

Key Decisions

April, 2008

IMPORTANT NOTICE:

Please visit our website: www.bergerkahn.com. If you would prefer to receive the Summary by e-mail, please notify us at: keydecisions@bergerkahn.com

Everett v. State Farm General Insurance Company

pg. 6 *An Insured Homeowner Was Not Entitled To The Full Cost Of Repairing Her Fire Damaged House*

Garibay v. Hemmat

pg. 3 *An Expert Opinion Is Only As Good As The Facts Upon Which It Was Based*

Great Western Drywall, Inc. v. Interstate Fire & Casualty Company

pg. 5 *A Cross-Insured Exclusion Eliminated Coverage For The Named Insured's Action Against An Additional Insured.*

Johnson v. American Standard, Inc.

pg. 1 *The Sophisticated User Doctrine Is Applicable In Products Liability Actions Whether Based On Negligence Or Strict Liability*

Lyons v. Fire Insurance Exchange

pg. 4 *When Both Versions Of Events Reflect Purposeful Conduct, There Is No Accident Or "Occurrence"*

Miller v. American Greetings Corporation

pg. 2 *An Employer Was Not Vicariously Liable For An Automobile Accident When The Employee Was On Personal Business But Had Previously Been Conducting Business On A Cell Phone*

Ortega v. Sacramento County Department of Health and Human Services

pg. 8 *Social Workers Were Immune From Suit Even Though They Exercised Their Discretion Poorly*

Prince v. Sutter Health Central

pg. 7 *MICRA Limits Noneconomic Damages*

Rodriguez v. Bank of the West

pg. 9 *A Bank Did Not Owe A Duty Of Care To The Victim Of Identity Theft*

Salma v. Capon

pg. 8 *Amending The Complaint Does Not Circumvent An Anti-SLAPP Motion*

The Sophisticated User Doctrine Is Applicable In Products Liability Actions Whether Based On Negligence Or Strict Liability

Johnson v. American Standard, Inc.

(Cal. Sup. Ct.), filed April 3, 2008, published April 4, 2008

KEY FACTS

William Johnson was an EPA certified HVAC (heating, ventilation, and air conditioning) technician who worked on commercial systems. He sued a number of manufacturers of air conditioning equipment, including American Standard, a number of chemical manufacturers, and a number of chemical suppliers, alleging that he was injured by the phosgene gas which was created during the ordinary maintenance and repair of commercial air conditioning systems.

The causes of action against American Standard were negligence, strict liability for failure to warn, and strict liability for design defect under the consumer expectations test. Johnson's theory was that American Standard knew that harmful phosgene gas would be created when its evaporator was serviced, but failed to provide an adequate warning. In Johnson's view, a warning would be adequate if it informed users that brazing refrigerant lines can result in creation of phosgene, that phosgene inhalation can result in potentially fatal lung disease, that phosgene can be detected through its fresh-cut-grass smell, changes in flame color during brazing, or physical symptoms like burning eyes or shortness of breath, and that users should wear respiratory protection while brazing and stop brazing on detection of phosgene.

American Standard moved for summary judgment, raising the "sophisticated user" doctrine. It argued it had no duty to warn because the risk was within the professional knowledge of HVAC installers and repairers.

The trial court granted the motion. The Court of Appeal affirmed.

HOLDING & REASONING

The question presented was whether California should adopt the “sophisticated user” doctrine in products cases.

The California Supreme Court examined the doctrine in great detail. It said:

Generally speaking, manufacturers have a duty to warn consumers about the hazards inherent in their products. The requirement’s purpose is to inform consumers about a product’s hazards and faults of which they are unaware, so that they can refrain from using the product altogether or evade the danger by careful use. Typically, under California law, we hold manufacturers strictly liable for injuries caused by their failure to warn of dangers that were known to the scientific community at the time they manufactured and distributed their product. Conversely, when a sufficient warning is given, “the seller may reasonably assume that it will be read and heeded; and a product bearing such a warning, which is safe for use if it is followed, is not in defective condition, nor is it unreasonably dangerous.”

The sophisticated user defense exempts manufacturers from their typical obligation to provide product users with warnings about the products’ potential hazards.

Under the sophisticated user defense, sophisticated users need not be warned about dangers of which they are already aware or should be aware. Because these sophisticated users are charged with knowing the particular product’s dangers, the failure to warn about those dangers is not the legal cause of any harm that product may cause. This is because the user’s knowledge of the dangers is the equivalent of prior notice.

The Court then examined existing precedent, followed by public policy arguments. As to these, it said:

Not all warnings, however, promote user safety. Requiring manufacturers to warn their products’ users in all instances would

place an onerous burden on them and would “invite mass consumer disregard and ultimate contempt for the warning process.”

Quoting the Restatement (3d) of Torts, the Court admonished: “[R]equiring warnings of obvious or generally known risks could reduce the efficacy of warnings generally.” And from this it reasoned: “The sophisticated user defense fits into this understanding of the role of warnings; it helps ensure that warnings will be heeded.”

Affirming the lower courts’ holdings, the Court held that the doctrine applies as a defense to both negligence and strict liability cases. And, it held that the test is whether the sophisticated user *should have known* about the danger, not whether he actually did.

ANALYSIS

The sophisticated user doctrine is now part of California law. There will still be room to argue about who qualifies as a “sophisticated user” and exactly what risks are or should be known to “sophisticated users.”

This opinion appears in the April 4, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4701.

An Employer Was Not Vicariously Liable For An Automobile Accident When The Employee Was On Personal Business But Had Previously Been Conducting Business On A Cell Phone

Miller v. American Greetings Corporation

(Cal. Ct. of App., 2d Dist.), filed April 7, 2008, published April 9, 2008

KEY FACTS

Christopher Magdaleno negligently hit Holly Miller with his pick-up truck while she stood next to her car on a major thoroughfare in South Pasadena. She suffered severe injuries, requiring surgery and two weeks’ hospitalization.

Miller and her husband, Paul Miller, sued Magdaleno. In his deposition, Magdaleno testified he was driving to meet a lawyer on a personal matter, and hit Miller when he glanced down at a piece of paper to check the lawyer’s address and looked back up too late to avoid the collision.

During discovery, the Millers learned that Magdaleno was an installation supervisor for American Greetings Corporation. In his job, he supervised a work crew that installed greeting card stands in stores throughout Los Angeles County. When not visiting stores to inspect installations by his work crew, he spent much of his time talking on his cell phone with the chief of his work crew and coordinating installations with American Greetings' account managers.

Based on this, the Millers amended their complaint to add respondent American Greetings as a defendant. They asserted that as Magdaleno's employer, American Greetings was liable.

American Greetings moved for summary judgment. It argued that while it was Magdaleno's employer, at the time of the accident, Magdaleno was on personal business and was not acting in the course or scope of his employment. The Millers opposed the motion. They argued that while on the particular trip, Magdaleno had used his cellular telephone to conduct business on behalf of American Greetings.

The evidence showed that Magdaleno had made a call of approximately one minute duration at 9:26 a.m. and that the collision happened at approximately 9:35 a.m.

The trial court granted American Greetings' motion.

HOLDING & REASONING

The Court of Appeal affirmed.

The court concluded that the Millers did not have evidence sufficient to go to a jury on the question of whether Magdaleno was talking on his cell phone and therefore conducting business at the time of the accident. Thus, the legal issue was whether an employee whose car is a "mobile office" is acting in the course and scope of employment when he is not actually conducting business and is on a personal errand. The court explained:

We envision the link between respondeat superior and most work-related cell phone calls while driving as falling along a continuum. Sometimes the link between the job and the accident will be clear, as when an employee is on the phone for work at the moment of the accident. Oftentimes, the link will fall into a gray zone, as when an employee devotes some portion of his time and attention to work calls during the car trip so that the journey cannot be fairly called entirely personal. But sometimes, as here, the link is de minimis – one call of less than one minute

8 or 9 minutes before an accident while traveling on a personal errand of several miles' duration heading neither to nor from a worksite. When that happens, we find no respondeat superior as a matter of law.

In addition to holding American Greetings was not liable, the court held that American Greetings was not entitled to recover its costs of proving facts that the Millers refused to admit by way of requests for admissions. The court held that the Millers had a reasonable basis for believing that American Greetings could be held liable based on the doctrine of respondeat superior and that as such the requests it denied were not denied unreasonably.

ANALYSIS

This is an important case in view of how much business is conducted by cell phone in the car. While the facts here supported a summary judgment, that will not always be the case. As such, employers might wish to consider whether they want employees conducting business calls while driving.

This case is also interesting in its treatment of the Millers' denials of the requests for admissions. Most of the requests were directed at ultimate issues and legal issues and as a result, their denials did not expose them to liability for the cost of proof. Had the requests been directed primarily to factual issues, there may have been a different result.

This opinion appears in the April 9, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4989.

An Expert Opinion Is Only As Good As The Facts Upon Which It Was Based

Garibay v. Hemmat

(Cal. Ct. of App., 2d Dist.), filed April 1, 2008, published April 3, 2008

KEY FACTS

Alexandra Garibay and Toby Barron, Jr. sued Dr. Mehdi Hemmat for medical malpractice as the result of a surgical procedure performed by Dr. Hemmat. The procedure was to have been a bilateral tubal ligation, whose purpose was to make it impossible for Garibay to become pregnant. Despite the procedure, Garibay became pregnant.

Hemmat moved for summary judgment arguing that the undisputed facts established that he did not commit medical malpractice and that as a result there was no need for a trial. To establish the “undisputed facts,” Hemmat relied on the opinion of a medical expert witness, Dr. William Frumovitz.

Frumovitz was a Board-certified obstetrician and gynecologist licensed to practice medicine in California. His declaration stated that he reviewed medical records from Hemmat’s office and from Kaiser Harbor City regarding care rendered to Garibay. Frumovitz stated he was familiar with the standard of care of physicians performing a bilateral tubal ligation procedure like the one performed on Garibay and that based on his knowledge, experience and training, it was his opinion that Hemmat had performed within the standard of care.

Garibay and Barron opposed the motion. They argued that the facts Hemmat proffered were not undisputed and that the actual facts had to be established by way of a trial. In particular, they argued that the medical records upon which Frumovitz based his opinion were not before the court and that as a result, his opinion was not one upon which the court could rely on establishing the facts he asserted.

The trial court granted the motion.

HOLDING & REASONING

The Court of Appeal reversed. It held the records on which Frumovitz relied were not properly before the trial court, that as a result, Hemmat failed to meet his burden of producing evidence in support of the assertedly undisputed facts, and that as a result, Hemmat was not entitled to a summary judgment.

A defendant moving for summary judgment bears the burden of showing that a cause of action has no merit because plaintiff cannot establish an element of the claim or because defendant has a complete defense. If the defendant makes this showing, the burden then shifts to the plaintiff opposing the summary judgment motion to establish that a triable issue of fact exists as to these issues. In terms of meeting this burden a litigant can rely on affidavits and declarations. However, such affidavits or declarations “shall be made by any person on personal knowledge, shall set forth admissible evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated in the affidavits or declarations.”

In professional malpractice cases, expert opinion testimony is required to prove or disprove that the defendant performed in accordance with the prevailing

standard of care, except in cases where the negligence is obvious to laymen.

Thus, in seeking summary judgment in a medical malpractice case, a defendant seeking to establish he or she did not act negligently, needs to establish that by way of expert opinion. A properly qualified expert may offer an opinion relating to a subject that is beyond common experience, if that expert’s opinion will assist the trier of fact. Even so, the expert opinion may not be based on assumptions of fact that are without evidentiary support or based on factors that are speculative or conjectural.

Because the medical records for Garibay’s operation were not properly authenticated, they were not properly considered and were not something on which Frumovitz could base his opinion. Thus, Frumovitz’s declaration did not establish that Hemmat had not acted negligently and summary judgment was improper.

ANALYSIS

This case stands in marked contrast to many other summary judgment cases in which the opposing party, while disputing the moving party’s facts, fails to properly object and preserve his or her objections for appeal. Had the plaintiffs failed to object or get rulings on their objections, the judgment would likely have been affirmed.

This opinion appears in the April 3, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4626.

When Both Versions Of Events Reflect Purposeful Conduct, There Is No Accident Or “Occurrence”

Lyons v. Fire Insurance Exchange

(Cal. Ct. of App., 2d Dist.), filed March 7, 2008, published April 7, 2008

KEY FACTS

Stephen Lyons, a former professional baseball player and sportscaster for Fox TV and the Los Angeles Dodgers, met Stacey Roy while they were both vacationing with their families in Hawaii. Following an afternoon of poolside conversation, Lyons followed Roy in the elevator to the floor of her hotel room.

According to Roy, Lyons pulled her into an alcove and sexually attacked her, shoved her against a vending

machine, partially removed her clothes, exposed himself, and tried to force her to perform a sexual act. According to Lyons, upon exiting the elevator, he simply asked Roy to show him her breasts. Then, when she complained that people might see, Lyons took her wrist and led her to the alcove where he repeated his request, only to have her again decline.

Although authorities declined to prosecute Lyons, Roy sued him civilly. Lyons tendered the claim to his homeowners insurance carrier, Fire Insurance Exchange, and sought a defense and indemnity.

Fire Insurance Exchange's policy provided liability coverage for "bodily injury, property damage or personal injury resulting from an occurrence to which this coverage applies" and defined personal injury as including "false arrest, imprisonment ... and detention." The policy specifically defined and limited an "occurrence" to "an accident including exposure to conditions which results during the policy period in bodily injury or property damage."

Based on this language, Fire Insurance Exchange denied coverage. After Lyons settled Roy's claim, he sued Fire Insurance Exchange for "bad faith."

The trial court, relying on the definition of an "occurrence" granted Fire Insurance Exchange's motion for summary judgment.

HOLDING & REASONING

The Court of Appeal affirmed.

Lyons argued that (1) since the policy covered "personal injury," which included false imprisonment, and (2) taking Roy by the wrist amounted to false imprisonment, there was a claim for "personal injury." He then argued that because the definition of "occurrence" did not refer to "personal injury," coverage for a "personal injury" did not require that there be an "occurrence." The court rejected this argument pointing out that the basic promise of coverage expressly required that claims for "bodily injury," "property damage" and "personal injury" be caused by an occurrence.

The court held under any version of the alleged facts, there was no accident and therefore no "occurrence." If Roy's version was accurate, then there was an intentional sexual assault. And, if Lyons' version was accurate, his action in taking Roy by the wrist and leading her to the alcove, though based on a mistake, was no accident.

Unlike a situation in which the insured's version of events could lead to the conclusion that some

unexpected event caused the injury, even Lyons' version could not have led to the conclusion that there was an accident.

The court noted that there are instances in which false imprisonment might be an accident. It gave the example of a shopkeeper who, in closing the shop for the night, inadvertently locks an employee in the vault. It contrasted this with the shopkeeper who mistakenly detains a shoplifting suspect.

Because the court concluded Lyons' potential liability could not be the result of an "occurrence," Fire Insurance Exchange had correctly concluded that there was no coverage.

ANALYSIS

The outcome of this case is consistent with prior cases that considered whether a mistaken subjective belief about another person's consent amounts to an accident.

Since even Lyons' version showed he intended to do exactly what he did and accomplished just what he intended to accomplish, no accident was involved.

This opinion appears in the April 7, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4829.

A Cross-Insured Exclusion Eliminated Coverage For The Named Insured's Action Against An Additional Insured.

Great Western Drywall, Inc. v. Interstate Fire & Casualty Company

**(Cal. Ct. of App., 4th Dist.), filed March 12,
2008, published April 8, 2008**

KEY FACTS

Roel Construction Co., Inc. was the general contractor on a construction project. Roel hired Great Western Drywall to install drywall and perform other work on the project.

The contract between Roel and Great Western included a Type I indemnity agreement, which required Great Western to indemnify Roel "from and against all claims, damages, losses and expenses ... for personal injury, death, property damage or otherwise arising out of or resulting from [Great Western's] performance" unless the claim arose from Roel's sole negligence or willful misconduct.

Great Western sued Roel over a payment dispute. Roel cross-complained against Great Western for breach of contract, negligence, “money due for work and materials,” account stated, and money had and received. The cross-complaint alleged Roel overpaid Great Western under the contract, and Roel was required to hire other subcontractors to finish and correct Great Western’s work after it abandoned the project. The cross-complaint also alleged that in the course of its work Great Western negligently caused property damage to other work on the project, specifically window glass and tubs.

Interstate Fire & Casualty Company insured Roel under a commercial general liability (CGL) policy. As a subcontractor, Great Western was a named insured on the policy. The policy covered “those sums that the insured becomes legally obligated to pay as damages because of ‘bodily injury’ or ‘property damage’” arising from an “occurrence,” which was defined as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.” The policy included a duty to defend.

The policy also contained the following exclusion: “CROSS SUITS EXCLUSION [hereafter cross-suits exclusion]. [¶] THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY. [¶] This policy does not apply to any claim or suit for injury or damage by one Insured against another Insured. [¶] This exclusion does not apply to ... actions to apportion liability between Insured’s [sic] where any Insured has been sued for a covered loss.”

After the suit between Great Western and Roel was resolved by a trial, Great Western sued Interstate for breach of contract and “bad faith.” Interstate moved for summary judgment. The trial court granted the motion.

HOLDING & REASONING

The Court of Appeal affirmed. It held that the cross-suits exclusion excused Interstate from defending Roel’s action against Great Western. It interpreted the policy as covering claims when one insured is sued by a third party and the insured sues another insured for indemnity or contribution.

In an instance in which one insured is sued by a third party and the insured sues another insured for indemnity or contribution, the question is how the damages are apportioned as between two insureds. However, when there is no third party suit, the parties are actually seeking money from each other for their own claimed damages. The policy did not contemplate coverage for this latter kind of claim.

ANALYSIS

Policy provisions such as that involved in this case are becoming more common.

As a result, it is not always beneficial to be an additional insured under someone else’s policy or to let someone else be an additional insured under your policy. There may be coverage when a claim is made by a third party, but not when the named insured is sued by an additional insured or an additional insured is sued by the named insured.

This opinion appears in the April 8, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4932.

An Insured Homeowner Was Not Entitled To The Full Cost Of Repairing Her Fire Damaged House

Everett v. State Farm General Insurance Company

(Cal. Ct. of App., 4th Dist.), filed April 29, 2008, published May 1, 2008

KEY FACTS

In October 1991, Agnes Everett purchased a home for approximately \$99,000. She purchased a homeowner’s policy from State Farm and renewed it annually. The original policy included an endorsement for guaranteed replacement cost coverage. It provided that State Farm would pay the full amount needed to repair the damaged or destroyed dwelling with like or equivalent construction, without regard to the policy limits.

In 1997, State Farm eliminated the guaranteed replacement cost coverage in its homeowner policies. State Farm sent each policyholder a notice of the change in coverage. In it, State Farm informed its insureds that if they chose to renew their homeowners policies with State Farm, guaranteed replacement cost coverage would no longer be available. Portions of the notice contained red or boldfaced, large capital letters and informed insureds that the document was an “IMPORTANT NOTICE ... about changes to your policy.”

Everett does not deny that she received this notice.

Each year from 2000 to 2003, State Farm sent a renewal certificate to Everett. State Farm provided Everett and other insureds with a replacement cost estimate. However, the renewal certificate stated that it was

Everett's responsibility to insure her home with adequate coverage.

In addition to the annual renewal certificate, every two years State Farm mailed Everett, a "California Residential Property Insurance Disclosure." It explained the terms "replacement cost" and "extended replacement cost," as written by the Legislature. Extended replacement cost coverage was defined as the amount of replacement cost up to a specified amount above the policy limit.

On October 25, 2003, Everett's home was destroyed by fire. She submitted a claim to State Farm under her homeowner's policy.

State Farm adjusted Everett's claim and paid her \$138,654.48 for her structural loss and \$76,620 for her personal property. This amount took into account the increased sum under Everett's "Option ID" provision and the increase for inflation and "Ordinance/Law" coverage.

Everett sued State Farm and its agent for breach of contract, breach of implied covenant of good faith and fair dealing, negligence, reformation, and fraud. Everett's contract claims were based on two theories. First, she alleged that the policy in effect at the time of her loss provided guaranteed replacement cost coverage such that she was entitled to full payment to replace her property without regard to policy limits. Alternatively, she alleged that State Farm failed to provide her with sufficient notice of the changes in her policy and thus her prior policy containing guaranteed replacement cost coverage should remain in effect.

State Farm moved for summary adjudication on the ground that Everett's policy, which was in effect at the time of her loss, did not include guaranteed replacement cost coverage. It argued that Everett received sufficient notice about the change in her coverage with her 1997 renewal notice. Regarding her claim of bad faith, State Farm argued that because there was no breach of contract, there could be no bad faith. Finally, State Farm argued that Everett's fraud-based claims were invalid because it never represented to her that her home was covered for up to 100 percent of the amount to replace her property.

The trial court granted State Farm's motion for summary adjudication. It then granted a motion for judgment on the pleadings as to Everett's remaining claim for reformation.

HOLDING & REASONING

The Court of Appeal affirmed.

It ruled that the policy clearly notified Everett that any payment was limited by the stated policy limits, even if they were insufficient to fully repair her house. In the process, the court explained the difference between paying a claim on the basis of "actual cash value" versus paying it on the basis of "replacement cost."

The court also ruled that State Farm's reduction in the applicable coverages complied with the requirements of the Insurance Code.

The court rejected Everett's arguments that State Farm was liable for not having increased the policy limits so that they would be sufficient to repair or replace her house in the event of a total or near total loss. The court noted that State Farm had adequately alerted Everett to the fact it was her responsibility to determine what limits she should have.

ANALYSIS

There are few cases addressing the adequacy of an insurer's notification of a reduction in coverages.

This case is also important in that it deals with the question of the adequacy of the policy limits. Prior to this case, one of the leading cases was *Desai v. Farmers Ins. Exchange*, 47 Cal.App.4th 1110 (1996), which the appellate court has distinguished.

This opinion appears in the May 1, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 6307.

MICRA Limits Noneconomic Damages

Prince v. Sutter Health Central

**(Cal. Ct. of App., 3d Dist.), filed April 4, 2008,
published April 7, 2008**

KEY FACTS

James Prince had health coverage with Kaiser. Kaiser subcontracted mental health services to Sutter Health Central. Sutter employed Juliet Stevenson.

While Prince was in the care of and under the custody of Sutter, Stevenson allegedly made the decision to release him. After his release, Prince killed himself.

Prince's wife and daughter sued Kaiser, Sutter Health and Stevenson.

Kaiser settled the action for the plaintiff's economic damages plus \$250,000 for noneconomic damages

permitted. The \$250,000 figure represented the maximum liability allowed under Medical Injury Compensation Reform Act of 1975 (MICRA).

The plaintiffs continued the suit against Sutter Health, claiming that Stevenson's acts did not fall under MICRA and therefore that they could recover further noneconomic damages from Stevenson and Sutter Health.

After the plaintiffs conceded that the MICRA issue would dispose of their remaining claims, the trial court granted Sutter Health's motion for summary judgment.

HOLDING & REASONING

The Court of Appeal affirmed. It held that an unlicensed social worker, registered with the appropriate agency and working toward licensure, is a "health care provider" rendering "professional services" under MICRA. As such, Stevenson's acts and omissions fell within the provisions of MICRA. Therefore, Sutter Health and Stevensons' liability for noneconomic damages was capped at \$250,000.

ANALYSIS

Although MICRA has been the law since 1975, there are still periodic attempts to find ways around the cap it put on damages for pain and suffering in medical malpractice cases.

This opinion appears in the April 7, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4859.

OTHER CASES OF INTEREST

Amending The Complaint Does Not Circumvent An Anti-SLAPP Motion

Salma v. Capon

(Cal. Ct. of App., 1st Dist.), filed April 9, 2008, published April 11, 2008

David Salma filed a cross-complaint against Daniel Capon. Salma alleged, among other things, causes of action for conversion and intentional interference with prospective economic advantage. Capon filed a special motion to strike (anti-SLAPP motion).

Before the trial court ruled on Capon's motion, Salma filed an amended cross-complaint that revised the two claims. Capon filed a second motion to strike the

amended claims. The trial court ultimately struck the conversion claim in the original cross-complaint but did not strike the conversion claim in the amended cross-complaint or the intentional interference claims in either cross-complaint.

In the ensuing appeal, the appellate court held that a plaintiff or cross-complainant may not avoid a pleadings challenge pursuant to Code of Civil Procedure section 425.16 by amending the challenged complaint or cross-complaint before the motion to strike is heard. It also held that the trial court properly considered Salma's verified pleadings in assessing Salma's probability of prevailing on the merits.

This opinion appears in the April 11, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 5108.

Social Workers Were Immune From Suit Even Though They Exercised Their Discretion Poorly

Ortega v. Sacramento County Department of Health and Human Services

(Cal. Ct. of App., 3d Dist.), filed April 1, 2008, published April 2, 2008

KEY FACTS

On August 21, 2001, police arrested Michael Ortega because he was screaming uncontrollably in the street and around his apartment and was violently banging on a refrigerator. A urine test showed Michael was under the influence of PCP.

The Sacramento County Department of Health and Human Services — Child Protective Services of Sacramento County (CPS) — took Michael's 11-year-old daughter, Mijalina into protective custody.

A CPS social worker conducted an investigation and returned Mijalina to her father's home on August 24, 2001.

On August 28, 2001, Michael stabbed Mijalina in the heart and lung. She survived.

Acting through her legal guardian, Mijalina sued CPS and two social workers who participated in the release of Mijalina to her father.

The trial court granted summary judgment, relying in

part on the immunity for discretionary acts of government employees set forth in Government Code Section 820.2

The Court of Appeal affirmed.

It held that the Legislature has chosen to immunize government employees from liability for discretionary acts “whether or not such discretion be abused.” It noted that the Legislature determined that government could not function if its employees were subject to liability for their discretionary acts, even where the discretion is exercised badly.

In reaching its decision, the court recognized that “[s]uch a rule necessarily causes individual hardship in those cases where discretion is exercised badly and the result is serious injury.” However, it held that it is not the proper role of the courts to countermand the Legislature’s mandate.

This opinion appears in the April 2, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 4591.

A Bank Did Not Owe A Duty Of Care To The Victim Of Identity Theft

Rodriguez v. Bank of the West

**(Cal. Ct. of App., 2d Dist.), filed April 24, 2008,
published April 28, 2008**

Attorney Stephen Rodriguez was the victim of an identity fraud perpetrated by his own office manager. The office manager opened bank accounts in Rodriguez’ name, took retainer checks payable to Rodriguez, deposited them in the new accounts and then withdrew the money.

Or, Rodriguez filed a cross-complaint against the banks. However, the trial court sustained the banks’ demurrers to Rodriguez’ cross-complaint.

The Court of Appeal affirmed. It ruled that since Rodriguez did not actually have a contractual relationship with the banks, by virtue of the fact he never actually contracted with them, the banks owed him no duty of care. The court rejected Rodriguez’ argument that since it was his name on the account, he was a “putative customer” and in a relationship with the banks.

The court suggested that the problem of identity thefts is for the Legislature, not the courts and it is not for the courts to shift the risk to the ones defrauded by the thieves and off of the ones whose identities were stolen.

This opinion appears in the April 28, 2008 edition of the Los Angeles Daily Journal, Daily Appellate Report, at p. 5912.

Berger Kahn

A Law Corporation

IF YOU HAVE ANY QUESTIONS REGARDING THE CASES discussed in this newsletter, please contact the attorney with whom you regularly work, or one of the Berger Kahn attorneys listed below:

Orange County

Lance A. LaBelle, (949) 474-1880;
llabelle@bergerkahn.com

David B. Ezra, (949) 474-1880;
dezra@bergerkahn.com

Los Angeles

Allen L. Michel, (310) 821-9000;
amichel@bergerkahn.com

Leon J. Gladstone, (310) 821-9000;
lgladstone@bergerkahn.com

San Diego

Roberta S. Winston, (858) 547-0075;
rwinston@bergerkahn.com

Marin County

Ann K. Johnston, (415) 899-1770;
ajohnston@bergerkahn.com

Berger Kahn A Law Corporation

L.A. County Office
4551 Glencoe Ave., Suite 300
Marina del Rey, CA 90292
310-821-9000
FAX: 310-775-8775

Orange County Office
2 Park Plaza, Suite 650
Irvine, CA 92614
949-474-1880
FAX: 949-474-7265

San Diego County Office
10085 Carroll Canyon Road, Suite 210
San Diego, CA 92131
858-547-0075
FAX: 858-547-0175

Marin County Office
7200 Redwood Blvd., Suite 325
Novato, CA 94945
415-899-1770
FAX: 415-899-1769

Copyright 2008 Berger Kahn. Permission to reprint any portion of the Monthly Summary of Key Decisions may be obtained by contacting Lance A. LaBelle or Dave Ezra of Berger Kahn. The cases summarized may or may not remain valid legal precedent. The summaries themselves are not legal advice. Berger Kahn does not guarantee the outcome of any particular legal matter. Application of these cases to any specific matter may require legal advice. To the extent this publication may constitute unsolicited "advertising," it is hereby identified as such.