WASHINGTON INSURANCE LAW LETTER™

A SURVEY OF CURRENT INSURANCE LAW AND TORT LAW DECISIONS

EDITED BY WILLIAM R. HICKMAN

VOLUME XXIX, NO. 3 *IT WAS SUMMER 2005*

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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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NO HARM; NO BAD FAITH

FACTS:

Mike, while driving his wife's uninsured car, caused an auto accident. Dean died. Prior to the accident, Mike had filed for Chapter 13 bankruptcy. After the accident, he switched to Chapter 7 bankruptcy. His debts were discharged.

Dean's estate sued for wrongful death. Mike's liability carrier defended him under a reservation of rights, and filed a declaratory action. After the court ruled that there was coverage, the liability carrier tendered the policy limits to the Estate. The Estate rejected the offer.

The Estate and Mike entered into a settlement agreement. In exchange for a $5 million settlement, the Estate agreed not to hold Mike personally liable. The trial court concluded that the settlement was unreasonable because Mike had no personal liability exposure because he had been discharged in bankruptcy. That ruling was affirmed on appeal. *Werlinger v. Warner*, 126 Wn. App. 342, 109 P.3d 22 (2005).

Meanwhile, the Estate, with an assignment from Mike, sued Mike's liability carrier, Clarendon, for bad faith, and Consumer Protection Act violations. The trial court dismissed that case because there was no injury to Mike. That was affirmed on appeal with the court holding that there was no evidence that Mike suffered any harm.

HOLDINGS:

(1) To succeed on a bad faith claim, the policyholder must show the insurer's breach of the insurance contract was unreasonable, frivolous, or unfounded.

(2) The insured may not base a bad faith or Consumer Protection Act (CPA) claim on an insurer's good faith mistake, which occurs when the insurer acts honestly, bases its decision on adequate information, and does not overemphasize its own interest.

(3) The insured who pursues a bad faith claim against the insurer must prove duty, breach of duty, and damages proximately caused by any breach of duty.

(4) Harm to the insured is an essential element of every bad faith or CPA claim against the insurer.

(5) An insurer is entitled to a dismissal of a bad faith claim if, after viewing the facts in the insured's favor, a reasonable person could only conclude that its actions were reasonable.

(6) Because harm is an essential element of a bad faith claim, summary judgment in favor of the insured is appropriate if a reasonable person could only conclude that the insured suffered no harm.

(7) Mike suffered no harm as a result of Clarendon's actions. He was shielded from personal liability by his Chapter 7 bankruptcy status.

(8) It was reasonable for Clarendon to dispute coverage based on the policy definitions and exclusions. Clarendon fulfilled its duty to defend Warner under a reservation of rights, and it sought a timely coverage resolution. No presumption of harm arose.

(9) Because harm is an essential element of both a bad faith and CPA claim, and there is no evidence that Mike suffered harm, the Estate cannot prevail as a matter of law.

COMMENT:

A clear, concise, precise opinion which should send a message that the courts are getting tired of the "bad faith" machinations engaged in by plaintiffs' counsel and the policyholder. One of these days, the Washington courts will realize that they are seriously out of step with the rest of the states, e.g., in most jurisdictions, the type of deal made here violates the cooperation clause and the prohibition on voluntary payments. Even in California, the state which invented insurance bad faith, this type of deal is a nullity.

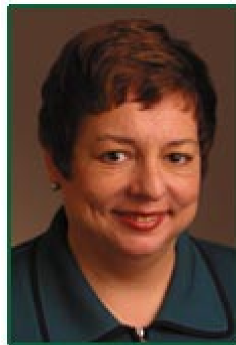
Werlinger v. Clarendon National Ins. Co., ___ Wn. App. ___, 120 P.3d 593 (2005).

SUPER LAWYERS

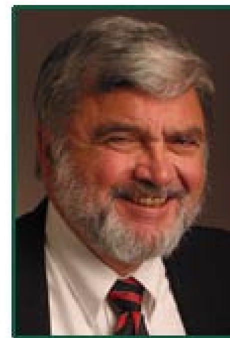
Reed McClure is proud to mention that four of its attorneys have been named as 2005 Super Lawyers by the magazine Washington Law & Politics:

John W. Rankin, Jr.

Pamela A. Okano



Nancy C. Elliott



William R. Hickman

TIME TO PAY THE PIPER

FACTS:

Zack's house in Sedro Woolley burned down. He had a fire policy with Standard. They could not agree on the amount of the loss. The company asked Zack "repeatedly" for an EUO and more documents. Zack did not comply. He filed suit.

The company moved for summary judgment. The trial court found a failure to comply with the policy and that the company had been prejudiced by the failure. But the court only dismissed "without prejudice" until Zack complied.

Zack did not comply. Instead, two months later, he sued again. The company moved for dismissal and attorney fees. The court dismissed with prejudice but no fees. Everyone appealed. The Court of Appeals affirmed everything.

HOLDINGS:

(1) Persuasive authority indicates that once an insurer has done all it is required to do to set in motion the completion of requirements of the policy, the burden shifts to the insured to come into compliance, including offering to complete an interview under oath.

(2) When he initiated this suit, Zack was still subject to, and not in compliance with, the September order. He was therefore precluded from commencing this action.

(3) The court's denial of the motion for attorney fees was not based on untenable grounds.

COMMENT:

This was a golden opportunity for the court to add a scintilla of good faith and fair dealing back into policyholder/insurer litigation. As this opinion indicates, a policyholder can lose, not just once, but twice because of his noncooperation and he pays nothing. He was precluded from filing the second suit, but he did it anyway. That sounds frivolous. Litigation is not a recreational activity. The time has come: If the policyholder wants to engage in the litigation dance, he should pay the piper.

Flanders v. Travelers, 2005 WL 2002133 (Wn. App. 2005).

SHOOT THE CAT

FACTS:

Jim lived across the street from the Chrisps. The Chrisps had a cat. (The court did not tell us the name of the cat.) The cat was very protective of his food.

One day, Jim walked into his sun porch. The cat was there. The cat attacked Jim. Jim shot the cat.

Jim sued the cat's owner, alleging strict liability and common law liability. The trial court dismissed on summary judgment.

The Court of Appeals affirmed.

HOLDINGS:

(1) To make a cause of action on strict liability, the plaintiff must show that the animal's owner knew or had reason to know the animal was abnormally dangerous; the animal must have "dangerous propensities abnormal to its class."

(2) Jim made no showing that the Chrisps knew or had reason to know their cat was abnormally dangerous.

(3) At common law, an owner is required to exert the amount of control which would be exercised by a reasonable person based on circumstances such as the animal's past behavior and foreseeable injuries.

(4) There is no showing that the cat ever attacked a person. And there had been no complaints about the cat.

(5) The Chrisps had no reason to believe their cat would attack.

COMMENT:

That was one tough pussycat. (See photo.) I am reminded of another soft fuzzy which was described as "the most foul, cruel, and bad tempered rodent you ever set eyes on. . . . [T]hat rabbit's got a vicious streak a mile wide, it's a killer!"

Lawson v. Chrisp, 2005 WL 1594358 (Wn. App. 2005).

A FAILURE OF PROOF

FACTS:

Dennis was the manager of a scrap metal yard. After the owner fired him, he sued the owner alleging that he had been fired because of his age and his religion.

The owner said he had 23 reasons to fire Dennis. Among them were: advancing $200,000 without security to a bankrupt client; allowing an employee to run up a $50,000 repair bill on a $24,000 truck; allowing a customer to have a key to the yard so he could take liquid oxygen free of charge and without supervision; not paying overtime to its employees by requiring a supplier to pay the employees in cash; permitting an employee to run an undocumented company store selling food and cigarettes; buying scrap which contained asbestos; losing $5 million in two years.

The owner moved for summary judgment but the trial court judge denied the motion and the case went ahead to a jury trial. The jury awarded Dennis $2,000,000.

The owner appealed, and the Court of Appeals reversed, pointing out that Dennis had failed to show that the reasons for his discharge were pretextual and unworthy of belief. In addition, his evidence of age and religious discrimination was insufficient as a matter of law to support such a claim.

HOLDINGS:

(1) An employee makes a prima facie case of discriminatory termination if the employee shows that he or she (1) belongs in a protected class; (2) was discharged; (3)
was doing satisfactory work when the termination decision was made; and (4) was replaced by someone not in the protected class.

(2) Once an employee presents a prima facie case of employment discrimination, a presumption of discrimination exists and the employer must produce evidence of legitimate, nondiscriminatory reasons for the termination.

(3) If the employer produces evidence of legitimate, nondiscriminatory reasons for the termination, then the employee must show that the employer's stated reasons for the termination are pretextual and unworthy of belief.

(4) An employee shows that an employer's stated reasons for the termination are pretextual if the proffered justifications have no basis in fact, are unreasonable grounds upon which to base the termination, or were not motivating factors in employment decisions for other similarly-situated employees.

(5) An employee's subjective beliefs and assessments as to his or her performance are irrelevant.

(6) An employer who has been accused of employment discrimination will be entitled to judgment as a matter of law if no rational trier of fact could conclude that discrimination was a substantial factor in the employer's action.

(7) The evidence was insufficient as a matter of law for a trier of fact to reasonably conclude that religious or age discrimination was a substantial factor in employee's termination.

COMMENT:

The problem here was that the trial court failed to dismiss on summary judgment. The judge failed to follow the directive of the Supreme Court that courts must not be used as a forum for appealing lawful employment decisions. (*Hill v. BCTI Income Fund*, 144 Wn.2d 172, 190, 23 P.3d 440 (2001)). An example of what the trial court is supposed to do is found in *Becker v. Cashman*, 128 Wn. App. 79, 114 P.3d 1210 (2005). There, where it became apparent on summary judgment that the employer had good reasons to discharge the employee, summary judgment was granted, and the Court of Appeals affirmed.

FURTHER COMMENT:

Reed McClure represented the scrap metal yard owner on appeal.

Griffith v. Schnitzer Steel Indus., 128 Wn. App. 438, 115 P.3d 1065 (2005).

THE DISCONNECTED LEG

FACTS:

Marjorie was going north on I-5. Roger sideswiped her car as he merged onto I-5. They both pulled off and stopped to exchange information. According to Marjorie, she gouged the back of her leg when she got out of her car. Although she had nine stitches to close the wound, it did not heal properly. They had to cut off her leg.

Marjorie's PIP carrier paid its $10,000 limits. Roger's liability carrier paid its $25,000 limits. Marjorie then asked her UIM carrier, Progressive, for the $500,000 limits.

Progressive felt there was a lack of connection between the collision and the injuries. It got a coverage opinion and then filed a declaratory action. Marjorie counterclaimed for . . . bad faith.

The trial judge ruled that Roger's negligence did not cause Marjorie to lose her leg, and in a stunning demonstration of logic and common sense, said: "If there's no coverage, there can't be any bad faith."

The Court of Appeals said he got it all wrong. Not only is there a jury question as to whether Roger's negligence caused Marjorie to cut her leg on her door after the accident, but in Washington, a policyholder may sue an insurer for bad faith regardless of whether there is coverage or not.

HOLDINGS:

(1) The public policy behind UIM insurance is to provide a second layer of floating protection for the insured.

(2) An insurer providing UIM protection steps into the shoes of a negligent third party to pay the insured the amount, up to policy limits, by which the damage caused to the insured by the negligent third party exceeds the third party's liability coverage.

(3) The UIM insurer undertakes a duty to pay that extends no farther than the legal liability of the involved tortfeasors, if any.

(4) The record shows a sufficiently close, actual, causal connection between the injuries and the negligence. Reasonable minds could differ on the question of cause in fact in this case.

(5) The injuries were not too remote from the negligence in time or place or sequence of events. Because the facts and circumstances of this case are unusual, allowing recovery would not open the door to fraudulent claims or unreasonably burden users of the highway.

(6) The duty of good faith owed by an insurer to its insured is both legislatively and judicially imposed. This duty is broad, and conduct not amounting to intentional bad faith or fraud may still breach the duty. But an insurer acts in bad faith only if its conduct is unreasonable, frivolous, or untenable.

(7) Over six months passed before Progressive took action to resolve the liability issue. Considering that the determination of liability stemmed entirely from the facts of the accident and Progressive knew all of these facts well before Marjorie submitted her UIM claim, there is a question about why Progressive did not refer the liability issue to a coverage attorney, and then to a court, much sooner.

(8) Progressive provides no reason why it waited so long to evaluate the liability issue. There is a genuine issue of fact as to whether Progressive's conduct was unreasonable, frivolous, or untenable.

COMMENT:

It is ironic that if Progressive had filed suit upon receipt of the UIM limits demand, then it would have been sued for bad faith failure to negotiate and bad faith forcing of policyholders into litigation.

Progressive West Ins. Co. v. Bateman, 2005 WL 1719929 (Wash. App. 2005).

NO COVERAGE; NO BAD FAITH

FACTS:

Barry ran his car into a freeway guardrail. He claimed he was rear-ended by a hit-and-run vehicle. He made a UIM claim. His insurer, Progressive, investigated and decided it did not happen.

Barry sued Progressive for breach of contract and bad faith. The bad faith claims were dismissed on summary judgment. The breach of contract claim was tried to a jury which found that Barry had not been involved in an accident with an uninsured motorist.

Barry appealed. The Court of Appeals affirmed the breach of contract verdict but reversed on the bad faith claim, saying that the jury's finding of no coverage did not necessarily mandate a conclusion of no bad faith. Progressive petitioned for review.

The Supreme Court of Texas granted review, and, without oral argument, issued a *per curiam* opinion reversing the Court of Appeals, dismissing Barry's lawsuit, and pointing out that the lack of coverage negated the bad faith claim.

COMMENT:

Some day, we hope that Washington will wake up to the fact that when there is no coverage, there can be no bad faith. As it is now, if I am involved in an accident and get sued, I can tender the defense to nine carriers besides my own. Any of those nine which fail to fully investigate the accident (because they do not insure me) can be sued for bad faith.

Progressive County Mut. Ins. Co. v. Boyd, 48 Tex. Sup. Ct. J. 1020, 2005 WL 2045816 (Texas 2005).

A CLEAR REGULAR USE EXCLUSION

FACTS:

Deanna worked as a substitute driver for a rural route mail carrier in Odessa. (That's in eastern Washington.) Ron, the regular carrier, would pay her $60 per day to substitute for him every other Saturday and when he went on vacation. When she substituted for him, she would use his car, which had a right-hand drive.

While substituting for Ron and driving his car, Deanna was involved in an accident. She sought UIM benefits under her policy with Mutual of Enumclaw. But Mutual of Enumclaw said the "regular use" exclusion barred coverage because Jim's car was available for her regular use.

In the superior court, Mutual of Enumclaw moved for summary judgment. Although he said there were no fact issues, the trial court denied the motion. So Mutual of Enumclaw asked the Court of Appeals for discretionary review. Division III granted review, and the court said the car was furnished or available for her regular use. The exclusion applied.

HOLDINGS:

(1) If the language of an insurance policy is clear and unambiguous, those terms must be given the effect of their plain meaning by the courts.

(2) The clause here is clear and unambiguous.

(3) The purpose of regular use provisions "is to provide coverage for isolated use without the payment of an additional premium, but to disallow the interchangeable use of other cars which are not covered by the policy."

(4) Specifically, the purpose of the regular use clause is to: (1) prevent an insured from receiving the benefits of coverage by purchasing only one policy; and (2) provide coverage to an insured when the insured is engaged in the casual or infrequent use of a nonowned vehicle.

(5) The critical factor is not the purpose of the use, but the frequency of the use.

(6) Deanna used the car 16 times in a 4 month period. Her use of the vehicle was frequent.

COMMENT:

We should not lose sight of the fact that this result was so clearly ordained that the Court of Appeals

granted the extraordinary relief of discretionary review. That is granted only when the error of the trial court was "obvious" or "probable." RAP 2.3(b).

Nelson v. Mutual of Enumclaw, 128 Wn. App. 72, 115 P.3d 332 (2005).

TOUGH CLAIMS MADE

FACTS:

The hospital had a claims made policy with Executive Risk. The policy period was 12:01 a.m., August 1, 2001 to 12:01 a.m., August 1, 2002. The policy covered claims made against the hospital during the policy period and claims made after the policy period, provided written notice of the potential claim was made before the policy expired.

On July 31, 2002, the hospital's risk manager bundled up notices of seven potential claims and gave them to FedEx. The notices were delivered at 9:03 a.m., August 1, 2002, just nine hours after the policy expired. Executive took the position: too late, no coverage.

The parties went to federal court. But the judge was not sure of the answer so he sent it to the New Hampshire Supreme Court. That court said that the policy means exactly what it says: neither more nor less. In short: too late, no coverage.

HOLDINGS:

(1) Courts will not perform amazing feats of linguistic gymnastics to find an insurance policy term ambiguous.

(2) While courts have the duty to construe an insurance contract in a reasonable manner, they are not free to rewrite its terms by giving them a meaning which they never had.

(3) When an insurance policy's meaning and intent are clear, it is not the prerogative of the courts to create ambiguities where none exist or to rewrite the contract in attempting to avoid harsh results or a result claimed to be unreasonable.

(4) There is no requirement that a liability insurer prove prejudice due to lack of notice under a claims-made policy.

(5) The insured's failure to give timely notice forfeits coverage under claims-made liability policy as a matter of law.

(6) Substantial compliance with the notice requirement of a claims-made liability policy does not entitle the insured to coverage.

COMMENT:

Refreshing to read that somewhere there are judges who do not believe that their job description includes redrafting the insurance policy.

Catholic Medical Center v. Executive Risk Indem. Inc., 151 N.H. 699, 867 A.2d 453 (2005).

CUTTING INTO TB

FACTS:

Morton went to the hospital because of upper respiratory problems. Tests were inconclusive as to whether the problem was cancer or tuberculosis. A pulmonologist referred Morton to a surgeon. He also told the surgeon the infectious disease workup was negative.

The surgeon removed part of Morton's lung. An analysis of what was removed revealed that Morton had tuberculosis, not cancer. Morton sued the pulmonologist and the surgeon for negligently taking out part of her lung. Both doctors moved for summary judgment and the trial court dismissed. On appeal, the court affirmed as to the surgeon but reversed as to the pulmonologist. It said the surgeon was not negligent in relying on what the pulmonologist told her. As to the pulmonologist, the court said that Morton's "expert" witness, an "internist," was qualified to give an opinion which created an issue of fact as to whether the pulmonologist had violated the standard of care.

HOLDINGS:

(1) The standard of care required of professional practitioners must be established in a medical malpractice action by the testimony of experts who practice in the same field.

(2) In order to testify on the applicable standard of care, a physician must demonstrate that he or she has sufficient expertise in the relevant specialty.

(3) There is no general rule that prohibits a specialist from testifying regarding the standard of care applicable to a general practitioner; or a specialist in one area from testifying about another area.

(4) So long as a physician with a medical degree has sufficient expertise to demonstrate familiarity with the procedure at issue, the physician will be considered qualified to express an opinion on any sort of medical question including questions in areas in which the physician is not a specialist.

COMMENT:

The case continues the trend in Division I of liberally evaluating experts in medical malpractice cases.

FURTHER COMMENT:

Reed McClure represented the surgeon.

Morton v. McFall, 128 Wn. App. 245, 115 P.3d 1023 (2005).

SUDDENLY AN EMERGENCY

FACTS:

While driving , ZZ experienced a seizure, lost consciousness, crossed the median and collided with Octavio. ZZ died. Octavio was injured. Octavio sued ZZ's Estate. The Estate moved for summary judgment on the basis that recovery was barred under the sudden emergency doctrine.

The trial court dismissed. The Court of Appeals reversed, saying there were some fact issues.

HOLDINGS:

(1) Under the sudden emergency doctrine, a driver who becomes suddenly stricken by an unforeseen loss of consciousness, and is unable to control the vehicle, is not chargeable with negligence.

(2) The sudden emergency doctrine applies in instances where the driver is an epileptic with a history of seizures.

(3) The issue is one of foreseeability: Was the driver's loss of consciousness foreseeable?

(4) A trier of fact could reasonably conclude from the evidence that ZZ's loss of consciousness that resulted in the fatal accident was foreseeable.

COMMENT:

The court did a yeoman's job of discovering conflicting factual inference so the case could be sent back for trial. Of course, it probably did not help the analysis that ZZ had been up 'til midnight the night before drinking beer, that he had two prior rollover accidents, and that three years earlier he had had a seizure.

Sandoval v. Estate of Zink, 2005 WL 1965930 (Wn. App. 2005).

WHAT'S WRONG WITH THIS PICTURE?

FACTS:

Janice caused an auto accident with Miguel. At mandatory arbitration, Miguel was awarded $8,600. Janice requested trial de novo. The jury awarded Miguel $11,000.
So then, having improved his position from $8,600 to $11,000, Miguel asked for $46,600 in attorney fees and $4,700 in costs. Janice argued that the request was excessive.

The trial judge agreed, saying the fee request was exorbitant and unreasonable on its face. The judge then said he had carefully reviewed the statement of fees and activities and concluded that $10,000 was a reasonable fee.

Miguel appealed, arguing the judge abused his discretion. The court reversed and remanded, saying the record was insufficient for it to tell how the judge reached that particular number.

HOLDINGS:

(1) Because Janice failed to improve her position after she requested a trial de novo, the court was required under RCW 7.06.060 and MAR 7.3 to assess costs and reasonable attorney fees against her.

(2) Washington has adopted the lodestar method for determining the amount of an award for fees and costs.

(3) First, the award is determined by multiplying a reasonable hourly rate by the number of hours reasonably expended on the matter; second, the award is adjusted either upward or downward to reflect factors not already taken into consideration. The burden of justifying any deviation from the 'lodestar' rests on the party proposing the deviation.

(4) The trial court abused its discretion in awarding attorney fees because it failed to provide the appellate court with a record to determine what it considered a reasonable amount of hours expended and whether it considered the hourly rate to be reasonable.

COMMENT:

What is wrong with this picture is that a $2,400 additional recovery can generate a $46,600 legal bill. No civilized society can condone such a waste of assets. Truly, the inmates are running the asylum.

Rodriguez v. Reed, 2005 WL 2840344 (Wash. App. 2005).

ONE LIMIT CONSORTIUM

FACTS:

Sheila was in the crosswalk when she was run down and killed by Elise. Elise's liability insurer paid the $100,000 limit to Sheila's estate.

Sheila's daughter Ruth claimed that her loss of consortium claim entitled her to a separate $100,000. The trial court dismissed Ruth's claim and the Court of Appeals affirmed.

HOLDINGS:

(1) The fact that loss of consortium claims may provide the basis for an independent lawsuit does

not prevent an insurer from treating them as derivative of bodily injury for purposes of setting its policy limits.

(2) A contract of insurance does not violate public policy unless a statute prohibits it, a judicial decision condemns it, or it is contrary to the public morals.

(3) No statute prohibits Washington insurers from treating loss of consortium claims as derivative for purposes of determining coverage limits.

COMMENT:

In this unpublished opinion, the court relied primarily upon *Grange Ins. Ass'n v. Morgavi*, 51 Wn. App. 375, 753 P.2d 999 (1988). There, the court had said that it had been long settled in this state that insurance for a claim for loss of consortium is restricted to the single person limit of the policy.

Burr v. PEMCO, 2005 WL 2065280 (Wn. App. 2005).

TACOMA IS ALL WET

FACTS:

One rainy morning, Larry slipped and fell in a small amount of water which had been tracked into Costco. The trial court dismissed because Larry did not prove that the wet floor was an unreasonable risk. The Court of Appeals reviewed a host of Washington slip-and-fall cases, and concluded the trial court was correct.

HOLDINGS:

(1) In order to prove actionable negligence, a plaintiff must establish the existence of a duty, a breach of that duty, and a resulting injury proximately caused by the breach.

(2) The mere presence of water on a floor where a plaintiff slips is not enough, in and of itself, to prove a breach of duty by the landowner.

(3) Our Supreme Court's decisions manifest an enduring concern about expanding liability. If we were to hold that a person who slips inside a door where a mat has been placed, on a day when it is wet outside, may recover for injuries sustained without showing anything more, we would place an intolerable burden on businesses in Tacoma where it is often wet outside.

COMMENT:

It rains in Tacoma. It rains in Seattle. It rains all over this side of the mountains. That is why we have developed webbing between our toes.

Horstman v. Costco Wholesale, 2005 WL 2840348 (Wash. App. 2005)

BANG BANG OCCURRENCE

FACTS:

Wesley and John were police officers in South River (that's in New Jersey). They were driving down the street, responding to a report of gunshots. Out stepped Ed, Jr., wearing his camouflage gear and carrying a shotgun. He shot the car, injuring both officers. He shot again, hitting them again. Wesley got off a few shots before he was hit again. Another officer arrived on the scene and killed Ed, Jr.

Wesley and John sued Ed, Jr.'s parents. They alleged that the parents negligently had guns in the house, and negligently entrusted guns to their son. The parents had an insurance policy with State Farm. It had a $100,000 per occurrence limit. A question arose as to how many occurrences had occurred. The officers were of the view that each gunshot fired by Ed, Jr. was a separate occurrence. State Farm was of the view that the only occurrence was the alleged negligence of the parents in letting their adult son get his hands on the shotgun.

The trial court ruled there was a single occurrence. The appellate court agreed.

HOLDINGS:

(1) When the terms of an insurance policy are clear, those terms will be enforced so as to meet the expectations of the parties.

(2) Courts must avoid writing a better policy for either the insurer or the insured than the one that the parties have created themselves.

(3) It is inappropriate for the court to engage in a strained interpretation of the language of the policy simply to support a finding of coverage.

(4) For the purpose of counting the number of occurrences, the term must be construed from the point of view of the cause or causes of the accident rather than its effect.

(5) There was but one occurrence, namely, the negligence of the gunman's parents in permitting him to have access to the firearms in their home.

COMMENT:

Nice commonsense application of clear thinking.

Bomba v. State Farm Fire & Cas. Co., 379 N.J. Super. 589, 879 A.2d 1252 (N.J. App. Div. 2005).

GETTING THE DEFENSE COSTS BACK

A fascinating case came out of the California Supreme Court this summer. It started when the policyholder was sued by a third party. Scottsdale, the company, agreed to defend but reserved its right to recoup the defense costs. The company filed a declaratory action seeking a ruling that its policy provided no potential coverage, and that it was entitled to defense costs.

The third party action settled, and in the declaratory action, the trial court found a potential for coverage. The company appealed. The Court of Appeals reversed, holding that the allegations in the complaint never triggered a possibility of coverage. But Scottsdale could not get its defense costs back because the determination of "no potential coverage" applied only prospectively and not "retroactively."

The Supreme Court said the distinction was nonsense, and held that the company, which had reserved its right to recover the defense costs, was entitled to be reimbursed for defense costs once it was determined that the third-party action never presented any possibility of coverage.

Scottsdale Ins. Co. v. MV Transportation, 36 Cal. 4th 643, 115 P.3d 460 (2005).

ODD CASE FROM SPOKANE

A couple of years ago an odd opinion came out of Division III. In it, the majority reversed the trial court judge and held that a hearsay affidavit by a stranger to the litigation could be utilized to impugn the verdict of the jury. The dissenting judge said that what the majority was doing was

procedurally, legally, factually, and philosophically wrong. *Dalton v. State*, 115 Wn. App. 703, 63 P.3d 847 (2003).

What makes this significant is that this summer, a slightly different panel of Division III vacated that earlier opinion. It seems that the lady whose affidavit had been used to impugn the jury verdict read about the appellate decision in the newspaper. She got ahold of the defendant's attorney and told him she had not made the statements attributed to her. A hearing was held. The lady and the plaintiffs' attorneys told very different stories about the affidavit. The trial court found as a fact that one of the plaintiffs' attorneys had altered the affidavit. He further found that the lady had not made the statement which was added. The trial court judge then struck the affidavit from the record.

Plaintiffs appealed that ruling. The court noted that an appellate tribunal is not permitted to weigh the evidence or the credibility of witnesses. That is the job of the trial court. Therefore, the order striking the affidavit is affirmed. With no affidavit, the court vacated its earlier opinion and sent the case down for a rehearing.

There is something of a conundrum here, in that an unpublished opinion is being utilized to vacate a published opinion.

Dalton v. State, 2005 WL 2038537 (Wn. App. 2005).

QUICKLY, QUICKLY, QUICKLY

In a long, complex, and detailed opinion, the federal district court in Boston has ruled that a liability insurer (St. Paul) can sue its policyholder's personal corporate counsel for malpractice. It appears that the corporate counsel, in addition to collecting $1.8 million in defense fees, made a couple of highly questionable decisions while defending the policyholder, and it was its failure to warn its client about the downside risk in the first place which caused its client to get sued. St. Paul had referred the defense to its staff counsel, but because he had no experience in intellectual property litigation, the policyholder's corporate counsel controlled the defense.

St. Paul Fire & Marine Ins. Co. v. Birch, Stewart, Kolasch & Birch, LLP, 379 F. Supp. 2d 183 (D. Mass. 2005).

Division II welcomed newly appointed Judge Penoyar to the bench by reversing a deck collapse case in which he was the trial court judge.

Monohon v. Antilla, 2005 WL 2746675 (Wash. App. 2005).

Opinions dealing with the vacation of default judgments continue to be published. In the most recent, Division II held that a letter from the City of Tacoma denying a bidder's claim constituted an informal appearance entitling the City to notice of the motion for default.

In an earlier opinion, Reed McClure's Marilee C. Erickson helped convince Division II that the liability insurer's extensive communications with the plaintiffs' counsel constituted an informal appearance entitling the defense to notice of the motion for default.

Matia Investment Fund, Inc. v. City of Tacoma, ___ Wn. App. ___, 119 P.3d 391 (2005).

Gutz v. Johnson, 128 Wn. App. 901, 117 P.3d 390 (2005).

An interesting construction litigation case came out of Division I. Although the plaintiff subcontractor got a money judgment in its favor, the defendant general contractor got an award of attorney fees greater than the plaintiff's judgment because the defendant prevailed in defending "the major claims of the case." The court also demonstrated that it will reverse trial court judges who fail to provide an adequate written, articulate basis for its decision as to the size of an attorney fee award.

Crest, Inc. v. Costco Wholesale Corp., 128 Wn. App. 760, 115 P.3d 349 (2005).

In another construction litigation case, the court held that the indemnity agreement did not cover claims involving harm covered by construction defects which did not result in injury to or destruction of tangible property. The court drew a distinction between construction defects and injury to tangible property. Injury to tangible property occurs when property is damaged and then decreases in value. On the other hand, a construction defect is not "injury," but rather poor craftsmanship or design and it occurs during production adversely affecting the quality and value when complete.

Heritage at Deer Creek Associates v. Kirtley-Cole Associates., 2005 WL 1899412 (Wn. App. 2005).

Some readers have asked when I am going to comment on the case "whose name cannot be mentioned." In a nutshell, the answer is, "Never." The opinion "whose name cannot be

mentioned" occupies a spot in the galaxy of opinions roughly equivalent to Voldemort at Hogwarts. Each time I think of it, I recall those words of Fielding Mellish:

"This trial is a travesty. It's a travesty of a mockery of a sham of a mockery of a travesty of two mockeries of a sham."

We shall speak no more of the opinion "whose name cannot be mentioned."

___ Wn. App. ___, ___ P.3d ___ (2005).

Up near the front of this publication, you will find the disclaimer and warning which our E&O carrier insisted we use. It seems the old one, "The legal analysis in this publication is worth every dime you paid for it," did not satisfy the underwriter. In the recent issue of the "Alaska Bar Rag" (I am not making this up), we find:

> As with all *Bar Rag* articles, advertisements and letters, we do not vouch for, stand by, or support most of what we publish. Nor have we cleared any of this with either the FDA or the Department of Homeland Security (fka Interior Ministry). We sure as hell won't be responsible for your hurt feelings or misguided reliance on anything we publish.

The Washington Supreme Court has indicated that the concept of remittitur is not entirely dead in Washington, our personal belief to the contrary notwithstanding. The court stated that "unquestionably" appellate courts have the authority to reduce jury damage awards. It was pointed out that remittitur was a part of the common law at the time Washington became a state. Thus, "an appellate court's common law authority to remit jury awards is consistent with the constitutional right to a jury trial."

Then the court proceeded to rule that the Court of Appeals was wrong when it reduced a $260,000 noneconomic damages award to $25,000.

Bunch v. King County Dept. of Youth Servs., 155 Wn.2d 165, 116 P.3d 381 (2005).

Anderson Kill, the New York policyholder's firm, is already out with the 12 steps to insurance coverage for the Katrina, Rita, and Wilma disasters. However, underlying these are their two principles of insurance recovery:

> (1) The first principle of insurance recovery—*The purpose of insur ance is to insure*.
>
> (2) If your insurance company appears to be beating a retreat rather than riding to the rescue and paying your claim, remember the second principle of insurance recovery—*Do not take "No" for an answer*.

Division I issued an opinion setting out the law of the sudden brake failure defense in a rear-end collision case:

> In Washington, defendants are per se negligent if they fail to stop behind the stopped car ahead of them. Defendants may, however, assert the affirmative defense of sudden brake failure to excuse their breach. If a defendant asserts this defense, he or she must prove the

reasons for the brake failure, and the jury must decide whether the defect was reasonably discoverable. For a jury to find that sudden brake failure excused the [negligence], it must find that the defect in the brake was latent, or if the defect was patent, it would not have been discovered by reasonable inspection, had such inspection been made.

Vira v. Smith, 2005 WL 1724991 (2005).

Welcome Aboard

Reed McClure is pleased announce that Megan Kirk has joined the firm as an associate. She is a member of the Washington State Bar and the Washington Defense Trial Lawyers Association. Prior to joining Reed McClure, Ms. Kirk worked for over two years as a law clerk to the Honorable Ann Schindler at the Washington State Court of Appeals, Division I. She is working in defense litigation, insurance coverage, and appeals.

Remember, selected back issues of the Law Letter are available on our web site at www.rmlaw.com/newsltr.htm ... and Pam Okano's Coverage Column is available at www.wdtl.org/ (see Coverage Uncovered).

For up-to-date reports on Reed McClure attorneys please visit our website at www.rmlaw.com

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