

HEADLINES

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No Coverage For Computer Data Losses

The Fourth Appellate District Court determined whether a first party insurance policy covered the loss of stored computer data not accompanied by the loss or destruction of the storage medium. Specifically, the court was interpreting the insurance policy language requiring a “direct physical loss.”

A commercial insurance policy was issued to Ward General Insurance Services, Inc. (“insured”). During the policy period, the insured’s computer database system crashed when the system was being updated. The crash resulted in the loss of the insured’s electronically stored data used to service its client’s insurance policies. To resume its normal business operations, the insured hired consultants to restore the database manually. Thus, the insured incurred the extra expense of restoring the data and also suffered loss of business income because of the disruption and sought \$260,000 from its insurer. The insurer paid \$5,000, but denied the remainder of the claim.

The insured argued that the building and personal property coverage form and the endorsements captioned “valuable papers and records coverage form,” “electronic equipment and software coverage,” “electronic data processing coverage,” and “business income coverage form (an extra expense) actual loss sustained” afforded coverage for the loss. However, the insurer asserted that coverage for the type of loss suffered was not available under any of these coverage forms because each required a “direct physical loss of or damage to” property and none of the loss or damage suffered was a direct physical loss. The insurer also contended that the losses were specifically excluded under various exclusions in the coverage forms.

Following *AIU Insurance Company v. Superior Court* (1990) 51 Cal.3d 807, 822 and *Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, the court rejected the insured’s suggestion that public policy favored coverage due to the computer’s importance to our economy and the importance of the data system they support. The court refused to utilize public policy as an interpretative aid finding that the insurance policy was a contract to be interpreted and enforced as such.

The court found that the risk in this case was a

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negligent computer operator and perhaps a defective computer program. Thus, unless the harm suffered (i.e. the loss of electronic store data without loss or damage of the storage medium) was determined to be physical loss, the court could not say that negligent operation constituted a risk of direct physical loss. The court would not reach the conclusion that a computer operator “sitting at a keyboard pressing keys or moving a mouse, presents [such a] risk.”

The court interpreted the words “direct physical loss” in their ordinary and popular sense and found that the word “physical” is defined as “having material existence and perceptible to the senses and subject to the laws of nature.” *Id.* at 13761. Thus, relying on the ordinary and popular sense of the words, the court believed that the loss of the database did not qualify as a direct physical loss unless the database had a material existence formed out of tangible matter and it is perceptible to the sense of touch. Since a database was a large collection of data organized for rapid search and retrieval, and data is defined as factual or numerical information, the court concluded that the loss of the database is a loss of organized information and determined that “information” could not have a material existence formed out of tangible matter or perceptible to the sense of touch. The court concluded the loss suffered by the insured was a loss of information so the insured did not lose the tangible material of the storage medium.

Citation: *Ward General Insurance Services v. Employers Fire Insurance Company*, 03 Daily Journal 13759 (Dec. 19, 2003)

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Application Of Economic Loss Rule Is A Jury Question In Component-To-Component Damage Case

The Second Appellate District Court addressed applicability of the economic loss rule barring recovery in tort for economic damages in a component-to-component defective product case. KB Homes sought the appellate court's review of the trial court's decision applying the economic loss rule precluding KB Homes from pursuing negligence and strict products liability actions against the manufacturer of a defective furnace. The trial court determined that the economic loss rule barred coverage because the furnace was a single integrated product and physical damage caused by the furnace defective emissions control device to other components in the furnace did not constitute "other property" within the meaning of the economic loss rule. The appellate court remanded the case back to the trial court finding the applicability of the economic loss rule could not be determined as a matter of law as "the nature of the product at issue and whether the injury is to the product itself or to property other than the defective product in a component-to-component damage case is in the province of a trier of fact." Thus, the appellate court concluded that the trial court deprived KB Homes of its right to have material issues of fact submitted to a jury. Further, the court opined that distinguishing between "other property" and the defective product itself in a case involving com-

ponent-to-component damage requires a determination of whether the defective part is a sufficiently discreet element of the larger product so that it is not reasonable to expect its failure will invariably damage other portions of the finished product. "If that is the case, permitting tort recovery when the defective part causes physical injury to other components is consistent with the underlying principle recognizing a manufacturer's liability in tort . . ." *Id.* 11706. If the contrary is true, the court felt that it is fair to impose upon the consumer the risk that the product will not match its economic expectations with no recovery unless the manufacturer agrees to warrant the product.

The appellate court did reject KB Homes' attempt to adopt a limited "life safety defect exception" to the economic loss rule. KB Homes argued this exception applies in unusually compelling circumstances such as the facts before the court where defective furnaces created an active fire hazard resulting in a number of houses being actually destroyed and threatening others if they went unrepaired. The court stated "as compelling KB Homes' policy arguments may be, the Supreme Court has unequivocally rejected such a life safety exception to the economic loss rule."

Citation: *KB Homes v. Superior Court*, 03 Daily Journal 11703 (Oct. 27, 2003)

Supreme Court Grants Review Of Two Decisions

The California Supreme Court has granted review of two unrelated appellate decisions. The first, *Kinsman v. Unocal Corp.*, 03 Daily Journal 11904 (Oct. 31, 2003) addressed asbestos related injuries against premises owners. The second, *CDM Investors v. Am. National Fire Ins. Co.*, 03 D.A.R. 11469 (October 17, 2003) found that an insurer is not required to cover response costs.

KINSMAN V. UNOCAL CORP.

The First District Court of Appeal reviewed a \$3 million award against Unocal for the negligent maintenance of a refinery that purportedly caused bodily injuries to an employee of an independent contractor for Unocal. Specifically, Unocal employed an independent contractor to provide scaffolding work at the Unocal refinery. While working on the scaffolding, the injured employee was exposed to airborne asbestos produced by other contractors at the facility. As a result of the airborne asbestos expo-

sure, the injured employee developed mesothelioma.

When the matter was reviewed by the First Appellate District Court, the court reversed and remanded the case back to the trial court finding that the jury was incorrectly instructed regarding the limitations on Unocal's liability as a premises owner. The court found that the liability of a premises owner such as Unocal was limited to cases where the owner had control over the dangerous condition that caused the injury. Thus, if the owner did not create the dangerous condition, the owner must have affirmatively contributed to the injury or hazard. The court found that Unocal did not create the hazard that caused the injuries, but rather the injuries were caused by neighboring contractors over which Unocal had no control.

CDM INVESTORS V. AM. NATIONAL FIRE INS. CO.

The Sixth Appellate District Court affirmed the trial court's determination that

the absolute pollution exclusion clearly foreclosed coverage for any cost or expense arising out of governmental direction for testing of pollutants.

The appellate court found that the insured could not be reimbursed for expenses it incurred to test for pollutants based on the exclusion. The court further found the definition of damages under the liability policy precluded coverage for the repair costs. "The duty to indemnify is limited to court-rendered damages. The duty to defend suits is linked to the term 'damages' of a civil action. The phrase 'ultimate net loss' in the coverage clause did not expand the meaning of damages. It is used to reference the amount the insurer will pay after the insured became obligated to pay, rather than operating as a trigger of the insurer's obligation to pay."

The California Supreme Court accepted review noting further action is deferred pending consideration and disposition of *Powerine Oil Company v. Superior Court*, S113295, and *County of Can Diego v. Ace Property & Casualty Co.*, S114778.

Insurer May Be Sued For Unfair Competition

The Second Appellate District Court determined that an insurer could be sued for unfair competition due to an insurer's failure to disclose imminent material changes in a health insurance policy. Thus, the court concluded the demurrer granted by the trial court was improper and should have been overruled.

Health insurance policies were issued by the defendant insurers to California Farm Bureau members. The plaintiffs in the lawsuit filed a class action lawsuit against the insurers alleging that the plaintiff and members of the class were not told of "impending material premium increases and benefit reductions under the policies" before the policies "went into effect." *Id.* at 12012. The insureds contended that they purchased the policy after receiving the descriptions of the premiums, lack of deductibles and other policy benefits. Yet two months after the policies went into effect, they were mailed notice of material changes to the policy. The insureds contended that the defendant insurers knew that such changes would be made to the coverage when the plaintiffs purchased the policies and failed to disclose the changes prior to the plaintiffs' purchase.

The first cause of action for unfair competition asserted that the defendant insurers knew about the changes and the failure to disclose those changes violated Insurance Code §§ 332 and 331 and was further an unlawful and unfair competition of business practice under the Business & Professions Code § 17200. Other causes of action in the complaint were for fraud and negligent failure to disclose based on the same factual allegations.

In the demurrer to the complaint, the defendant insurers asserted that because they complied with Insurance Code § 10199.1, (the statutory requirement of giving 30 days notice of benefit changes and premium increases) the unfair competition claim was without merit. Further, they demurred contending the fraud and negligent claims were invalid because the insureds failed to allege any duty to disclose benefit changes and premium increases before the statutory deadline for giving

notice. Further, the insurer argued that the insureds failed to allege a fiduciary relationship which is a general requirement of a fraudulent concealment claim.

In reviewing Business & Professions Code § 17200, the court recognized that the statute is to cover anything that can be properly called a business practice and at the same time is forbidden by law. The court noted that the statute prohibits three separate types of unfair competition practices. Those that are either "unfair," "unlawful," or "fraudulent."

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The insureds argued that the defendant insurers acted unlawfully. They contended that under Insurance Code § 330, 331, 332, 334 and 361, the defendant insurers had a duty to disclose to the insureds pending amendments to the policies changing the premiums and benefits even before the purchase of the policies. The court concluded that literally applied, these allegations were not without merit.

Noting that the review required on a demurrer was to read the facts alleged as being true, the court found that the allegations "upon information and belief" that the defendants knew of impending material changes to the policies must be accepted as true because the appeal followed from sustaining of a demurrer. Because the case had yet to be developed and the most basic documents, including the insurance policy and the insurance application, had yet to be admitted into evidence, the court was disinclined to find that the defendant insurers did not have a duty, as a matter of law, to disclose the information about impending policy changes to the insureds before they bought their policies. Thus, the court concluded "given that there is a statutory viola-

tion, there is an unlawful act upon which to base an unfair competition claim under Business & Professions Code § 17200." *Id.* at 12014.

The insureds also pleaded unfair competition based on "unfairness" and the court found that under the two tests utilized by the courts, the demurrer should have been overruled on this type of unfair competition. Because the court concluded there could be a statutory duty to disclose, the court also concluded that there could be a violation of a legislative declared policy to disclose. Thus, the court found that the facts alleged could satisfy the test for unfairness.

Celtech Communications, Inc. v. Los Angeles Cellular Telephone Company (1999) 20 Cal.4th 163, 186-187 was relied on significantly by the court. *Celtech* involved a dispute between competitors rather than between a supplier of goods and services and a consumer. The court noted that distinction but also noted that the court in *Smith v. State Farm Mutual Automobile Insurance Company* (2001) 93 Cal.App.4th 700, 720, footnote 23, formulated a test for "unfairness" to be applied in the consumer context. Thus, the court applied the *Smith* test (weighing competing interests of the impact of the practice on the alleged victim against the reasons, justification and motives of the wrongdoing) to the case before it. Thus, the court found there was alleged unfairness. The court further noted that based on the allegations, the defendant/insurer's failure to inform the potential buyers of the changes allegedly influenced the insureds to purchase a policy that was inferior to their pre-existing insurance and also precluded them from finding equivalent insurance from another carrier.

The court did note that the defendant/insurers have not had an opportunity to state their reasons, justifications or motives for selling the insurance without giving notice of the changes so the court could not say whether those outweighed the plaintiffs' interests in being fully informed of the impending changes. Therefore, the court felt that these issues could not be decided as a matter of law and the action should proceed.

Post Auto Accident Death Not Covered By Uninsured Motorist Policy

As a result of a minor traffic accident, a policyholder was killed when the uninsured motorcycle driver punched the policyholder in the face knocking him to the ground where he hit his head on a pavement causing craniocerebral trauma. Coverage was sought under the policyholder's automobile liability insurance policy seeking coverage for bodily injury caused by uninsured motor vehicles.

While it was conceded that the policy did afford coverage for uninsured motor vehicles and the motorcycle did qualify as an uninsured motor vehicle, the insurer denied the claim contending that the injury did not arise out of the use of the uninsured motorcycle. The Second Appellate District Court found that the California cases supported no coverage for the death of the policyholder. In so holding, the court rejected a "but for" causation analysis of the "arising out of the . . . use" language and adopted the "predominating cause/substantial factor test" which has been applied by the majority of California courts addressing the issue.

The "predominating cause/substantial factor" test was applied in *Truck Insurance Exchange v. Webb* (1967) 256 Cal.App.2d 140, wherein the Court required the use of the vehicle be a "predominating cause" or a "substantial factor" in causing the injury. In restricting the coverage, the court noted that an automobile policy is very much a part of the American life and that there are very few activities in which the "use of an automobile does not come into play somewhere in the chain of events." Thus in *Webb*, the court concluded that an automobile policy does not provide general liability coverage which would be the result if the mere existence of an automobile in the chain of events triggered an automobile policy's coverage. Subsequent to *Webb*, the California cases have supported this analysis. Thus, the court found that the collision of the two

vehicles and the subsequent death of the policyholder did not constitute an unbroken chain of events arising from the automobile accident. Rather, the court concluded that the intervening tortuous act of the motorcycle driver broke the chain of causation between the use of the uninsured motorcycle and the policyholder's death.

The court further found that the policyholder's attempt to comply with the Vehicle Code's mandate that information be exchanged at a scene of an accident did not extend "use" of the uninsured vehicle to the assault. Rather, the court found that the policyholder's compliance with the statutory mandate was no more a cause of the fatal injury than his compliance with other traffic laws at the time of the accident. The court found that the performance of the statutorily mandated duty did not change the fact that the only "use" of the uninsured motorcycle in the chain of events was the means of transportation to the site where the assault was committed. The court concluded that the assault was the sole legal cause of the injuries.

The court further rejected the argument that public policy supported finding coverage. The court noted that uninsured motorists coverage was not intended to be a substitute for general liability coverage for injuries which by chance happen to also involve uninsured motorists. Thus, the court concluded that there was no reasonable expectation that coverage would be afforded and public policy did not support a finding of coverage.

As a side note—the uninsured motorcycle driver was convicted of manslaughter.

Citation: *California Automobile Insurance Company v. Hogan*, 03 Daily Journal 11886 (Oct. 31, 2003)

In restricting the insurance coverage, the court noted that an automobile policy is very much a part of the American life.

Unfair Competition - continued from page 3

The insureds also contended that the failure to give notice was deceptive which also supported the unfair competition claim. In reviewing this aspect of the complaint, the court noted that "this type of Business & Professions Code § 17200 claim is not based upon proof of the common law tort of deceit or deception, but is instead premised on whether the public is likely to be deceived." Given the fact that the court had to review the allegations as if true, the court concluded that the allegations were sufficient to state a Business & Professions Code § 17200 claim based upon deception.

The court also found that the trial court should have overruled the demurrer on the fraudulent non-disclosure cause of action.

The general rule is that even if material facts are known to one party and not the other, the failure to disclose the facts is usually not actionable fraud absent a fiduciary relationship giving rise to the duty to disclose. Neither party to the case asserted that a fiduciary relationship was present in the case before the court. However, the insureds contended that there was a duty based upon violation of § 330, *et seq.* of the Insurance Code which is an exception to the general rule enumerated in certain case law. The court concluded "there is a duty to disclose based upon Insurance Code § 330, *et seq.* as explained above. There is no need for us to rule on plaintiffs' second argument with regard to the purported applicability of an exception of the general rule. We, therefore,

conclude that the demurrer should be overruled as to the fraud cause of action." *Id.* at 12014.

The court further overruled the demurrer to the negligent failure to disclose claim. The court found that the cause of actions survived the attack by demurrer because a duty to disclose is established by Insurance Code §§ 330 and 332. "It is insufficient for defendants to declare that the provisions only apply to applicants for insurance and insureds are not insurers. The distinction is absent from the plain language of these provisions."

Citation: *Pastoria v. Nationwide Insurance*, 03 Daily Journal 12012 (Nov. 4, 2003)

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Contractor May Seek Compensation For Any Act If Duly Licensed During Performance Of The Act

The Fourth Appellate District Court addressed the issue of whether a subcontractor could pursue its contract rights if it failed to complete the application process and obtain the requisite contractor's license before executing two contracts for work. The lower court granted the general contractor's motion for summary judgment based on the subcontractor's non-compliance with the licensing requirements. The subcontractor asserted that the trial court erred in granting the motion because it had substantially complied with the applicable licensing requirements before completion of the first contract and before undertaking work pursuant to the second contract. Based on review of the Business & Professions Code § 7031, the court concluded that the statutory provision permitted the

contractor to recover compensation for the acts performed while licensed and that being the case, the contract was neither illegal nor void. Thus, the court concluded that Business & Professions Code § 731 did not bar the subcontractor from seeking compensation for all the acts performed under the first contract or the second subcontract. The court refused to address the issue of whether the subcontractor had the appropriate license for performance under the second contract noting that it merely needed to find an issue of fact in order to reverse the summary judgment and remand the case for further proceedings to the trial court.

Citation: *M.W. Erectors, Inc. v. Niederhauser Ornamental and Metal Works Company*, 04 Daily Journal 1198

Failure To Submit To Examination Under Oath Bars Action Against Insurer For Recovery Of Loss

The Second Appellate District Court determined that the failure of the named insured to submit to an examination under oath pursuant to the policy terms barred an action against the insurer. Citing four decisions establishing precedent on the issue, the court concluded that an insured's submission to examination under oath is a condition precedent to the duty to pay on a claim. (See, *Hickman v. London Assurance Corp.* (1920) 184 Cal. 524, *Globe Indemnity Company v. Superior Court* (1992) 6 Cal.App.4th 725, *Robinson v. National Auto, etc. Insurance Company* (1955) 132 Cal.App.2d 709 and *West v. State Farm Fire & Casualty Co.* (9th Cir. 1989) 868 F.2d 348. The court found the holding in *Gruenberg v. Aetna Insurance Company* (1973) 9 Cal.3d 566 inapplicable because there was no evidence that the insurer rejected the insured's claim based on trumped up charges by the insurer. Furthermore, there was no evidence that the lack of cooperation in submitting to an examination under oath was due to any statements or conduct by the insurer or any of its agents. (In *Gruenberg*, the

Court found that although the requirement that the insured provide a statement under oath is a condition precedent to coverage, the insurer yet owed a duty of good faith and fair dealing to the insured which included the duty not to willfully or maliciously enter into a scheme to deprive the insured of the benefits of the policy. Specifically, in *Gruenberg*, the insured was fighting criminal charges for arson when the insurer insisted that he submit to a statement under oath. The insurer knew the insured would just submit to the examination given the pending criminal charges.)

Citation: *California Fair Plan Association v. The Superior Court of Los Angeles County*, 04 Daily Journal 796 (Jan. 26, 2004); reprinted on 04 Daily Journal 813 (Jan. 27, 2004)