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LEGAL UPDATE

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2011 Legislative Legal Update

By: Edward H. Lindsey, Jr.

The 2011 legislative session witnessed some of the most substantial changes affecting the practice of law in many years: A new evidence code; jury pool reform; and more.

Here are some of the highlights:

HB 24 – Evidence Code Rewrite

HB 24 is an update and rewrite of Georgia's antiquated Evidence Code. The present Code was first adopted in 1868 and has been added to and supplemented over the years through a patchwork of statutory updates and court opinions ever since. As a result, many legal scholars and practitioners believe an update after 140 years or so is well past due.

An earlier attempt twenty years ago by the State Bar to update the evidence code passed the Senate but stalled in the Georgia House. The latest effort started with an exhaustive review by a State Bar Study Committee beginning in 2005. Subsequently, a joint House/Senate Study Committee picked up the baton in 2008 with weekly meetings from July through November of that year. In 2010, an evidence code revision bill passed the House but stalled that year in Senate. Finally, in 2011, HB 24 passed both chambers and has been signed by the Governor.

HB 24 adopts much of the Federal Rules of Evidence to the extent that it is consistent with the Georgia Constitution. As a result, Georgia now joins with 43 other states that have similarly adopted a version of the Federal Rules of Evidence providing consistency between the states and its attorneys. In addition to modernizing our code, this bill should provide an easier work tool for attorneys and judges, resulting in more predictability and efficiency within the court system and better justice for all Georgians.

HB 30 – Restrictive Covenant Statute

Georgia voters ratified a constitutional amendment in November 2010, recognizing restrictive covenants in employment contracts. HB 30 is the enabling legislation that permits judges to “blue pencil” such contracts that they deem overly broad rather than simply ruling the entire contract as being in violation of public policy. Similar laws are in place in over 40 other states.

LEGAL UPDATE is a review of recent judicial and legislative developments in areas affecting the insurance claims community. It is not the intention of LEGAL UPDATE to provide an exhaustive report on all cases relevant to insurance defense or to offer legal advice. Readers should not rely on cases cited in LEGAL UPDATE without checking the current status of the law. LEGAL UPDATE was created for clients of Goodman McGuffey Lindsey & Johnson, LLP and the possibility of circulation beyond the firm's clientele should not be construed as advertisement.

HB 41 – Fix Appeal Record Per Page Fee

To err is human . . . HB 41 removes the unintended consequence created with the last omnibus fee bill. The fee for an Appellate or Supreme Court record and transcript would be reduced from \$10 to \$1 per page, while a case involving a capital felony would be reduced from \$5 to \$1 per page. This was the previous fee under Georgia law.

HB 200 – Anti-Human Trafficking

A tragic by-product of our boom state's growth has been that Georgia has become a national hub for human trafficking in general and trafficking in young people for sex crimes in particular. The victims are coerced or deceived into sexual servitude by the use of drugs, physical violence, mental abuse, and threats. HB 200 is a result of a cooperative effort between the legislature and other interested parties from prosecutors to social workers that toughens the penalties for those who engage in the practice, and provides a compassionate pathway out for those victims caught in the dark web of this sinister behavior.

HB 265 – Council of Criminal Justice Reform

This study committee will seek ways in which to enhance public safety, reduce victimization, hold offenders more accountable, enhance probation and parole supervision, and better manage a growing prison population by improving rehabilitation and lowering state expense. In short, the study committee will look for ways within our criminal system to distinguish between individuals who are convicted of crimes that we are simply mad at as opposed to those we are afraid of.

HB 343 – Good Faith Immunity for Mental Health Facilities in Following Stare Mandated Admission and Discharge Provisions

Under existing Georgia law, a physician, psychologist, peace officer, attorney, health official, or hospital official enjoys good faith immunity from civil or criminal liability if they act in compliance with admission and discharge provisions under Chapter 4, Section 37 of the Georgia code. The Georgia Court of Appeals refused to extend this immunity, however, to the hospital itself in the case of *Krachman v. Ridgeview Institute*, A09A1108 (December 1, 2009). HB 343 includes an amendment which closes this loop hole to include hospitals in this good faith immunity.

HB 415 – Jury Pool Reform

This bill revises how Georgia pulls together jury pools in each of the 159 counties. It requires the Council of Superior Court Clerks to establish and maintain a state administered master jury list for each county. Prospective jurors' names will be pulled from not only voter rolls but also the Department of Driver Services and the Secretary of State. By allowing for the screening of drivers' license records, vital records, and voter registration records a more inclusive source list of eligible jurors should be able to be gleaned. The database will be periodically cleaned of duplicates, bad addresses, and the names of felons and deceased people. Once this "clean list" is produced, the Council of Superior Court Clerks will certify and distribute annually an inclusive list to each individual county's Board of Jury Commissioners.

SB 88 – Child Care Restraint Seats

SB 88 increases age requirements for use of child restraint systems to eight years old. The current age is six. This keeps up with orthopedic medical experts' estimation of the safe range for children. There continues to be exceptions to this requirement if the child is over 40 pounds or over 4'9".

Conclusion

Your involvement in the legislative process is desperately needed and I urge you to get involved directly with your local legislator or through the Bar.

To see the entire bills mentioned in this paper visit the Georgia General Assembly web site at <http://www.legis.ga.gov>.

CASE NOTES

Georgia Liability

PREMISES LIABILITY: Regardless of visitor status, a plaintiff in premises liability action can only recover if she proves the proprietor had superior knowledge of the hazard.

Freeman v. Eichholz, 308 Ga. App. 18, 705 S.E.2d 919, decided February 17, 2011.

On November 15, 2003, Carolyn Freeman visited her friend, a prison inmate, at Wayne State Prison. When she sat down in a chair in the visitation area, it collapsed. Freeman fell backward and struck her head, which knocked her unconscious. She suffered injuries to her neck, head and back.

Freeman retained Benjamin Eichholz to represent her in a personal injury action against the State of Georgia and the Department of Corrections. Eichholz failed to timely file ante litem notice, required by O.C.G.A. § 50-21-26, and her lawsuit, was dismissed with prejudice.

Freeman then filed a legal malpractice suit against Eichholz. The trial court granted summary judgment for Eichholz holding that Freeman was a “licensee” at the prison, and that she failed to prove that, but for Eichholz’s negligence, she would have won a judgment in her favor on the underlying personal injury claim.

An “invitee” is one who enters the premises for any lawful purpose “by express or implied invitation.” O.C.G.A. § 51-3-1. The Court of Appeals stated that, since the prison

uses visitation rights as a tool to punish, reward or rehabilitate its inmates, the prison receives a benefit from the inmates’ visitors. As such, Freeman was an invitee, not a licensee.

The record showed no evidence that the prison had any knowledge of a defect to the chair. Further, Freeman could not provide any evidence as to why the chair broke when she sat in it.

Georgia law provides that the grounds for liability to an invitee in a premises liability case derive from the owner/occupier’s superior knowledge of the danger. Since Freeman provided no evidence that the prison had knowledge of any defect in the chair, she could not have prevailed in the underlying case. Therefore, although the Court of Appeals determined the trial court erred in finding Freeman was a licensee, it still affirmed because Freeman could not show that Eichholz’s failure to file the ante litem notice proximately caused the harm claimed in the legal malpractice suit.

Summary prepared by Kristy P. Kramp, kkramp@gmlj.com.

CIVIL PROCEDURE AND SERVICE OF PROCESS: The trial court is authorized to reconcile conflicting evidence regarding whether the defendant was properly served in determining whether to grant a Motion to Dismiss for failure to serve the defendant within the statute of limitations.

Jones v. Lopez-Herrera, 308 Ga. App. 81, 706 S.E.2d 609, decided February 24, 2011.

Inyianie Jones filed a complaint on June 30, 2008 against J. Soledad Lopez-Herrera, for injuries arising out of an October 24, 2007 accident. That case was dismissed by the trial court on August 30, 2009 for failure to prosecute. Jones refiled her complaint on August 31, 2009. Contemporaneous with her complaint, she filed a motion to appoint a process server. On October 27, 2009, just a few days after the statute of limitations expired, Jones claims that the court appointed process server served Lopez-Herrera.

Lopez-Herrera disputed he was served and filed both a Special Appearance Answer, which reserved “all defenses arising from service, process and jurisdiction,” and a Motion to Dismiss for lack of service. Lopez-Herrera supported his Motion with an affidavit in which he claimed that he had not been served and he did not live at the address where the process server allegedly served him. Jones responded to the Motion and supported the response with another affidavit from the process server; the process server averred in the second affidavit that a Hispanic male answered the door and that the man responded to the name Soledad. Based on the evidence presented both in favor of and in opposition to the Motion, the trial court granted the Motion to Dismiss.

On appeal, the Court of Appeals reasoned that although a return of service is prima facie evidence of personal service, the defendant can overcome that evidence when he presents evidence that is “the strongest of which the nature of the case will admit.”

The Court of Appeals held that the affidavit Lopez-Herrera presented was sufficient evidence to support the trial court’s dismissal. The Court of Appeals reasoned that Jones offered an affidavit from the process server, who averred that the man who answered the door answered to the name of Soledad. However, Lopez-Herrera showed the trial court that he did not reside at the address where the process server served the complaint (his brother lived there), and that his brother advised him he had received a copy of the complaint. Lopez-Herrera also presented evidence from his landlord that he lived at a different address.

Although there was conflicting evidence presented, the Court of Appeals held that the trial court was authorized to reconcile these conflicts and grant the Motion to Dismiss.

Summary prepared by James T. Hankins, jhankins@gmlj.com.

VICARIOUS LIABILITY OF EMPLOYER: Employer is not vicariously liable for accident caused by employee during the employee’s morning commute to work.

Farzaneh v. Merit Constr. Co. Inc., 309 Ga. App. 637, decided May 27, 2011.

While commuting to work in his personal vehicle, David Redic struck and severely injured a pedestrian crossing the street. The pedestrian, Peyman Farzaneh, filed suit against Merit Construction Company, Inc., Redic’s employer, arguing that it was vicariously liable for its employee’s negligence.

Merit moved for summary judgment, arguing that because Redic was not acting in the

course and scope of his employment at the time of the collision, it could not be held vicariously liable for Redic’s negligence. The trial court granted summary judgment to Merit.

The record evidence showed that Merit did not have a central office where all of its field employees reported at the beginning of the day. Instead, the foremen, carpenters and other laborers were assigned to particular job sites and

commuted to those locations directly from their homes in the morning.

On the day of the incident, Redic had an employer-issued cell phone that had a 'walkie-talkie' function, and an employer-issued power screw gun in his vehicle.

Under Georgia law, to hold an employer liable for a tort committed by its employee, it must appear at the time of the injury, the employee was engaged in the employer's business and not upon some private and personal matter of his own. Georgia law further holds an employee on the way to work is not in the course of his employment, but rather is engaged in a personal activity.

However, there are special circumstances where commuting to work is not a purely personal matter and an employer could be held vicariously liable for its employee's negligence. For example, if the employee was discussing a business matter on the cell phone at

time of the collision, or if employee was distracted by an incoming business-related call at time of collision.

Farzaneh argued that a special circumstance existed to hold Merit vicariously liable because Redic had an employer-issued cell phone and an employer-issued tool in his truck while on the way to work. The Court of Appeals rejected those arguments because there was no evidence that Redic was on the phone at the time of the collision.

Farzaneh also argued that this case involved a special circumstance because Merit did not commute to a fixed location at the beginning of every work day. The Court of Appeals also rejected that argument and affirmed the grant of summary judgment to Merit.

Summary prepared by Michael A. Melonakos, mmelonakos@gmlj.com.

ENFORCEMENT OF SETTLEMENT AGREEMENT: If a party varies the terms of a settlement agreement, then that 'agreement' is unenforceable and operates as a counteroffer because there was not a meeting of the minds.

Penn v. Muktar, 2011 WL 1957530, (Ga. App.), decided May 18, 2011.

Following an automobile collision, Cedric and Tina Penn sued Zubeida Muktar for property damage and bodily injury sustained in the wreck. Muktar had a liability insurance policy with State Farm.

The Penns' attorney sent State Farm a letter offering to settle only the bodily injury claims against Muktar. In the letter, their attorney informed State Farm, "we need a release of my clients' bodily injury claims against only your insureds." Further, the letter stated, "[i]f you get me all of the requested insurance information with that release and a draft for the available bodily injury liability insurance within twenty days of this letter, then my clients will sign the release."

Within the twenty (20) day time-frame, State Farm sent a letter purporting to accept the settlement offer to the Penns' attorney. The letter, however, included a release, which stated

that State Farm and Muktar were released from "any and all claims ... of any kind or nature ... including all claims, known or unknown, both to person or property" that resulted from the automobile collision. Based on that language, the Penns refused to sign the release prepared by State Farm.

Muktar then filed a Motion to Enforce the settlement agreement. In response to that motion, the Penns filed a Motion for Partial Summary Judgment asserting that the parties did not reach an agreement. The trial court granted Muktar's Motion to Enforce.

In order to have an enforceable settlement agreement, the parties must reach a meeting of the minds. If a party varies the terms of a settlement agreement, there is no meeting of the minds, and the variation merely operates as a counteroffer.

Based on that standard, the Court of Appeals held that the settlement agreement was unenforceable because these parties had not reached a meeting of the minds. As a result, the

Court of Appeals reversed the trial court's Order enforcing the settlement.

Summary prepared by Kevin C. Patrick, kpatrick@gmlj.com.

EVIDENCE/DAMAGES: It is not an abuse of discretion to allow the mention of liability insurance during voir dire; Sufficiency of evidence required for an award of pain and suffering in a wrongful death case.

Park v. Nichols, 307 Ga. App. 841, 706 S.E.2d 698, decided February 15, 2011.

Stacey Camacho died following a car with Seung Park, who was drunk, ran a red light, and struck the vehicle Camacho was driving. Park admitted liability and went to trial only on the issue of damages. The jury awarded the Camacho's estate \$715,000 for her pain and suffering, and \$5,115,000 to Camacho's surviving spouse for wrongful death. Park appealed.

In Georgia, a mistrial should be granted "only where the testimony is so obviously prejudicial in its nature that its adverse effect cannot be eradicated from the minds of the jury or its consequences avoided by proper cautionary instructions from the court..." That determination rests within the discretion of the trial court.

Park's first enumeration of error was that the trial court erred by allowing the matter of liability insurance to come up during voir dire. Initially the jury was to be prequalified as to whether they had any relationship with Park's auto liability insurer. However, because it was unclear if the jurors were actually pre-qualified the judge asked the venire:

The Court of Appeals held there was no abuse of discretion by the trial court because the issue of liability insurance had previously been mentioned to the jury, and a second mention of insurance did not require that a mistrial be granted.

Are any of you an officer—director, officer, agent, employee, shareholder or policy holder of Nationwide Mutual Fire Insurance Company? Are any of you related by blood or marriage, third cousin or closer, to any director, officer, agent, employee or share holder of Nationwide Mutual Fire Insurance Company?

Park also argued the trial court erred by denying his directed verdict on the estate's claim for pain and suffering. The Court of Appeals held, although there was conflicting evidence offered during trial as to whether Camacho was conscious after the wreck, that there was evidence to support the jury's verdict on pain and suffering.

Later in voir dire, counsel again mentioned Nationwide Mutual Insurance Company. Park moved for a mistrial based upon the reinjection of insurance into the case. The trial court denied that motion.

The Court of Appeals affirmed the trial court on both issues and refused to grant a new trial.

Summary prepared by Sean B. Cox, scox@gmlj.com.

TORTS/CHOICE OF LAW: The public policy exception to rule of *lex loci delicti* precluded application of Florida's substantive wrongful death law.

Carroll Fulmer Logistics Corp. v. Hines, 309 Ga. App. 695, decided May 27, 2011.

Travis Lamar Hardaway was killed when the tractor-trailer he was driving rear-ended another tractor-trailer owned and operated by Carroll Fulmer Logistics Corp. outside Jacksonville, Florida. Hardaway's estate brought wrongful death and estate claims in Georgia, but sought to use Florida's Wrongful Death Act (Fla. Stat. § 768.16 *et seq.*) rather than Georgia's Wrongful Death Act (O.C.G.A. § 51-4-1 *et seq.*). The parties filed Cross-Motions for Summary Judgment on the issue of whether Florida or Georgia law applied.

In cases involving conflict of laws, Georgia adheres to the rule of *lex loci delicti*, or "place of the wrong," which requires application of the substantive law of the place where the tort or wrong occurred. As the alleged tort occurred in Florida, the rule of *lex loci delicti* would require application of Florida's substantive law. An exception to *lex loci delicti*, however, exists where application of the law of the other forum contravenes the public policy of the State of Georgia.

Georgia's Wrongful Death Act provides that designated persons have the right to recover "the full value of the life of the decedent without deducting for any of the necessary or personal expenses if the decedent had he lived." Those damages are measured from the viewpoint of the decedent, resulting in no recovery by the decedent's survivors for such claims as mental or emotional suffering. Additionally, Georgia's survival statute, O.C.G.A. § 9-2-41, provides that

the decedent's personal representative has the right to recover separate damages for the decedent's pre-death physical and mental pain and suffering.

Florida's Wrongful Death Act, however, provides for recovery of damages for the decedent's death, including the right to recover certain damages suffered by the decedent's survivor, not the decedent. While allowing a decedent's survivor to recover for their own pain and suffering, Florida's Wrongful Death Act specifically eliminates any recovery for a decedent's pre-death physical and mental pain and suffering.

Although both wrongful death acts provide for recovery of damages, Florida's Act measures damages from the perspective of the survivors' losses, while Georgia's act does so from the perspective of the lost value of the decedent's life. Application of Florida law in this instance would eliminate the possibility of the separate recovery allowed under Georgia law for any pre-death physical and mental pain and suffering consciously experienced by the decedent. As such, the application of Florida law in this instance contravenes Georgia public policy, and pursuant to the public policy exception to *lex loci delicti*, the Court of Appeals held that Georgia, rather than Florida, law should be applied.

Summary prepared by Phil W. Lorenz, plorenz@gmlj.com.

Georgia Coverage

ADDITIONAL INSURED/WAIVER AND ESTOPPEL: An entity must be a named insured or additional insured to have standing to raise waiver and estoppel against an insurer.

Flintlock Const. Services, LLC v. American Safety Risk Retention Group, Inc., 2011 WL 1827977 (U.S.D.C., N.D. Ga.), decided May 12, 2011.

American Safety Risk Retention Group, Inc. issued a policy of insurance effective January 2003 through 2004 to Flintlock Construction Services, Inc. In March 2004, Well-Come Holding, LLC retained Flintlock, LLC as general contractor of a project in New York. Well-Come and Flintlock, LLC entered into a construction contract which required Flintlock LLC to defend, indemnify and hold harmless Well-Come as well as for Flintlock LLC to insure itself and Well-Come. Flintlock LLC provided Well-Come with two certificates of insurance which listed American Safety Indemnity Co. as the insurer.

In 2004, suit was filed against Flintlock LLC and Well-Come regarding the project. Well-Come demanded a defense from Flintlock LLC, which originally rejected the defense. Eventually, Flintlock LLC agreed to defend Well-Come and American Safety Risk agreed to defend Flintlock LLC. Well-Come contends that American Safety Risk retained a defense for it, which American Safety Risk denies.

In 2008, American Safety Risk disclaimed coverage to Flintlock LLC asserting that Flintlock Inc. was the only named insured under the policy. Flintlock LLC sued American Safety Risk and American Safety Insurance Services, Inc. seeking coverage. Well-Come filed a Complaint in Intervention against American Safety Risk, American Safety Insurance Services and Flintlock LLC. All parties moved for summary judgment.

Well-Come argued it was an additional insured under the policies pursuant to the certificates of insurance it was issued. Because the certificates pertained to Flintlock LLC, not Flintlock Inc. and listed American Safety Indemnity and not American Safety Risk, American Safety Risk and American Safety Insurance Services argued that Well-Come was not covered under the Flintlock Inc. policy at issue.

Well-Come also argued that the American Safety entities were estopped from arguing that Well-Come was not an additional insured because American Safety Risk defended Flintlock LLC and Well-Come in the underlying actions.

The District Court found there was a question of fact as to whether American Safety Risk had indeed assumed Well-Come's defense. However, the court held that even if American Safety Risk had defended Well-Come in the underlying action, Well-Come did not have standing to argue waiver and estoppel against American Safety Risk since Well-Come was neither a named insured nor an additional insured under the American Safety Risk policy issued to Flintlock, Inc. The court granted the American Safety entities' motion for summary judgment.

Summary prepared by Cheryl A. Staugaitis, cstaugaitis@gmlj.com.

INSURANCE COVERAGE/LATE NOTICE: Questions of fact exist as to whether an insured was reasonable under the circumstances in waiting for two years after a slip and fall incident to give notice to its insurer.

Forshee v. Employers Mutual Insurance Company, 2011 WL 1587109 (Ga. App.), decided April 28, 2011.

The Forshees owned a Chevron station insured by Employers Mutual Insurance Company. In November 2007, a woman fell while walking from her car to the entrance of the Chevron station. None of the employees of the station saw the woman fall, but Mr. Forshee saw the woman laying on the ground after the incident. He helped her back to her feet, and helped her to her car. He then returned to the station to obtain a drink for her.

By the time Mr. Forshee returned to the parking lot, the woman was seated in her car. He offered to call for medical assistance, but the woman refused, and stated she was going home. The woman then left the station without giving Mr. Forshee her name or contact information. She may have indicated that her arm hurt, but did not give any indication of the severity of her injuries.

The woman apparently broke her arm when she fell at the Chevron station and was hospitalized. The Forshees claim they first learned of the broken arm two years later, when they were served with a lawsuit. They immediately forwarded the lawsuit to their insurance agent, and the agent forwarded it to Employers Mutual. Employers Mutual defended the Forshees under a reservation of rights, and filed a declaratory judgment action in which it argued the Forshees failed to provide notice of the potential personal injury claim “as soon as practicable” as required by the policy.

After a bench trial, the trial court entered judgment in favor of Employers Mutual, holding the Forshees’ failure to provide notice of the incident to Employer’s Mutual until two years after the fall was unreasonable. The Forshees appealed, arguing the trial court applied the wrong legal standard when it found the Forshees unreasonably failed to give timely notice.

The Court of Appeals vacated the judgment and remanded the case, holding that the lower court focused improperly on the severity of the woman’s injuries, rather than the extent to which a reasonable person in the Forshees’ position would have thought the event could form the basis for a possible claim. The Court of Appeals held that a question of fact existed as to whether the Forshees were objectively reasonable when they decided not to provide notice to Employers Mutual at the time of the fall. It is the nature and circumstances of the incident and the immediate conclusion of a reasonable person that determine whether an insured has reasonably justified a decision not to notify an insurer of a potential claim. The Court of Appeals remanded the case for a factual determination as to the reasonableness of the Forshees.

Summary prepared by Daniel L. Delnero, ddelnero@gmlj.com.

DUTY TO DEFEND: Where the facts as alleged in a complaint even arguably bring the occurrence within the insurance policy’s coverage, the insurer has a duty to defend the action, and any ambiguities in the insurance contract or any exclusion sought to be invoked, will be strictly construed against the insurer.

Landmark American Insurance Company v. Khan, 307 Ga. App. 609, 705 S.E.2d 707, decided Jan. 25, 2011.

On November 4, 2006, Jamil Khan parked behind Flashers Nightclub, paid an entrance fee and entered the club, where he

stayed for approximately 45 minutes. As Khan left the club and walked back to his car, two individuals exited the club behind him. As Khan

got into his car, one of these individuals shot at him, hitting him six times in the chest and back.

Khan filed a lawsuit against the club asserting claims of premises liability and alleging that Flashers had negligently failed to provide adequate security. Khan also made a claim for assault and battery, alleging that an employee or employees of Flashers either ordered and directed the assault on him or actually shot him.

Flashers notified Landmark American Insurance Company of the lawsuit. Landmark refused to defend or indemnify Flashers, stating that the claims Khan made in the lawsuit were not covered under Flasher's insurance policy. Specifically, the policy only covered an assault or battery if it was committed by a Flashers employee *while the employee was trying to protect persons or property*. According to Landmark's own investigation, the person who shot Khan did not fall within that description.

Flashers did not retain counsel and did not file any responsive pleadings. The trial court entered a default judgment and awarded Khan over \$2.3 million in damages.

Flashers assigned all of its causes of action against Landmark under the insurance policy to Khan, in exchange for Khan not executing the judgment against Flashers' assets. Khan then filed a lawsuit against Landmark, asserting claims for (1) breach of duty to defend,

(2) bad faith refusal to defend or settle and (3) breach of contract.

Landmark moved to dismiss the action and Khan moved for partial summary judgment on Landmark's liability for breach of the duty to defend. The trial court found that Landmark had breached its duty to defend Flashers in the underlying lawsuit and it denied Landmark's motion to dismiss the action.

The Court of Appeals of Georgia agreed with the trial court. It determined that the controlling issue is whether the insurance policy covers either of the claims asserted by Khan – the assault and battery claim or the premises liability claim.

It also found that the trial court was correct in its determination that Khan's allegation that the Flashers employee was acting within the scope of employment was sufficient to trigger coverage.

The appeals court finally stated that Landmark could have defended the case under a reservation of rights, requested a stay of the underlying case and then filed a declaratory judgment action to determine its obligation to provide a defense. "It is Landmark's failure to exercise this reasonable option, not the trial court's ruling in this case, that has placed Landmark in its present position."

Summary prepared by David M. Abercrombie, dabercrombie@gmlj.com.

UNINSURED MOTORIST COVERAGE ACROSS POLICY RENEWAL PERIODS: A renewal policy carries the same coverage as a prior policy if the insured does not elect different coverage, even if there is a lapse in coverage prior to the renewal.

Infinity General Insurance Company v. Litton, 308 Ga. App. 497, 707 S.E.2d 885, decided March 17, 2011.

Jason Litton brought an action for damages for personal injuries he sustained in an automobile wreck on November 27, 2007. He claimed he was working for his employer, JM Brick and Stone (JM) at the time of the wreck. Litton made an uninsured motorist claim against JM's commercial automobile insurance carrier; Infinity General Insurance Company.

Infinity answered the Complaint in its own name.

Infinity's predecessor-in-interest issued a commercial vehicle insurance policy to JM effective July 2005 through July 2006. The 2005 policy was a new insurance contract that provided \$1,000,000 per person bodily injury

(BI) liability coverage and \$50,000 per person uninsured motorist (UM) coverage.

JM was several weeks late in renewing its policy in 2006. When JM eventually paid the premium the policy was issued with a declaration page that indicated, "*THIS POLICY HAS BEEN RENEWED WITH A LAPSE IN COVERAGE.*" The declarations page for the 2006 policy listed the same \$1,000,000 per person BI liability limit and \$50,000 per person UM limit as the 2005 policy. The policy was timely renewed in 2007 with no further coverage elections, including for UM, being made.

As a result of the 2006 coverage lapse, Litton argued at trial he was entitled to \$1,000,000 in UM coverage. He argued the 2006 renewal policy was a new contract, and JM's failure to affirmatively elect \$50,000 in UM coverage resulted in the 2006 policy providing the default amount of UM limits which are those equal to the BI liability limits of \$1,000,000. Litton contended the same thing occurred with the 2007 renewal. Infinity argued the 2006 policy was a renewal of the 2005 policy (as was the 2007 policy) and, pursuant to O.C.G.A. § 33-7-11(a)(3), no additional election by JM was necessary to retain the \$50,000 UM limit in both the 2006 and 2007 policies.

After a jury trial awarded Litton an undisclosed amount, the trial court entered judgment holding that the Infinity policy provided \$1,000,000 per person in uninsured motorist (UM) coverage. Infinity moved for judgment notwithstanding the verdict re-asserting its argument in a motion for directed verdict that the policy's unambiguous terms

provided only \$50,000 per person in UM coverage. The trial court denied the Motion for JNOV, and Infinity appealed.

The Court of Appeals reversed holding the 2006 and 2007 policies were renewal policies with the same \$50,000 UM limits as the 2005 policy. The Court held that a "renewal" of an automobile insurance policy is defined as the "issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer and providing no less than the coverage contained in the superseded policy." O.C.G.A. § 33-24-45(b)(2). Further, following a decision of the Georgia Supreme Court, the Court of Appeals held that a lapse in coverage between the expiration of the first policy and the effective date of the superseding policy does not preclude the superseding policy from being a renewal.

In light of the fact the 2006 and 2007 Infinity policies were renewals, in light of the plain and clear language delineating renewal status and coverage limits on the declarations pages of the 2006 and 2007 Infinity policies, and in light of the Georgia Supreme Court's binding precedent regarding a lapse in coverage not eliminating the renewal status of a subsequent policy, the Georgia Court of Appeals held the Infinity policies issued to JM in 2006 and 2007 were renewals of the 2005 policy and maintained the \$50,000 in UM limits.

Summary prepared by Kristen S. Cawley,
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Georgia Workers' Compensation

WORKERS' COMPENSATION/STANDARD OF REVIEW: The Appellate Division may substitute its findings of fact for those of the Administrative Law Judge. The Superior Court must affirm an Award that is supported by any evidence.

Georgia Mountain Excavation, Inc., v. Dobbins, 305 Ga. App. 144, 710 S.E.2d 205, decided April 6, 2011.

In February 2007, Dobbins injured his back while removing a toolbox from a truck. He missed one month from work and received income and medical benefits. Three months later, he claimed another injury, which was "medical only." Finally, Dobbins claimed that he reinjured his back on November 25, 2008, while he and a coworker were attempting to pick up a piece of equipment.

Dobbins did not report the new injury that day. He claimed he reported the injury to his supervisor the next day, but the supervisor denied it and time records showed that Dobbins did not work the next day. Neither the coworker assisting Dobbins nor a coworker who supposedly witnessed the injury testified at the hearing, but the supervisor testified that when he heard about the alleged injury on December 8, 2008, he investigated but could locate no one who could confirm it. Medical records showed that Dobbins told a doctor on December 18, 2008, that he hurt his back "a couple of weeks ago" when he slipped getting off a truck at work.

Following a hearing, the ALJ awarded temporary total disability benefits. On appeal, after considering the conflicting testimony about whether Dobbins reported the injury and his own inconsistent accounts of how it happened, the Appellate Division concluded Dobbins had failed to prove he had suffered an injury by accident arising out of and in the course of his

employment on November 25, 2008. Therefore, benefits were denied.

The Superior Court concluded that the evidence did not support the Appellate Division's award, and reinstated benefits.

The Court of Appeals reversed. Under Georgia law, if the Appellate Division concludes that an award by an administrative law judge is not supported by a preponderance of competent and credible evidence, then it may reject the administrative law judge's factual findings and substitute its own. It may assess witness credibility, weigh conflicting evidence, and draw its own conclusions from the evidence.

On judicial review, however, the Superior Courts must review the evidence in the light most favorable to the decision of the Appellate Division, and as long as there is "some evidence" in the record to support the award, it must be upheld. The Superior Courts are not authorized to reweigh the evidence.

The Court of Appeals found "some evidence" to support the Appellate Division's conclusion. Because the Superior Court had "simply weighed the evidence itself," its decision was reversed.

Summary prepared by Neal B. Childers, nchilders@gmlj.com.

WORKERS' COMPENSATION/STANDARD OF REVIEW: The Appellate Division may substitute its findings of fact for those of the ALJ. The Superior Court must affirm an award that is supported by any evidence.

Master Craft Flooring v. Dunham, 308 Ga. App. 430, 708 S.E.2d 36 (2011)

Michael Dunham injured his neck in a motor vehicle accident in November 2004 while working for Master Craft Flooring. He was out of work for approximately six weeks, but thereafter resumed light duty work. In May 2007 Dunham had a second injury to his neck and thereafter resigned his position with the company. He was subsequently hired by a new employer, The Tub Doctor.

In December 2007, a hearing was held at Dunham's request with regard to the May 2007 accident. Master Craft was ordered to pay income benefits during a period of total disability following the injury, as well as to authorize medical treatment related to the May 2007 aggravation for as long as the aggravation continued. The Appellate Division affirmed the ALJ's award.

In January 2008 Dunham was laid off by The Tub Doctor. He subsequently requested a hearing seeking income benefits on the grounds that he was being denied employment as a result of his May 2007 injury. Master Craft contended that the May 2007 aggravation had subsided and that his disability was related either to the original injury or to an aggravation of his condition which occurred while working for the Tub Doctor. Master Craft presented surveillance footage showing Dunham working without limitation in March 2009.

The ALJ issued an award concluding Dunham had undergone a change in condition for the worse when he stopped working for the Tub Doctor, was still suffering from the limitations resulting from the May 2007 neck injury and had not returned to his pre-aggravation condition. The ALJ based his conclusion primarily on the opinion of a treating doctor who stated that Dunham had not returned to his pre-accident baseline. The ALJ further determined that Dunham had engaged in a diligent job search, but was denied suitable

employment because of his condition. The ALJ, however, found that Dunham had "a full change in condition for the better" as of the date of the surveillance video. Dunham was awarded TTD benefits from January 2008 through March 18, 2009.

The Appellate Division reversed. It found that the ALJ's findings of fact were not supported by the preponderance of the evidence and substituted its own factual findings. Specifically, it discounted Dunham's own testimony and relied upon the surveillance footage as well as the testimony of Dunham's supervisor from The Tub Doctor, who testified that he was not aware that Dunham had any work limitations. The Appellate Division also discounted the medical opinion of the doctor as well as Dunham's testimony regarding his job search, which was unsupported by any documentary or other testimonial evidence.

The Superior Court reversed the Appellate Division and reinstated the ALJ's award, which it found was supported by the preponderance of the competent and credible evidence in the record. Master Craft appealed to the Court of Appeals.

The Court of Appeals reversed the Superior Court and reinstated the Appellate Division's Award denying benefits. The Court stated that a Superior Court does not have authority to substitute itself as a fact-finding body in lieu of the Board. If the Board's findings are supported by any record evidence, its findings are conclusive and binding, regardless of whether or not the Court of Appeals would have reached the same result if given the opportunity to weigh the evidence in the first instance.

Summary prepared by Jeff K. Stinson, jstinson@gmlj.com.

WORKERS' COMPENSATION/STANDARD OF REVIEW: The Appellate Division may substitute its findings of fact for those of the ALJ. The Superior Court must affirm an Award that is supported by any evidence.

Bonus Stores, Inc., v. Hensley, 309 Ga. App. 129, 710 S.E.2d 201, decided April 5, 2011.

Edward Hensley injured his back in March 2002 while working for Bill's Dollar Store. He received temporary total disability benefits through November 2003 and temporary partial disability benefits until November 2008.

Hensley then requested a catastrophic designation. After the hearing, the ALJ determined that Hensley had suffered a catastrophic injury, based on a November 5, 2003 letter from Hensley's family physician stating he was "totally disabled from physical labor;" a September 2004 functional capacity questionnaire from the same physician stating Hensley could sit and stand or walk less than two hours each day and would have to take frequent rest breaks; and a November 2007 vocational assessment stating Hensley was not capable of performing any work that was available in substantial numbers in the national economy.

The Appellate Division reversed the decision, finding the preponderance of the competent and credible evidence did not support the catastrophic designation. The Appellate Division gave greater weight to the employer's evidence, which included a May 2009 orthopedic evaluation concluding Hensley had reached maximum medical improvement in the year following the back injury and had no

remaining impairment related to the injury. The Appellate Division also considered reports from two other physicians, from December 2003 and July 2005, who opined that Hensley could return to work without restrictions.

The Superior Court reinstated the ALJ's award of the catastrophic designation upon finding that the Appellate Division had improperly applied a *de novo* standard of review by weighing the evidence and substituting its opinion for that of the ALJ.

The Court of Appeals reversed the Superior Court and reinstated the decision by the Appellate Division, reasoning that the Appellate Division must weigh the evidence received by the ALJ to determine if the award was supported by the preponderance of the evidence. If the award does not meet the evidentiary standard, the Appellate Division may substitute its own findings for those of the ALJ. Because the Superior Court and Court of Appeals cannot substitute their findings for those of the Appellate Division, its decision must be upheld as long as it is supported by some evidence.

Summary prepared by James R. Reed, jreed@gmlj.com.

WORKERS' COMPENSATION/ENFORCEMENT AND MODIFICATION OF AWARD: Superior Court must set aside an approved settlement when the only evidence in the record is that the settlement was the result of a mistake.

City of Atlanta v. Holder, 2011 WL 1878857, (Ga. App.), decided May 18, 2011.

Holder filed fifteen separate claims for workers' compensation benefits, against the City of Atlanta, including an injury of January 16, 1993.

The parties submitted a proposed Stipulation and Agreement to the State Board covering fifteen specified dates of injury. The

January 16, 1993, injury was not listed, but an injury date of January 6, 1993, was. The Stipulation also contained language by which Holder agreed that there were no other accidents other than those listed. The State Board approved the settlement on January 23, 2007, and the City paid Holder and his attorney.

On January 25, 2007, the State Board approved another Stipulation. The second Stipulation was identical in every respect to the January 23, 2007 Stipulation, except that on page 1, where the typewritten dates of injury were listed on the first stipulation, the date of January 16, 1993, was written by hand.

The City appealed the January 25, 2007 award, contending that the approval was the result of mistake or fraud. The Superior Court did not enter an order in a timely manner, so the Award was affirmed by operation of law. The Superior Court later entered an order to remand the case to the State Board. The City appealed to the Court of Appeals, but its appeal was dismissed.

Holder then filed a Demand for Judgment, requesting that the Superior Court enter judgment on the January 25, 2007, award. The Superior Court denied the Motion because of the remand, but on appeal, the Court of Appeals reversed. The Court said that, because the Award was affirmed by operation of law due to the Superior Court's failure to issue a timely ruling, it had no jurisdiction to remand the case to the State Board, and its attempt to do so was void. The Superior Court then granted Holder's Motion and entered judgment requiring the City to pay the settlement.

The City moved to set aside the judgment and attached an affidavit from an employee of the State Board that the second Stipulation was created at the State Board by mistake and that it was not a second agreement of the parties. Holder submitted no evidence in response.

The Superior Court denied the City's Motion and ordered it to pay Holder \$124,900.20, which included the amount of the settlement, penalties, interest, and attorney's fees. The City appealed again.

The Court of Appeals first ruled that, because no hearing was required, Holder's failure to submit any evidence in response to the City's Motion meant that all of the evidence showed that he was not entitled to the second settlement payment. Second, *res judicata* did not bar the City's motion because the Award was affirmed by operation of law due to the Superior Court's failure to rule in a timely manner, which was not the City's fault. Therefore, the Court ruled the Award was to be set aside, and the City was not obligated to pay the second settlement.

Summary prepared by Neal B. Childers, nchilders@gmlj.com.

REVIEW OF AWARD BY APPELLATE DIVISION: The Appellate Division of the State Board is authorized to make its own findings of fact, but cannot base a decision on an erroneous finding of fact.

McEwen v. Bremen Bowdon Inv. Co., 309 Ga. App. 170, 709 S.E.2d 908, decided April 8, 2011.

Brandi McEwen was employed with Bremen Bowdon Investment Company and was responsible for the manufacture of various military uniform items. She began to notice problems with her back as a result of her work duties, specifically the twisting associated with making buttonholes. She reported the problems to her supervisor, although there was a dispute as to whether McEwen specifically related the problems to her work duties. Her supervisor told her to seek medical treatment, which she did.

On January 23, 2009, McEwen was terminated for excessive absenteeism, which she

attributed to her missed time from work resulting from her back problems. She subsequently filed a claim seeking income benefits from the date of her termination and continuing.

Following a hearing, the ALJ found McEwen's back injury was compensable and ordered payment of income benefits, as well as authorization of medical treatment. In reaching that conclusion the ALJ noted McEwen had testified she did not have any prior back problems and did not have any injury to her back outside of her job with Bremen.

Bremen appealed to the Appellate Division, which reversed the ALJ's decision and denied McEwen's claim for benefits. In reaching its decision the Board relied heavily on McEwen's alleged testimony that she did not have a specific work injury and did not report a work injury to Bremen. The Board's decision was affirmed on appeal by the Superior Court.

The Court of Appeals vacated the decision of the Superior Court and the Appellate Division, and remanded the case to the Board for further consideration. In doing so, the Court of Appeals found that, while the Appellate Division is authorized to substitute its own factual

findings for those of the ALJ if it determines that the ALJ's findings were not supported by a preponderance of the evidence, the Appellate Division cannot base its decision on an erroneous finding of fact. The Court noted that there was no testimony by McEwen that she did not report a work injury to Bremen, and, in fact, McEwen testified she told her supervisor she injured herself at work. The Court of Appeals, therefore directed the Board to "reconsider the case in light of all relevant testimony."

Summary prepared by Jeff K. Stinson, jstinson@gmlj.com.

WORKERS' COMPENSATION/CAUSATION: An employee terminated for reasons unrelated to his workers' compensation injury carries the burden to prove his inability to find work is proximately caused by the injury.

Veolia Environmental Services v. Vick, 309 Ga. App. 658, decided May 2, 2011.

On April 27, 2007, Jeffrey Vick fell and broke his left ankle in the course of his employment with Veolia Environmental Services. After receiving temporary total disability benefits, Vick returned to light duty work on June 28, 2007 and continued working with restrictions until March 2008, when he was given a prescription for morphine by his personal doctor.

Pursuant to its drug policy, which requires employees in safety sensitive positions to report the use of prescription medications that may prevent the safe performance of the job, Veolia removed Vick from work until he provided a clearance letter from his doctor stating it would be safe for him to work while on the medication. Veolia terminated Vick's employment on May 2, 2008, after he repeatedly failed to provide the requested documentation.

Vick requested a hearing seeking temporary partial disability benefits for the time that he worked on light duty restrictions and temporary total disability benefits from his last day of work. The ALJ denied the request for temporary total disability benefits finding that Vick had not made a diligent job search, but he did award temporary partial disability benefits. The ALJ further determined that Vick was

entitled to continuing temporary partial disability benefits after his termination because Veolia had not met its burden of proving a change in condition.

The Appellate Division reversed the award of continuing temporary partial disability benefits after Vick's termination. Vick appealed to the Superior Court, which remanded the case back to the Appellate Division with the instruction to place the burden of proof on Veolia to show that Vick was not entitled to temporary partial disability benefits after his termination. Veolia appealed, arguing the Superior Court erred in ruling Veolia had the burden of proving Vick was not entitled to temporary partial disability benefits after his termination.

The Court of Appeals agreed and reversed the Superior Court's judgment, holding that an injured employee who is terminated for reasons unrelated to his injury has the burden to prove his inability to find worked is proximately caused by the injury in order to qualify for income benefits.

Summary prepared by James R. Reed, jreed@gmlj.com

Florida Liability and Coverage

EVIDENCE/EXPERT TESTIMONY: Plaintiff's treating physician was not considered an expert witness such that the pretrial requirements of Rule 1.280(b)(4) did not apply.

Claire v. Perry, 2011 WL 519952 (Fla. 4th DCA), February 16, 2011.

Maria Claire, brought a personal injury action for alleged injuries sustained in an automobile accident. After Perry admitted negligence, the case went to trial on the issue of damages only.

At trial, Claire sought to introduce the testimony of her treating physician, Dr. Theophilos. Perry objected to the portion of Dr. Theophilos' testimony that dealt with whether Claire sustained a permanent injury. Perry objected on the basis that the doctor's testimony constituted an expert opinion which was not properly disclosed pursuant to Fla. R. Civ. P. 1.280(b)(4). Claire had not provided notice of the doctor's opinion, which would be required if Rule 1.280(b)(4) applied.

The trial court initially agreed and excluded the doctor's testimony on his opinion regarding permanency. The jury found that Claire had not sustained any permanent injury and Claire made a Motion for New Trial on the grounds that the doctor was not an expert witness and was not subject to the Rule 1.280(b)(4) requirement. The trial court agreed and granted a new trial. Perry appealed.

Rule 1.280 provides that a party is entitled to the "facts known and opinions held by experts" retained by the other party to testify at trial. This rule, however, applies only to facts and opinions "acquired or developed in

anticipation of litigation or for trial." The appellate court stated that the record reflected that Dr. Theophilos was the plaintiff's treating doctor and his opinions were not "acquired or developed in anticipation of litigation or for trial," as the court interpreted this phrase. The appellate court noted that while a treating doctor is unquestionably an "expert" under Florida case law, he does not acquire his expert knowledge for the purpose of litigation, but simply in the course of attempting to make his patient well. Therefore, the court noted, a treating physician is not normally classified as an expert for the purposes of Rule 1.280(b)(4), prescribing disclosure of expert opinions.

The appellate court affirmed the trial court's grant of a new trial, holding that without a new trial Claire would have been substantially prejudiced in her ability to present her case since the trial court found that the doctor was a critical witness for her. The appellate court noted that had Perry shown that the doctor had derived his permanency opinion by reviewing the medical records or conclusions of other physicians as part of litigation preparation it might rule otherwise. Without any other basis of his opinion other than his treatment of Claire, however, Rule 1.280(b)(4) did not apply.

*Summary prepared by Michelle E. Concepcion,
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TORTS/CONSORTIUM CLAIM: Spouse was entitled to a new trial where jury failed to award any damages for loss of consortium claim when undisputed testimony was presented supporting the claim.

Peterson v. Sun State International Trucks, LLC, 56 So.3d 840 (Fla. 2d DCA), decided March 25, 2011.

Lori Peterson was injured when she was rear-ended in an automobile accident. She and her husband filed a lawsuit against Sun State International Trucks, the employer for the driver who struck her, including in their action a claim for loss of consortium by Mr. Peterson.

Sun State admitted liability but defended claiming that Mrs. Peterson's injuries were not permanent, and that her physical problems stemmed from pre-existing conditions and a subsequent automobile accident. At trial the jury found that Mrs. Peterson had sustained a permanent injury and awarded her damages for past and future medical expenses, and for past and future noneconomic damages. The jury did not, however, award Mr. Peterson anything for his loss of consortium claim.

The Petersons moved for a new trial arguing, among other issues, that the jury's failure to award Mr. Peterson anything for his claim for loss of consortium entitled them to a new trial. The trial court denied the motion for new trial, finding that since the jury found Mrs. Peterson's injury did not affect the Petersons' marital relationship, it was supported.

The appellate court explained that a claim for loss of consortium is one for the loss of the companionship and fellowship of husband and wife, and the right of each to the company, cooperation, and aid of the other in every conjugal relation, including that affection, solace, comfort, companionship, conjugal life, fellowship, society and assistance so necessary to a successful marriage.

When a jury finds one spouse has sustained an injury, in order to prevail on a claim for loss of consortium, the claiming spouse must present competent testimony about the impact that the incident has had on the marital relationship.

The test for granting a new trial to a spouse that was awarded zero damages on a loss of consortium claim under Florida law is whether testimony establishing the substantial impact the accident had on the marital life of the couple is 'substantial,' 'undisputed,' and 'unrebutted.'

The appellate court reviewed the evidence introduced at trial regarding the impact Mrs. Peterson's injuries had on their relationship, and her inability to contribute in the same manner as before the accident. The Court found the undisputed evidence was sufficient to require an award of at least nominal damages for Mr. Peterson's loss of consortium claim.

Despite some conflicting evidence regarding Mrs. Peterson's injuries, there was no disputing or contradicting evidence regarding Mr. Peterson's consortium claim. As such, the Court held that the trial court should have granted a new trial and ordered the case be remanded for a new trial limited to the issue of the amount of damages on Mr. Peterson's loss of consortium, even if nominal.

Summary prepared by Michelle E. Concepcion, mconcepcion@gmlj.com.

UNINSURED MOTORIST CLAIM/BAD FAITH: Bad faith claim is premature where appeal is pending for underlying UM claim for damages.

Illinois National Ins. Co. v. Bolen, 53 So.3d 388 (Fla. 5th DCA), decided February 4, 2011.

Patricia Bolen was involved in an automobile accident and made an uninsured motorist claim with her insurer, Illinois National Insurance Company.

When Illinois denied the claim, Bolen filed a Complaint against Illinois alleging claims for Uninsured Motorist benefits and for bad faith for Illinois' alleged breach of its fiduciary duty in the handling of Bolen's UM claim. Illinois moved to dismiss alleging there had been no final determination of liability and damages against the tortfeasors. The trial court abated the bad faith claim until there had been a final determination of liability and damages against Illinois on Bolen's UM claim.

The UM claim proceeded to trial and a verdict of \$870,366.90 was returned against Illinois. Illinois appealed. Bolen then moved to dissolve the abatement of her bad faith claim. Illinois argued that dissolving the abatement was premature where its appeal was still pending.

The appellate court agreed with Illinois and held that the bad faith claim could not proceed until the UM carrier's appeal was finally determined.

Summary prepared by Michelle E. Concepcion, mconcepcion@gmlj.com.

INSURANCE COVERAGE/PROPERTY: Summary judgment was improperly entered in favor of insurer on issue of coverage; excavator that struck insured's building foundation was considered a "vehicle" within the meaning of the named perils building and personal property policy.

Barcelona Hotel, LLC v. Nova Casualty Co., 57 So.3d 228 (Fla. 3d DCA), decided March 2, 2011.

The Barcelona Hotel sustained damage to its foundation from a City of Miami Beach contractor operating an excavator. Barcelona made a property damage claim under its building and personal property insurance policy with Nova Casualty Co. Barcelona's policy provided coverage for named perils. The policy included the following language:

Aircraft or Vehicles, meaning only physical contact of an aircraft, a spacecraft, a self-propelled missile, a *vehicle* or an object thrown up by a vehicle with the described property or with the building or structure containing the described property.

Nova denied coverage for Barcelona's claim, stating that the policy provided basic named peril coverage, and that Barcelona's loss did not fall within those named perils. Barcelona filed an action for breach of the

insurance policy against Nova for damages and Nova counterclaimed seeking declaratory judgment.

Nova moved for summary judgment and argued that the damage from the excavator that struck the building did not fall within the covered causes of loss. After the trial court requested the parties brief the issue of whether the excavator was a "vehicle" under the policy, the court granted Nova's motion for summary judgment on the basis that the excavator was not a vehicle. The court entered final summary judgment against Barcelona.

On appeal by Barcelona the Court reviewed the trial court's finding, pointing out Florida law on the interpretation of an insurance policy is that an undefined term should be given its plain and ordinary meaning. The term "vehicle" was not defined in the Nova policy.

The Court noted that in construing terms appearing in insurance policies, Florida courts commonly adopt the meaning of words from legal and non-legal dictionaries. The definition of vehicle does not require a certain speed or the ability to travel on roadways.

The Court also noted that the inclusion of the term “vehicle” in the definition and endorsements to the policy supported its interpretation of including the excavator within the definition of vehicle. The Mobile Equipment endorsement included reference to what

“vehicles” were covered which included vehicles maintained to provide mobility to permanently mounted shovels and diggers. Nothing in the policy stated that a vehicle was excluded because it is mobile equipment.

The Court held that the trial court erred and reversed the granting of summary judgment.

Summary prepared by Michelle E. Concepcion, mconcepcion@gmlj.com.

Florida Workers’ Compensation

STANDARD FOR ATTORNEY FEES: Workers’ compensation statute limits claimants’ attorney fees to a percentage of benefits obtained.

Kauffman v. Community Inclusions, Inc./Guarantee Insurance Co., 57 So. 3d 919 (Fla. 1st DCA), decided March 23, 2011.

Kauffman retained an attorney, who, after a Final Merit Hearing, secured \$3,417.03 in benefits on her behalf. The JCC awarded a fee for the benefits obtained. In his Order as to the amount of fee awarded, the JCC found a reasonable fee to be \$25,075.00. Nonetheless, the JCC concluded that the statute limited the fee to a percentage of benefits obtained, and ultimately awarded a fee of \$684.41 pursuant to the percentages set forth in section 440.34(1), Florida Statutes.

Kauffman appealed and argued the JCC either misinterpreted the amended statute, or alternatively, that the statute correctly interpreted is unconstitutional.

Section 440.34(3) provides that a claimant is entitled to recover a fee from the Employer/Carrier “in an amount equal to the amount provided for in subsection (1) of subsection (7) [disputed medical only claims].”

Relying on its plain language, the First District Court found the statute clearly limits attorney fees to a percentage of benefits obtained, based on the formula set forth in subsection (1).

As it had done previously, the First DCA further rejected Kauffman’s arguments as to equal protection, due process, separation of powers, and access to courts.

Thus, at this juncture, attorney fees awarded in relation to post-July 1, 2009 (the date section 440.34(3) was amended to exclude the “reasonableness” requirement) dates of accident are limited to a percentage of total benefits obtained.

Summary prepared by Kristen L. Magana, kmagana@gmlj.com.

DETERMINING APPROPRIATE HOURLY RATES: In arriving at an hourly rate, JCCs must rely upon evidence properly submitted, not unsworn responses and arguments of counsel.

McDermott v. United Parcel Service/Liberty Mut., 57 So. 3d 933 (Fla. 1st DCA), decided March 28, 2011.

At hearing on the amount of McDermott's counsel's attorney fee, McDermott's attorney offered evidence in support of his position that he should be awarded an hourly fee between \$300 and \$400. In response, counsel for the Employer/Carrier argued that the customary hourly rate in the locality for similar services was \$200. The JCC ultimately accepted counsel's argument as testimony and awarded an hourly rate of \$200.

Section 440.34(1)(b), Florida Statutes, requires the JCC to determine, when awarding a fee based on an hourly rate, "[t]he fee customarily charged in the locality for similar legal services." The JCC must rely upon evidence properly submitted in arriving at the customary fee, not his subjective belief and personal experience. Thus, unsworn responses and arguments of counsel (such as that offered

by the E/C's counsel at this hearing) are not evidence upon which a JCC may rely when determining the amount of a reasonable fee.

In other words, when contesting the hourly rate to be paid to Claimant's counsel, the E/C must either provide a sworn statement at hearing and/or a written verified response to Claimant's petition; alternatively (or, as a supplement to their argument), it might be beneficial to appoint an expert attorney who might provide evidence of a lower hourly rate via an affidavit or sworn testimony.

As no such evidence was provided by the E/C, the JCC's finding that the \$200 was the customary hourly rate was reversed.

Summary prepared by Kristen L. Magana, kmagana@gmlj.com.

EMPLOYER/CARRIERS' ENTITLEMENT TO COSTS: Statutes pertaining to suits brought at law or in admiralty, and addressing enforcement and sanctions, do not restrict Employer/Carriers' entitlement to prevailing party costs.

Punsky v. Clay County Bd. of County Commissioners and Scibal Assoc., 60 So. 3d 1088 (Fla. 1st DCA), decided March 31, 2011.

After prevailing at Final Merit Hearing on the issue of compensability of Punsky's heart condition, the JCC awarded costs to the Employer/Carrier in the amount of \$8,992.93.

On appeal, Punsky argued that, to the extent the E/C are entitled to costs at all, (1) per section 440.19(6), Florida Statutes, the award may not exceed \$250 in cases where they prevail on the issue of compensability, and (2) if prevailing party costs may be awarded, they are entitled to only \$1,116.70 as Chapter 440 precludes recovery of costs incurred for depositions, experts and IMEs.

As to the first argument, the First DCA concluded that section 440.19(6) applies only when a claimant first proceeds against an employer at law or in admiralty, and such relief

is denied on the basis of workers' compensation exclusivity/immunity. In this case, the E/C were not seeking to recover costs incurred in that specific situation, such that the limits set forth in section 440.19(6) do not apply.

The First DCA also rejected the Claimant's arguments under section 440.24(4), which addresses enforcement and sanctions. Because the E/C were proceeding under section 440.34(3) (concerning any prevailing party's entitlement to costs), the Court concluded that 440.24(4) simply had no bearing on the instant case.

As to the argument pertaining to the specific costs awarded, Claimant's arguments under section 440.13(5) and section 440.30 were rejected in favor of application of section

440.34(3), which makes the award of costs mandatory, and expands the right to recover costs to all the parties, not just the Claimant.

In light of the foregoing conclusions, the JCC's award of \$8,992.93 in costs was affirmed.

(As an aside, the Court recognized that the E/C could go to the circuit courts for enforcement of this order.)

Summary prepared by Kristen L. Magana, kmagana@gmlj.com.

CLAIMANT'S UNEQUIVOCAL RIGHT TO A ONE-TIME CHANGE: Employer/Carrier must name at least one physician not professionally affiliated with currently authorized physician within five days of request for a one-time change.

Seigler v. RMC Americas of Florida, LLC, 57 So. 3d 913 (Fla. 1st DCA), decided March 22, 2011.

Seigler submitted a request for a one-time change on April 14, 2010. The E/C's attorney reviewed the letter on April 20, 2010, at which time he located and contacted Dr. Zeigler inquiring as to whether he would treat Seigler. Dr. Zeigler requested medical records to review first, and counsel for the E/C instructed his office to submit same. Later that day, counsel for the E/C contacted counsel for Seigler advising that the one-time change had been authorized.

Counsel for the E/C followed up with Dr. Zeigler's office on May 10, 2010, at which time he was informed that no appointment had been scheduled. Two days later, the appointment was scheduled for May 17, 2010. The letter advising Seigler and his attorney of the appointment was mailed the same day, on May 12, 2010.

In his Final Compensation Order, the JCC concluded that the E/C is not obligated to provide a specific doctor within five days of the request, and that the E/C's attorney's actions following receipt of Seigler's letter were "prudent, timely, swift and responsive." Thus, the JCC found that the E/C's authorization of Dr. Zeigler was proper and timely under section 440.13(2)(f), Florida Statutes.

Section 440.13(2)(f) provides that, "upon written request of the employee, the

carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident ... The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary."

Relying upon the statute and its earlier holding in *Harrell v. Citrus County School Bd.*, 25 So. 3d 675 (Fla. 1st DCA 2010), the Court of Appeals noted that simple acknowledgement of a claimant's statutory entitlement to a one-time change is not sufficient to comply with the statute. Compliance requires an E/C to name at least one physician within five days of the written request.

Thus, the JCC erred in denying Claimant the right to select his change in physician, and the matter was reversed and remanded for further proceedings.

Summary prepared by Kristen L. Magana, kmagana@gmlj.com.

ENTITLEMENT TO PERMANENT TOTAL DISABILITY BENEFITS: When determining whether Claimant is entitled to permanent total disability benefits, the adequacy of his job search must be considered.

Martinez v. Lake Park Auto Brokers, Inc., 60 So. 3d 522 (Fla. 1st DCA), decided April 29, 2011.

Martinez filed a claim for permanent total disability (PTD) benefits, citing restrictions imposed by a doctor, vocational factors and evidence of a good faith unsuccessful job search.

The JCC relied upon the doctor's testimony that Martinez could work four hours per day at a sedentary level and the testimony of one of the vocational experts' that Martinez was employable within those restrictions. In his Final Compensation Order, the JCC concluded that Martinez "has failed to sustain his burden of proof to show that he is unable to engage in, at least sedentary work, within a 50-mile radius of his residence, due to the physical limitations resulting from the [date of] accident." Thus, the claim for PTD benefits was denied.

Section 440.15(1)(b), Florida Statutes provides that an injured worker may prove entitlement to PTD benefits by "establish[ing] that he or she is not able to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to his or her physical limitation." However, the Court recognized a total of three alternative methods by which a claimant may prove entitlement to PTD benefits: by presenting evidence of (1) permanent medical incapacity to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to

physical limitation; (2) permanent work-related physical restrictions coupled with an exhaustive but unsuccessful job search; or (3) permanent work-related physical restrictions that, while not alone totally disabling, preclude Claimant from engaging in at least sedentary employment when combined with vocational factors.

While the JCC's Order addressed the first method (i.e., Martinez's physical limitations), the JCC failed to consider the possibility of entitlement under the second method (adequacy of Martinez's job search). Moreover, the Court rejected the E/C's contention that Martinez must present direct proof of a causal connection between his physical limitations and his unsuccessful job search, noting that a finding could be inferred from Martinez's inability to find employment.

Ultimately, the Court reversed the UCC Order and remanded with instructions that the JCC consider the adequacy of Martinez's job search (the Court did note that the JCC retained a good deal of discretion in determining the adequacy of the search), in addition to the factors included in section 440.15(1)(b).

Summary prepared by Kristen L. Magana, kmagana@gmlj.com.

North Carolina Liability and Coverage

GOVERNMENTAL IMMUNITY: Where county operated a public park in the same manner it could have been operated by a private business, it was not afforded governmental immunity.

Estate of Erik Dominic Williams v. Pasquotank County Parks and Recreation Department and Pasquotank County, 2011 WL 1646957 (N.C. App.), decided May 3, 2011.

Erik Williams drowned at a public park owned by Pasquotank County and operated by Pasquotank County Parks and Recreation Department. The park contained a pond, swimming pool, picnic tables, pavilion and playground. The Estate filed a civil action for wrongful death against Pasquotank County alleging negligence. Pasquotank County answered the Complaint and asserted, *inter alia*, the defense of governmental immunity. The trial court denied Pasquotank County's Motion for Partial Summary Judgment on its defense of governmental immunity which found the proprietary nature of the park's operation precluded the defense of immunity. Pasquotank County appealed.

The Court of Appeals affirmed. In holding that the operation of the public park was a proprietary function, the Court set forth the following test in an effort to distill controlling law from prior "irreconcilable splits of authority:" (1) whether the undertaking is one traditionally provided by local governmental units; (2) if the undertaking of the municipality is one in which *only* a governmental agency

could engage, or if any corporation individual or group of individuals could do the same thing; (3) whether the county charged a substantial fee; and (4) if a fee was charged, whether a profit was made.

The Court agreed that the operation of a public park was traditionally a governmental function, that the defendant charged only a \$75.00 rental fee for the use of the facility for a private party, generated only \$2,052 in revenues from the park, and incurred \$160,384 in operating costs from the park (a ratio of 1.3% revenue to expenditures). However, the Court of Appeals determined that second factor of the test was the "guiding principle" and found that the park was the type of entity that any corporation, individual or group of individuals could have operated. The Court deemed the operation of the park a proprietary function thereby precluding Pasquotank County's defense of governmental immunity.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.

INSURANCE LAW/COVERAGE: Summary judgment for CGL insurer in declaratory judgment action against additional CGL insurer for contribution is not appropriate where affidavit of repairman indicated water intrusion caused damage to previously undamaged property of insured.

Builders Mutual Ins. Co. v. Maryland Cas. Co., et al., 709 S.E.2d 528 (N.C. App.), decided April 5, 2011.

McKinney, a homeowner, built a residence in 1992, thereafter experiencing water drainage and rot issues resulting in damages to the home's interior and decks. McKinney hired Umstead, an insured contractor, to repair the residence. After six years of attempted repairs, McKinney fired Umstead when he discovered that the repairs were not being performed in a workmanlike manner.

McKinney hired another contractor to complete the work and filed suit against Umstead under various theories, including negligence. The case against Umstead was defended and settled by Umstead's insurer, Builders Mutual Insurance, who provided CGL coverage to Umstead for the first three years of the repair project. Builders filed a complaint for a declaratory judgment against Maryland Casualty Company, who provided CGL coverage to Umstead for the remainder of the project's duration, seeking contribution for half of the costs of defense and settlement. The trial court granted summary judgment to Maryland Casualty.

The Court of Appeals reversed. In opposition to the appeal, Maryland Casualty argued that all of the homeowner's damages (which had been paid by Builders in settlement) fell outside the scope of Maryland Casualty's coverage as resulting from faulty workmanship provided by Umstead. However, Builders

submitted an affidavit from the contractor who completed the repair project stating that the work provided by Umstead resulted in damage to *previously undamaged* portions of the home. The affidavit included the opinion that the damage to previously undamaged areas was caused by Umstead's failure to protect the home from physical damage during the repair work.

The Court of Appeals relied upon the affidavit submitted by Builders in concluding that the damage to the previously undamaged portion McKinney home could constitute an "accident," thus "occurrence," triggering coverage under the Maryland Casualty policy. As the non-moving party, the Court assumed that the facts in the contractor's affidavit were true, holding that the credibility, expertise and knowledge of the contractor could not be examined in summary judgment. In reversing the trial court, the Court of Appeals held that the extent and nature of the damage to the previously undamaged property of the homeowner presents a genuine issue of material fact for the jury and summary disposition was inappropriate. For the same reasons, the Court also held that the exclusions for "your work" contained in the Maryland Casualty policy also necessitated determination by the jury.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.

COVERAGE: An intoxicated motorist who does not have a driver's license and is instructed not to drive an insured's vehicle while drinking is not afforded liability coverage due to a lack of a reasonable belief that he was entitled to operate the vehicle.

State Farm Mutual Ins. Co. v. Bustos-Ramirez, Perez and Arriaga, 2011 WL 1467583 (N.C. App.), decided May 17, 2011.

Perez, an unlicensed driver, resided with Ramirez, an automobile owner, for a period of several years. Prior to the date of loss, Ramirez "specifically instructed" Perez not to use his

vehicle when he had been drinking. The jury also received evidence that Perez had been allowed to use Ramirez's vehicle in the past, despite his lack of a driver's license. On January

11, 2009, Perez took the keys to the Ramirez vehicle without permission and was involved in an accident that killed a passenger in his vehicle. Perez was drinking on the night of the accident.

State Farm filed a declaratory judgment action seeking a judgment that it did not provide coverage to Perez for the death of the passenger. Summary judgment was granted for State Farm. The passenger's estate appealed.

The Court of Appeals held that the evidence presented revealed that Perez did not possess a driver's license, did not ask for permission to use the vehicle on the night of the accident and admitted that he had been instructed not to drive Ramirez's vehicles.

However, conflicting evidence was presented indicating that Perez had operated Ramirez's vehicles on prior occasions. While the Court of Appeals acknowledged that a genuine factual dispute existed as to whether Perez had been allowed to operate Ramirez's vehicles on other occasions, there was no dispute that Ramirez had told Perez not to use his vehicles after consuming alcohol. Therefore, the Court held that Perez could not have a reasonable belief that he was entitled to operate the Ramirez vehicle on the night in question, precluding coverage under the policy.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.

North Carolina Workers' Compensation

WORKERS' COMPENSATION: An Opinion and Award issued by the North Carolina Industrial Commission that reserves the issue of an employee's continuing disability for future determination is not ripe for appeal because there is no final order.

Allison v. Wal-Mart Stores, Inc., 2011 WL 1843860 (N.C. App.), decided May 17, 2011.

The parties stipulated that Allison suffered an injury by accident and sustained a contusion and lumbar sprain. Allison requested and was granted a hearing on the issue of permanent partial disability, medical expenses and additional medical treatment, which was denied by the employer. Following a denial of benefits by the deputy commissioner, the Full Commission awarded Allison the relief sought, but expressly reserved the right to make a future determination as to Allison's continuing disability, citing insufficient evidence. Wal-Mart appealed.

The Court of Appeals held that Wal-Mart's appeal was improper in that there was no final order entered by the Full Commission. The Full Commission's Opinion and Award was an order that "contemplates further proceedings or which does not fully dispose of the pending stage of the litigation." Therefore, the issue was not ripe for appeal.

Summary prepared by Adam E. Whitten, awhitten@gmlj.com.

WORKERS' COMPENSATION: When the carrier's last payment of benefits was issued on July 31, 2003, and employee applied for additional compensation on July 18, 2007, the claim was barred by the statute of limitations, despite ongoing treatment to the same body part.

Theresa A. Busque v. Mid-America Apartment Communities, 707 S.E.2d 692 (N.C. App.), decided March 1, 2011.

Theresa Busque suffered from a foot condition arising in 1995. On January 18, 2003, Busque tripped and fell while working for the Mid-America Apartment Communities. Busque was released from care on April 21, 2003. By letter dated July 11, 2003, Busque was notified that Mid-America would not approve further medical treatment and her last medical expense was paid by check dated July 31, 2003. The record reveals that the employee continued to receive ongoing treatment, all of which was denied pursuant to the carrier's July 11, 2003 letter.

As part of her ongoing medical treatment, Busque was informed that she may be a candidate for a surgically implanted spinal

cord stimulator, and she filed a Form 33 requesting a hearing. The Full Commission awarded Busque a second opinion evaluation and rating at Mid-America's expense, which Mid-America appealed.

The Court of Appeals agreed with Mid-America and reversed the Full Commission's order awarding Busque a second opinion. The Court of Appeals relied upon the fact that there was no "continuing denial" by Mid-America as Busque did not make a single filing with the Industrial Commission in the two years following Mid-America's denial letter.

Summary prepared by Adam E. Whitten, awhitten@gmlj.com.

WORKERS' COMPENSATION: Where employer requests and receives a reduction in its policy premium due to a change in its operation, the fact that it has paid more than the required 50% premium deposit does not relieve it of the obligation to make quarterly payments of the remaining balance.

Herbert M. Bell v. Hype Manufacturing, LLC., 705 S.E.2d 926 (N.C. App.), decided March 1, 2011.

Hype Manufacturing was a California corporation expanding into North Carolina to operate a NASCAR team. Hype secured a policy of workers' compensation insurance from the carrier and paid a 50% premium deposit consistent with the NC Rate Bureau deposit premium guidelines. Following receipt of a bill from the carrier seeking payment of the quarterly premium due, the employer requested and received a premium reduction resulting from the closing of a North Carolina facility.

The carrier properly acted upon the premium reduction and adjusted the policy premium accordingly. While the premium reduction went into effect three days before the quarterly payment became due, no payment was

tendered by the employer. The policy was cancelled effective September 11, 2006.

On September 28, 2006, Herbert Bell sustained an on-the-job injury and payment was forwarded to the carrier on the same day. The carrier processed the payment and reinstated coverage effective September 29, 2006. Following the settlement of Bell's claim, Hype sought reimbursement from the carrier for the amounts paid to resolve the claim. The Full Commission denied reimbursement to the employer and deemed effective the carrier's cancellation of the policy between September 11 and September 29.

The Court of Appeals affirmed the Full Commission's decision, holding that the

premium reduction processed by the carrier did not absolve the employer from its contractual duty to make a quarterly payment. While the premium reduction resulted in an overpayment of the 50% premium due at the inception of the policy, the NC Rate Bureau guidelines required the remaining balance to be paid in three equal

quarterly installments. The employer failed to make any payment in accordance with the Rate Bureau guidelines thus providing the basis for an effective cancellation for non-payment.

Summary prepared by Adam E. Whitten, awhitten@gmlj.com.

WORKERS' COMPENSATION: Where employee suffers from four separate compensable work-related injuries (an injury with three aggravations), and the carrier denies the claim citing the lack of a specific traumatic incident, the carrier defended the claim without reasonable ground and is taxed with attorney's fees.

Terry Cawthorn v. Mission Hospital, Inc., 2011 WL 1467583 (N.C. App.), decided April 19, 2011.

Terry Cawthorn was employed by Mission Hospital for over twenty years. Cawthorn alleged an injury to her low back following a post-surgical patient transport. The injury was reported to Cawthorn's supervisor the next day, and a report was entered into a computerized reporting system before Cawthorn was seen by the Mission's staff physician. While remaining on restricted duty, Cawthorn sustained three separate aggravations as a result of lifting. In a conversation with Cawthorn, an adjuster for the self-insured hospital informed Cawthorn that her claim was denied because she had not slipped, tripped or fallen during the patient transfer where she alleged the injury was received.

The Full Commission found that Cawthorn was disabled by a specific traumatic incident and awarded benefits, attorney's fees pursuant to N.C.G.S. § 97-88, but denied attorney's fees pursuant to N.C.G.S. § 97-88.1. Both parties appealed.

The Court of Appeals affirmed the award of temporary total disability benefits and reversed the Full Commission's denial of attorneys fees under N.C.G.S. § 97-88.1 based upon an unreasonable defense of a legitimate claim. Cawthorn's evidence revealed that Mission's own staff, records, and medical experts added to the "overwhelming evidence" of a compensable injury.

The Court of Appeals held that Mission intentionally disregarded information indisputably known to it, and affirmatively failed to investigate obvious avenues that would clarify the events surrounding the reported injuries. That conduct was not only unreasonable, but was a "conscious attempt to mislead Plaintiff as to her entitlement to workers' compensation benefits." The case was remanded to the Industrial Commission to determine the amount of attorney's fees.

Summary prepared by Adam E. Whitten, awhitten@gmlj.com.

WORKERS' COMPENATION/SUBROGATION: Court of Appeals upheld trial court's reduction of workers' compensation subrogation lien from \$238,470.54 to \$30,000.00 where lien was created pursuant to Tennessee law but the forum of the negligence action was in North Carolina.

Cook v. Lowe's Home Centers, Inc., et al., 704 S.E.2d 567 (N.C. App.), decided January 18, 2011.

Cook was employed by a Tennessee corporation, but working on the premises of Lowe's Home Improvement, Inc. in North Carolina. Cook sustained an injury arising out of his employment and sought workers' compensation benefits pursuant to the laws of Tennessee. A Tennessee Chancery Court approved a lump-sum settlement agreement between Cook, his employer and its workers' compensation insurer. The total payments made to the Plaintiff following settlement totaled \$238,470.54 and the insurer maintained a lien in that amount.

Cook filed a civil action against Lowe's and others alleging negligence. A settlement was reached between all parties in the amount of \$220,000.00, and Cook dismissed the action as to the alleged tortfeasors. Immediately thereafter, Cook filed a motion in Guilford County Superior Court seeking to extinguish or

otherwise reduce the amount of the workers' compensation lien pursuant to N.C.G.S. § 97-10.2(j). The Court reduced the lien held by the employer/carrier to \$30,000.00. The employer/carrier appealed, arguing that the lien held by Lowe's was governed by Tennessee law and was not subject to reduction pursuant to N.C.G.S. § 97-10.2(j).

The Court of Appeals held that a workers' compensation lien provides a remedial benefit, thus the law of the forum where the remedy is sought controls. Cook sought recovery of damages for negligence in the forum of North Carolina and the law of North Carolina applies. The Court of Appeals affirmed the decision of the trial judge in reducing the workers' compensation lien.

Summary prepared by Adam E. Whitten, awhitten@gmlj.com.

South Carolina Coverage

COVERAGE UNDER A CGL POLICY FOR FAULTY WORKMANSIP IN SOUTH CAROLINA: The South Carolina Supreme Court found faulty workmanship was not an occurrence under a CGL policy. Four months later the South Carolina legislature passed a law stating it was.

Crossman Communities of North Carolina, Inc. v. Harleysville Mutual Insurance Company, 2011 WL 93716 (S.C. Supreme Court), decided January 7, 2011.

South Carolina Law S. 431, South Carolina Code Section 38-61-70 (May 17, 2011).

Crossman Communities of North Carolina, Inc. was a developer of several condominium projects in South Carolina. Homeowners filed suit against Crossman for

negligent construction. Crossman settled the homeowner suits and sought coverage from its commercial general liability (CGL) insurer, Harleysville Mutual Insurance Company. The

trial court found the homeowners' claims against Crossman were covered "occurrences" under the insuring agreement of the Harleysville policy which covered "property damage" caused by an "occurrence." The policy defined an "occurrence" as "an accident including continuous or repeated exposure to substantially the same general harmful conditions."

The South Carolina Supreme Court reversed the trial court, in a yet to be published opinion. The South Carolina Supreme Court found that the faulty workmanship alleged against Crossman was not an "occurrence" under the Harleysville CGL policy. The Court held that damages to the insured's project were not "occurrences" since the damages were the natural and probable consequence of faulty workmanship. Thus, for faulty workmanship to be covered, it must result in an unintended, unforeseen, fortuitous or injurious event.

In this case, the South Carolina Supreme Court overruled its previous decision in *Auto Owners Ins. Co. v. Newman*, 385 S.C. 187 (2009) to the extent *Newman* espoused coverage for faulty workmanship that caused damage to property in the absence of an "occurrence" with its fortuity underpinnings.

Rehearing was granted in the *Crossman* case in March 2011 with argument occurring in July 2011. As of the publication of this summary a decision from the rehearing has not yet been issued.

On May 17, 2011, the South Carolina Legislature passed S. 431 which the governor signed into law, and which will be codified as South Carolina Code Section 38-61-70. The South Carolina Code now states that CGL policies covering construction professionals' risks in South Carolina are "deemed to contain" a definition of the term "occurrence" which expressly includes "property damage" (or "bodily injury") resulting from faulty workmanship, exclusive of the faulty workmanship itself. The law is to be applied retroactively to any disputes pending as of the date of the signing. In July 2011, constitutional challenges to the retroactive nature of the law were raised, but have yet to be ruled upon.

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