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LEGAL UPDATE

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Use of Technology and Social Media In Investigations and Litigation

By: C. Wade McGuffey, Jr.

I. INTRODUCTION

Social media is ubiquitous and surrounds and affects our lives daily. Those who investigate claims or are involved in litigation must pay attention to online activities and behaviors. It is a new electronic world with a plethora of electronically generated information which you can use to assist you or which may be used against you. You ignore the technology at your own peril.

Social networking sites are often the best and most profitable sites to search when looking for information on an individual. The information available can include contact information, education and employment histories, photos, videos, emails, messages, lists of friends, associate information and other personal data. This data can and is being used by companies all over the world to challenge the veracity of claims that are being made.

Individuals can post information and pictures on these sites and often do so with wanton disregard for what others can see on the internet or who sees it. Anyone can look at unrestricted information. On Facebook, as with most sites, however, the user is permitted to select privacy settings that limit what the general public can view. The private information typically requires registration, a password and/or some form of a login or username to gain access to it.

Those searching for data must, however, be aware of the legal limitations and ethical obligations when investigating claims through internet based searches. Nonetheless, the public information alone can often be useful in investigations and litigation.

II. INVESTIGATION

One of the most popular aspects of the Internet is that it permits anonymity. Both the federal and state governments have attempted to regulate the access of information on the Internet. Privacy protections prevent providers of communication services from divulging private communications to certain entities and/or individuals. The status of obtaining social media information in a civil case is an area of the law that is rapidly developing. Currently, a civil subpoena cannot be used to compel a service provider to divulge content from its site.

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.

The type of information that can be obtained in response even to a legal request is restricted by federal law. In response to a subpoena, these social media outlets may lawfully produce basic subscriber information and IP logs for a user's account. They are prohibited, however, from lawfully producing the contents of a user's private mail messages or stored content files held or maintained on behalf of a user to any non-government entity, by the Stored Communications Act ("SCA") 18 U.S.C. §§ 2702-2703. The information that is protected includes, but is not limited to, friend lists, photos, blogs and private messages.

If these records are truly integral to the claim or case, the best mechanism for obtaining them is to get the owner of the account to consent. For civil matters, this consent must still be accompanied by a subpoena. To provide proper consent, the sites usually require that a user supply a signed statement containing the ID for the account, the password associated with the account, the user's zip code, and the birth date listed on the site. Another option for a case in litigation is to obtain an Order from the court compelling the owner of the account to consent to the disclosure of the emails in question.

In a recent civil case, the District Court for the Central District of California overruled a Magistrate Judge's determination that the Act did not apply because the communications were for public display. The California court concluded the SCA protection applied to private messages on social networking sites. Crispin v. Audugeir, 2010 U.S. Dist. LEXIS 52832 (C.D. Cal. May 26, 2010). In Crispin, the plaintiff wanted messages and wall posts to be subpoenaed from a social networking website. The California Court found that these items deserved the SCA's protection since they were not readily accessible to the general public. The court went one step further and implied that there might not be SCA protection for information on social networking websites that is available to a wider audience or lacks privacy restrictions.

Determining the privacy expectations of the users must be done on a case by case basis. States have not acted as pervasively as this federal court. Some states, however, do have laws limiting the disclosure of privacy information by Internet Service Providers. The laws often prohibit the disclosure of employee email and internet activity. Information kept in plain view, be it a telephone book or web page, is not subject to restriction in its viewing or use, however.

There are signs the law is changing. Last year, a New York trial court ordered a plaintiff in a personal injury case to execute an authorization for Facebook and MySpace to allow the defendant to obtain information from the plaintiff's "locked" account where pictures such as the plaintiff traveling at a time she claimed to be house-bound suggested that the non-public information might be used to support the defendant's claim the plaintiff was malingering. See Romano v. Steelcase, Inc., 907 N.Y.S.2d 650 (N.Y. Sup. Ct. 2010). The New York court held that because sites such as Facebook and MySpace advise their users that the information they download is not entirely private, that plaintiff's expectation no one other than those she invited would ever view her pictures and updates was "wishful thinking." Romano, 907 N.Y.S.2d at 656. In Pennsylvania, a trial court ordered the personal-injury plaintiff to provide his user name, login, and passwords to the social network sites plaintiff belonged to after a review of the public portions of his Facebook site revealed comments about his conduct which were inconsistent with his claimed injuries. See McMillian v. Hummingbird Speedway, Inc., No. 113-2010 CD (C.P. Jefferson County, Penn., Sept. 9, 2010).

As noted earlier, much of the information available through a Web based search is not available for public view. This information should not be acquired surreptitiously if you want to use it legally.

III. RESOURCES

There are a number of different media available and in use. Facebook is now the most popular social networking service. As of January 2011, Facebook has more than 750 million active users. Users may create a personal profile, add other users as friends, and exchange messages, including automatic notifications when they update their profile. Additionally, users may join common interest user groups, organized by workplace, school or college, or other characteristics. Interestingly, the company's fastest growing group of users is individuals 30 years and older.

One indication of how popular discovering information in social media has become is that Facebook, having received so many subpoenas, has recently been telling attorneys of an alternate way to obtain the information that Facebook would produce in response to a subpoena. By using the procedure outlined on its site, you can download anything the account user has ever placed on Facebook, even deleted postings and untagged photographs. The procedure recommended by Facebook is to have the claimant identify any social media account they have through discovery and then use a Request for Production of Documents to the Claimant/Plaintiff, including instructions of how to download the information, and provide the claimant with a flash drive on which to download the account information.

While most litigants respond honestly to discovery, to be absolutely certain that all available information is obtained, obtaining the information directly from Facebook is often required. Facebook requires that a court order for civil matters be obtained through California or a federal court to obtain information directly from it.

MySpace is a social networking website as well. The number of its monthly U.S. unique visitors is estimated at approximately 43.2 million. MySpace, which was active before Facebook existed, now is the second most popular social networking website primarily attracting the younger crowd from 18-29. MySpace requires personal service of legal requests to its registered agent in Los Angeles, California.

Twitter is a social networking and microblogging website, based in San Francisco, California. Twitter enables users to send and read text-based posts composed of up to 140 characters, called tweets, which are displayed on the user's profile page. The website has gained popularity worldwide and is estimated to have more than 200 million active users, generating 65 million "tweets" a day and handling over 800,000 search queries per day. Twitter requires a subpoena, court order, or other valid legal process to disclose information about our users. Most Twitter profile information is public, so anyone can see it. A Twitter profile contains a profile image, background image, and status updates, called Tweets. Private information requires a subpoena or court order.

LinkedIn is a business-oriented social networking site. It is mainly used for professional networking. As of 22 March 2011, LinkedIn reports more than 100 million registered users, spanning more than 200 countries and territories worldwide, with more than 21.4 million monthly unique U.S. visitors and 47.6 million globally. Additionally, service of process on LinkedIn requires service of process in San Francisco, California. Twitter refuses to honor requests for information that you provide without legal service of process.

YouTube is a video-sharing website on which users can upload, share, and view videos. Most of the content on YouTube has been uploaded by individuals, although media corporations including CBS, BBC, Vevo, Hulu and other organizations offer some of their material as part of a YouTube partnership program. Unregistered users may watch videos, and registered users may upload an unlimited number of videos. Videos that are considered to contain potentially offensive content are available only to registered users 18 and older. In November 2006, YouTube, LLC was bought by Google Inc. and now operates as a subsidiary of Google.

Google Inc. hosts and develops a number of Internet-based services and products. Google runs over one million servers in data centers around the world, and processes over one billion search requests and about twenty-four petabytes of user-generated data every day. Google is also considered by some as the most powerful brand in the world. Google has now started its own social networking site called "Google Plus." The dominant market position of Google's services has led to criticism of the company over issues including privacy, copyright, and censorship.

Google only shares personal information with other companies or individuals outside of Google in the following limited circumstances: (a) a consent, (b) to satisfy any applicable law, regulation, legal process or enforceable governmental request, (c) to enforce applicable Terms of Service, including investigation of potential violations thereof, (d) to detect, prevent, or otherwise address fraud, security or technical issues, or (e) to protect against harm to the rights, property or safety of Google, its users or the public, as required or permitted by law.

Yahoo! Inc. provides services via the Internet worldwide. Yahoo! Does not rent, sell or share personal information about its members with other people or non-affiliated companies except to provide products or services. Yahoo will provide information with its members' permission or in compliance with legal process.

AOL is best known for its online software suite, also called AOL, that allows customers to access the world's largest controlled online community and eventually reach out to the Internet as a whole. At its prime, AOL's membership had over 30 million members worldwide, most of whom accessed the AOL service through the AOL software suite. AOL says it will release non-content account information upon receipt of a properly issued subpoena.

IV. LITIGATION

In any case involving the potential need to access Web based information, once litigation is started then formal discovery that addresses the issues can be served in the form of interrogatories, requests to produce, requests to admit and subpoenas. The use of legal process can potentially help obtain electronic information from the internet sites. However, you should expect the opposing party to challenge these requests.

Before serving discovery or as a part of the initial efforts in a case, sending opposing counsel a litigation hold letter demanding that the information you (intend to) seek be preserved can help to ensure that electronically stored information is not altered. Data changes so quickly on the Web that the information sought may be deleted or changed before the investigating party actually has an opportunity to acquire it through answered discovery or produced responses. In United States v. Suarez, the court held that the government's failure to preserve text messages among police officers and an informant warranted an adverse inference instruction. 2010 WL 4226524 (D.N.J. Oct. 21, 2010)

As with a request for any information that is potentially harmful to their clients and their cases, Plaintiffs lawyers will oftentimes object to a request for the production of information from the different social media websites outlined above. Fortunately for the defense side of the cases, Judges are continually holding that well-tailored requests can be relevant to the case and order the production of the material.

CASE NOTES

Georgia Liability

GEORGIA DRAM SHOP ACT: Liability under the Georgia Dram Shop Act can apply to the sale of alcohol contained in closed or packaged containers not intended for consumption on the premises where sold.

Flores v. Exprezit! Stores 98-Georgia, LLC, 289 Ga. 466, 713 S.E.2d 368, decided July 5, 2011.

This lawsuit stems from a motor vehicle wreck in which six people were killed and several others were injured. Billy Joe Grundell drove with a passenger to a convenience store and was noticeably intoxicated when he walked in and purchased a 12-pack of beer in a closed container. Grundell and his passenger then drove off and consumed the beer while driving. Grundell subsequently crossed the centerline of the highway and ran head-on into a van traveling in the opposite direction. Grundell was found to have a blood alcohol concentration of 0.181.

Suit was brought against the convenience store owned by Exprezit! Stores 98-Georgia, LLC under the Dram Shop Act. Exprezit! filed a motion for summary judgment arguing the Dram Shop Act does not apply to circumstances where a store sells closed or packaged alcoholic beverages not intended for consumption on the premises.

The trial court granted summary judgment, and the Court of Appeals affirmed.

On further appeal, the Supreme Court of Georgia disagreed with both the trial court and the Court of Appeals. It held that when a

convenience store sells alcoholic beverages to a customer it will often have an opportunity to observe how the customer arrived, and conversely, the manner in which he will depart. In that connection, the Supreme Court determined that, in this case, both the trial court and the Court of Appeals should have focused only on the convenience store's knowledge as to whether its customer was noticeably intoxicated and would be driving soon. If a convenience store sells alcohol to such a customer, it is foreseeable that the customer will drive while intoxicated and injure an innocent third party. If a plaintiff can prove that such sale of alcohol was a proximate cause of any injuries, the convenience store will be held liable under Georgia's Dram Shop Act.

Accordingly, the Supreme Court reversed the rulings of both the trial and appeals courts, and it allowed the lawsuit to proceed against Exprezit! This ruling represents an expansion of the Dram Shop Act to the sale of alcohol in closed or packaged containers.

*Summary prepared by David M. Abercrombie,
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APPLICATION OF UNINSURED/UNDERINSURED MOTORIST BENEFITS UNDER AN UMBRELLA POLICY: Written rejection of this type of coverage by an insured under an umbrella policy can be non-binding based on information contained in the application.

Georgia Farm Bureau Mutual Insurance Company v. North et al. v. Dubose et al., 311 Ga. App. 281, 714 S.E.2d 428, decided July 14, 2011.

After being injured in a motorcycle accident, Ricky North filed a lawsuit against the driver of the other vehicle. North also maintained that he had uninsured motorist insurance coverage under his motor vehicle policy and an umbrella policy through Georgia Farm Bureau. At the time North applied for the umbrella policy, he simply elected the following option: "... [T]hat in consideration of the premium charged, I do not desire the umbrella policy to apply to uninsured/underinsured motorists coverage."

Both Georgia Farm Bureau and North filed partial motions for summary judgment to determine whether North was covered under the policy. Georgia Farm Bureau asserted North was not entitled to coverage because he rejected in writing that type of coverage. North asserted the application itself misinformed him of the other coverage options.

The trial court granted North's motion for summary judgment and denied Georgia Farm Bureau's motion. Georgia Farm Bureau

appealed arguing the trial court erred because the governing statute in this case, O.C.G.A. § 33-7-11(a)(3), only requires that North reject that type of coverage in writing.

As a fundamental principle in Georgia law, provisions in insurance contracts that conflict with the law have no effect. Furthermore, O.C.G.A. § 33-7-11(a) allows for an insured to have the option under a motor vehicle insurance policy of rejecting, selecting minimum coverage, or choosing policy limits for uninsured or underinsured coverage.

The Court of Appeals held that Georgia Farm Bureau misstated North's other options; therefore, his rejection of this type of coverage was invalid as a matter of law. However, the dissenting opinion contended that the Court's holding essentially rewrote the unambiguous terms of O.C.G.A. § 33-7-11(a)(3), and that North should not be entitled to the coverage.

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

PUNITIVE DAMAGES: In cases involving automobile collisions, punitive damages are only authorized when the accident results from a pattern of dangerous driving, not when the driver simply violates a rule of the road.

Lindsey v. Clinch County Glass, Inc. et al., 2011 WL 4057533 (Ga. App.), decided September 14, 2011.

William Holtzclaw, the principal of Clinch County Glass, Inc. was involved in a rear-end accident with Rebecca Lindsey. Holtzclaw admitted he was not paying attention and did not notice traffic had stopped at a red light in front on him because he was searching for a phone number on his cell phone. Lindsey and her husband filed a lawsuit seeking general damages, special damages and punitive damages.

Holtzclaw filed a motion for partial summary judgment on the claim for punitive

damages. The trial court granted the motion and Lindsey appealed.

In affirming the trial court's decision, the Court of Appeals reiterated "punitive damages may only be awarded in such tort actions in which it is proven by clear and convincing evidence that the defendant's actions showed willful misconduct, malice, fraud, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to consequences."

In cases involving automobile collisions, punitive damages are authorized when the accident results from a pattern or policy of dangerous driving, such as speeding or driving while intoxicated. Lindsey argued that the fact that Holtzclaw frequently talked on his cell phone while driving and admitted that he was searching for a phone number and not paying attention at the time the subject accident occurred showed a pattern of dangerous driving.

The Court of Appeals disagreed stating the proper use of a cell phone while driving is permissible in Georgia; therefore, the fact that Holtzclaw used his cell phone frequently while driving did not show a pattern or policy of dangerous behavior. A violation of a rule of the road, without more, will not be sufficient to award punitive damages against an at-fault driver.

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

SPOLIATION OF EVIDENCE: The fact that a person was injured in a slip-and-fall on one's property, without more, is not notice that the injured person is contemplating litigation sufficient to automatically trigger rules of spoliation.

Paggett v. The Kroger Company, 311 Ga. App. 690, 716 S.E.2d 792, decided September 15, 2011.

Glenn Paggett filed a premises liability action against The Kroger Company after a slip and fall. After the fall, Kroger's unit manager filled out a standard "Slip/Fall Incident Report" that contained the following pre-printed language: "This report is being prepared in anticipation of litigation under the direction of the legal counsel." However, the unit manager did not believe Paggett's fall might lead to litigation, so he did not complete the entire form, nor did he conduct the full investigation required in the report, nor did he view the video. Additionally, Kroger did not preserve the video recording of the fall.

Paggett sued Kroger, and during the litigation, moved for a spoliation charge against Kroger because it did not preserve the video recording from the security camera. Spoliation is "the destruction or failure to preserve evidence that is necessary to contemplated or pending litigation."

To meet the standard for proving spoliation, Paggett had to show Kroger was put on notice that he was contemplating litigation. However, "notice of potential liability is not the same as notice of potential litigation ... the

simple fact that someone is injured in an accident, without more, is not notice that the injured party is contemplating litigation sufficient to automatically trigger the rules of spoliation." Paggett argued that Kroger had "notice of potential litigation" once the fall was reported to the manager.

The trial court denied the request for a spoliation charge, ruling that Kroger did not have notice Paggett was contemplating litigation at the time of the incident. It also ruled that even though the Slip/Fall Incident Report had boilerplate language which was produced in anticipation of litigation, that language does not automatically put Kroger on notice of potential litigation. That is especially so where the manager testified that he did not believe the fall would lead to litigation, he never fully completed the report, and he never reviewed the video recording.

Using the same analysis, the Court of Appeals affirmed the trial court's ruling.

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ACTIONS TO RECOVER UNINSURED/UNDERINSURED MOTORIST BENEFITS: Unless a plaintiff obtains a nominal judgment against an uninsured motorist tortfeasor who was served by publication before voluntarily dismissing the case, an attempted renewal action against the UM carrier will be void.

Durrah v. State Farm Fire and Casualty, 2011 WL 4905655 (Ga. App.), decided October 14, 2011.

Yolanda Durrah was involved in an automobile wreck with Carmen Hernandez. Durrah timely filed suit against Hernandez and her UM carrier, State Farm. Durrah served State Farm personally and served Hernandez by publication because she could not be located.

Durrah later voluntarily dismissed her complaint without prejudice. She refiled the complaint against Hernandez and State Farm within the six month renewal period, but after the statute of limitations had expired. Both Hernandez and State Farm filed motions to dismiss. The trial court granted both motions based on Durrah's failure to personally serve Hernandez in the underlying original action.

Hernandez was dismissed from the renewal action for lack of personal service in the original action. The renewal statute only applies to actions that are originally valid. Personal

jurisdiction cannot be conferred upon an uninsured motorist by service by publication. The failure to personally serve the uninsured motorist in the original action made the original action void and incapable of being renewed. Because Durrah could not obtain a judgment against the uninsured motorist, State Farm, as the UM carrier, also had to be dismissed.

Based on the same well-settled reasoning, the Court of Appeals affirmed the trial court's decision. A plaintiff must obtain a nominal judgment against an uninsured motorist served by publication before voluntarily dismissing the case. Otherwise any attempted renewal action after the expiration of the statute of limitations will be void against the uninsured motorist and the UM carrier.

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

VICIOUS PROPENSITIES AND KNOWLEDGE THEREOF: Recovery for a dog attack is precluded where plaintiff had equal knowledge of dog's vicious propensities as the owner.

Stolte v. Hammack, 311 Ga. App. 710, 716 S.E.2d 796, decided September 16, 2011.

Edward Stolte shared a townhouse with several individuals, including Andrew Hammack. Hammack's pit bull, Cujo, lived with them at the townhouse. One day, Stolte went to take Cujo for a walk. In the process, Cujo attacked Stolte and bit him on his arms, chest and stomach. Roughly three months earlier, Cujo had bit another individual in Stolte's and Hammack's presence.

Stolte filed suit against Hammack, seeking recovery under Georgia's Vicious Animal Statute, O.C.G.A. § 51-2-7, and the premises liability statute, O.C.G.A. § 51-3-1. Hammack subsequently moved for summary judgment based on the parties' equal knowledge of Cujo's vicious propensity.

To succeed on claims brought under O.C.G.A. § 51-2-7, a plaintiff must show that a dog's owner knew of the dog's propensity to commit the act that caused the injury and had superior knowledge of the dog's temperament as opposed to the plaintiff.

O.C.G.A. § 51-3-1 holds a homeowner liable for injuries caused by the failure to exercise ordinary care in keeping the premises and approaches safe, and a plaintiff in a dog bite case who asserts a cause of action under § 51-3-1 must also show that the premises owner had superior knowledge of the dog's vicious propensity over the plaintiff.

As a common principle, when both plaintiff and the dog owner have equal

knowledge of the dog's propensity to bite, the plaintiff cannot prove that the owner had superior knowledge of the dog's temperament, as necessary to impose liability on dog owner pursuant to the vicious animal statute.

As a result of Stolte being present when Cujo attacked someone three months earlier, the

Court of Appeals held the trial court correctly found the parties had equal knowledge of Cujo's temperament and vicious propensity and properly granted summary judgment.

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

PREMISES LIABILITY: Summary judgment in a slip and fall case is not proper when facts exist as to a defendant's lack of reasonable inspection procedures to discover potentially dangerous conditions on its premises or when a plaintiff has not traversed a specific area where the dangerous condition was located prior to the fall.

Landrum v. Enmark Stations, Inc., 310 Ga. App. 161, 712 S.E.2d 585, decided June 20, 2011.

Margaret Landrum brought a premises liability action after she slipped and fell at Enmark Stations, Inc.'s ("Enmark") gas station. Landrum stopped to purchase gasoline and walked across the parking lot to prepay for the gas inside the store. After paying, Landrum walked back toward her vehicle; however, she took a slightly different route than she had taken to enter the store. Landrum tripped and fell over an uneven crack in the pavement.

Enmark moved for summary judgment based on its lack of knowledge of the pavement crack, and Landrum's failure to exercise ordinary care for her own safety. The trial granted Enmark's motion.

The Court of Appeals reversed for several reasons. First, when establishing a defendant's knowledge of the hazard, a plaintiff can show that the defendant had constructive knowledge of the hazard by showing that the defendant lacked a reasonable inspection procedure to discover dangerous conditions that may exist on the premises. Because Enmark failed to show what inspection procedures it had implemented in order to discover such hazards on the premises, a question of fact existed

as to whether Enmark had knowledge of the pavement crack.

Second, a question of fact existed regarding Landrum's knowledge of the hazard. The law remains where a person successfully traverses an area, she is presumed to have knowledge of the dangerous condition on the premises. However, because there was no evidence that Landrum had walked through the particular area where the crack was located, she cannot be presumed to know of the crack's existence.

Finally, the evidence did not demand a finding as a matter of law that Landrum should have seen the pavement crack based on uniform color of the surrounding pavement.

This case demonstrates the Court of Appeal's steadfast and continued approach in its factual analysis on these types of slip and fall cases. It continues the precedent that the lack of reasonable and continuous inspection procedures can prevent an award of summary judgment.

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

Georgia Coverage

INSURANCE COVERAGE: Insured's two year delay in notifying insurer of an occurrence is unreasonable as a matter of law.

Hoover v. Maxum Indemnity Company, 310 Ga. App. 291, 712 S.E.2d 661, decided June 24, 2011), cert. granted October 7, 2011.

Maxum Indemnity insured Emergency Water Extraction Services under a commercial general liability (CGL) policy. In October 2004, James Hoover, an employee of Emergency Water, fell from a ladder while on the job and sustained life-threatening injuries. A co-owner of Emergency Water learned of the accident and Hoover's injuries the day it occurred. He also knew that Emergency Water had a policy with Maxum.

Hoover's father, an insurance agent for State Farm, requested Emergency Water's insurance information. He then told the owner of Emergency Water that he "put in a call to somebody and was waiting to hear back." The owner of Emergency Water testified he believed Hoover's father, who passed away before trial, contacted Maxum. Maxum denied that Hoover's father gave it notice of the occurrence.

Hoover filed a workers' compensation action against Emergency Water in October 2005. That action was dismissed as Emergency Water was not subject to the Workers' Compensation Act. Hoover then filed a tort suit against Emergency Water on September 22, 2006. Emergency Water forwarded the Complaint to Maxum on October 18, 2006 and requested Maxum provide a defense.

Maxum denied Emergency Water a defense on the ground that coverage was

excluded due to late notice of the claim and reserved its rights to deny on other grounds.

Hoover obtained a judgment in excess of \$16 million against Emergency Water. Emergency Water assigned its rights under the Maxum policy to Hoover. Hoover then filed suit against Maxum. The trial court granted summary judgment to Maxum on the late notice issue, and the Court of Appeals affirmed.

Hoover argued a jury could conclude Hoover's father provided Maxum with notice of the occurrence. The Court of Appeals disagreed. It reasoned there was no evidence that Hoover's father spoke with anyone at Maxum. There also was no evidence of what Hoover's father told any person with whom he may have spoken, or if he even disclosed the details of the accident, as required by the policy's notice provisions. Thus, the Court found the notice eventually given by Emergency Water – two years later – was late as a matter of law.

Note: Hoover sought certiorari from the Supreme Court of Georgia which was granted in October. We anticipate a ruling in spring or summer 2012.

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WAIVER OF COVERAGE DEFENSES: The insured in a declaratory judgment action filed by its insurer must show prejudice amounting to more than a disagreement over coverage to prove that the insurer waived coverage defenses by its delay in filing a declaratory judgment action.

OneBeacon America Ins. Co. v. Catholic Diocese of Savannah, 2011 WL 3878337 (U.S.D.C., S.D.Ga.), decided September 2, 2011.

OneBeacon America Ins. Co. (“OneBeacon”) filed a declaratory judgment action in the U.S. District Court for the Southern District of Georgia, seeking to clarify its obligations under insurance policies issued to the Catholic Diocese of Savannah (“Catholic Diocese”) in the late 1970’s through the early 1980’s. The insurance dispute related to a lawsuit filed in 2006 in South Carolina which alleged that Allan Carl Ranta had been sexually molested by Wayland Yoder Brown from 1978 – 1982 while Brown was employed as a priest by the Catholic Diocese.

The Catholic Diocese filed a motion for summary judgment claiming that OneBeacon had waived all coverage defenses by waiting until 2010 to seek declaratory relief related to an underlying suit that was filed in 2006. The Catholic Diocese alleged it was prejudiced by the delay because it was forced to contribute a larger amount toward settlement of the underlying claim. OneBeacon filed a cross-motion for summary judgment arguing the Catholic Diocese failed to comply with the policies’ notice provisions by waiting until 2008 to notify OneBeacon of the 2006 suit. OneBeacon also claimed the Catholic Diocese made a voluntary payment in the underlying matter.

The trial court granted summary judgment to OneBeacon finding that the two year delay in giving notice of the suit was late as a matter of law. The court rejected the Catholic Diocese’s argument it took that long to discover the existence of the relevant policies which were 26 – 33 years old. The court noticed that

ignorance of the right to submit a claim did not provide an excuse for delay, and OneBeacon was not required under law to show prejudice by the Catholic Diocese’s delay in providing notice.

Further, the court denied the Catholic Diocese’s motion for summary judgment finding that the Catholic Diocese had not waived its right to seek declaratory judgment and that OneBeacon needed to show prejudice in order to recover. The court held the Catholic Diocese was not prejudiced because it never went into default in the underlying suit.

Additionally, OneBeacon had been providing the Catholic Diocese a defense under a reservation of rights for three months before the Catholic Diocese sent a notice objecting to the reservation of rights. The court noted that by failing to immediately object to the reservation of rights, the Catholic Diocese had consented to the terms of the reservation of rights, and that was independent grounds for denial of the Catholic Diocese’s summary judgment motion.

The court also noted that even if the Catholic Diocese had been able to show prejudice, OneBeacon was neither precluded from filing a declaratory judgment action nor advancing any defenses it had to coverage because an insurer’s decision to deny coverage is not final where it has indicated a willingness to reconsider its position.

Summary prepared by Kristen S. Cawley, kcawley@gmlj.com.

UNINSURED MOTORIST COVERAGE: A municipality's motor vehicle liability coverage secured through an interlocal risk management agency is not statutorily obligated to satisfy the requirements for uninsured and underinsured motorist coverage that are applied to commercial insurance policies and private self-insurance plans.

Godfrey v. Georgia Interlocal Risk Management Agency, 2011 WL 4905611 (Ga. Sup. Ct.), decided October 17, 2011.

This case arose from an automobile collision in which Daniel Godfrey, a police officer employed by the City of Newnan, was driving a City police car when it was struck by a motor vehicle owned and operated by Hural Henderson. Henderson had only \$25,000 of motor vehicle liability coverage. The City of Newnan had a Member Coverage Agreement with the Georgia Interlocal Risk Management Agency ("GIRMA"), established under O.C.G.A. § 36-85-1. Godfrey and his wife sued Henderson in tort, and served a copy of the complaint on GIRMA to notify GIRMA it might be held responsible as an uninsured or underinsured motorist carrier pursuant to O.C.G.A. § 33-7-11.

GIRMA filed a declaratory judgment action to determine its obligation to provide uninsured motorist coverage, contending the Coverage Agreement did not contemplate the coverage sought by the Godfreys. The trial court found the coverage provided by GIRMA was, for the purposes of O.C.G.A. § 33-7-11, the equivalent of an insurance policy. As a result, the trial court ruled that GIRMA was required to provide the Godfreys the opportunity to select or reject uninsured motorist coverage up to the limits of liability under the GIRMA contract. Further, because that opportunity had not been afforded, the trial court found GIRMA was

obligated to provide uninsured motorist protection up to the limits of the Agreement, which was \$1,000,000.

The Court of Appeals reversed, finding that the purchase of GIRMA coverage as authorized under O.C.G.A. § 36-85-1 constitutes the purchase of liability insurance for purposes of the waiver of sovereign immunity and does so only *to the extent of the liability coverage purchased*. The Court rejected the Godfreys' argument that GIRMA coverage must be governed by O.C.G.A. § 33-7-11 because O.C.G.A. § 36-85-1 specifically states agencies created under that statute are "not an insurance company or an insurer under Title 33." Thus, to apply Title 33 would be inconsistent with the General Assembly's declaration.

The Supreme Court of Georgia affirmed the Court of Appeals, finding that GIRMA was not statutorily obligated to satisfy the requirements for uninsured and underinsured motorist coverage that are applied to commercial and private insurance plants, although three of the Justices dissented.

Summary prepared by Kristen S. Cawley, kcawley@gmlj.com.

EVIDENCE OF POLICY CANCELLATION: Proof of actual delivery of the policy cancellation notice is not required to prove a policy was cancelled. The notice of delivery is legally affected by the act of mailing and receiving a Post Office receipt of mailing.

Burnside v. GEICO General Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606, decided June 15, 2011.

On November 7, 2006, the Burnsidess' vehicle was involved in a wreck. They made a claim with GEICO whom they believed to be their auto insurance carrier at the time.

The Burnsidess renewed their auto policy with GEICO on August 24, 2006. GEICO sent a renewal invoice the same day with a due date of September 15, 2006. When GEICO did not receive payment by September 15th, it mailed a notice of cancellation on October 16, 2006 to the Burnsidess with an effective cancellation date of October 27, 2006. The Burnsidess claim they never received the cancellation notice and did not learn of it until they called GEICO after their wreck.

The Burnsidess filed a declaratory judgment action to determine whether their automobile policy was effectively cancelled pursuant to O.C.G.A. §§ 33-24-44 and 33-24-45(c), which require that notice of cancellation be mailed to the policyholder via first class mail at least 10 days prior to the effective date of cancellation.

GEICO submitted evidence of its method of sending cancellation notices, copies of the Burnsidess' cancellation notice, and the USPS mailing receipt. The trial court granted summary judgment to GEICO, finding that was sufficient proof of mailing, and the policy was effectively cancelled. The Burnsidess appealed, arguing GEICO failed to show what document was actually sent and there was no proof the Burnsidess actually received the notice.

The Court of Appeals, finding GEICO had presented sufficient proof the notice of cancellation was mailed to the Burnsidess. The Court confirmed that proof of actual delivery of the notice is not necessary. It is sufficient if an insurer can show it mailed the notice by obtaining a stamped receipt from the United States Post Office. Whether the insured actually received the notice is irrelevant in determining whether the statutory requirements for cancellation are met.

The Court also rejected the Burnsidess' argument the mailing receipt was defective because it reflected broadly that "cancellation notices, notice of non-renewal, and/or surcharge notices" were being sent to the addressees. GEICO submitted the Burnsidess' statement of account which showed a notice of cancellation was issued to the Burnsidess on the same day as the mailing receipt. That was sufficient proof the Burnsidess had been mailed a notice of cancellation and not a notice of non-renewal or surcharge notice.

Finally, the Court held a subsequent premium payment, made after the accident on November 7, 2006, was irrelevant to the determination of whether the policy was effectively cancelled on October 27, 2006.

Summary prepared by R. Tyler Bryant, tbryant@gmlj.com.

INSURANCE COVERAGE AND CONTRACTUAL LIABILITY EXCLUSION: Exclusion in insurance agreement for claims “arising out of or in any way connected with breach of contract” excluded coverage for subcontractor’s claim against city even though claim was not for breach of contract. The subcontractor’s claim arose out of a breach of contract; therefore, the exclusion applied regardless of the theory of liability against the city.

City of College Park v. Georgia Interlocal Risk Management Agency, 2011 WL 4790757 (Ga. App.), decided October 11, 2011.

A subcontractor filed suit for breach of contract against a general contractor who hired the sub to perform work for the City of College Park. After determining the general contractor was insolvent, the subcontractor sued College Park for failure to obtain a payment bond on the project. College Park, a participant in the Georgia Interlocal Risk Management Agency (“GIRMA”), tendered this claim to GIRMA for defense and indemnity. GIRMA denied the claim because it fell within the insuring agreement’s exclusion for claims “arising out of or in any way connected with breach of contract.”

College Park filed suit against GIRMA for GIRMA’s failure to defend or indemnify College Park, alleging breach of contract and seeking attorney fees. The parties filed cross-motions for summary judgment, and the trial court awarded partial summary judgment to College Park on its breach of contract claim.

On appeal, College Park argued the subcontractor’s claim did not fall within the exclusion because the claim was for failure to

obtain a payment bond, not for breach of contract. The Court of Appeals rejected that argument, finding that the exclusion was not restricted by the particular theory of liability against the insured; rather, the underlying facts and circumstances of the claim asserted determined whether the exclusion applies. The origin of the subcontractor’s claim was its claim against the general contractor for breach of contract. Accordingly, the subcontractor’s claim was “arising out of or in any way connected with breach of contract” and thus fell within the exclusion.

Because the claim against College Park fell within the exclusion, the Court found GIRMA had no duty to provide coverage and thus did not breach its contract with College Park. Accordingly, the Court of Appeals reversed the grant of summary judgment in favor College Park.

Summary prepared by R. Tyler Bryant, tbryant@gmlj.com.

Georgia Workers' Compensation

PROPER PROCEDURE FOR CONTROVERTING AND SUSPENDING BENEFITS: If controverting within the 60 day "late controvert" period, the employer must pay all benefits due before filing notice and ending compensation, or the controvert is invalid.

Crossmark, Inc. v. Strickland, 310 Ga. App. 303, 713 S.E.2d 430, decided June 27, 2011.

Crossmark initially accepted Mary Strickland's injury as compensable, but then terminated benefits and filed notice of its intent to controvert the claim. Strickland requested a hearing seeking a resumption of workers' compensation benefits.

The ALJ found that Strickland had failed to establish by a preponderance of the evidence that her injury arose out of and in the course of her employment. Strickland appealed to the Appellate Division, contending for the first time that the notice to controvert was invalid because Crossmark failed to pay her all benefits due before filing the notice and ending her compensation.

Crossmark responded that Strickland had waived the notice to controvert issue by failing to raise it before the ALJ. The Appellate Division vacated the ALJ's decision and remanded the claim to allow Crossmark the opportunity to be heard on whether its notice to controvert was valid. Crossmark appealed the remand order, but the Court of Appeals ruled that the remand order was not final and thus could not be appealed.

On remand, the ALJ found the notice to controvert was invalid because Crossmark had failed to pay all benefits due before filing and ending compensation. Because Crossmark had failed to pay the first seven days of benefits and had underpaid Strickland \$100 per week, the company was precluded from contesting the compensability of Strickland's claim without newly discovered evidence or a subsequent

change in condition. Crossmark was therefore ordered to pay continuing temporary total disability benefits, related medical expenses, and assessed attorneys fees under O.C.G.A. § 34-9-108(b)(2) for its failure to comply with O.C.G.A. § 34-9-221.

The Appellate Division and the superior court affirmed the decision. Crossmark appealed to the Court of Appeals and argued the superior court erred in affirming the Appellate Division because the previous decisions by the Court of Appeals holding that a notice to controvert is invalid if the employer has not paid the employee all the benefits due as of the date of notice should be overruled.

Crossmark argued that it should have been absolved of paying benefits after controverting Strickland's claim within 60 days, despite the fact that it failed to pay all benefits due until that point, because O.C.G.A § 34-9-221 did not specifically require this procedure. The Court of Appeals refused to overrule the prior cases enumerating this rule, stating that any decision to the contrary would allow an employer to base its compliance with the statute upon its assessment of the merits of its employee's claim and ignore the statutory payment requirements without consequence if the claim is ultimately found not to be compensable. The Court, therefore, upheld the award of benefits and assessed attorney's fees.

Summary prepared by Zachary J. Nelson,
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REQUIREMENTS OF A DILIGENT JOB SEARCH: The State Board of Workers' Compensation may not impose additional burdens on an employee as a condition of a diligent job search, particularly where the additional burden is beyond the employee's control.

R.R. Donnelley v. Ogletree, 2011 WL 4982669 (Ga. App.), decided October 20, 2011.

On October 10, 2002, Tedral Ogletree sustained a work-related injury to his neck and upper extremities. He returned to restricted duty work at several different jobs that exceeded his restrictions, and his condition deteriorated over time. In April 2008, Ogletree was laid off due to a reduction in force. In October 2008, Ogletree underwent a lumbar fusion.

After surgery, Ogletree filed a claim for reinstatement of TTD benefits. Ogletree claimed he was unable to obtain suitable employment after applying to 24 jobs using the internet and newspaper, due to his injury.

Following an evidentiary hearing, the ALJ found Ogletree sustained a fictional new accident and had performed a diligent, but unsuccessful, search for suitable employment, and the ALJ awarded benefits. The Appellate Division affirmed the ruling that Ogletree sustained a new accident, but found Ogletree had not conducted a diligent job search because he never obtained any interviews, nor did he ever personally visit any potential employers.

The superior court reversed the decision of the Appellate Division and reinstated the ruling of the ALJ.

The Court of Appeals addressed the employer's contention that Ogletree did not perform a diligent job search. The superior court stated that whether an employee was granted an interview was out of his control and that imposing this additional burden was not the proper application of the law as outlined in the Supreme Court's decision in *Maloney v. Gordon County Farms*. The Court of Appeals agreed, holding that requiring a claimant to secure interviews and make in-person site visits with prospective employers was improper as it would put an impossible burden on a claimant, essentially requiring him to control the hiring process. The Court further suggested that, as Ogletree had followed the Georgia Department of Labor's instructions during his job search, he had done what was required of him.

Summary prepared by Zachary J. Nelson, znelson@gmlj.com.

APPEAL TO SUPERIOR COURT: If the State Board does not make its own findings of fact, it is not possible for Superior Court to determine if "any" evidence exists to support the decision and the case must be remanded to the Board to make its own findings.

J & D Trucking et al v. Martin, 310 Ga. App. 247, 712 S.E.2d 863, decided June 22, 2011.

Jimmy Martin was injured while working as the sole proprietor of J & D Trucking, which has workers' compensation insurance coverage through American Interstate Insurance Company. Martin's claim was accepted as a compensable "medical only" claim and the insurer paid for Martin's medical treatment while he continued to work.

On May 26, 2009, Martin had surgery and became disabled from work as a result. The insurer agreed that Martin was disabled, but did not pay income benefits because they contended

Martin had failed to prove he had earned any wages from the company, and therefore, there was no basis for calculation of his average weekly wage or payment of income benefits. The insurer did not controvert payment of income benefits and requested a hearing seeking a determination that Martin was not entitled to any income benefits.

At the hearing, Martin contended he had, in fact, produced evidence of his wages such that he should be entitled to payment of income benefits. He further argued that he should be

entitled to assessed attorney's fees because the insurer had defended the income benefit issue without reasonable grounds or for failing to comply with O.C.G.A. § 34-9-221, in violation of O.C.G.A. § 34-9-108(b)(1) or (2).

The ALJ agreed with Martin that he had provided the insurer with sufficient evidence of his wages. The ALJ further found the insurer had failed to comply with O.C.G.A. § 34-9-221, because it did not timely pay income benefits or file a notice to controvert payment of income benefits, and therefore, owed attorney fees to Martin in the amount of \$12,690.00.

The insurer appealed to the Appellate Division, which agreed Martin had met his burden of proving his average weekly wage. However, the Board disagreed with the ALJ's findings that the insurer had violated O.C.G.A. § 34-9-221 and reversed the ALJ's award of

assessed attorney's fees to Martin. The Board did not substitute its own findings of fact, as it is entitled to do, in place of the ALJ's findings.

Martin appealed to the Superior Court, which reversed the Appellate Division and reinstated the award of attorney's fees.

The Court of Appeals vacated the Superior Court's decision and directed the Superior Court to remand the case to the Appellate Division for reconsideration. In so ruling, the Court of Appeals held that because the Board did not make any findings of fact, it was not possible for the Superior Court to determine if "any" evidence existed to support them.

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

WORKERS' COMPENSATION INSURANCE: Absent evidence showing other insurance coverage for subcontractors, a general contractor is liable for premiums to its insurer based on the potential risk for workers' compensation claims as a statutory employer.

Dennis Perry Homes, Inc. v. Companion Property & Casualty Insurance Company, 311 Ga. App. 706, 716 S.E.2d 798, decided September 16, 2011.

Companion issued a workers' compensation insurance policy to Dennis Perry Homes, Inc. under an "assigned risk" policy because Dennis Perry was unable to obtain insurance in the open market. The initial premium was \$750.00, but the actual premium could not be determined until after the policy term, as workers' compensation insurance premiums are based upon the actual amount paid to workers. Dennis Perry had estimated its payroll was zero because it claimed it did not have employees, only contractors and subcontractors.

At the end of the premium term, an audit showed an additional premium payment due of \$79,523.00. An additional \$24,551.00 was due at the end of the second term. Dennis Perry refused to pay, and Companion sued to collect the premium.

The trial court granted summary judgment to Companion. Dennis Perry appealed and argued the trial court erred by ruling there

was no factual issue as to whether Dennis Perry was the statutory employer of the workers listed by the audit, and asserted that a jury should decide whether the workers should be counted for the purposes of the premiums.

The Court of Appeals affirmed the trial court's decision. In so ruling, the Court of Appeals noted Dennis Perry had failed to present any evidence at the trial court level that the contractors and subcontractors were covered by other workers' compensation insurance. Therefore there were no issues to be decided by a jury.

As the general contractor, Dennis Perry could be found to be a statutory employer pursuant to O.C.G.A. § 34-9-8. As a statutory employer, Dennis Perry could have ultimately been responsible for workers' compensation coverage for any injured contractor or subcontractor, and therefore, Companion was entitled to collect premiums based on the payments to contractors and subcontractors.

Since Dennis Perry did not present any evidence to rebut Companion's prima facie showing of entitlement to judgment as a matter of law the

trial court's grant of summary judgment was appropriate.

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

CHANGE OF CONDITION VS. FICTIONAL NEW ACCIDENT: If income benefits are paid, after which the claimant resumes work but later stops work due to a gradual worsening of her condition, the date she stops working is a change in condition and not a fictional new accident if the employee continued working for the same employer.

Shaw Industries v. Scott, 310 Ga. App. 750, 713 S.E.2d 917, decided July 12, 2011.

On February 16, 1996, Valencia Scott was injured when her right foot became caught in a carpet roller. The injury was serious. Scott eventually required a partial amputation of her foot and missed ten months of work, during which she was paid temporary total disability (TTD) benefits. In January 1997, Scott returned to work in a modified capacity. In May 1997, she required bilateral knee surgery as a result of the awkward gait resulting from her foot injury.

Scott continued working for the next 12 years and over time her knee problems became progressively worse. Her treating physician recommended she take a brief absence from work. Scott tried to work over the next few months, but again in September 2009, it was recommended she stop working, this time altogether, which Scott did.

Scott sought payment of TTD benefits as of September 2009, which Shaw denied on the grounds that her disability was the result of a change of condition and thus barred by the statute of limitations provisions of O.C.G.A. §

34-9-104. The ALJ disagreed and found that Scott had a fictional new accident on March 24, 2009, the date her physician first recommended that she stop working.

Shaw appealed, to the Appellate Division and the Superior Court, both of which affirmed the ALJ's decision. Shaw then appealed to the Court of Appeals.

The Court of Appeals reversed the lower courts' decisions. In so ruling, the Court of Appeals held that when compensation is paid in a claim, and the employee returns to work, but later ceases work due to a worsening of her condition, the date she stops working is a change in condition and not a fictional new injury. Since Shaw paid income benefits to Scott, the date she ceased work was a change in condition, not a fictional new injury, and thus her claim for additional income benefits was barred by the statute of limitations.

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

CLAIMS AGAINST THE SUBSEQUENT INJURY TRUST FUND: Lump sum advance payments to prevent extreme hardship are not the payment of income benefits that count against the 78 weeks of income benefits within which an employer must file a Notice of Claim against the Fund.

Subsequent Injury Trust Fund v. City of Atlanta, 310 Ga. App. 581, 713 S.E.2d 706, decided July 6, 2011.

O.C.G.A. § 34-9-362 provides that an Employer may file a claim for reimbursement from the Subsequent Injury Trust Fund within 78 calendar weeks after the injury, or prior to the payment of 78 weeks of income or death benefits, whichever occurs last. Ollie Thornton, a City employee, sustained a compensable injury on April 5, 2001, and income benefits were commenced.

After Thornton had received 59 weeks of benefits, the City gave notice to the Fund of a claim for reimbursement on October 15, 2002. In the interim, however, Thornton had requested, and the State Board had ordered, a lump sum advance of \$12,000.00 against which the City could take credit when it subsequently paid PPD benefits to Thornton.

The City and Thornton settled his claim, and the City requested reimbursement from the Fund. The Fund denied the request on the ground the City's notice of claim was untimely. The Fund contended the \$12,000.00 advance constituted income benefits and, therefore, Thornton had received more than 78 weeks of income benefits prior to the City's notice of claim (the 78 calendar weeks from the date of injury had already run).

The State Board found the City's claim was untimely. On appeal, the Superior Court reversed, finding only 59 weeks of income benefits had been paid when the City filed its Notice of Claim, and the Notice was therefore timely. The Court of Appeals granted the Fund's application for discretionary appeal.

Because less than 78 calendar weeks had passed when the City's Notice of Claim was submitted, the issue for decision by the Court of Appeals was whether or not the advance ordered by the Board constituted payment of income

benefits. If so, the claim was too late. If not, it was timely.

The State Board is given the authority in O.C.G.A. § 34-9-222, to order an employer to make "advance payments" of "future income benefits" to prevent extreme hardship or if it is essential to the employee's rehabilitation. The Code section allows the Board to authorize credit for the advance against any future income benefits, including PPD benefits. In this case, the Board allowed the City to take credit for the advance against future PPD benefits.

However, the advance could not simply be considered to be PPD benefits because Georgia law also prohibits an employee from receiving PPD benefits at the same time as TTD or TPD benefits for the same injury. O.C.G.A. § 34-9-263. Nevertheless, the advance was authorized, based on the State Board's authority to provide for an advance in cases of extreme hardship. If that advance was deemed to constitute weekly income benefits, then employers might be arbitrarily deprived of the full time allotted to submit claims to the Fund. Although the Court did not mention it, that interpretation might also have made the State Board reluctant to authorize advance payments, contrary to the legislative intent that the Workers' Compensation Act serve a humane purpose.

Therefore, the Court of Appeals declined, in cases of advance payments ordered to foreclose extreme hardship, to convert those benefits to weekly income benefits paid so as to count against the 78 weeks given employers to file a notice of claim against the Fund.

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

RES JUDICATA: Res judicata does not prevent the employer and insurer who had paid TPD benefits under O.C.G.A. § 34-9-104, from offsetting those payments if the injury is later designated catastrophic and TTD benefits are awarded for time periods for which TPD benefits were previously paid.

North Fulton Regional Hospital v. Pearce-Williams, 2011 WL 5222760 (Ga. App. A11A1196), decided November 3, 2011.

Cathy Pearce-Williams sustained a compensable work injury at North Fulton Regional Hospital in 1999, and North Fulton commenced TTD benefits. Pearce-Williams was released to light duty, but did not return to work, and North Fulton utilized the provisions of O.C.G.A. § 34-9-104 to convert Pearce-Williams to TPD benefits on February 3, 2003.

In 2008, Pearce-Williams filed hearing request, seeking a designation of her injury as catastrophic and requesting a retroactive award of TTD benefits from 2003. Following a hearing, the ALJ found the injury was catastrophic and awarded TTD benefits commencing February 3, 2003. The Appellate Division and the Superior Court affirmed the award, and the Court of Appeals refused to permit North Fulton to appeal.

Once its appeals were exhausted, North Fulton paid the TTD benefits awarded by the ALJ in a lump sum, taking a credit for the amount of the TPD benefits previously paid. Pearce-Williams requested a second hearing, contending that North Fulton had not requested a credit at the prior hearing, nor had the ALJ authorized one, and therefore North Fulton was not entitled to a credit for the TPD benefits that it had already paid.

The ALJ found Pearce-Williams was “seeking a windfall” by, in effect, requesting the statutory maximum of \$350.00 in TTD benefits in addition to the \$233.33 per week she had already received in TPD benefits (a total of \$583.33 per week). North Fulton was not seeking a traditional credit but offsetting what it had previously paid. The Appellate Division of the State Board affirmed. However, the Superior

Court found North Fulton was seeking a credit, its failure to seek that credit at the first hearing was res judicata, and prevented it from taking the credit or asking the State Board to authorize the credit.

The Court of Appeals first noted that res judicata applies to workers’ compensation cases, and a party cannot re-litigate an issue that was, or should have been, litigated in a previous proceeding. However, Pearce-Williams’ hearing request sought a designation of her injury as catastrophic, and an award of TTD benefits from February 3, 2003, and continuing. She did not request TTD benefits *in addition to* TPD benefits, and so there was no reason for North Fulton to litigate that issue.

In addition, Georgia law does not authorize an employee to receive TTD and TPD benefits for the same time for the same injury. North Fulton should not have been expected to anticipate Pearce-Williams would claim, after benefits were awarded, she was entitled to an award of benefits contrary to law. Therefore, res judicata did not prohibit the offset.

Finally, the Court of Appeals noted that O.C.G.A. § 34-9-243, which provides for a credit for other payments, and for which the State Board rules require that the Employer file a WC-243 at least 10 days’ prior to the hearing to obtain the credit, does not apply to the payments made by North Fulton. Thus, its failure to file the form prior to the hearing did not prohibit the offset. Accordingly, the Court reversed the decision of the superior court.

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

Florida Liability and Coverage

HOMEOWNERS' INSURANCE COVERAGE: Private community roadway was not an "insured location" under homeowners' insurance policy.

Elliott v. State Farm Florida Ins. Co., 61 So.3d 502 (Fla. 4th DCA), decided June 1, 2011.

The Elliotts maintained a homeowners' insurance policy with State Farm. Their minor son was involved in an accident while operating a golf cart on a private road near, but not on, the Elliott's residential property in the community in which they lived. The accident happened when the passenger of the golf cart, also a minor, somehow fell out of the golf cart and was injured.

The injured minor's parents filed a negligence action against the Elliotts. Thereafter, State Farm filed a declaratory judgment action seeking a determination regarding insurance coverage under the homeowners' policy. The Elliotts counterclaimed for declaratory judgment in their favor, arguing that State Farm had an obligation to defend and indemnify them for the negligence claim under the homeowners' policy. The trial court granted final judgment in State Farm's favor and the Elliotts appealed.

The homeowners' policy with State Farm excluded coverage for any "bodily injury or property damage arising out of the ownership, maintenance, use, loading or unloading" of any "motor vehicle owned or operated by or rented or loaned to any insured." The policy specifically defined a golf cart as a "recreational vehicle," but a recreational vehicle was considered a *motor vehicle* "while off an insured location." The policy defined "insured location" to include any premises used by the insured in connection with the residence premises or premises used by the insured as a residence. Thus, the key issue was whether the golf cart was on an "insured

location" at the time of the accident. If it was off the insured location during the accident it would be excluded as a motor vehicle.

The Elliotts argued the private street in the development where the accident happened was an "insured location," and thus the golf cart would not be excluded under the "motor vehicle" exclusion. Although the roadway was not on the insured's property, the Elliotts argued the language including "any premises used" in "connection with the premises" includes private roads and common areas of the community.

The evidence at trial showed the private roads and common areas in the community were owned by the homeowners' association. The covenants also provided that each homeowner had an easement for ingress and egress for all walkways, private streets and walkways.

The Court of Appeals affirmed the trial court's finding in favor of State Farm and concluded that a private road cannot be part of the premises where the individual homeowners exercise no control over the roadway. It held considering a private roadway in and out of the community, blocks away from the insured location, as used "in connection" with the insured location would render the terms "insured premises" and "insured location" meaningless without a geographical limitation to coverage.

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

DISCOVERY: Plaintiff was not entitled to subpoena the defendant's expert CME doctor to bring to his deposition files relating to other CME's he has conducted pursuant to Fla. Stat. § 456.057(7)(a)(3).

Crowley v. Lamming, 66 So.3d 355 (Fla. 2nd DCA), decided July 22, 2011.

Lamming filed an action for personal injuries allegedly sustained in an automobile wreck with Crowley, who was driving a vehicle for his employer, HBMI. During the litigation, Crowley requested, Lamming, submit to a Compulsory Medical Examination ("CME") pursuant to Fla. R. Civ. P. 1.360. Crowley retained Dr. Padar to conduct the CME, and Dr. Padar issued a report following his evaluation of Lamming.

Lamming scheduled Dr. Padar's deposition and served a subpoena for deposition duces tecum. The subpoena required that Dr. Padar bring to his deposition any and all CME reports he prepared for the last three (3) years. Crowley objected to the subpoena, and Lamming filed a motion to compel Dr. Padar to comply with the subpoena. Lamming's argument was that he did not seek "production" of the non-party CME reports, but only wanted Dr. Padar to bring the reports to be available for the doctor's review during his deposition to give accurate testimony.

The trial court initially denied Lamming's motion to compel, telling Lamming to ask his questions and see what happened first. After taking Dr. Padar's deposition, Lamming renewed his motion to compel, claiming Dr. Padar was evasive and nonresponsive, asking Dr. Padar be required to attend another deposition in which he brought all of his CME reports from the last three years.

Lamming agreed such CME reports were not subject to "production," but wanted to be able to go through the reports and ask the doctor questions regarding his opinions on

future medical care and permanency for the patients, and who retained him. The trial court granted Lamming's motion to compel, ordering the doctor to bring to his deposition all of the reports for CME's he had prepared in the past three years. The court limited Lamming's questions to dates of the CME's, the entity who hired Dr. Padar, the injury, and the doctor's opinion regarding permanency and the need for future medical care. Crowley filed a petition for certiorari, seeking to quash the order compelling Dr. Padar to bring all of the non-party CME reports to his deposition.

The Court of Appeals looked to Fla. Stat. § 456.057(7)(a)(3), which prohibits the disclosure of a patient's medical records or discussion of the patient's medical condition without the patient's consent. The statute provides an exception for a subpoena issued in a civil or criminal action, provided that proper notice to the patient is made.

The Court held that, although the trial court attempted to limit the questions asked of Dr. Padar, even limited disclosure of the non-parties' private health information violated Section 456.057(7)(a)(3).

The Court noted that if the doctor was being evasive in responding to questions in his deposition, more appropriate sanctions or remedies are available. A party may not seek CME reports or information relating to such reports in discovery in an attempt to impeach a CME doctor or in deposing him.

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

OFFER OF JUDGMENT: Fla. Stat. § 768.79 does not apply where a plaintiff seeks both monetary damages and injunctive relief as part of the same claims.

Winter Park Imports, Inc. v. JM Family Enterprises, 66 So.3d 336 (Fla. 5th DCA), decided August 1, 2011.

The plaintiff, Winter Park Imports, Inc. (“Winter Park”), brought a lawsuit against JM Family Enterprises (“JM Family”) for alleged violations of the Florida Motor Vehicle Dealer Act. Winter Park sought injunctive relief, requesting that JM Family be prohibited from engaging in a number of activities, and also sought monetary damages. Although Winter Park’s claims were divided into counts, each arose from alleged violations of the Act that would be supported by the same proof.

During the litigation, JM Family served an offer of judgment on Winter Park, offering a monetary amount as full and final settlement of Winter Park’s claims. Winter Park did not accept the offers. The trial court later granted summary judgment in favor of JM Family, which was affirmed on appeal. Following final entry of judgment in their favor, JM Family filed a motion for attorney fees since Winter Park had rejected JM Family’s offer.

Fla. Stat. § 768.79 is Florida’s offer of judgment statute which applies to “any civil

action for damages. . . .” The Court of Appeals noted it has been established in earlier case law that a party can serve an offer or demand for judgment directed to a claim for monetary damages, but a party cannot avail itself of the statute where a claim seeks non-monetary relief only. The issue presented by this case was whether a party can serve an offer of judgment directed to a claim for which both monetary and injunctive remedies are requested. The Fifth DCA held the offer of judgment statute makes no provision for a court to determine the value of any injunctive relief obtained in calculating the “judgment obtained,” as those terms appear in the statute.

Therefore, the Court held the statute does not authorize a party to serve an offer of judgment directed to or offering to settle a claim in which both monetary and injunctive relief are sought.

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

EVIDENCE/DAMAGES: In support of his damages claims, a plaintiff can offer medical bills reflecting the full amount of charges, rather than only the reduced amount paid.

Durse v. Henn, 68 So.3d 271 (Fla. 4th DCA), decided September 21, 2011.

George Durse brought an action for personal injuries he sustained as a passenger in a vehicle driven by Cushman which collided with a vehicle driven by Janice Henn. At trial, Henn filed a motion in limine to preclude Durse from presenting evidence of the full amount of his medical bills, arguing that Durse should only be allowed to introduce the amount of medical bills his providers accepted as satisfaction for the bills.

On appeal, Durse argued the trial court erred by refusing to allow him to present the full amount of his medical bills to the jury in support of his damages. He argued that the ruling barring him from introducing the full amount of

the medical bills (not the amount paid) prejudiced his ability to establish the value of future medical expenses and non-economic damages.

The Court of Appeals agreed with Durse and held the trial court improperly limited the medical bills evidence introduced at trial. The Court explained that the collateral source rule in Florida, permits an injured plaintiff to recover his full compensatory damages from the tortfeasor, irrespective of any payment of any element of those damages by another source.

Prior Florida case law has held that in cases where Medicare paid bills for the plaintiff,

it is reversible error to permit evidence of the gross medical bills rather than the amount actually paid in full settlement of those bills

The Court also distinguished cases where the reduction or difference in amount paid for medical bills was a result of health insurance rather than Medicare. The policy behind the collateral source rule is inapplicable when the plaintiff has incurred no expense, obligation, or liability in obtaining the service or benefit, such as public benefits. Thus, when a plaintiff has paid premiums for his/her health insurance, it is clear that the plaintiff has incurred expense or liability and the gross amount of medical bills may be introduced as evidence.

In this case, Durse had neither health insurance nor Medicare coverage that paid any reduced amounts of his medical bills. Durse had no insurance coverage. However, he negotiated reduced payments to satisfy his outstanding medical bills. The Fourth DCA held that although Durse did not pay any premiums for health insurance, by negotiating a lower amount for his bills he had “earned in some way” the lower settlement amount for his bills, causing the collateral source rule to apply. The trial court should have permitted the plaintiff to introduce the full amount of the charges in the plaintiff’s medical bills.

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

Florida Workers’ Compensation

IMMIGRATION STATUS AND INDEMNITY BENEFITS: Claimant’s status as illegal immigrant did not preclude his entitlement to permanent total disability benefits.

HDV Const. Systems, Inc. v. Aragon, 66 So.3d 331 (Fla. 1st DCA), decided June 28, 2011.

Luis Aragon, an illegal immigrant from Mexico, sustained a compensable injury to his left foot and forearm. He was determined to have permanent injuries and was permanently restricted to sedentary work only, which prohibited Aragon from performing any of his pre-injury occupations. Additionally, Aragon had no proper documentation allowing him to work legally in the United States. Further an inability to speak, read or write English, meant he had no transferrable skills which would assist him in obtaining lighter employment.

Aragon filed a claim for permanent total disability (PTD) benefits. The Employer/Carrier (“E/C”) denied the same on the basis Aragon was physically capable of performing sedentary work and was unemployable only because of his illegal status. The claim proceeded to a final

hearing on the merits, following which the Judge of Compensation Claims (JCC) concluded Aragon was, in fact, permanently and totally disabled and entitled to benefits through the date of the merit hearing. Interestingly, the JCC denied ongoing benefits, finding Aragon was legally prohibited from receiving same. Aragon appealed.

Employers who employ illegal workers, are precluded from asserting the status as an illegal alien as a defensive matter to avoid liability for disability benefits when the employers “knew or should have known the true status of the employee.” As the employer stands to benefit and profit from its employment of labor, it is improper to place on society medical costs created by industry. Further, an entity that knowingly employs unlawful labor should not be

able to shirk the cost of the injuries it creates, thus shifting said cost to the public.

In this instance, the JCC relied upon the expert vocational testimony that Aragon's injury, combined with the aforementioned vocational impediments, rendered him permanently and

totally disabled. Thus, the panel affirmed the JCC's award of permanent and total disability benefits, as well as reversed the decision insofar as the JCC denied ongoing benefits.

Summary prepared by Brian D. Tadros, btadros@gmlj.com.

SCOPE OF THE "120-DAY RULE" FOUND IN SECTION 440.20(4), FLORIDA STATUTES: Section 440.20(4) does not operate to preclude an Employer/Carrier from denying a specific claim for benefits on grounds that the claimant's need for such benefits did not stem from a compensable accident or injury.

School Distr. of Hillsborough County/Broadspire v. Dickson, 67 So.3d 1080 (Fla. 1st DCA), decided July 12, 2011.

Maryann Dickson sustained a compensable injury to her left knee on September 17, 2008, following which Dr. Scott Goldsmith was authorized. Dr. Goldsmith performed arthroscopic surgery on Dickson's knee and prescribed post-surgery physical therapy. Upon completion of this treatment regimen, Dickson reported no complaints of weakness in the left knee.

On July 5, 2009, Dickson injured the same knee at her home. She reported to Dr. Goldsmith the next day, describing the injury and voicing new complaints of pain. Ultimately, Dr. Goldsmith concluded Dickson had suffered a new meniscal tear in the knee, and performed a repeat arthroscopy.

On September 29, 2009, the E/C asked Dr. Goldsmith whether the 2008 accident was the major contributing cause of the new meniscal tear, and Dr. Goldsmith indicated it was not. One week later, the E/C asked whether Dickson was at maximum medical improvement ("MMI") as to the 2008 injury. Dr. Goldsmith replied that, but for the July 5, 2009 fall at home, Dickson would have been at MMI as to the 2008 injury in late July 2009. Based on those opinions, the adjuster prepared a Notice of Denial for the new injury which was dated November 27, 2009.

Dickson subsequently filed a Petition seeking authorization of the second arthroscopy and continued treatment for the left knee, which the E/C denied on the basis of major contributing cause.

At the Final Hearing, neither party argued for application of the provisions of section 440.20(4), Florida Statutes, which provides E/Cs with a 120-day period to investigate compensability of a claim prior to denying same. Still, in her Final Compensation Order, the JCC found this statute to be "mandatory," and applied it in concluding that the E/C had waived the right to deny compensability of the July 5, 2009 accident as the Notice of Denial had, purportedly, been issued more than 120 days after July 5, 2009.

The Court of Appeals reversed the JCC on two grounds. First, the Court held the E/C's due process rights were violated because they were denied the opportunity to present evidence regarding the applicability of section 440.20(4).

Second, the Court restated the well-established principle that section 440.20(4) operates only to resolve the issue of whether a claimant suffered a compensable work injury, not to preclude an E/C from challenging the claimant's entitlement to benefits (e.g., surgery or other medical treatment), particularly in instances of major contributing cause. Because the E/C had accepted compensability of the original 2008 injury and ultimately denied future benefits on the grounds of major contributing cause, section 440.20(4) was inapplicable.

Summary prepared by Brian D. Tadros, btadros@gmlj.com.

THE “ARISING OUT OF” STANDARD: An accident occurring while the claimant was on a purely personal mission having no relationship to work (even on the employer-owned and controlled premises) is not compensable.

Sentry Insurance Co. and Express Script, Inc. v. Hamlin, 69 So.3d 1065 (Fla. 1st DCA), decided September 22, 2011.

Leon Hamlin was working at his cubicle when his supervisor informed him that a tow truck was near his vehicle in the company lot (which is used exclusively by the employer). Hamlin immediately exited the building and spoke with the tow truck driver, who informed Hamlin he had orders to take possession of the car. Hamlin went back inside and phoned his bank, which advised him his car was being repossessed because Hamlin was two months behind on his payments. Hamlin went back to his vehicle to retrieve his belongings. While he was doing so, the tow truck driver drove off, dragging, and eventually running over Hamlin.

That episode occurred over a fifteen to twenty minute period. Hamlin, who is allowed two breaks per day, had not taken a break at the time of the incident, and the employer paid him for that time.

Hamlin filed a Petition for Benefits seeking compensability of the incident and workers' compensation benefits associated with his injuries. The E/C denied compensability, asserting that the incident had not “arisen out of” Hamlin’s employment, as required by section 440.09, Florida Statutes. The JCC denied compensation, and Hamlin appealed.

In order for an injury to “arise out of work performed,” the injury must (1) be causally connected to the claimant’s employment, (2) have had its origin in some risk incident to or connected with the employment; or (3) flow from the employment as a natural consequence. The Court emphasized that mere presence of the workplace is never enough, standing alone, to

meet the “arising out of” prong. Because Hamlin’s accident was not caused by any risk incidental to his work, his argument fails under that analysis.

Further, the Court concluded the “personal comfort” doctrine did not apply because Hamlin did not meet a three-pronged test: (1) the activity is incidental to Hamlin’s work; (2) Hamlin’s participation in the activity benefits the employer by producing a refreshed employee; and (3) the injury results from a work-created or neutral risk. As the Court noted, “[r]ecovering property from a repossessed vehicle is not the type of activity normally associated with creating a ‘refreshed’ employee,” and again, is not associated with any risk incidental to Hamlin’s employment.

Finally, the Court rejected Hamlin’s argument as to the tipsy coachman rule, specifically, that his actions were part of an “emergency undertaking” covered under section 440.092(3), Florida Statutes. In order for that doctrine to apply, the emergency must arise in a situation that would be objectively recognized by others as an emergency requiring the similar action undertaken by Hamlin. The Court did not think Hamlin’s “rash act” of recovering personal items met that criterion.

As a result, the Court upheld the JCC’s denial of compensability.

Summary prepared by Brian D. Tadros, btadros@gmlj.com.

NONVERBAL CONDUCT AS MISREPRESENTATION: Nonverbal conduct can be grounds for misrepresentation defense when medical testimony establishes that said conduct is inconsistent with objective findings.

Lucas v. ADT Security Inc./Sedgwick CMS, 72 So.3d 270 (Fla. 1st DCA), decided October 17, 2011.

Jerette Lucas sustained a compensable injury to her lower back arising out of her employment. Lucas was seen by numerous physicians, all of whom placed her at maximum medical improvement with a 0% permanent impairment rating, and concluded the objective findings noted on exam did not support the level of subjective complaints of pain Lucas reported.

Ultimately, the E/C appointed Dr. Chaim Rogozinski as Independent Medical Examiner. Dr. Rogozinski's examination occurred on February 6, 2008. In his report, and later in deposition, Dr. Rogozinski indicated that Lucas was at maximum medical improvement, with 0% impairment, and at full duty. More important, however, the doctor testified Lucas was malingering, or "faking" her injury and symptoms.

Subsequently, the E/C denied benefits on the basis of section 440.105(4)(b)1, which provides that it shall be unlawful for any person "to knowingly make, or cause to be made, any false, fraudulent or misleading oral or written statement for the purpose of obtaining or denying any benefit or payment under this chapter." The JCC found that Lucas intentionally made numerous false and misleading statements with regard to the extent of her injuries for the purpose of obtaining benefits, some of which included reporting pain complaints grossly out of proportion to the physical findings on examination and diagnostic studies. The JCC denied Lucas' request for benefits.

On appeal, the Court compared and contrasted Lucas' verbal statements of pain (e.g., rating it as "5 out of 10") with her actions during Dr. Rogozinski's physical examination, and ultimately, the doctor's own findings. Relying heavily on the doctor's testimony as to his personal observations of Lucas' behavior, the Court concluded her behavior was inconsistent with her pain complaints, such that the JCC's denial of benefits on the basis of 440.105(4)(b) was proper.

The Court distinguished between a surveillance video, which the Court has held, in and of itself, cannot provide a basis for a misrepresentation defense, when the claimant's actions in the video were not inconsistent with her statements or presentations, with the statements of a claimant to a physician which are inconsistent with the objective findings. In this case, the Court held Dr. Rogozinski's testimony was sufficient evidence that Lucas' reports of pain were inconsistent with her nonverbal conduct.

Note: Lucas recently moved to invoke the jurisdiction of the Florida Supreme Court, citing a direct conflict between this opinion and one from another district. The Supreme Court has not yet decided whether it will accept jurisdiction.

Summary prepared by David M. Havlicek, dhavlicek@gmlj.com.

OPINIONS OF INDEPENDENT MEDICAL EXAMINERS: The statute providing that parties are bound by their Independent Medical Examiners (IME's) does not preclude a party from moving for and obtaining an Expert Medical Advisor due to a conflict between the IME and another physician.

Keeton v. Kentucky Fried Chicken, 2011 WL 5561247 (Fla. App. 1st Dist.), decided November 16, 2011.

Sherry Keeton developed carpal tunnel syndrome and sought compensability as a workers' compensation injury.

Dr. DiGeronimo was authorized and opined that Keeton's condition was not work-related. Nonetheless, the E/C sought an independent medical examiner ("IME"), who opined that the carpal tunnel syndrome was caused by Keeton's employment.

Subsequently, the E/C moved for an expert medical advisor ("EMA"), citing the conflict between Dr. DiGeronimo and their IME. Keeton objected, arguing that the E/C was bound by the opinion of its IME per section 440.13(5)(b), Florida Statutes. The JCC granted the E/C's motion over those objections and appointed Dr. Paul Maluso. Ultimately, Dr.

Maluso sided with Dr. DiGeronimo, and the JCC denied the claim for compensability of the carpal tunnel syndrome.

On appeal, the Court concluded the JCC had correctly rejected Claimant's arguments as to section 440.13(5)(b), agreeing that section 440.13(9)(c) (providing for appointment of EMA's) does not contain an exception in reference to the former statute. Instead, section 440.13(5)(b) is intended to preclude "serial independent medical examinations." As a result, the panel upheld the JCC's appointment of Dr. Maluso, and consequently, the denial of compensability and associated benefits.

Summary prepared by David M. Havlicek, dhavlicek@gmlj.com.

PAYMENT OF PERMANENT TOTAL DISABILITY BENEFITS PRIOR TO REACHING MAXIMUM MEDICAL IMPROVEMENT: A claimant may be entitled to receive permanent total disability benefits prior to reaching maximum medical improvement if he can establish that he will be totally disabled upon reaching MMI.

Matrix Employee Leasing, Inc. and First Commercial Claims Services v. Hadley, 2011 WL 5925050, (Fla. 1st DCA), decided November 29, 2011.

Shawn Hadley sustained a compensable injury to his left knee and leg on January 18, 2007. Hadley underwent numerous surgeries, and in May 2009, was placed on a no-work status pending even more surgeries. At that time, the authorized physician, Dr. Hakim, could not predict when Hadley would reach maximum medical improvement ("MMI"), or what his disability status would be. Dr. Hakim ultimately testified that Hadley would "most probably" be able to go back to, at least, light duty work at some point.

By January 18, 2009, Hadley had exhausted the 104-week statutory cap of temporary indemnity benefits. At that point, the E/C began paying Hadley impairment benefits

pursuant to the 10% rating Dr. Hakim had estimated. Thereafter, Hadley filed a Petition for Benefits seeking an award of PTD benefits from January 18, 2009 and continuing. The E/C denied the claim, asserting that Hadley must first reach MMI to make the claim for PTD ripe for adjudication.

After a final hearing on the merits, the JCC, while acknowledging that there is no creature in the workers' compensation law known as "temporary permanent disability," nevertheless awarded PTD benefits. In so concluding, the JCC reasoned that "the Legislature did not intend to leave a claimant ... out in the cold with no basis for indemnity

benefits when that worker is totally disabled for more than 104 weeks.” The E/C appealed.

The Court focused on a prior opinion in which the Court reversed an award of PTD benefits and stated that benefits were not due because the claimant was neither at MMI, nor had he proven that he would be totally disabled upon reaching MMI. In so concluding, the Court recognized an exception to the “ripeness” rule pertaining to PTD benefits (i.e., that claims for same are premature unless the claimant is at MMI): an employee whose 104 weeks of temporary benefits are about to expire can establish entitlement to PTD benefits by proving that he will be permanently and totally disabled after reaching MMI. The Court specifically held it was not enough to establish total disability upon reaching statutory MMI or at the time the 104 weeks are exhausted.

In light of the Court’s prior holdings, it reversed the JCC’s award of PTD benefits to Hadley.

Justice Padovano explicitly dissented from the majority opinion, asserting that the statutes do allow for award of PTD benefits once a claimant reaches statutory MMI. In so arguing, he cited sections 440.15(3)(d)1 and 2, which pertain to the nature of the report required by a doctor six (6) weeks before statutory MMI. Justice Padovano reasoned that, reading the statutes together, it is clear that an injured worker who is still totally disabled at the end of the 104-week period of eligibility is deemed to be at MMI (pointing out that the statutes do not distinguish between physical or statutory MMI at all), such that a claim for PTD benefits would be ripe and proper.

This opinion was very recent at the time *Legal Update* went to print. Given the extent of Justice Padovano’s dissent, it is possible there will be further discussion of this issue, either by the full First District Court of Appeal, or by the Florida Supreme Court.

Summary prepared by David M. Havlicek, dhavlicek@gmlj.com.

North Carolina Liability and Coverage

COVERAGE/BUSINESS RISK: “Your work” exclusion was narrowly drafted such that it failed to exclude consequential damages and lost income.

Alliance Mut. Ins. Co. v. Dove, 714 S.E.2d 782 (N.C. App.), decided August 16, 2011.

Alliance Mutual filed a declaratory judgment action seeking a declaration that the “your work” (business risk) exclusion in its general liability policy excluded coverage for all damages caused by its insured, Glen Dove, while performing services at a feed mill. Dove, a welder, was hired to repair a grain bucket-elevator. During the welding process, grain-dust ignited, and an explosion damaged the rail receiving bucket and elevator rail receiving leg. The mill owner filed suit against Dove seeking the cost of repairs, in addition to the cost of

having to obtain grain by truck rather than by rail as a result of the damaged rail elevator. The mill owner also sought damages for business interruption and lost revenue. Dove sought coverage for the loss from Alliance.

The trial court narrowly construed the policy’s “your work” exclusion clause to find coverage for consequential damages and the Alliance appealed. In analyzing the coverage exclusion, the Court of Appeals compared the exclusion to prior “your work” exclusions

interpreted by the Supreme Court of North Carolina. The Court of Appeals held that the exclusion in the Alliance policy was narrower than those previously interpreted by North Carolina appellate courts because the Alliance policy excluded coverage for damages to the “specific part of any property that must be [repaired] ... because of faults in your work.” Previous appellate decisions relied upon exclusionary language that applied to “all faulty work,” which was construed to exclude consequential damages.

The Court of Appeals ultimately held the Alliance policy excluded coverage only for damages to the grain elevator bucket because it was the specific property upon which the insured was performing services. Once it determined the exclusion did not except coverage for additional components of the grain elevator, the Court held the “your work” clause did not exclude consequential damages as it was not explicitly referenced in the exclusion.

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

PREMISES LIABILITY: Owner of land lacked sufficient control over property to subject it to liability for injury to third-person.

Hylton v. Hanesbrands, Inc., 716 S.E.2d 54 (N.C. App.), decided September 6, 2011.

James Hylton was injured while operating a front-end loader which turned over when he failed to navigate a large pile of sawdust. Hylton was working on property owned by Hanesbrands, Inc. and leased to his employer, Suez Energy, to operate a steam plant. Hylton did not name Suez in the complaint because that claim would be barred by the exclusivity provision of the Workers' Compensation Act.

Hanesbrands control over the property sufficient to impose liability. The Court reviewed each provision in the lease and determined each proffered lease provision merely granted access to the property by Hanesbrands or governed activity of the employees of Suez Energy while visiting the plant for which the steam was necessary. Therefore, Hanesbrands lacked sufficient control over the property to establish a duty of care to Hylton.

Despite the fact Suez Energy was the lessee of the property and maintained exclusive possession, Hylton argued Hanesbrands owed him a duty of reasonable care because it retained control over the property pursuant to the terms of its lease agreement with Suez Energy.

In affirming summary judgment for Hanesbrands, the Court of Appeals determined that Suez Energy maintained exclusive control over the safety of the premises pursuant to the other lease provisions governing safety, traffic control and maintenance of the premises.

Hylton pointed to six (6) separate lease provisions that he contended afforded

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

PREMISES LIABILITY/NOTICE: A landlord is not liable for injuries without actual/constructive knowledge of the existence of a hazardous condition.

Martin v. Kilauea Properties, LLC, 715 S.E.2d 210 (N.C. App.), decided August 2, 2011.

Stephanie Martin visited the apartment of a friend who lived on the second floor. When Martin exited to the second-floor deck of the home to smoke a cigarette, she wandered toward the corner of the deck that had, until recently, held a planter box. The deck gave way and Martin was injured in the fall.

Martin filed suit against Kilauea Properties alleging it maintained the leased location in an unsafe condition. The trial court granted summary judgment to Kilauea Properties on Martin's negligence claims finding that it cannot be held liable for a hazardous

condition for which it was not provided notice. Martin appealed.

The Court of Appeals affirmed holding that there was no evidence Kilauea Properties knew, or should have known, of the existence of the hazardous condition. The planter box had been removed by the tenant prior to the accident. Although the tenant recognized the potentially dangerous condition upon removing the planter box, she did not communicate her concerns to the landlord.

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

PROPERTY DAMAGE/DIMINUTION IN VALUE: Plaintiff was entitled to introduce evidence of repair cost paid by Defendant's insurer in support of claim for diminution in value to motorcycle.

Smith v. White, 712 S.E.2d 717 (N.C. App.), decided July 5, 2011.

Michael Smith was driving a motorcycle when Grady White turned left in front of him resulting in personal injuries and property damages. White paid the property damage to the motorcycle, but not for diminution in value. Smith filed suit seeking recovery for personal injury and diminution in value of the repaired motorcycle.

At trial, Smith sought to introduce evidence of the extent of the motorcycle repairs, in addition to the actual cost of the repairs. The trial court excluded evidence of the repair cost, which had previously been paid by White. The jury entered a verdict in favor of Smith, but did not award damages for diminution of value for the motorcycle. As a result, White was awarded costs because he previously served an Offer of Judgment in excess of the jury verdict. Smith appealed the trial court's denial of his motion for a new trial.

The Court of Appeals held the trial court improperly excluded evidence of the repair costs paid by White. White argued that allowing evidence of the cost to repair the motorcycle would amount to a double recovery for Smith who had already received the benefit of the repairs.

The Court determined the appropriate measure of damages for injury to personal property is the difference in the market value of the property immediately before and immediately after the injury. The Court ruled that evidence of the cost to repair the motorcycle (despite the fact that it had already been paid by White and was not recoverable) was admissible to establish Smith's diminution in value claim.

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

North Carolina Workers' Compensation

EMPLOYMENT RELATIONSHIP: Employer deemed to employ the claimant who was hired by supervisor who lacked actual authority to make hiring decision, but possessed “apparent authority” to hire the claimant.

Campos-Brizuela v. Rocha Masonry, LLC, 716 S.E.2d 427 (N.C. App.), decided October 4, 2011.

Nelson Campos-Brizuela moved to North Carolina from Maryland seeking greater employment opportunities. Campos-Brizuela became acquainted with Felipe Quintero who worked for Rocha Masonry, and Campos-Brizuela began assisting Quintero.

Campos-Brizuela suffered a severe injury to his hand on April 15, 2009. Rocha Masonry denied the claim on the basis that Campos-Brizuela was not employed by Rocha Masonry at the time of his injury. Following a hearing, the Deputy Commissioner issued an opinion and award concluding Campos-Brizuela failed to prove he was employed by Rocha Masonry at the time of his injury. The Full Commission reversed the Deputy Commissioner and ruled that Campos-Brizuela was employed by Rocha Masonry at the time of his injury and awarded medical treatment, disability benefits and attorney fees.

The Court of Appeals affirmed the Full Commission's award of disability and medical benefits. The Court relied upon Campos-Brizuela's belief he was hired by Quintero and was informed he would be paid with a company check. Campos-Brizuela observed Quintero giving orders to other workers and believed Quintero possessed authority to hire assistants. While substantial evidence obtained directly from Quintero suggested Campos-Brizuela was merely tagging along at the worksite to find employment with other subcontractors, the Court held Quintero was afforded little credibility. The Court determined, pursuant to common law principles, that Quintero had apparent authority to hire Campos-Brizuela on behalf of Rocha Masonry; therefore, Rocha Masonry was deemed the employer.

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

INDEMNITY COMPENSATION: Court of Appeals rejects distinction between pre-MMI and post-MMI suitable employment prior to legislative amendment.

Wynn v. United Health Services/Two Rivers Health-Trent Campus, 716 S.E. 2d 373 (N.C. App.), decided August 2, 2011.

Tamida Wynn, a CNA, suffered a compensable injury to her knee on August 1, 2008. Prior to her injury, Plaintiff worked a very fixed schedule that allowed her to work weekends and second shift to accommodate the childcare needs of her seven children.

Following her release to light-duty employment, Plaintiff was offered the position of “light-duty CNA” which was reserved for

employees recovering from compensable injuries. That light-duty position was only available during hours that conflicted with Wynn's unmovable childcare arrangements. After working her weekend shifts, Wynn informed her supervisor she would not be able to report to work first-shift on weekdays.

The employer terminated Wynn and denied temporary total disability benefits as a

result of Wynn's constructive refusal of suitable employment. Following a hearing, the Industrial Commission awarded Wynn disability benefits, agreeing that the light-duty CNA position was not "suitable employment" as defined by the Workers' Compensation Act. The employer appealed.

The Court of Appeals engaged in a detailed analysis of the definition of pre-MMI and post-MMI "suitable employment." The Court held there is no authority in the Workers' Compensation Act, or in the corresponding case law, to support the employer's proposition that pre-MMI suitable employment is distinct from post-MMI suitable employment. The Court of Appeals invited the North Carolina General

Assembly to legislatively adopt a different standard for pre-MMI suitable employment.

Note: On June 24, 2011, North Carolina passed the Protecting and Putting NC Back to Work Act, which defined "suitable employment" *for claims arising after June 24, 2011* as "employment offered to the employee ... that (i) prior to reaching maximum medical improvement is within the employee's work restrictions, including rehabilitative or other noncompetitive employment with the employer of injury approved by the employee's authorized health care provider..."

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

DEATH BENEFITS – PICKRELL PRESUMPTION: When the presumption operating against the employer in a death claim is rebutted, it requires the claimant to prove death by accident.

Mary Gray, widow David D. Gray, Deceased Employee v. United Parcel Services, Inc., 2011 WL 4784136 (N.C. Sup. Ct.), decided October 6, 2011.

David Gray was found lying on the ground in UPS' parking lot, with his glasses three to four inches away. Gray died at the scene, and an autopsy identified the cause of death as acute arrhythmia due to severe coronary atherosclerosis. Gray's wife, Mary, filed a Form 33 alleging that Gray "fell out of his truck striking his head which contributed to a heart attack resulting in his death." UPS' expert witness testified that the Gray's employment did not contribute to the heart attack causing his death and deemed the death an acute cardiac event.

The North Carolina Industrial Commission filed an Opinion and Award concluding that Gray's death was a result of an accident sustained in the course of his employment, following application of the *Pickrell* presumption. Pursuant to *Pickrell*, when an employee dies in the course and scope of his

employment, and there is no evidence whether the death was caused by an accident, the employee is presumed to have died as a result of injury by accident. The burden shifts to the employer to prove the death was not accidental or did not arise out of the deceased-employee's employment.

In this case, the Court of Appeals held the Industrial Commission failed to properly apply the *Pickrell* presumption. Upon receiving the testimony of the UPS' expert witness refuting a work-related cause of the Gray's heart attack, UPS had effectively rebutted the *Pickrell* presumption, and the burden of proof shifted back to Gray to show, by a preponderance of the evidence, the death was due to an injury by accident or arose from his employment.

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

REFUSAL OF VOCATIONAL REHABILITATION: Where the employee failed to meaningfully participate in vocational rehabilitation efforts, the Industrial Commission must determine whether the employee is substantially complying with rehabilitation.

Powe v. Centerpoint Human Services, 715 S.E.2d 296 (N.C. App.), decided September 6, 2011.

Mary Powe is a well-educated human services clinician who sustained a compensable injury to her back and hip on May 21, 2001. The Industrial Commission ordered a suspension of TTD upon Centerpoint's claim that Powe failed to cooperate with vocational rehabilitation. In 2008, Powe moved the Industrial Commission to reinstate temporary total disability benefits, stating that she was prepared to comply with vocational rehabilitation. The Full Commission entered an Opinion and Award denying additional indemnity benefits due to Powe's failure to "fully comply" with vocational rehabilitation as required by N.C.G.S. § 97-25. Powe appealed.

The Court of Appeals reversed the Full Commission's denial of indemnity benefits. While the Full Commission upheld a denial of benefits based upon the Powe's lack of compliance with vocational rehabilitation, the Court undertook an analysis to determine whether Powe's efforts (or lack thereof) constituted substantial compliance with vocational rehabilitation, or whether her refusal

was sufficient to trigger suspension of indemnity benefits. The Court of Appeals remanded the case to the Full Commission to apply the following standard: "when an employee is participating to some degree in vocational rehabilitation services, the Commission must determine, in deciding whether to reinstate benefits, whether the employee is substantially complying with those services and not significantly interfering with the vocational rehabilitation specialist's efforts to assist the employee in returning to suitable employment."

Pursuant to the test set forth by the Court of Appeals, employers seeking to suspend benefits due to a claimant's failure to participate in vocational rehabilitation, must prove either that the plaintiff's failure to participate was intentional (i.e., refuses to participate), or that the plaintiff's lack of effort was so severe that it significantly interferes with the efforts of the vocational rehabilitation specialist.

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