WASHINGTON INSURANCE LAW LETTER™

A SURVEY OF CURRENT INSURANCE LAW AND TORT LAW DECISIONS

edited by William R. Hickman

VOLUME XXIV, NO. 1 *SUMMER OF NEW BEGINNINGS 2000*

THE NEW REED MCCLURE 1

COVERAGE FOR A REALLY BIG DUMP 2
Goodwin v. Wright, 100 Wn. App. 631, ___ P.2d ___ (2000).

GRAFT LEADS TO INSURER'S VICTORY!!!!!! 3
Hayden v. Mutual of Enumclaw Ins. Co., 141 Wn.2d 55, 1 P.3d 1167 (2000).

OH, WHAT A LOVELY OPINION 6
Overton v. Consolidated Ins. Co., ___ Wn. App. ___, ___ P.2d ___ (August 1, 2000).

A TRULY DREADFUL OPINION 8
Anderson v. State Farm Mutual Automobile Ins., _____ Wn. App. ____, 2 P.3d 1029 (2000).

IS ADJUSTING THE UNAUTHORIZED PRACTICE OF LAW? 10
France v. Jones, No. 99-2-02212-2SEA (King County Superior Court, Jan. 14, 2000).

THE INVIOLATE RIGHT TO A JURY TRIAL 12
Godfrey v. Hartford Cas. Ins. Co., 99 Wn. App. 216, 993 P.3d 281 (2000).

THE *WINTERS* OF OUR DISCONTENT: COULD ANYTHING BE WORSE THAN *MAHLER*? 13
Winters v. State Farm Mutual Auto. Ins. Co., 99 Wn. App. 602, 994 P.2d 881 (2000).

GREEN EGGS AND *HAMM* 15
Hamm v. State Farm Mut. Auto. Ins. Co., __ Wn. App. ___, 3 P.3d 761 (2000).

A NIGHT TO REMEMBER 17
Wothers v. Farmers Ins. Co., 101 Wn. App. 75, ___ P.3d ___ (2000).

SEXUAL MOLESTATION COVERAGE 18
Kim v. National Indemnity Co., ___ P.3d ___ (Alaska Aug. 11, 2000).

SOME LITIGANTS ARE MORE EQUAL THAN OTHERS 19
Lenzi v. Redland Ins. Co., 140 Wn.2d 267, 996 P.2d 603 (2000).

AN ALTOGETHER STRAINED INTERPRETATION 21
National Merit Ins. Co. v. Yost, 101 Wn. App. 1009, 3 P.3d 203 (2000).

Published and Distributed by:

REED McCLURE
ISSN 1064-1378
Two Union Square, 601 Union Street, Suite 4901
Seattle, Washington 98101-3920
206/292-4900
© 2000

AN AUTOMOTIVE SLIP AND FALL 22
Tyrrell v. Farmers Ins. Co., 140 Wn.2d 129, 994 P.2d 833 (2000).

UNTIMELY NOTICE COSTS INSURED AN ARM AND A LEG 23
Northwest Prosthetic & Orthotic Clinic v. Centennial Ins. Co., 100 Wn. App. 546, 997 P.2d 972 (2000).

YOU SNOOZE, MAYBE YOU LOSE 25
Panorama Village Condominiums v. Allstate Insurance Co., 99 Wn. App. 271, 992 P.2d 1047 (2000).

FRANKENLAW 27

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.

The entire contents are copyrighted. All information as to permission to copy may be obtained from Alissa Panzer at 206/386-7149; Fax: 206/223-0152; E-mail: apanzer@rmlaw.com.

CHANGE OF ADDRESS: Please call Mary Clifton at 206/386-7060; Fax: 206/223-0152; E-mail: mclifton@rmlaw.com.

INDEX

PAGE

Actual Prejudice 23
Arbitration
- Binding 12
- Non-Binding 12
Auto Accident - Defined 22
Bad Faith 8
- Elements 6
CGL
- Completed Operations 2
- Loss of Use 3
- Products 2
Coverage - Child Rape 18
Discovery Date 25
Discovery Rule 25
Duty to Defend 3, 6
Estoppel 3
- Collateral 19
Exclusion
- Completed Operations 2
- Loss of use 3
- Products 2
Failure to Cooperate 23
Frankenlaw 27
Good Faith - Fact Issue 6
Late Notice 23
Mahler
- PIP 13
- Tortfeasor 15
- UIM 13
Policy Construction
- Ambiguity 21
- Unreasonable 21
Regulations 3, 8
Suit Limitation Clause 17
UIM
- Anti-Stacking 21
- Arbitration 12
- *Mahler* 13
- Trial 12

THE NEW REED MCCLURE

"Nothing endures but change."
Heraclitus, c. 500 B.C.

"To every thing there is a season,
and a time to every purpose under the heaven . . .
A time to break down, and a time to build up."
Ecclesiastes, 3:1,3.

"For the times they are a-changin'."
Bob Dylan, 1963

This spring and summer has seen enough changing to last Your Editor the rest of his life. I was still recovering from the shock of moving to Two Union Square from the Columbia Tower. And then in the spring a number of our business/transactional attorneys indicated they were thinking they might be happier somewhere else. And so, consistent with normal procedure, all the shareholders got together to discuss the situation. It was concluded that in the current law business, it no longer made sense for Reed McClure to offer a smorgasbord of services to clients.

In light of the current pressures facing full service mid-size firms, the decision was made to abandon the full-service model and downsize by concentrating on two practice areas: insurance and litigation.

If I thought that was a tough decision, it was nothing as compared to the next several weeks watching as folks with whom I had practiced for upwards of 25 years packed up and moved out.
But our new president, Jack Rankin, summed it up: "Reed McClure is returning to its roots: insurance and litigation." We're excited about our new "old" look.

We will be moving again. Not so far this time: from the 48th floor to the 49th floor of Two Union Square. That should be done by August 28. Our new address is on the cover.

The Going Forward Reed McClure contemplates more changes, all directed toward the goal of the timely delivery of quality legal services. This issue of the Law Letter (a bit late, I realize) contains articles prepared by Pamela A. Okano, GailAnn Y. Stargardter, Michael S. Rogers, Earl M. Sutherland, Anamaria Gil, Marilee C. Erickson and David S. Cottnair, with a few editorial comments by Your Editor. In the future, you will also see contributions from Mary R. DeYoung, Sherry H. Rogers, Christy Arden Karjeker, Jennifer L. Scully, and Jack Rankin, as well as Your Editor.

In addition, by the dawn of 2001, we hope to have most of our readers receiving their Law Letter via the Internet. More about that later. For now, sit back and read what the judiciary has been doing to Insurance Law this year.

COVERAGE FOR A REALLY BIG DUMP

FACTS:

For a company called Fruhling, Ken drove an end dump trailer—the old-fashioned kind that tips up and dumps out the back. George ran Eastside Machine.

Fruhling gave George a couple of old, inoperative hydraulic cylinder ram contraptions that are used to tip up a dump truck bed. George was supposed to take the two cylinders and make one cylinder that would work.

George took the cylinders apart, cleaned them, took out gouges and other defects, and put on new seals, guides, and maybe a new piston ring.

Then he sent the cylinder ram back to Fruhling. Fruhling put it back in the dump truck which Ken drove.

Ken had 25 tons of wet sand in the dump truck. He tried to dump it out using the "new" cylinder ram.

The cylinder exploded. Shrapnel hit the cab of the truck. The bed loaded with 25 tones of wet sand collapsed onto the truck frame. Ken bounced around inside. He was injured.

George had an insurance policy for Eastside Machine. He had paid a premium of $1,215 for basic CGL premises and operations coverage. This policy excluded coverage for liability arising from products-completed operations hazards. He did not pay the extra $12,000 for products-completed operations coverage.

Ken sued George and Eastside Machine. The insurer did not defend. Ken obtained a default judgment of $261,924 against George. Ken then served a writ of garnishment on the insurer. The trial court granted a motion for summary judgment for the insurer. Ken appealed.

HOLDINGS:

Division I affirmed. The purpose of the products-completed operations coverage is to insure against the risk that the product or work, if defective, may cause bodily injury or damage to property of others after it leaves the insured's hands. The insured here purchased only premises and operations coverage. He chose not to buy completed operations coverage.

The court ruled that the cylinder was George's product, since it was both manufactured and traded by him. That the cylinder ram was made to order was immaterial. Whether George was in the business of manufacturing cylinders was immaterial. Thus, the products hazard exclusion applied.

The court also rejected Ken's argument that the cylinder ram qualified as "your work" but had not been completed. The court observed that one cannot create or trade a product without performing "work;" "product" is the narrower definition, and once satisfied, the exclusion applies. The definition of completed work did not render the exclusion ambiguous. In any event, George's work was completed; there was no ongoing process. George delivered the cylinder ram, and Fruhling paid for it.

The fact that George negligently omitted a lock ring or improperly welded the cylinder ram was also immaterial. The majority of courts have rejected the idea that an operation negligently performed cannot be a completed operation.

COMMENT:

This is one hell of an opinion. As you know, there is almost no case law in Washington dealing with the CGL concepts of "products" or "completed operations." In doing an opinion letter we end up sorting through opinions of various levels of clarity from dozens of jurisdictions. All for the purpose of predicting what a Washington court would do if presented with the problem. This opinion adds 25 tons of predictability to CGL analysis.

Goodwin v. Wright, 100 Wn. App. 631, ___ P.2d ___ (2000).

GRAFT LEADS TO INSURER'S VICTORY!!!!!!!

FACTS:

Jim was an expert in graft. He contracted to graft fruit buds onto an orchard owner's fruit tree rootstock. In the first try Jim damaged the buds. The next time the graft failed because Jim used bad tape. The fruit did not develop. The rootstock, however, suffered no physical damage.

Jim agreed to try again. He and the owner bought new buds. The buds rotted because Jim had improperly stored them. Again, the rootstock itself suffered no physical damage.

The owner sued Jim. He claimed Jim's actions had caused crop loss.

Jim's insurer declined to defend. The denial letter failed to mention exclusion (h), which provided:

This insurance does not apply:

> (h) to loss of use of tangible property which has not been physically injured or destroyed resulting from
>
> > (1) a delay in or lack of performance by or on behalf of the NAMED INSURED of any contract or agreement, or
> >
> > (2) the failure of the NAMED INSURED'S PRODUCT or work performed by or on behalf of the NAMED INSURED
> >
> > but this exclusion does not apply to loss of use of other tangible property resulting from the sudden and accidental physical injury to or destruction of the NAMED INSURED'S PRODUCTS or work performed by or on behalf of the NAMED INSURED after such products or work have been put to use by any person or organization other than an INSURED.

Jim settled with the owner. As part of the settlement, a default judgment of almost $500,000 was entered against Jim in exchange for a covenant not to execute and an assignment of his rights against the insurer.

The owner sued the insurer for breach of the duty to defend and coverage. The owner claimed that the insurer should be estopped from raising exclusion (h) under WAC 284-30-380(1), which precludes insurers from denying a claim on the grounds of specific policy provision unless reference to that provision is included in the denial. The owner also claimed that the insurer could not use deposition testimony to support its argument that it had no duty to defend. The trial court granted summary judgment to the insurer.

The Court of Appeals affirmed. It held that the policy clearly excluded coverage and that the company had no duty to defend or pay.

The Supreme Court accepted the owner's petition for review, but held that the insurer was not precluded from raising additional defenses not cited in the denial of coverage letter and that the duty

to defend was properly denied based on the "loss of use" exclusion. The court decided to exercise judicial restraint and not address the issue of whether extrinsic evidence can be utilized in determining the duty to defend.

HOLDING:

(1) WAC 284-30-380 does not preclude an insurer from raising coverage defenses other than those raised in its denial letter, without regard to whether there was prejudice to the insured or whether the insurer acted in bad faith.

(2) The regulations within WAC 284-30 do not, in and of themselves, create causes of action. Rather, they require an attendant Consumer Protection Act claim to be given effect.

(3) Even if there had been a CPA claim in this case, estoppel would not have been the appropriate remedy. The CPA does not expressly provide for estoppel or preclusion as a remedy. RCW 19.86.170 provides that "no penalty or remedy shall result from a violation of this chapter except as expressly provided herein." Therefore, estoppel cannot be a CPA remedy.

(4) Under traditional forms of estoppel, insureds must show that they either suffered prejudice or the insurer acted in bad faith in failing to raise all grounds for its denial in its initial denial letter. The owner did not allege either prejudice or bad faith. Thus, the insurer was not estopped from raising additional coverage defenses.

(5) CGL policyholders purchase general liability insurance, not a performance bond, product liability insurance, or malpractice insurance.

(6) The duty to defend is broader than the duty to indemnify. Whereas the duty to indemnify hinges on the insured's actual liability to the claimant and actual coverage under the policy, the duty to defend exists if the complaint alleges facts that could conceivably render the insurer liable to the insured under the policy.

(7) There was no duty to defend. The gravamen of the complaint was the failure of Jim's grafts or grafting work to live up to the parties' expectations. The complaint does not allege physical injury to tangible property that would render the exclusion inapplicable under either its general language or its exception for sudden and accidental physical injury.

(8) The "loss of use" exclusion clearly and unambiguously excludes coverage for the budding claim and supports the denial of the defense.

COMMENT:

A very important decision. Not just because it broke a streak of six straight anti-insurance company opinions, but because it expressly indicated that the Regulations do not create causes of action and the Consumer Protection Act does not have common law or equitable remedies attached thereto.

Of course it would have been nice to know to what extent the real facts in the real world can be utilized in determining a duty to defend. (As an exercise, try explaining to the hypothetical common person why the truth should not be utilized in determining duty to defend. Didn't someone once say that "the truth shall make you free"? Or are we to be like Pilate who said jesting, "What is truth?" but would not stay for an answer. Bacon, Essays, 1, "Of Truth." But we digress.)

Hayden v. Mutual of Enumclaw Ins. Co., 141 Wn.2d 55, 1 P.3d 1167 (2000).

OH, WHAT A LOVELY OPINION

FACTS:

In 1976, the EPA took soil samples and informed Jerry, the owner, that they found PCBs. Jerry was hostile. But Jerry went out and bought insurance.

In 1981 Jerry sold the land. In the 90's the new owner discovered PCB contamination and cleaned up the site. Then he sued Jerry. Jerry tendered to the insurance companies. They denied coverage, and refused to defend. So Jerry sued them.

The trial court first ruled that there was no coverage because Jerry knew about the contamination when he bought the policy. Then he ruled that there was no occurrence, no bad faith failure to defend, and no CPA violation.

Jerry appealed. Division III reversed saying there was an issue of fact as to what Jerry knew and when he knew it, that there was a duty to defend, and that the refusal to defend was not bad faith in light of the coverage questions.

HOLDINGS:

(1) Interpretation of an insurance policy is a question of law. We construe the policy as a whole and give force and effect to each clause. The policy's language should receive a "fair, reasonable, and sensible construction," such as the average person buying insurance would give it. Insurance coverage in environmental claims is highly jurisdiction-specific.

(2) The policies define an "occurrence" as continuous or repeated exposure to conditions which results in property damage neither expected nor intended from the standpoint of the insured. The phrase "neither expected nor intended" modifies "property damage," not "exposure." It describes the subjective state of mind of the insured with respect to the property damage—here the cost of cleaning up the property of third parties.

(3) Whether Jerry had the requisite expectation or intent of the particular loss so as to disqualify coverage is a question for the trier of fact.

(4) The duty to defend is broader than the duty to indemnify. The duty to defend is triggered by the filing of a complaint against the insured alleging facts which, if proved, will potentially trigger the duty to indemnify under the policy. The insurer need not look beyond the face of the complaint if the complaint filed against the insured is unambiguous. Only if the complaint alleges liability that is clearly not covered by the policy or falls unequivocally within an exclusion is the duty to defend excused. The burden is on the plaintiff to show that the loss suffered is covered by the policy.

(5) The complaint alleged that PCBs were deposited in the soil during the coverage period, and that Jerry is strictly liable for the cleanup costs by statute. These are facts which, if proved, will trigger the duty to indemnify. The filing of the complaint, therefore, triggered the duty to defend.

(6) The insurer's duty of good faith is based on a fiduciary relationship which involves more than the usual "honesty and lawfulness of purpose" which constitutes the standard definition of good faith. "It implies 'a broad obligation of fair dealing,' and a responsibility to give 'equal consideration' to the insured's interests."

(7) Good faith by an insurer is a question of fact.

(8) An insurer breaches its duty if it acts without reasonable justification in handling a claim. But denial of coverage based on a reasonable interpretation of the policy is not bad faith.

(9) We will not find bad faith where the legal sufficiency of the insurer's reasons for denying coverage is unclear.

(10) Jerry's tender triggered a duty to defend. The allegations in this complaint arguably placed the loss within the terms of the policy. However, the coverage questions raised by the insurance companies are reasonable or, at least, not so unreasonable as to amount to bad faith.

COMMENT:

I think this is a perfectly delightful little opinion. The author of this opinion accurately applied Washington insurance law as it exists in the summer of 2000.

Holding no. 6 will of course have to be clarified some day. As noted in *Safeco v. Butler*, 118 Wn.2d 383, 389, 823 P.2d 499 (1992), the fiduciary relationship between an insurer and an insured "is not a true fiduciary relationship." The relationship is something more than the normal arm's length business relationship of contracting parties but it is "something less than a true fiduciary relationship."

Overton v. Consolidated Ins. Co., ___ Wn. App. ___, ___ P.2d ___ (August 1, 2000).

A TRULY DREADFUL OPINION

FACTS:

Sharon was driving south on I-5. Chuck was her passenger. Sharon's Honda and a Camaro were changing lanes. Sharon lost control of the Honda and ran into the jersey barrier. She was seriously injured. Chuck had minor injuries.

Chuck told State Farm the Camaro was playing tag. He could not remember what actually happened right before Sharon lost control.

The only independent eye witness said Sharon and the Camaro were zig-zagging through traffic. It looked like a game of chicken. The eye witness said the Honda and Camaro were going much faster than the other traffic.

Sharon confirmed that she and the Camaro were changing lanes. She moved over to the exit lane. She said another car moved in front of the Camaro and then headed into her lane. She lost control of the Honda.

State Farm concluded Sharon was at fault for the accident. State Farm advised Chuck he had a liability claim against Sharon and attempted to settle the claim.

Ten months later, Sharon hired an attorney who notified State Farm she was making a UIM claim. State Farm renewed its investigation. It concluded that Sharon was still primarily liable for the accident but offered $7,500 to Sharon to resolve the claim.

Sharon's attorney finally requested UIM arbitration on liability only. The arbitrator concluded Sharon was 25% liable. State Farm paid the $100,000 UIM policy limits.

Sharon sued State Farm for bad faith, CPA violations, and attorneys fees. She claimed that State Farm had a duty to tell her that her policy provided UIM coverage. The trial court granted summary judgment to State Farm. The Court of Appeals affirmed in part and reversed in part.

HOLDINGS:

(1) An insurer commits bad faith and engages in an unfair claims settlement practice when it fails to disclose the existence of UIM coverage to an injured insured whose damages are substantial and whose account of the accident plausibly indicates a "phantom" driver is at fault.

(2) State Farm's failure to advise Sharon of her UIM coverage violated WAC 284-30-350 and constituted bad faith as a matter of law.

(3) State Farm's failure to disclose UIM coverage also establishes, as a matter of law, an unfair insurance claims practice actionable under the Consumer Protection Act.

(4) Establishing a violation of WAC 284-30-350 satisfies the unfair practice element of a Consumer Protection Act claim.

(5) Sharon is entitled to trial to determine the amount of damages caused by the ten-month delay before she knew that a UIM claim under her own policy was possible.

(6) State Farm complied with WAC 284-30-330(4) because it conducted a reasonable investigation before denying Sharon's claim.

(7) Based on the large disparity between State Farm's offers and the ultimate result, a jury could find that State Farm forced Sharon into arbitration by making unreasonably low offers.

(8) State Farm was reasonably justified in waiting for the outcome of the liability phase of the UIM arbitration before committing resources to evaluate damages.

(9) Sharon is not entitled to *Olympic Steamship* attorneys fees because the dispute is about the amount of the claim, not the denial of a claim.

COMMENTS:

Upon reading this opinion, one is struck by the thought: Is this the worse insurance opinion of the new decade, or is it just the worst one of 2000? In contrast to the *Overton* opinion, which applies

the current law this opinion misapplies the law. The conflict between this opinion and *Overton* and even *Hayden* are remarkable. (E.g., bad faith is a fact issue.)

The author of the opinion strongly criticized State Farm for not giving credence to Sharon's statement that a "phantom" car forced her off the road. The author of the opinion appears to be unaware that RCW 48.22.030(8)(a) and the State Farm policy require independent proof of a "phantom" car. Neither Sharon or Chuck could establish a "phantom" car. The only independent witness said nothing of a "phantom" car. The author of the opinion appears to be expressing some bizarre rule that in an accident investigation an insurer should base its decision solely on the statement of the insured.

Anderson v. State Farm Mutual Automobile Ins., _____ Wn. App. ____, 2 P.3d 1029 (2000).

IS ADJUSTING THE UNAUTHORIZED PRACTICE OF LAW?

FACTS:

Janet was injured in an accident with Jeremy. Jeremy was insured by Allstate with a $25,000 policy limit. Shortly after the accident, Allstate's adjuster sent Janet a letter stating: "As your claim representative, my role is to insure that you receive this quality service . . . ." The adjuster promised to fully explain the claims process, promptly and fairly investigate the facts, and make an appropriate offer of compensation.

The adjuster contacted Janet's insurer, and learned that it was waiving any subrogation claim. The adjuster investigated the accident, and determined that it was a limits claim. The adjuster then sent Janet and her husband a check for $25,000 with a letter that said: "Allstate has issued payment of $25,000, payable to you, which represents the bodily injury limits . . . ." On the check was typed: "FINAL PAYMENT OF ANY AND ALL CLAIMS ARISING FROM BODILY INJURY CAUSED BY ACCIDENT ON 11/21/97." The check was also accompanied by a release of any person from all claims arising out of injuries sustained in the accident.

Janet's husband had already spoken to two different attorneys before receiving the check. He did not call them to ask about the check. Instead, he had Janet sign the check. Janet and her husband did not sign and return the release because they did not want to release all persons from the accident. They thought they might have a claim against the manufacturer of Janet's car. Janet understood she was settling for Jeremy's policy limit. She testified she knew she had an "adversarial-type relationship" with Jeremy and Allstate.

On June 14, 2000, Judge Phillip Hubbard granted summary judgment finding Allstate liable for the adjuster's "unauthorized practice of law."

HOLDINGS:

(1) It is the nature of the services performed that governs whether given activities constitute the practice of law, not the nature or status of the person performing the services.

(2) The practice of law consists of services which are ordinarily performed by licensed lawyers and that involve legal rights and obligations, specifically including: the preparation of legal instruments and contracts by which legal rights are secured; the selection and completion of formal legal documents or the drafting of such documents; and determining for the parties the kinds of legal documents they should execute to effect their purpose.

(3) There is an overlap between activities that lawyers and nonlawyer professionals can perform.

(4) The adjuster "represented" Janet and engaged in the practice of law.

(5) The adjuster negligently practiced law, in that she did not advise Janet that the release might affect her claims against third parties, such as the car manufacturer.

COMMENT:

Judge Hubbard held that the adjuster provided legal representation to Janet as her "agent," even though Janet did not think the adjuster was acting as her legal representative, and even though Janet's husband spoke with two real attorneys. Judge Hubbard also stated that to avoid this result, adjusters must "maintain the plainly adversary posture." So much for customer service.

The plaintiffs' bar has had a field day with this ruling. WSTLA gave Janet's attorney its President's Award for his attempts "to stop insurance claims adjusters from negotiating settlements with people injured by their policyholders." We always thought the primary purpose of adjusting was the settlement of claims.

The Court of Appeals has accepted discretionary review of Judge Hubbard's ruling. It will decide this fall whether to refer the case up to the Supreme Court.

France v. Jones, No. 99-2-02212-2SEA (King County Superior Court, Jan. 14, 2000).

THE INVIOLATE RIGHT TO A JURY TRIAL

FACTS:

Mr. G. was injured while riding a bus. Because the bus had no insurance (it was "self-insured;" an oxymoron for the ages), he made a UIM claim under his own UIM insurance.

The insurance policy provided that if the parties thereto could not agree as to entitlement or amount of damages, either party could demand arbitration. It also provided that the company would pay for the arbitration. The policy also expressly said that the arbitration decision as to entitlement was final and binding, but that the arbitration decision as to the amount of damages was subject to trial if either party demanded it.

The dispute was arbitrated. Mr. G. was awarded $165,000. The company demanded a trial on the amount of damages. Mr. G. opposed that. The superior court held the new trial provision void because of the Arbitration Act.

Division One of the Court of Appeals reversed, upholding the right to freedom of contract and holding that a bilateral nonbinding arbitration agreement was valid.

HOLDINGS:

(1) Binding arbitration differs from other forms of alternative dispute resolution that are compulsory or nonbinding, such as conciliation, mediation, and nonbinding arbitration, although the latter is often mistakenly referred to as "arbitration."

(2) Arbitration under the contract in the instant case is not intended as a final and binding process. Instead, it provides that *either* party dissatisfied with the damages awarded at arbitration may set aside that award and proceed to trial.

(3) Because the Legislature has not imposed a requirement for binding UIM arbitration in the UIM statute or the arbitration statute, and because the Legislature has not otherwise invalidated nonbinding arbitration clauses such as the one in the instant case, we are further persuaded to decline Mr. G's invitation to invalidate the trial clause on public policy grounds.

(4) We conclude that the arbitration statute does not control where parties have not contractually (or otherwise) agreed "to settle" a dispute by arbitration.

(5) We see no reason why this court should declare nonbinding arbitration to be an invalid form of alternative dispute resolution in this state.

COMMENT:

In *Petersen v. USAA*, 91 Wn. App. 212, 955 P.2d 852 (1998), Division III held an identical clause to be invalid on public policy grounds. That was nonsense. As Judge Baker of Division I points out, the parties have an absolute right to select and agree upon a method of resolving their dispute. The Arbitration Act has application when the parties select binding arbitration. When nonbinding is selected, the Act has no application.

Mr. G. petitioned the Supreme Court for review. In light of the impossible-to-overlook conflict between Division I and Division III the court accepted the case and set it for argument this fall!

Another interesting aspect to this case is the moral conundrum which it creates for our friends at WSTLA. While the most fundamental tenet (the "holy of holies") of the organization is that the Right to Trial By Jury Shall Remain Inviolate, in this case they are arguing against a party's right to trial by jury. We should be thunderstruck by this abandonment of First Principle. We would be but for our experience in the post-*Nevers* appeals. In over 30 cases we argued that a defendant's right to trial by jury was much too important to be abrogated by a legal secretary's oversight in failing to timely file a piece of paper attesting to the fact that another piece of paper had in fact been filed on time.

But in all those post-*Nevers* appeals, we never heard a peep from WSTLA. The crack cadre of amicus brief writers was silent. Their silence filled volumes. "The Right To Trial By Jury Shall Remain Inviolate, unless it is a defendant's right to a jury trial."

Godfrey v. Hartford Cas. Ins. Co., 99 Wn. App. 216, 993 P.3d 281 (2000).

THE *WINTERS* OF OUR DISCONTENT: COULD ANYTHING BE WORSE THAN *MAHLER?*

FACTS:

Sarah was injured in a three-car collision. One driver had liability limits of $25,000. The other driver was uninsured. Sarah was fault-free. She had UIM and PIP coverages.

Sarah's policy provided that her insurer was to be repaid its payments "out of any recovery" but that its "right to recover our payments applies only after the insured has been fully compensated." A nonduplication-of-benefits clause provided that any amount paid or payable as damages under the PIP coverage would not be paid again under the UIM coverage. The policy also provided:

> If the insured recovers from the party at fault **and we share in the recovery, we will pay our share of the legal expenses**. Our share is that per cent of the legal expenses that the amount we recover bears to the total recovery. [Emphasis added.]

Sarah's insurer paid her $8,271 in PIP benefits. Her insurer then retained an attorney to sue the uninsured driver. Sarah's insurer obtained a $8,271 default judgment against the uninsured driver. In the meantime, Sarah settled with the liability carrier of the insured driver for its $25,000 policy limits.

Sarah made a UIM claim under her policy. The UIM arbitrator found total damages of $40,271, including special damages of $8,271 and general damages of $32,000. The parties agreed that Sarah's insurer could deduct the $25,000 liability limits collected from the insured tortfeasor. The insurer also deducted the $8,271 it had paid in PIP benefits.

Sarah sued for the additional $8,271. **She conceded that her insurer had not shared in her recovery from the underinsured motorist**. However, she claimed that not only was she entitled to the $8,271, but she was also entitled to a share of her legal expenses under *Mahler v. Scuzs*, 135 Wn.2d 398, 957 P.2d 632, 966 P.2d 305 (1998). The trial court granted the carrier's motion for summary judgment.

Division II affirmed the carrier's entitlement to the offset. However, it reversed on the question of attorneys fees. It ruled the carrier was liable for a portion of plaintiff's attorneys fees under *Mahler*.

HOLDINGS:

(1) A PIP carrier has a right to be reimbursed for PIP payments made to a fault-free insured after the PIP insured has been fully compensated, at least where the policy so provides. The policy here so provided, and the carrier did not seek to reimburse itself until after the insured had been fully compensated.

(2) The carrier did not lose its right to reimbursement by attempting to subrogate against the underinsured motorist. Public policy is to return the PIP carrier to its pre-accident position, provided that the PIP insured is fully compensated first. To allow the PIP carrier to reimburse itself means that it has paid the medical bills only once. To return the carrier to its pre-accident position, it must be allowed to also recover from the at-fault tortfeasor.

(3) However, the common fund doctrine requires the PIP carrier to pay a pro rata share of Sarah's attorneys fees and costs. The common fund doctrine provides that when one person creates or preserves a fund from which another then takes, the two should share pro rata the fees and costs reasonably incurred to generate that fund. Sarah created a common fund when, after receiving PIP

payments, she recovered full compensation from the insured tortfeasor and the UIM proceeds. This is because the UIM carrier stands in the shoes of the tortfeasor.

(4) The policy language defines the common fund to include both the liability and UIM proceeds: it provides that the PIP carrier will share in its insured's legal expenses if the insured recovers from the party at fault and the PIP carrier shares in that recovery. **The UIM proceeds recovered from the UIM carrier are deemed to be a recovery from the party at fault**. The PIP carrier shared in the proceeds due to the PIP offset. Moreover, the entire common fund was created by Sarah's efforts, since both the suit against the underinsured tortfeasor and the UIM arbitration were adversary proceedings, neither of which would have born fruit but for her efforts.

COMMENT:

Let's see if we have this right: The PIP insured concedes her PIP insurer did not share in her recovery from the insured tortfeasor. In fact, her insurance company hires its own attorney and gets a default judgment against the uninsured tortfeasor for the amount of its PIP subrogation interest. But her insurance company still has to pay a share of her legal expenses for recovering its PIP interest? Huh?

Yes, the insurer has petitioned for review to the Washington Supreme Court.

Winters v. State Farm Mutual Auto. Ins. Co., 99 Wn. App. 602, 994 P.2d 881 (2000).

GREEN EGGS AND *HAMM*

FACTS:

Rebecca was injured by an uninsured motorist. She did not recover anything from the tortfeasor. Her insurance company paid her PIP benefits. After an arbitration, it also paid her UIM benefits. Pursuant to a nonduplication of benefits clause, the insurer set off the amount of the PIP payments against the damages she was legally entitled to recover from the uninsured motorist.

Rebecca sued her insurance company. She claimed she was entitled to a share of her legal expenses under *Mahler v. Szucs,* 135 Wn.2d 398, 957 P.2d 632, 966 P.2d 305 (1998). Her insurance policy provided:

> If the insured recovers from the party at fault and we share in the recovery, we will pay our share of the legal expenses. Our share is that per cent of the legal expenses that the amount we recover bears to the total recovery. . . .

The trial court upheld the PIP setoff. But it awarded *Mahler* fees. The insurer appealed.

Division I reversed the *Mahler* fee ruling.

HOLDINGS:

(1) *Mahler* does not control. *Mahler* was interpreting a policy provision that specifically applied to a situation where the PIP insured recovers from the tortfeasor. Rebecca did not incur legal expenses in obtaining an award against the tortfeasor. She did not obtain an award against the tortfeasor.

(2) Rather, Rebecca incurred legal expense in recovering her UIM benefits in an arbitration. Under *Dayton v. Farmers Ins. Group*, 124 Wn.2d 277, 876 P.2d 896 (1994), she is not entitled to recover such legal expense from her own insurance company.

(3) *Winters* is distinguishable because the plaintiff there recovered from the tortfeasor.

(4) We need not address the soundness of the *Winters* reasoning, since it is distinguishable factually.

COMMENT:

Now, of course, *Mahler* is/was an awful decision. However, it does not require a legal scholar to figure out when it applies, and, more importantly, when it does **not** apply. *Mahler* was based on the court's interpretation of a specific clause in the State Farm policy. Absent that specific clause, application of *Mahler* is risky.

In *Mahler*, where the clause was present, the PIP insured settled with and recovered from the tortfeasor's liability carrier. From that recovery the PIP insured was to reimburse the PIP carrier. The Supreme Court held that under the policy language if the PIP carrier wished to be reimbursed, it had to share in the insured's legal expenses. If there is no PIP recovery, then there is nothing to be reimbursed out of and *Mahler* does not apply.

Yes, Rebecca has petitioned for review to the Washington Supreme Court.

Hamm v. State Farm Mut. Auto. Ins. Co., __ Wn. App. ___, 3 P.3d 761 (2000).

A NIGHT TO REMEMBER

FACTS:

The evening of December 29, 1996, was an unusual night in Western Washington. Our normal balmy winter weather was displaced by snow and ice and more snow. Many patio roofs, garages, commercial buildings, and residents were stomped flat under the heel of Old Man Winter.

Among the casualties was the roof on Deborah's house. She gave prompt notice and the company hired a contractor and an engineer to assess the damage. The company paid the repair bid, the living expenses, the architectural fees, and the emergency repair fees. It hired two engineers to inspect the foundation and paid for part of the settlement in the 70-year-old house.

But Deborah, she was not satisfied. She wanted more. She hired a lawyer. The company asked for documentation. The lawyer did not respond. They asked again. He did not respond. They stopped work. Deborah went ahead with her aesthetic improvements and upgrades.

The company wrote counsel. No response. The company wrote again. No response. On the third try, still no response.

But in December 1997, counsel informed the company that Deborah was going to sue it. Then new counsel appeared saying he would supply the requested information. But he did not.

Deborah filed her suit December 29, 1997. She served the company April 7, 1998. The policy required that the insured "bring suit" within one year of the loss.

The trial court dismissed the suit. Deborah appealed.

The Court of Appeals affirmed saying that just filing the suit but not serving it within 90 days did not meet the policy condition.

HOLDINGS:

(1) Washington courts have upheld the validity of the one-year limitation in insurance policies.

(2) Although filed in superior court, the complaint was not served within the requisite 90 days. Thus, the "action" was incomplete. Washington courts have repeatedly held that the mere filing of a complaint alone does not constitute the commencement of an action for the purposes of tolling any applicable statute of limitation, whether statutory or by contract.

(3) A person bringing suit must also serve the defendant within 90 days of the date of filing in order for the commencement to be complete. RCW 4.16.170 provides that filing tentatively tolls the statute of limitation.

(4) If the additional step (service after filing) is not accomplished within 90 days, the action is treated as if it had not been commenced.

(5) A statute of limitation cannot enlarge the time for the commencement of an action when the time limitation therefor is fixed by contract.

(6) Deborah failed to bring suit within the one-year period fixed by the policy.

COMMENT:

With a minimal investment of words, the author establishes that the words of the policy mean exactly what they say.

Wothers v. Farmers Ins. Co., 101 Wn. App. 75, ___ P.3d ___ (2000).

SEXUAL MOLESTATION COVERAGE

FACTS:

Kim, a taxicab driver in Bethel, Alaska, was sued for the rape of a minor who was a passenger in his taxi. He tendered to his auto insurer. It defended under a reservation until Kim confessed judgment and assigned to the plaintiff.

The trial court found no coverage and the Alaska Supreme Court agreed.

HOLDING:

The policy covers only injuries that result from an accident, and it specifically excludes coverage for injuries that are expected or intended. Kim's child rape was not an accident. We infer an intent to injure in this case. Coverage does not exist here.

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). The Ninth Circuit said it was ruling that way because that is what the Alaska Supreme Court would do. Wrong!

Kim v. National Indemnity Co., ___ P.3d ___ (Alaska Aug. 11, 2000).

SOME LITIGANTS ARE MORE EQUAL THAN OTHERS

FACTS:

Tom was injured in an auto accident. Joe was at fault. Joe had no insurance.

Tom notified his insurer, Redland, of the accident and sought PIP payments. Redland did not pay for many months.

Tom's lawyer wrote to Redland demanding UIM. The UIM limits were $500,000. Redland did not respond. A month and a half later, the lawyer wrote again. Redland responded, declining to acknowledge that Joe was uninsured.

The lawyer exchanged letters with Redland for more than two years. They agreed on very little. Tom demanded $60,000 to settle. Redland countered at $5,500 and continued to refuse to admit that Joe was uninsured.

Finally, the lawyer sued Joe, and mailed a copy of the Complaint to Redland, with a letter stating that Joe had not yet been served. The Pleadings were stamped with a court docket number, indicating they had been filed. Redland did not intervene in the lawsuit. A month later, Joe was served. A month after that, Tom moved for default. He obtained a $212,671 default judgment against Joe.

Tom demanded that Redland pay the judgment. Redland refused. Tom sued Redland, alleging that Redland was bound by the default judgment.

The trial court held that Redland was bound by the default judgment against Joe, and awarded prejudgment interest, plus costs and *Olympic Steamship* fees.

The Supreme Court affirmed. It re-affirmed what it called the *Finney-Fisher* rule, holding that the company received adequate notice of the action against Joe, and that the company was bound by the default judgment.

HOLDINGS:

(1) An insurer's receipt of a summons and complaint constitutes timely and adequate notice of its insured's lawsuit against the tortfeasor.

(2) An insurer is bound by the findings, conclusions, and judgment entered in a lawsuit between its insured and the tortfeasor if the insurer receives timely and adequate notice of the lawsuit, and has an opportunity to intervene.

(3) An insurer is obliged to protect its interests once it has received timely and adequate notice of a lawsuit between its insured and the tortfeasor.

(4) The insureds did not breach their duty of good faith by failing to notify Redland of their intent to serve Joe and obtain a default judgment.

(5) The elements of collateral estoppel are not strictly applied under the *Finney-Fisher* rule. The operative principle here really is *res judicata* or "claim preclusion". *Res judicata* refers to "the preclusive effect of judgments, including relitigation of claims and issues that were litigated, *or might have been litigated.*" Redland could have or should have litigated the underlying lawsuit by intervening in the lawsuit after receipt of the complaint. Redland failed to do so. Consequently, claim preclusion prevents Redland from litigating the damage award now.

COMMENTS:

As with the *Fisher* case from 1998 and the *Finney* case from 1979, this case demonstrates the double standard applied by Washington courts when one party is an insurance company. One of the traditional essential elements of *res judicata* and collateral estoppel is a "final judgment on the merits." In *Fisher* there was no judgment at all. There was an arbitration award which was never reduced into a judgment. Here, there was a judgment but it was a default judgment, not "a final judgment on the merits."

Now, if Tom had been involved in litigation with Microsoft or Boeing or Weyerhaeuser, these little legal technicalities would have come into play and might have been outcome determinative. But when one party is an insurance company the old cliché about equal justice under law just doesn't get much playing time.

Coincidentally, we note that on August 11, 2000, in *Powers v. USAA, No. S-8776*, the Alaska Supreme Court applied the elements of collateral estoppel in an insurance case. The insured arbitrated with State Farm, the primary UIM carrier. Then the insured claimed the excess UIM carrier, USAA, was bound by the arbitration award. USAA said, "Not so; we are not in privity with State Farm."

The Alaska Supreme Court held collateral estoppel did not apply because USAA was not in privity with State Farm. Interestingly, this is similar to the *Fisher* case where USAA was the primary UIM carrier and Allstate was in excess. But that time the Washington Supreme Court said it was not going to let a little thing like lack of privity between USAA and Allstate get in the way of its desired result.

Lenzi v. Redland Ins. Co., 140 Wn.2d 267, 996 P.2d 603 (2000).

AN ALTOGETHER STRAINED INTERPRETATION

FACTS:

Esther was riding with Sonja when they got hit by an uninsured driver. Sonja had a $100,000 UIM policy which paid Esther the limit.

Esther then turned to her own policy. It had $50,000 UIM limits and an "anti-external stacking" clause. It provided that if there were two UIM policies the company would pay its share, but that the maximum limit of liability under all the policies would be the highest limit of liability of any one policy.

The company was of the view that because the other policy was $100,000, and had been paid, there was nothing left for it to pay. The trial court agreed.

Esther appealed, contending the anti-stacking clause was ambiguous and in violation of the UIM statute. The Court of Appeals upheld the clause.

HOLDINGS:

(1) The interpretation of insurance policy language is a question of law.

(2) In construing insurance contracts, our principal function is to determine the parties' intent by examining the contract as a whole. We must give the policy a fair, reasonable, and sensible construction, not a "strained or forced construction" that would lead to absurd results.

(3) We apply the following rules of construction to aid in determining the parties' intent: (1) we construe exclusionary clauses strictly against the insurer; and (2) we enforce clear policy language as written and do not create an ambiguity where none exists. An ambiguity exists only "if the language on its face is fairly susceptible to two different but reasonable interpretations."

(4) The language of the clause at issue here is not susceptible to two such interpretations. Esther asserts that the language of the clause can be read as saying either (1) the insured's total recovery limit under all applicable policies is equal to the highest limit of liability under any one policy, or (2) the insured is entitled to recover up to that highest limit from each policy.

(5) Under the second interpretation, an insured could collect under every applicable insurance policy. The clause, then, would not serve as an additional limit on liability; it would merely limit liability to the amount stated in the policy.

(6) The second interpretation renders the clause redundant and meaningless and is unreasonable. Therefore, no ambiguity exists. Consequently, we must enforce the clear language of the policy as written.

(7) RCW 48.22.030(6) authorizes an exclusionary clause that limits the total UIM liability per accident to the single highest UIM liability when an insured is covered under more than one UIM policy. Anti-external stacking limitations that are either identical or virtually identical to the one at issue here have been upheld as consistent with our UIM statute.

COMMENT:

We can count on the fingers of one hand the number of times we have seen the court go through the drill to demonstrate for everyone that the interpretation espoused by the claimant is unreasonable. However, the primary impact of the case is a reaffirmation that the external anti-stacking provision will be applied in the all too frequent occasion of the non-owner passenger making a UIM claim.

National Merit Ins. Co. v. Yost, 101 Wn. App. 1009, 3 P.3d 203 (2000).

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 foot stool 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.

The Supreme Court reversed.

HOLDINGS:

(1) Where facts are not in dispute, "coverage depends solely on the language of the insurance policy"—and the interpretation of that language is a question of law.

(2) In reviewing the policy, it is considered as a whole so as to give effect to every clause in it.

(3) Where terms are undefined, they "must be given their 'plain, ordinary, and popular' meaning."

(4) There is no dispute over the fact that the injuries resulted from an "accident."

(5) The term motor vehicle accident is not an enigmatic one. The words evoke an image of one or more vehicles in a forceful contact with another vehicle or person, causing physical injury.

(6) A motor vehicle is being operated as a motor vehicle when it is being driven or when it is stopped while being driven. On the other hand, a motor vehicle is not being operated as a motor vehicle when parked.

(7) We hold that a "motor vehicle accident" occurs only when the covered motor vehicle is being operated as a motor vehicle.

COMMENT:

An extremely well-written, well-balanced opinion. It would have been very easy to say that it must be a motor vehicle accident because it was an accident which happened getting out of a motor vehicle.

The author of the opinion is retiring from the Court. He will be tough to replace.

Tyrrell v. Farmers Ins. Co., 140 Wn.2d 129, 994 P.2d 833 (2000).

UNTIMELY NOTICE COSTS INSURED AN ARM AND A LEG

FACTS:

The insured employer fired an employee in January 1995. The former employee sued for breach of contract. In March 1995, the trial court set a trial date of July 10, 1995. In May 1995, the former

employee moved to amend his complaint to add a (potentially covered) defamation claim. On May 25, 1995, the trial court granted the motion to amend.

The insured's attorney sent the amended complaint and tendered the defense to the insured's insurance agent on June 14, 1995. The letter said nothing about the July 10, 1995 trial date or the settlement conference scheduled on June 27, 1995.

The insurer received notice on June 26 and assigned the claim to an adjuster. On June 27, a paralegal for the insured telephoned the adjuster, but did not mention the trial date of July 10, or the settlement conference scheduled for that very day!

On June 30, 1995, 10 days before trial was to begin, and 4 days after the insurer received actual notice of the suit, the insured settled the suit for $325,000, characterized as damages for the defamation claim.

Meanwhile, the insurer was hiring attorneys to defend the insured on the defamation claim. On July 18, 1995, the insurer agreed to defend under reservation. On that day, the insurer learned of the settlement that had occurred three weeks earlier.

The insurer denied coverage for the $325,000 settlement based on violation of the notice, cooperation, and consent to settle clauses of the policy.

On cross-motions for summary judgment, the trial court granted the insurer's.

HOLDINGS:

(1) The insured had violated the notice, cooperation, and consent to settle clauses of the policy, since the insured had notice of the potentially covered defamation claim at least as early as May 15, 1995, but did not tender until June 14, 1995, 30 days later. Moreover, the insurer did not receive actual notice until June 26, and the insured's tender letter said nothing about the impending trial date, ask for permission to settle, or otherwise suggest that time was short and that the need for a response was urgent.

(2) The insurer must show "actual prejudice" resulting from the insured's noncompliance with policy provisions. Actual prejudice means some concrete detriment resulting from the delay which harms the insurer's preparation or presentation of defense to coverage or liability.

(3) The insurer was actually prejudiced because it had no opportunity whatsoever to investigate, prepare a defense, or conduct a defense through counsel of its choice.

(4) That there was no evidence that the defamation claim would have come out differently if the insurer had been able to defend is irrelevant.

(5) The insured's argument that the insurer should be estopped from asserting prejudice because it had failed to investigate whether it was prejudiced before denying coverage was rejected.

(6) Outside of litigation the insurer has no tools of discovery. Once the claim was settled, meaningful investigation by the insurer would have been next to impossible.

(7) The loss of a meaningful opportunity to investigate a debatable claim before it is settled is, alone, actual prejudice.

(8) The insurer did not act in bad faith. The insured settled the claim before the insurer had an opportunity to be guilty of bad faith. Given the untimely notice, nothing the insurer could have done would have increased its opportunity to investigate the claim.

COMMENT:

The court clearly made the right decision based upon the facts of this case. However, this case does not mean that every time an insurer receives late notice it can simply deny the claim. Key here was the fact that the insured settled the case 4 days after the insurer received notice. Therefore, the insurer had no opportunity to investigate this debatable claim.

Northwest Prosthetic & Orthotic Clinic v. Centennial Ins. Co., 100 Wn. App. 546, 997 P.2d 972 (2000).

YOU SNOOZE, MAYBE YOU LOSE

FACTS:

The Village was built in 1979. In late 1995/early 1996 in response to complaints, the homeowners Association solicited repair proposals. In May 1996, the Association hired an architect to head up an inspection team. It found potentially dangerous problems, suspected structural failure, and recommended investigative demolition.

The demolition began in June 1996. In July 1996, the team reported severe structural rot all over the place and warned of imminent collapse.

The Association was of the view that because the problems had been hidden behind the siding, the inspection revealed the decay for the first time.

The Association had property insurance with Allstate. It provided coverage for property in danger of imminent collapse caused by hidden decay. Allstate was of the view that coverage was negated by the one-year suit limitation clause, because the Association had known about the decay for nearly a decade.

The Association sued Allstate. The trial court dismissed Allstate's one-year suit defense on summary judgment. Allstate appealed. The Court of Appeals reversed saying that there were fact issues as to when the Association knew or should have known about the continuing damage.

HOLDINGS:

(1) The insured should act with reasonable diligence once an event occurs that puts it on notice of a cognizable coverage claim.

(2) The date of discovery serves as the time of accrual of the statute of limitations and applies with equal force to contractual suit limitation provisions.

(3) The discovery rule should apply in continuing damage situations when the insured initially lacks the ability to discover that property damage is occurring. Any other approach would either penalize unaware insureds or allow those who are aware of the condition to delay in repairing until the insured property literally collapses. The law does not condone waste.

(4) When the Association discovered or reasonably could have discovered covered damage is an issue of fact.

(5) Because there is a covered loss when the risk occurs, the Association discovered a covered loss when it knew or should have known of a "risk of direct physical loss involving collapse" caused by a hidden decay in a specific part of the complex.

(6) The question of when a reasonable insured would be on notice of a potentially insured loss for purposes of the known risk doctrine is a question of fact for the fact finder.

(7) Decay is not hidden if the insured knew or should have known about it from cues, clues, symptoms, or signs of such nature of the decay.

(8) The trial court's interpretation of "hidden" as meaning simply "out of sight" is rejected.

COMMENTS:

A very instructive opinion for insurers that write first-party coverage on Western Washington condos and apartments. There has been a rash of collapse claims for these types of buildings in the past few

years, often because of poor construction, materials, or design. It's hard to drive very far in the Greater Seattle area without seeing a condo or apartment building in some stage of repair. Worse yet, there may be no light at the end of the tunnel for these types of claims, given the current building boom and the local labor shortage in the construction industry.

The insured has petitioned for review to the Washington Supreme Court.

Panorama Village Condominiums v. Allstate Insurance Co., 99 Wn. App. 271, 992 P.2d 1047 (2000).

FRANKENLAW

In the August 13, 2000, issue of the New York Times, the language maven, William Safire, tells us that "A monstrous prefix is stalking Europe."

He recounts how a frightening metaphor was needed in the battle against genetically engineered crops. It was found in this 1992 sentence: "If they want to sell us Frankenfood, perhaps it's time to gather the villagers, light some torches and head to the castle." Since then, the antigenetic movement has denounced Frankenseeds, Frankenveggies, Frankenpigs, and Frankenchickens, to name just a few.

And then it hit me: we have a need for a new word. That word is Frankenlaw. And what does it mean? It is sort of the opposite of good sense; it is a description of judicial motivations for a creatively stupid decision.

As long as human beings continue to write legal opinions, there will be no shortage of examples of Frankenlaw.

STAY ON OUR DISTRIBUTION LIST!

As mentioned earlier in this edition, we are planning to revamp the method by which we have been distributing the Washington Insurance Law Letter. Since the vast majority of our clients and friends now have Internet access, and as we all move towards a more paperless business practice, our plan is to begin distributing the Letter via the Internet by Spring 2001. It will work like this: we will post the Letter on our firm's web page (www.rmlaw.com), where it will be available for viewing in PDF format (Adobe Acrobat). We will send you an e-mail letting you know it has been posted.

At the same time, we are updating our distribution list as we do every few years to ensure it is up to date, and to obtain updated e-mail addresses for our clients and friends. Accordingly, to remain on our distribution list, please complete the form below, and return it to us at your earliest opportunity.

Alternatively, you can send us the information requested below via e-mail (information@rmlaw.com).

- -

Yes I want to remain on the Washington Insurance Law Letter mailing list!

Name: ______________________________

Company: ______________________________

Address: ______________________________

____

____

____

My e-mail address: ______________________________

Comments? ______________________________

____

____

____

____

____

Return to:

WILLIAM R. HICKMAN
Reed McClure
Two Union Square
601 Union Street, Suite 4901
Seattle, WA 98101-3920

Visit us at our web site: www.rmlaw.com