's carrier, denied coverage. The superior court ruled that the "illegal acts" exclusion was ambiguous. The California Court of Appeal reversed, finding no coverage.

**HOLDINGS:**

- (1) "Illegal" means not according to or authorized by law.



(2) The common definition of the term “illegal act” does not imply anything about the actor’s state of mind.

(3) Our conclusion is reinforced when one considers the policy exclusion for bodily injury “which is expected or intended by an insured or which is the foreseeable result of an act or omission intended by an insured.” The exclusion for “illegal acts” would be rendered superfluous and redundant if it were interpreted as excluding only intentional illegal acts, which would merely be a subset of those intentional acts already removed from coverage by the other exclusion.

(4) An insured could not objectively, reasonably expect coverage to be provided for involuntary manslaughter in the face of an exclusion for any illegal act committed by an insured. Kelly’s conduct in shooting Christopher would be considered by the average layperson to be an “illegal act” although such conduct was a result of gross negligence rather than malicious intent.

#### COMMENT:

An imminently commonsense approach.

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*Safeco Ins. Co. v. Robert S.*, 70 Cal. App. 4th 757 (1999), *rev. granted* May 26, 1999.

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## POLLUTION EXCLUSION—CORRECT

#### FACTS:

The City had a sewage plant. It expanded and improved the plant. It got sued by the neighbors who suffered physical and economic harm. The neighbors complained of the emission of noxious and toxic fumes resulting from the City’s negligent design and operation of the plant.

The City had an insurance policy, but the policy had an exclusion for damage arising out of the discharge, release, or escape of pollutants. Pollutant was defined to include all irritants and contaminants including smoke, vapors, fumes, or gases.

The City sued the carrier. The trial court found for the insurance company. The Court of Appeals affirmed.





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**HOLDINGS:**

(1) The interpretation of an insurance policy is a question of law for the court.

(2) Coverage exclusions are contrary to the fundamental purpose of insurance and will not be extended beyond their clear and unequivocal language. Exclusions, therefore, are strictly construed against the insurer. Nevertheless, this general rule is merely an aid in determining the intention of the parties. A strict application should not trump plain, clear language, thereby resulting in a strained or forced construction.

(3) Any ambiguities in the insurance policy are strictly construed against the insurer. This rule applies with added force to exclusions limiting coverage. An exclusion is ambiguous if, on its face, its language is fairly susceptible to two different, but reasonable interpretations.

(4) If the language is clear and unambiguous, we must enforce the clause as written and cannot modify the contract or create ambiguity where none exists. When analyzing the policy and reviewing for an ambiguity, policy language is construed as if read by an average insurance purchaser.

(5) Liability for the alleged damages was subject to exclusion because the claims involved "pollutants." The language unambiguously excludes claims arising from "fumes" and "gases". A reasonable person reviewing this language would expect that "noxious and toxic fumes" and "foul and toxic odors and gases" are "pollutants" within the meaning of the pollution exclusion.

(6) This reading of the exclusionary language is consistent with *Cook v. Evanson*, 83 Wn. App. 149, 920 P.2d 1223 (1996), *rev. denied*, 131 Wn.2d 1016, 936 P.2d 416 (1997).

**COMMENT:**

This is the way the pollution exclusion was supposed to be read.

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*City of Bremerton v. Harbor Ins. Co.*, 92 Wn. App. 17, 963 P.2d 194 (1998).

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## POLLUTION EXCLUSION—INCORRECT

### FACTS:

Steve was delivering diesel fuel to a storage tank at the farm. After he was done, he shut the valve to the tank and removed the hose. As he did, the fuel came back through the valve. He tried to reattach the hose. He was doused with the diesel fuel. It ended up in his stomach and in his lungs.

He sued the farm, alleging physical and emotional injuries. The farm had a CGL policy which covered bodily injury caused by an occurrence. But it had a pollution exclusion. It excluded coverage for bodily injury arising out of escape of pollutants at any location owned or occupied by an insured. Pollutants was defined to include any liquid irritant or contaminant.

The farm sued the CGL carrier when it would not defend. Both sides moved for summary judgment. The trial court ruled in favor of the farm. The Court of Appeals, by a 2-1 vote, affirmed.

### HOLDINGS:

- (1) The interpretation of an insurance policy is a question of law for the court.
- (2) Coverage exclusions are contrary to the fundamental purpose of insurance and will not be extended beyond their clear and unequivocal language.
- (3) An exclusion is ambiguous if, on its face, its language is fairly susceptible to two different but reasonable interpretations.
- (4) When analyzing the policy and reviewing for an ambiguity, policy language is construed as if read by an average insurance purchaser.
- (5) In *Cook v. Everson*, 83 Wn. App. 149, 920 P.2d 1223 (1996), the court found a similar exclusion was not ambiguous, and precluded coverage for injuries resulting from exposure to fumes that escaped during the negligent application of concrete sealant. *Cook* is distinguishable.
- (6) Under a reasonable reading of the policy, the pollution exclusion could be construed to limit claims only for traditional environmental damages—for example, a gas leak from an underground tank that contaminates surrounding soil and groundwater.



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**COMMENT:**

The dissenting judge pointed out that *Cook* was not distinguishable:

The language of the exclusion is not ambiguous. A provision is ambiguous only if on its face it is susceptible to different, reasonable interpretations. . . . The language at issue here is not susceptible to more than one reasonable interpretation. Because the policy language is clear, we should construe it as written and not create ambiguity.

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*Kent Farms, Inc. v. Zurich Ins. Co.*, 93 Wn. App. 414, 989 P.2d 109 (1998), *review granted*, June 1, 1999.

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**PREJUDICIAL LATE NOTICE****FACTS:**

In 1992, Mischelle was hit by Sean's car. The trooper noted that she was slightly injured. Sean did not inquire about potential injuries and did not notify his liability carrier of the accident.

In December 1994, Mischelle sued Sean. No answer or appearance was made. She recovered a \$125,000 default judgment in October 1995. Then she applied for a writ of garnishment against the liability carrier on Sean's car. The liability carrier first learned of the January 1992 accident in June 1996.

The company denied coverage based on late notice. The superior court and the Court of Appeals both said there was no coverage.

**HOLDINGS:**

(1) An insured is required to notify the insurer of a potential claim to allow the insurer to make an investigation of the accident in order to prepare a defense, and to afford the insurer an opportunity to control the litigation.

(2) Where no reasonable ground appears for a belief that a claim for damages against the insured driver may be expected to arise from a traffic incident, he (or she) is not required to notify the company until subsequent facts would suggest to a person of ordinary and reasonable prudence that a claim for damages may arise as a result of such incident.



(3) We hold that there is a “due diligence” requirement in Washington. An insured who is involved in a traffic accident, however slight, has a duty to conduct a reasonable inquiry with respect to injuries before he or she can claim there is no obligation to report the accident to his or her insurer.

(4) The insured is not required to give the insurer notice of an accident where he in good faith is ignorant of the injury and has used reasonable diligence in concluding that no claim would result from the accident.

(5) Sean’s failure to exercise due diligence before concluding that he had no obligation to report the accident to the insurer constitutes noncompliance with the policy.

(6) Noncompliance with the policy provisions does not deprive the insured of the benefits of the policy unless the insurer demonstrates actual prejudice resulting from the insured’s noncompliance.

(7) When the default judgment was entered establishing Sean’s liability to Mischelle, the company was prejudiced.

#### COMMENT:

A very rare event indeed to see a Washington court rule that an insured has an obligation under the policy.

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*Benham v. American States Ins. Co.*, \_\_\_ Wn. App. \_\_\_, 973 P.2d 1088 (1999).

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## GRABBING THE WHEEL

#### FACTS:

Robert was driving. His passenger reached over, grabbed the wheel, and the car collided with oncoming traffic. Robert was injured.

Robert made a UIM claim, asserting that the passenger was operating the vehicle at the time of the collision. The company denied coverage and filed a declaratory judgment action.



The trial court judge agreed with the policyholder. He ruled that because Robert could sue the passenger, there was UIM coverage.

The Court of Appeals said the trial court judge erred. The existence of a cause of action against the passenger has nothing to do with the interpretation of a written contract of insurance.

#### HOLDINGS:

(1) The clear, unambiguous meaning of “operator,” as understood by the average insurance consumer, is the person who controls all the critical functions of operating a car—the ignition, accelerator, brake, and steering.

(2) We are unwilling to strain the ordinary meaning of the term “operator” in an insurance policy to include one who momentarily controls one of the several parts of the process of operating a car. The interpretation proposed simply does not reflect the “sensible construction . . . an average insurance purchaser” would give it.

#### COMMENT:

If we were to rank cases by clarity of analysis and succinctness of the use of words, this would be at the top of the pile.

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*North Pacific Ins. Co. v. Christensen*, \_\_\_ Wn. App. \_\_\_, 975 P.2d 552 (1999).

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## QUOTE OF THE MONTH

#### FACTS:

As you know, we scour the insurance opinions, not just from Washington, but from Alaska, Idaho, Montana, and California, always looking for that case which says it all or says it better. Here, is a wonderful statement from a March 1999 California Court of Appeal opinion. The context was that Hartford had refused to defend based on an exclusion. A superior court judge ruled in Hartford’s favor. On appeal it was reversed because of “the fine nuances inherent in the English words ‘first material.’” On the second appeal, the question was whether Hartford’s first denial of coverage was reasonable:

[T]o say that *Hartford* was unreasonable in denying the FRI’s claim is to say that the trial judge was unreasonable in granting its summary judgment motion. We



have more respect for the learned trial judge than to assume he was taken in by some facile argument of an insurance carrier. The judge was acting as a neutral decision maker trying to do impartial justice: That he could conclude that the exclusion applied must certainly establish a very strong presumption that Hartford itself was reasonable in denying the claim. Surely the starting point in any bad faith analysis is that judges are presumptively reasonable people, and if *they*, acting in a judicial capacity, conclude that an exclusion applies, it means that an insurer who concludes the same thing also acted reasonably. FRI has no evidence to rebut this strong, natural presumption.

Moreover, as mentioned above, our opinion reversing the summary judgment turned on a fine point of language, not some obvious “what-were-you-thinking?” kind of mistake which, even on the merits, arguably might call into question the reasonableness of the trial court’s decision.

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*FRI Holdings, Inc. v. Hartford Cas. Ins. Co.*, 70 Cal. App. 4th 1023, 83 Cal. Rptr. 2d 29 (1999).

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## DON'T JUST DO IT ONCE—DO IT TWICE

### FACTS:

James was walking along a sidewalk between a parking lot and a restaurant. Jeanette was trying to park her car. As she tried to park, the car lurched forward, knocked down the handicapped parking sign, jumped the curb, and hit James.

James was a bit taken aback by this. So he stayed where he was as the car backed up several feet, lurched forward, and hit him again.

James claimed that this constituted two separate accidents. Jeanette’s liability carrier claimed there was only one accident.

The Court of Appeals noted that no Washington case had directly addressed the question whether one or two accidents occurs for purposes of insurance coverage when a single vehicle strikes the same person twice in rapid succession.



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The court held that the interdependent nature of the two impacts and their continuity and proximity in time and place required the conclusion that just one accident occurred.

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*PEMCO Mut. Ins. Co. v. Utterback*, 91 Wn. App. 764, 960 P.2d 453 (1998), *rev. denied*, 137 Wn.2d 1089 (1999).

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## CHIPPING AWAY THE DEFAULT

### FACTS:

Boss Logger used a chipper truck (*i.e.*, a dump truck with a wood-chipping unit integrally installed on it). It was involved in a collision and put out of commission. Boss submitted a business interruption claim to Aetna, which denied it.

Another carrier paid for the damage to the truck and it was back in service in 17 days. Boss went out business.

A couple of years later, Boss sued Aetna for business interruption and the truck damages. Aetna did not respond. Boss got a default judgment against Aetna.

When Aetna learned about the default judgment, it went running into court, asking the judge to please set it aside. The judge found that Aetna had a dispositive defense to the suit, vacated the default judgment, and dismissed Boss Logger's lawsuit.

Boss appealed and the Court of Appeals affirmed.

### HOLDINGS:

(1) A trial court's ruling on a motion to vacate a default judgment will not be disturbed on appeal unless the trial court has abused its discretion. Abuse of discretion means that the trial court exercised its discretion on untenable grounds or for untenable reasons, or that the discretionary act was manifestly unreasonable.

(2) Abuse of discretion is less likely to be found if the default judgment is set aside.

(3) A party seeking an order vacating a default judgment must prove four elements:

(a) there is substantial evidence supporting a prima facie defense to the claim upon which the court entered default judgment;



- (b) the moving party's failure to timely appear and answer the claim was due to mistake, inadvertence, surprise, or excusable neglect;
- (c) the moving party acted with due diligence upon notice of entry of the default judgment; and
- (d) no substantial hardship will result to the opposing party.

(4) The four factors are not weighted equally. Factors (a) and (b) are primary; factors (c) and (d) are secondary. If it clearly appears that a strong defense on the merits exists, the courts will spend scant time inquiring into the reasons which resulted in the entry of the order of default.

(5) Boss Logger's claim of coverage is based on the argument that an endorsement which supplied a definition of "vehicle" also added "vehicle" to the list of locations whose suspension of operations triggers business loss coverage. The contention is too strained to be reasonable. As a matter of law, Aetna's coverage defense is dispositive.

#### COMMENT:

Litigating a coverage question in Washington is tough enough without starting with a default judgment against you. Fortunately, in this case the company had the benefit of judges who actually understood and correctly applied the four-prong method of analysis for deciding whether to vacate a default judgment.

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*Boss Logger, Inc. v. Aetna Cas. & Sur. Co.*, 93 Wn. App. 682, 970 P.2d 755 (1998).

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## MORE ROPE, MORE ROPE

#### FACTS:

Kevin was injured in an auto accident. He underwent treatment, did not work, and collected PIP.

After a couple of months, his doctor became concerned that there was secondary gain involved. A neurosurgeon said he should go back to work. His doctor noted that there was certainly an element of secondary gain with the insurance claim.





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The PIP insurer decided it was time that Kevin was examined by a doctor of their choice. Kevin's lawyer said he would not show up. The company reset the exam and said that if Kevin did not show up, they would pull the plug on the benefits. Kevin's lawyer said he would not show up.

The company stopped the PIP benefits. Kevin sued the company. The company said it had an absolute right to at least one IME to determine if the treatment was necessary. The company set up another exam. Kevin said he would not attend.

The trial court granted summary judgment to the PIP carrier. The Court of Appeals affirmed.

On appeal, Kevin argued that the cooperation clause was unlawful, that the company had to show a reasonable basis for asking for the exam, and that PIP benefits could not be cut off without a demonstration of prejudice.

#### HOLDINGS:

- (1) The cooperation clause does not abridge the statutorily mandated PIP coverage.
- (2) We are not deciding whether the PIP carrier is required to have a reasonable basis before it can demand an exam.
- (3) In this case, the PIP carrier had a reasonable basis to demand an exam as a matter of law.
- (4) There is nothing in the record to support Kevin's construction that the IME doctors were too biased.
- (5) We are not deciding whether the PIP carrier was required to demonstrate prejudice resulting from Kevin's failure to submit to an exam before cutting off PIP benefits.
- (6) In this case, prejudice to the PIP carrier is evident as a matter of law. The carrier was trying to decide whether to pay PIP benefits, and in the absence of the exam, it was hampered in its ability to make that decision.



COMMENT:

It is clear that the PIP carrier demonstrated patience in dealing with Kevin. It gave him more and more rope until he had enough to create an appropriate neckpiece.

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*Albee v. Farmers Ins. Co.*, 92 Wn. App. 688, 967 P.2d 1 (1998).

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## HONEST! IT WAS 18 ACCIDENTS

FACTS:

Mike exchanged some words with a group of folks. He pointed his .22 "toward them down low." He fired. He fired 18 times. He fired until he ran out of bullets.

He did not intend to actually hit anyone. He just wanted to frighten them.

Tim, Nadia, and Magdalena sustained a total of five gunshot wounds.

State Farm, the homeowner's insurer, denied coverage and filed a dec action. The trial court said there was coverage, finding that the injuries were the result of an accident.

The appellate division reversed, saying there was no coverage as a matter of law.

HOLDINGS:

(1) Mike's criminal act of firing 18 shots in the direction of a group of people, inflicting five wounds, cannot be considered an accident within the meaning of the policies.

(2) The damage caused by his conduct flowed directly and immediately from an intended act, thereby precluding coverage.

COMMENT:

This case is noteworthy not just for the result, but for the economy of words and resources. After setting out the facts, procedure, and contention, the author took less than 75 words (excluding citations) to render the court's decision.



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*State Farm Fire & Cas. Co. v. Torio*, 250 A.D. 2d 833, 673 N.Y. 2d 696 (1998).

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## SEXUAL MOLESTATION COVERAGE

### FACTS:

In the context of a coverage suit arising out of the sexual molestation of five grandchildren by their grandfather and grandmother, a court said:

(1) We today hold that the sexual abuse of a child is so inherently injurious to the victim that the perpetrator's intent to harm the child will be inferred as a matter of law. In so holding, we follow the 41 other jurisdictions which recognize an inferred intent to harm when adults sexually assault children.

(2) Every jurisdiction having the opportunity to consider the issue in the context of sexual molestation of a minor by an insured has adopted the "inferred intent" doctrine and found that the intent to perform the act of molestation is sufficient to infer the intent to harm the child.

### COMMENT:

As far as we can tell, the only court in the United States which has found coverage for child rape under a third-party liability policy is the United States Court of Appeals for the Ninth Circuit: *St. Paul v. F.H.*, 117 F.3d 435 (9th Cir. 1997).

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*Manufacturers & Merchants Mut. Ins. Co. v. Harvey*, 330 S.C. 152, 498 S.E.2d 222 (Ct. App. 1998).

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## AN AUTOMOTIVE SLIP AND FALL

### FACTS:

The doctor was in his camper. The camper was attached to his pickup truck. He stepped down to a footstool from the camper; he slipped, hit the tailgate, and landed on the ground.



The doctor made a PIP claim. The insurance company said that this was not a "motor vehicle accident."

The trial court and the Court of Appeals both said there was coverage.

#### HOLDINGS:

(1) In Washington, construction of an insurance policy is a question of law for the courts, the policy is construed as a whole, and the policy should be given a fair, reasonable, and sensible construction as would be given to the contract by the average person purchasing insurance.

(2) Because "motor vehicle accident" is not defined, the term should be given its "plain, ordinary, and popular" meaning.

(3) The accident falls within a fair, reasonable, and sensible construction of the term as would be given by the average person. The relevant viewpoint is that of the average insurance purchaser, not an insurance claims adjuster.

(4) The injury resulted from the type of motoring risk the parties intended to cover.

#### COMMENT:

It is rather hard not to agree with the result given the unique facts of the accident.

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*Tyrrell v. Farmers Ins.*, 94 Wn. App. 320, 971 P.2d 960 (1999).

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## THE *OLYMPIC STEAMSHIP WAKE*

#### FACTS:

Karen was injured in a car accident. She was insured by Safeco for PIP incurred because of bodily injury caused by an auto accident.

She was treated in the neck and upper back. Later she complained about her left shoulder and knee. Safeco paid part of the expenses, but said the shoulder and knee problems were not caused by the auto accident.



Karen demanded arbitration. The arbitrator said the shoulder and knee problems were related to the accident. Safeco paid its limits.

Karen sued Safeco for *Olympic Steamship* fees. The question was whether Safeco's refusal to pay amounted to a "denial of coverage," thereby activating an *Olympic Steamship* claim.

The trial court and the Court of Appeals both said that *Olympic Steamship* did not apply.

#### HOLDINGS:

(1) Washington courts generally follow the American rule on attorneys' fees. It provides that fees are not recoverable by a prevailing party unless permitted by contract, statute, or a recognized ground of equity.

(2) An insured who must sue to obtain the benefit of its insurance contract is entitled to attorneys' fees.

(3) The *Olympic Steamship* rule is limited to cases in which the insurer unsuccessfully denies coverage. It does not include controversies over liability or damages.

(4) An insured is entitled to fees if compelled to take legal action to obtain the benefits under its insurance contract, but not if the issue is merely a dispute about the value of the claim.

(5) Where the insurer admits coverage but, in good faith, denies or disputes the value of the claim, *Olympic Steamship* does not authorize fees.

(6) Safeco did not deny coverage. It simply disputed the causal relationship between Karen's injuries and the accident. It is entitled to litigate that position unsuccessfully without being subject to attorneys' fees under the *Olympic Steamship* rule.

#### COMMENT:

An excellent opinion laying out the bright line rules of *Olympic Steamship* and the gray area in between them. The court points out that sometimes there is a fine line between a coverage dispute and a claim dispute. Coverage disputes include cases in which coverage is denied and those in which the extent of the benefit is disputed. Coverage questions focus on such issues as whether there is a contractual duty to pay, who is insured, the type of risk insured against, or whether an insurance contract exists at all.



Claim disputes raise factual questions about the extent of the insured's damages. They involve factual questions of liability, injuries, and damages. They are appropriate for arbitration. Coverage questions are not.

All in all an excellent review and analysis of the *Olympic Steamship* legacy.

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*Solnicka v. Safeco Ins. Co.*, 93 Wn. App. 531, 969 P.2d 124 (1999).

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## WE ARE OUT OF HERE!

### WE'RE MOVING!!

As of August 2, 1999, Reed McClure will be located in the Two Union Square Building. All the firm's phone numbers will remain the same - *main* 206/292-4900 and *fax* 206/223-0152. However, our new address will be:

REED McCLURE  
Two Union Square  
601 Union Street, Suite 4800  
Seattle, WA 98101-3900

After 15 years in one of the most magnificent buildings in Seattle's downtown legal/banking district, Reed McClure will be moving uptown to one of the most magnificent buildings in the downtown retail core. And so we will be off on a new adventure not far from Nike Town, GameWorks, Eddie Bauer, the Court of Appeals, and the State Liquor Store.



