Gallagher Sharp LLP

Insurance Newsletter

October 2015

Special Interest Areas:

Individual Highlights:

BASICS OF A FIRE LOSS INVESTIGATION

Claims arising from fire loss present distinct issues and challenges. This article provides a basic overview of the fire loss investigation process as well as suggestions for handling fire loss claims.

I. Initial Steps upon Notice of a Fire Loss

Coordinate with Responding Fire Personnel. Contact the fire department(s) who responded to the fire. In major conflagrations, multiple departments may respond. Request all reports, dispatch logs, and video footage (some firefighters wear body cameras). Determine if the State Fire Marshal is also investigating the fire, and if so, request all available materials from the Fire Marshal's Office as well.

Retain Appropriate Experts Early. Proper investigation of a fire requires specialized knowledge and training. Moreover, in multi-party claims (such as large losses involving numerous potentially-liable entities), a "race to the experts" often occurs. Time is of the essence in retaining qualified experts to represent the interests of the insured/insurer. Generally, a Certified Fire Investigator (CFI) or Certified Fire and Explosion Investigator (CFEI) should be retained as early as feasible. Depending upon the claim, engineers or other experts also may be needed.

Secure the Scene, Avoid Spoliation, and Provide Notice to Interested Parties. Upon release of the scene by the fire department, immediately take steps to secure the scene. The loss area should be preserved to the extent practicable, and care should be taken to not move/remove any evidence to avoid allegations of spoliation or scene contamination. Other potentially liable parties (for example, manufacturers of possible sources of ignition) should be notified of the fire and be provided an opportunity to participate in the investigation. Ideally, the investigation should be conducted jointly among all interested parties.

II. Investigating a Fire Loss

Investigation Should be Conducted in Accordance with NFPA 921. The National Fire Protection Association (NFPA) 921 Guide for Fire and Explosion Investigations is the national benchmark for fire investigation. NFPA 921 is based on the scientific method, and sets forth a multi-step process for investigating the origin and cause of a fire by using both inductive and deductive reasoning.

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Supreme Court of Ohio

Defense required because "personal injury" defined to include "humiliation" but humiliation is not a necessary result of housing discrimination, inferred intent doctrine inapplicable.

On August 18, 2015, the Supreme Court of Ohio declined to apply the inferred-intent doctrine, holding that the doctrine is not applicable when the specific harm is not an inherent result of the intentional act.

A landlord was sued for alleged discrimination against a prospective African-American tenant on the basis of familial status and race in violation of 42 U.S.C. 3604 and O.R.C. 4112.02(H). Coverage had been denied under the insured's primary policy because the lawsuit did not allege any covered "bodily injury", "property damage", or "personal injury". A claim was tendered under the landlord's umbrella policy. The umbrella policy had a broader definition of "personal injury," namely "(a) bodily injury, sickness, disease, disability or shock; (b) mental anguish or mental injury; (c) false arrest, false imprisonment, wrongful eviction, wrongful detention, malicious prosecution or humiliation; and (d) libel, slander, defamation of character or invasion of privacy; including resulting death, sustained by any person." The insured did not hear immediately from the umbrella insurer. Thirty-two days after the tender the insured settled the discrimination suit and then sued the umbrella insurer for its failure to provide coverage. Cross-motions for summary judgment were filed, and the trial court granted insurer's motion for summary judgment. The court of appeals reversed the trial court's judgment, and the Supreme Court of Ohio, addressing only the insurer's duty to defend under the umbrella policy, affirmed the court of appeals' decision. Justice Pfeiffer in the majority opinion found that the "the crux of the case" was the umbrella policy included coverage for particular harms rather than just for particular causes of action. The prospective tenant's complaint included a claim of emotional distress, which the Court concluded arguably implicated the coverage for "humiliation". The majority declined to apply the policy's Intentional-Acts exclusion and the inferred-intent doctrine because the appropriate question was whether the insured expected or intended the prospective tenant's alleged "personal injury" ("humiliation"), rather than whether the insured expected or intended the alleged discrimination.

Justices Kennedy and O'Donnell dissented because in their view the alleged discrimination and injury were intrinsically tied, and when the insured acted in a discriminatory manner the insured intended the injury (the "humiliation") as a matter of law. *Granger v. Auto-Owners Ins.*, 2015-Ohio-3279.

An automobile insurer is obligated to pay an insured's medical expenses at a rate that the automobile insurer itself negotiated to pay.

The Supreme Court of Ohio decided that under a medical-payments coverage provision, an automobile insurer is obligated to pay an insured's medical expenses at a rate that the automobile insurer itself negotiated to pay. The phrase "any negotiated reduced rate accepted by a medical provider" does not include the rate that is available to the insured's health-insurance provider.

A Grange automobile policy issued to the Laboys provided up to $5,000 in medical care for each person injured in any one accident. The Laboys received medical treatment as the result of an automobile accident and submitted some of their bills both to Grange and their health-insurance provider, Medical Mutual. Grange did not deny any part of the claim for medical expenses.

The Laboys reached a settlement with a third-party tortfeasor for the accident, after which Grange exercised its contractual right to subrogation against the Laboys. The Laboys objected, arguing that Grange had overpaid the medical providers. Specifically, the medical providers billed the Laboys $1,535 for certain services rendered. Grange paid a discounted rate of $1,441.36 for those services, but Medical Mutual paid only $648.32 for those same services. The Laboys argued that Grange should recover only $648.32, the amount paid by Medical Mutual. The Supreme Court of Ohio disagreed.

The single issue decided was the meaning of the phrase "any negotiated reduced rate accepted by a medical provider" in Grange's medical-payments provision. The Court held: "Under the medical-payments coverage, Grange is obligated to pay the expenses of an insured for medical services related to a bodily injury sustained in an accident. The only reasonable interpretation of [the policy language] is that Grange is obliged to pay reduced rates only when such rates have been negotiated between the medical provider and Grange or when the provider is in the preferred-provider network that Grange has access to through its contract…" The Court was unanimous in its decision. *Laboy v. Grange Indem. Ins. Co.*, 2015-Ohio-3308.

Ohio State Appellate Decisions

Pure excess policies provide no coverage broader than primary insurance; if no coverage is afforded under the primary policy, then none is afforded under the follow-form excess policies.

Peters was injured by an uninsured motorist while working within the course and scope of his employment. His employer was insured under a primary auto policy as well as under excess (not umbrella) policies issued by Great American Assurance Company and Westchester Fire Insurance Company. His employer had rejected uninsured/underinsured motorist coverage. The trial court granted summary judgment to the employer's primary insurer, finding that no formal offer and rejection was required. The trial court then granted summary judgment to the employer's two excess insurers, reasoning that they provided only follow form excess coverage. Because no coverage was provided by underlying insurance, no coverage was provided by either excess policy. Peters appealed only as to the trial court's decision finding no coverage under the two excess policies. The Court of Appeals affirmed, holding that "[t]he purpose of an excess policy is to increase the amount, not the scope, of coverage. Neither the Westchester nor Great American policy provides primary coverage; by virtue of the exclusion language, the policies are limited to the scope of coverage provided by the underlying policy." *Peters v. Tipton*, 7th Dist. No. 13 HA 10, 2015-Ohio-2323.

Whether claims fall within an agreement subject to binding arbitration is not arbitrable when one can easily discern what claims fall within the agreement.

First State Insurance Company (among many other insurers) and Eaton Corporation entered into an agreement dealing with coverage for Cutler-Hammer asbestos liability claims. The agreement "provided that any dispute as to coverage for Cutler-Hammer claims would be subject to binding arbitration." Eaton filed suit against First State (and other insurers) as to coverage afforded for asbestos liability claims against Eaton. First State claimed that some of the Eaton claims could be interpreted as Cutler-Hammer claims, so First State moved for stay and referral to binding arbitration of any Cutler-Hammer claims. Despite the recognized presumption favoring arbitration under Ohio law, the trial court and Court of Appeals held that because Eaton had expressly carved out Cutler-Hammer claims in its Complaint and Motion for Summary Judgment, those claims were not in issue and referral to binding arbitration was not required. The Court of Appeals further noted that "we cannot imagine that each case would not get the individual attention it deserves. Therefore, in the process of providing individual attention to each claim, the difference between non-Cutler-Hammer claims and Eaton claims would be easily discernible." *Eaton Corp. v. Allstate Ins. Co.*, 8th Dist. No. 101654, 2015-Ohio-2034.

An insurance adjuster's personal opinion as to the value of a claim is not, standing alone, reasonable justification for offering that value to the insured.

Toman had uninsured/underinsured motorist coverage ("UM/UIM") with State Farm when she was injured in an accident cause by an underinsured motorist. She alleged bruising and soft tissue injuries for which she sought prolonged treatment by a chiropractor. Toman recovered $22,500 in combined payments from the tortfeasor's insurer and under her own medical payments coverage. She then submitted a UM/UIM claim to State Farm, which rejected the claim. The adjuster offered his "personal opinion" of "[w]hat I believe the claim is worth," i.e. it was worth no more than the amount Toman had already received. The adjuster therefore made "no offer of payment to Toman on her UIM claim" despite additional coverage being available. Rather, he set a letter rejecting her claim but "fully expected to hear back from [Toman] and to engage in continued settlement discussions with respect to [Toman's] claim." The adjuster did not intend his denial to be "State Farm's last and best offer." Toman and her counsel did not contact State Farm to further negotiate; they filed suit for breach of contract and bad faith. State Farm moved for and was granted summary judgment on the bad faith claim in the trial court. The Court of Appeals reversed, however, holding "that the adjuster's 'conclusory opinion' did not constitute a 'reasonable justification' for its decision" because "State Farm needed to present evidence establishing that [the adjuster's] personal opinion . . . was reasonably based on the relevant facts." The Court of Appeals found it significant that the adjuster conducted no jury verdict analysis as to the value of Toman's claims and further observed that the adjuster's letter denying the claim, while at the same time withholding "State Farm's last and best offer" based on an intent to engage in further negotiations, "could certainly be suggestive of bad faith negotiation." *Toman v. State Farm Mut. Auto. Ins. Co.*, 8th Dist. No. 102483, 2015-Ohio-3351.

An insurance policy which defines "occupying" as "in, upon, getting in, on, out or off" of the vehicle is ambiguous when applied to a situation whether the insured has exited and is fleeing from the vehicle. A family member is an insured intended third-party beneficiary entitled to benefit from any ambiguity.

Darno owned a Jeep which stalled on a roadway. As Darno and his passenger/friend attempted to push the stuck Jeep off the roadway, they noticed an oncoming vehicle. They abandoned their efforts and fled to avoid the oncoming vehicle, but Darno was struck by the oncoming vehicle owned by Davidson. Darno's father had uninsured/underinsured (UM/UIM) motorist coverage through Westfield Insurance Company, although Darno's Jeep was not covered under that policy. The Westfield Policy excluded coverage "for bodily injuries sustained by '[a]n individual Named Insured while "occupying" or when struck by any vehicle owned by that Named Insured that is not a covered "auto" for Uninsured Motorists Coverage and/or Underinsured Motor Coverage[.]'" Darno nonetheless sued Westfield seeking UM/UIM coverage under his father's Westfield Policy claiming that he was covered because he was not "occupying" his Jeep at the time of his injuries. The trial court entered summary judgment in favor of Westfield, reasoning "that Mr. Darno was occupying his vehicle at the time of the accident because he 'had a sufficient relationship to the Jeep by pushing the stalled Jeep off of the road, which is a foreseeably identifiable use of the Jeep, and only ceased such activity in attempt to avoid being stuck by the oncoming vehicle.'" The Court of Appeals disagreed and reversed, finding coverage based on policy ambiguity. Specifically, the appellate court concluded that because the Policy defined "'occupying' as 'in, upon, getting in, on, out or off' of the vehicle," the Policy is ambiguous under "a liberal, but plain and ordinary reading" when applied to the facts at bar. The Court made this determination because "Darno had completely exited the Jeep and was running away from it when he was struck by the oncoming vehicle[.]" The Court of Appeals accordingly found coverage: "Because we determined that the term 'occupying' within the policy is ambiguous, the policy must be strictly construed against Westfield, which requires us to conclude that Mr. Darno was not an occupant of his Jeep at the time of the accident." The appellate court also found that Darno had standing to assert and benefit from the Policy ambiguity because he qualified as an insured "family member" under his father's Policy and "certainly was an intended third-party beneficiary[.]". *Darno v. Davidson*, 9th Dist. No. 27546, 2015-Ohio-2619.

"Additional Evidence" For UM Claim May Be Based On Testimony Of Insured.

The insured motorist swerved and hit a tree while trying to avoid another vehicle traveling the other direction. The two cars had no physical contact, and there were no witnesses or physical evidence. The Erie policy required that there be "independent corroborative evidence" of another vehicle to make a UM claim, and that the testimony of "anyone we protect" "does not constitute independent corroborative evidence, unless the testimony is supported by additional evidence." The Court of Appeals reversed summary judgment for Erie, finding that there was "addition evidence" of a second vehicle. The Court reasoned that the policy could be interpreted to read that the "additional evidence" could consist of evidence that was based on the testimony of the insured, such as medical records and police reports where the insured corroborates his version of events, and there was such evidence in this case. *Smith v. Erie Ins. Co.*, 6th Dist. No. OT-15-005, 2015-Ohio-3078.

Multiple per-occurrence UM/UIM limits may be available where the insured's vehicle came to rest between events cause by separate tortfeasors even though the insured sustained no damage in the first event.

Saah had uninsured/underinsured motorist coverage ("UM/UIM") with Peerless Indemnity Insurance Company. While traveling on the freeway, Saah was forced to change lanes because an accident caused by Meadows blocked part of the freeway. Saah spun out of control but did not hit anything. After Saah's vehicle had come to rest, Budzar's car struck Saah's vehicle. Peerless asserted that a single UM/UIM accident limit applied because Saah sustained no damages from the initial spinout and, regardless, when Budzar struck her, it was a continuation of the same accident caused by Meadows. Saah sued seeking a declaration that two UM/UIM coverage limits were available because there were two accidents. The Court of Appeals agreed and concluded that there were two available UM/UIM limits because: "it is evident that the parties did not intend to exclude non-impact incidents." The Court observed: "the evidence is undisputed that [Saah's] car was left vulnerable on the highway as a result of an unexpected and unintended happening . . . , then the conclusion is unavoidable that an 'accident' occurred before Budzar negligently caused the second one[.]" The Court found that because Saah's vehicle came to rest before being struck by Budzar, "the events were not part of a single 'chain reaction,'" but rather, were separate events caused by multiple tortfeasors. *Sarrough v. Budzar*, 8th Dist. No. 102422, 2015-Ohio-3674.

U.S. Sixth Circuit Court Opinions

Insurer required to provide coverage in gift card class actions.

In 2009 Abercrombie & Fitch provided gift cards to customers who purchased a certain amount of goods. Abercrombie refused to honor those gift cards after January 30, 2010, even though some of the cards had "no expiration date" printed on them and other cards contained no information whatsoever about their expiration. Abercrombie customers filed three class-action lawsuits in Illinois, Ohio, and California. Each of the class actions asserted claims of consumer fraud, while two of them also included breach of contract claims.

Abercrombie sought coverage under an "Advertisers and Internet Liability Policy" that was purchased from ACE in 2009. ACE denied the claim, stating that the subject matter fell outside the policy's coverage, so Abercrombie was forced to defend itself in the class action lawsuits. Abercrombie filed suit against ACE, seeking coverage under the policy. The court granted Abercrombie's motion for judgment on the pleadings and held that ACE breached its duty to defend Abercrombie in all three class actions. ACE appealed this judgment to the Sixth Circuit.

ACE's argument on appeal was centered on two exclusions in the policy: 1) that promotional gift cards are themselves contracts, and the policy excludes coverage for breach of contract; and 2) the promotional gift cards were coupons and excluded under the policy. The Sixth Circuit rejected both arguments. First, the Court held that the consumer fraud class actions were not derived from contract claims. Second, the Court ruled that a promotional gift card was not a "coupon" under the plain and ordinary meaning of the word. Thus, the Sixth Circuit held that ACE was required to defend Abercrombie in the three separate class action lawsuits and pay the defense costs incurred. *ACE European Grp., Ltd. v. Abercrombie & Fitch Co.*, 2015 U.S. Dist. LEXIS 14361 (6th Cir. August 13, 2015).

Federal District Court Opinions

Summary Judgment denied based upon a policy term and conflicting expert witness testimony.

The Southern District of Ohio denied cross motions for summary judgment from an insurer and an insured stemming from a fire loss at the insured's business. Following the fire, it was discovered there were no smoke detectors on the insured premises. The issue before the court was whether the insured's motion detectors qualified as "heat detectors" under the insurance policy, which required "functional and operational smoke/heat detectors." The term "heat detector" was not defined in the policy, so the Court used the ordinary meaning for the term "heat detector."

Each side hired an expert, but they came to opposite conclusions. The Court denied summary judgment for either party, holding that conflicting testimony of the plaintiff and defense experts raised a question of fact. *Muncy v. United States Liab. Ins. Co.*, 2015 U.S. Dist. LEXIS 79374 (S.D. Ohio June 18, 2015).

Northern District of Ohio holds that a triggering event for an occurrence-based policy occurs when the injury began.

The Northern District of Ohio faced the issue of when a triggering event "occurs" in an occurrence-based policy in a malicious prosecution claim. Based upon Ohio case law regarding property damages claims, the Court reasoned that when determining the triggering event for an occurrence-based policy, courts should look at the time when the injury began. Thus, for a claim of malicious prosecution, the injury begins on the day of the insured's arrest, even though it does not become readily apparently there may be a claim for malicious prosecution until the charges were dismissed. *Selective Ins. Co. v. RLI Ins. Co.*, 2015 U.S. Dist. LEXIS 9052 (N.D. Ohio July 13, 2015).

Basics of a Fire Loss Investigation, *continued from page 1*

While NFPA 921 is classified as a guide, Ohio courts generally consider it to be authoritative when examining the standard of care for fire investigation. *See, e.g., Abon, Ltd. v. Transcon. Ins. Co.*, 5th Dist. No. 2004-CA-0029 2005-Ohio-3052, ¶66. The admissibility of a fire investigator's conclusions may depend on whether the investigator properly adhered to NFPA 921 guidelines.

Determining Origin and Cause. The purpose of any fire investigation is determine a fire's area of origin and its cause. Accurately identifying the area of origin aids in determining the cause of the fire (as it allows investigators to focus on ignition sources near the area of origin).

The cause of a fire can be classified in one of four ways: (1) natural, (2) accidental, (3) incendiary (deliberately ignited), or (4) undetermined. A classification of "undetermined" does not suggest an improper investigation; rather, it indicates the investigator's use of NFPA 921 and the scientific method has produced one or more possible causes, but no probable cause.

III. Coverage Considerations in Possible Arson Cases

Arson is an affirmative defense to a fire loss insurance claim. Direct evidence of arson rarely exists and is not required; an insurer may prove the defense through purely circumstantial evidence.

In Ohio, an insurer may establish an arson defense through proof of three elements by a preponderance of the evidence:

(1) A fire of an incendiary nature;

- An incendiary fire is one deliberately ignited by a person who knows the fire should not be set.
- Common evidence includes the presence of an accelerant such as gasoline or kerosene at the fire's origin or evidence that the fire originated in multiple, separate locations (i.e. a second story bedroom and the basement).
- When the origin of a fire is clearly defined, the credible elimination of all potential ignition sources at the origin can serve as circumstantial evidence that the fire was started with an open flame and was incendiary in nature. *See, e.g., Abon, Ltd. v. Transcon. Ins. Co.*, 5th Dist. No. 2004-CA-0029, 2005-Ohio-3052.

(2) The insured had a motive to set the fire;

- Evidence of the insured's financial position is admissible to show motive. *See Gabor v. State Farm Mut. Auto. Ins. Co.*, 66 Ohio App.3d 141, 144, 583 N.E.2d 1041 (8th Dist. 1990); *Joseph v. State Farm Fire & Cas. Co.*, S.D. Ohio No. 2:11-cv-794, 2013 U.S. Dist. LEXIS 24511 (Feb. 22, 2013).

Basics of a Fire Loss Investigation, *continued from page 8*

- When there is evidence of possible arson, the insured's failure to provide the insurer with pertinent financial information such as tax returns may void a policy for breach of the cooperation clause. *Gabor, supra; Moore v. State Farm Fire & Cas.Co.*, 2nd Dist. Nos. 9200 and 9376, 1985 Ohio App. LEXIS 9595 (Dec. 3, 1985); *Gaston v. Allstate Ins. Co.*, N.D. Ohio No. 4:08 cv 0749, 2008 U.S. Dist. LEXIS 107996 (July 31, 2008).

(3) The insured or the insured's agent had an opportunity to cause the fire:

- Direct evidence that insured or agent was on scene at the time of ignition is not required.
- Circumstantial evidence may include the insured's control over access to a commercial building; lack of evidence of forced entry into a home; proof the insured was the last person in the building prior to the fire; or evidence the alarm system was disabled when the fire began. *Corbo Props. v. Seneca Ins. Co.*, 771 F. Supp. 2d 877, 889 (N.D. Ohio 2010); *Rainer v. Century Surety Ins. Co.*, 4th Dist. No. 1565, 1990 Ohio App. LEXIS 2504 (June 22, 1990); *Peters v. Mid-Westerin Ins.*, 12th Dist. No. CA85-03-003, 1986 Ohio App. LEXIS 5704 (Feb. 24, 1986).

An Ohio insurer may establish a good faith denial of a policyholder's claim by demonstrating that evidence of arson provided a "reasonable justification" for denial such that the claim was "fairly debatable" given either the pertinent facts or the applicable law. *Abon, Ltd. v. Transcon. Ins. Co.*, 5th Dist. No. 2004-CA-0029, 2005-Ohio-3052, ¶37; *Smith v. Allstate Indem. Co.*, 304 Fed. Appx. 430, 432 (6th Cir. 2008).

Utilize Examinations Under Oath as Appropriate. An examination under oath ("EUO") is often indicated in fire losses. If the insured refuses to sit for an EUO, that refusal may constitute a material and substantial breach of the policy and serve as a basis to deny coverage. *Williams v. Permanent Gen. Assur. Corp*., 8th Dist. No. 80536, 2002-Ohio-4445, ¶28.

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