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## LEGAL UPDATE

June 2007

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**Legislative Update**

**May 31, 2007**

**By:**

**Edward H. Lindsey, Jr., Esq.**

**Legislative Update**

My dad was a traveling businessman. On Friday night, he liked to conclude his week long journey by standing in the atrium of our house, dropping his bags and yelling, “don’t pay the ransom, I escaped!” At the end of my third session in the General Assembly this Spring, that is pretty much how I felt when we completed this year’s session.

Although the 2007 Session of the Georgia General Assembly lacked the fireworks surrounding the 2005 fight over Tort Reform and the 2006 Legislative avalanche surrounding Imminent Domain, the Legislature did pass significant legislation that will have an impact either directly or indirectly on civil litigation in Georgia. The following are some of the highlights of the session.

**I. What Passed in 2007**

A. HB136 – Public Policy; Contract of Insurance; Indemnification

Georgia law already prohibits construction related contracts which allow one party to the contract to require the other party to indemnify the first party for the first party’s own acts of negligence or willful misconduct. HB136 extends this prohibition to also prohibit the first party from requiring that the second party’s insurance carrier provides such indemnification.

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.

B. HB139 – Estates and Wills; Dissent and Distribution

House Bill 139 seeks to deal with situations in wrongful death actions and estate distributions in which one of the parents of a deceased minor child who had previously abandoned the child now seeks recovery for his or her portion of the proceeds from a wrongful death action or recovery from the minor's estate. The Bill allows for an action in Probate Court to strip the abandoning parent from any right to recover either for the wrongful death of a child or for a portion of the child's estate if the child died intestate.

C. HB221 - Professional Malpractice Charges; Affidavit

House Bill 221 modifies O.C.G.A. §9-11-9.1 which requires the filing of an Affidavit with a Complaint for professional malpractice. The Bill expands this requirement to include not only actions against individual professionals but also against professional partnerships and corporations performing duties recognized under Georgia law as professions.

In addition, the Bill also allows for the delayed filing of the Affidavit in a limited situation. Specifically, if the plaintiff's attorney is retained within 90 days of the statute of limitations, the plaintiff will have 45 days after the filing of the Complaint to supplement the pleadings with the Affidavit. The law requires an Affidavit from the attorney affirming the date in which his or her firm was retained. In addition, the law does not require the defendant to answer the Complaint until 30 days after the Affidavit has been filed.

D. HB551 – State False Medicaid Claims Act

Federal law has long recognized the right of individuals with knowledge of fraudulent claims being made against the federal government to file suit on behalf of the federal government against wrongdoers. HB 551 now creates a state false claims cause of action to deal with fraudulent Medicaid claims. The Act is similar in construction to the federal Qui Tam litigation procedures which require that the suit first be reviewed by the State Attorney General's Office. The State Attorney General can either elect to bring the action directly, allow the private individual to pursue the action, or seek to dismiss the action altogether. If found liable, the defendant may be required to pay in damages fines between \$5,500 to \$11,000 per claim and triple the amount of the initial claim, plus attorney's fees. Similarly, if the defendant prevails he or she is entitled to recover his or her attorney's fees.

This state cause of action has been very successful in other states in attacking fraudulent Medicaid claims. Since 2002, Texas has recovered over \$200 million in fraudulent claims. In 2005, the State of Florida recovered \$50 million in fraudulent claims for one year.

E. SB94 – Dispossessory Proceedings; Clarify the Process for Judgments by Default

SB94 requires that at the time of the commencement of a dispossessory action the landlord set out by Affidavit any and all damages for past due rent being sought. If the tenant fails to answer this action, the Court will not require any further evidence nor hold any hearings and the plaintiff shall be entitled to a verdict in judgment by default for all rents due if the proper Affidavit was filed with the commencement of the action.

In addition, SB94 also requires that non-refundable fees be expressly segregated from security deposits in leases.

F. SB101 – Agricultural Facilities in Nuisance Suits

Already under Georgia law, the timber industry enjoys certain protections from nuisance laws where surrounding landowners subsequently move close to a lumber plant already in operation. This Bill simply extends that protection to plants which also manufacture sheetrock. These nuisance limitations do not apply if the plant is operating in a negligent fashion or in violation of any state or federal law or environmental regulation.

G. SB182 – Torts; Asbestos/Silica Claims

In response to a recent Georgia Supreme Court decision, SB182 seeks to limit certain asbestos and silica claims. For claims which have accrued before the effective date of the statute, the Bill simply codifies existing law which requires that the claimant provide evidence from a qualified physician who certifies to a reasonable degree of medical probability that the personal exposure to either silica or asbestos was a contributing factor to the claimed injury. For claims which have accrued after the effective date of the statute, the doctor will need to provide a certification to a reasonable degree of medical probability that the asbestos or silica was the primary cause of the resulting injury. The Bill further requires that for all future claims mere exposure to silica or asbestos is insufficient to bring a cause of action. In the future there must be *prima facie* evidence of actual physical impairment or injury. Furthermore, the statute of limitations will not begin to run on these claims until such injury has been discovered through the exercise of reasonable diligence.

H. HB274 – Notary Public Applications

HB274 revises the requirements for individuals applying to be a notary in Georgia. The Bill requires that applicants be either a U.S. citizen or a legal resident of Georgia. In addition, the Bill requires that each applicant provide certain identification at the time of his or her application as well as their residence and a valid telephone number. The Bill also requires that the individual attesting to the character of the applicant to have known the applicant for at least 30 days.

HB274 is in response to a request by the Superior Court Clerks to tighten up on the application procedures for Notary Publics. The clerks are especially concerned with tracking notaries given the exponential increase in mortgage fraud in Georgia in recent years.

I. HB24 - Georgia's Advance Directive

HB24 is a major overhaul of Georgia's Advance Directive Procedures in terms of Living Wills and Durable Powers of Attorney. The Bill creates a unified advance directive written in plain English which will consist of the patient laying out what he or she wants to have done if they are incapacitated as well assisting both the individual's agent and healthcare providers.

II. **Coming Up in 2008**

The 2008 session is only 7 months away and it is not too soon to start looking ahead. There are also several Bills still pending before the General Assembly which may come up next year. These include:

- HB292 which expands the use of private process servers in Georgia;
- HB872 allows for juries to consider the failure of the plaintiff to wear a seatbelt as evidence of contributory negligence;
- HB97 & 102 provides for a judicial election reform;
- SB276 expands uninsured motorist coverage in Georgia

Stay tuned!

# CASE NOTES

## Georgia Liability

**SANCTION OF DISMISSAL: The sanction of dismissal requires a two-step process: first a motion to compel must be filed and granted; and second, the party in violation must have had an opportunity to be heard of the issue as to whether the violation is willful.**

*McConnell v. Wright*, 2007 WL 1183926 (Ga. Supreme Court), decided April 24, 2007.

On April 1, 2004, the McConnells (“Plaintiffs”) brought suit against Wright (“Defendant”) for injuries and damages sustained in an automobile accident. Subsequently, State Farm Mutual Automobile Insurance Company joined the litigation as a potentially-liable underinsured motorist carrier.

During the early portion of the discovery phase of the litigation, Plaintiffs were represented by counsel and complied with Defendant’s discovery requests. However, in the fall of 2004, Plaintiffs terminated their counsel.

Thereafter, State Farm noticed Plaintiffs’ depositions. The evening before the depositions, Plaintiffs contacted State Farm and asked to reschedule because they had yet to obtain replacement representation. State Farm consented and the depositions were rescheduled for a later date.

As with the first depositions, Plaintiffs contacted State Farm and requested the second depositions be rescheduled until Plaintiffs could obtain counsel. State Farm once again agreed and a third date was set.

Before the third deposition date, Plaintiffs notified State Farm that they had an initial meeting with an attorney who may represent them in the litigation, but Plaintiffs did not ask State Farm for another postponement. Instead, State Farm asked Plaintiffs for notice when the new attorney was retained. That never occurred, and Plaintiffs failed to appear for their scheduled depositions.

Subsequently, State Farm moved pursuant to O.C.G.A. §9-11-37 to dismiss Plaintiffs’ action as a sanction for Plaintiffs’ failure to appear for depositions.

The trial court granted State Farm’s Motion to Dismiss without holding a hearing to determine whether Plaintiffs acted willfully. The Georgia Court of Appeals affirmed that decision. The Supreme Court granted certiorari to determine whether, in the absence of a hearing on the willfulness of Plaintiffs’ failure to comply with discovery, the sanction of dismissal was appropriate.

According to the Supreme Court the sanction of dismissal requires a two-step process. First, a motion to compel must be filed and granted. Second, after the party seeking sanctions notifies the court and the obstinate party of the latter’s failure to comply with the order granting the motion to compel and the moving party’s desire for the imposition of sanctions, the trial court may apply sanctions after giving the obstinate party an opportunity to be heard and determine the obstinate party’s failure to obey was willful. However, with regard to the second step, the trial court is not required to provide the obstinate party a hearing in every situation. A hearing can be excused when the court heard arguments on the motion to compel by which the trial court is able to determine the obstinate party is willfully failing to comply with the discovery process.

The Georgia Supreme Court, applying the above two-part process to the record, reversed the Court of Appeals and the trial court. The Court based its decision on State Farm’s failure to bring a motion to compel against Plaintiffs and the trial court’s failure to provide Plaintiffs a hearing to determine the willfulness of Plaintiffs failure to appear for their depositions.

**PREMISES LIABILITY/OUT-OF-POSSESSION LANDLORD: A landlord is not liable for injuries to independent contractors injured on their premises where the landlord has surrendered complete control of the premises and did not have superior knowledge of the dangers.**

*Saunders v. Industrial Metals and Surplus, Inc.*, 2007 WL 1240407 (Ga. App.), decided April 30, 2007.

Stephen Saunders (“Plaintiff”) filed suit against Industrial Metals (“Defendant”) for catastrophic injuries sustained when he fell through a skylight while repairing a roof. Plaintiff was employed by Bodiford Corp. d/b/a AAA Welding (“AAA”). AAA entered into an oral contract to replace the rusting roofs on five buildings on Defendant’s property. Defendant warned Larry Bodiford, AAA’s owner, that the skylights present on the roof would not support a man’s weight, and Mr. Bodiford took efforts to warn his employees every morning to be careful when working around the skylights. Following discovery, the trial court granted Defendant’s Motion for Summary Judgment.

The law in Georgia states that a landowner is liable in damages to invitees who are injured on his property due to his failure to exercise ordinary care to keep the premises safe. However, a property owner who surrenders possession and control of his property to an independent contractor is generally not liable for injuries sustained by the contractor’s employees on the property due to unsafe conditions. Conversely, the owner may be liable for such injuries if he retains the right to direct or control the time and manner of executing the independent contractor’s work or interferes with the work to a sufficient degree.

The Court of Appeals in the present case found that the Defendant had surrendered complete control of the premises to AAA. That finding was based on AAA’s employees having unfettered access to the roof, which was accessible only by using a lift provided by AAA and operated by its employees. Further, Mr. Bodiford was given a key to the premises, AAA did not need permission to go on the roof or anyone affiliated with Defendant to accompany them. Additionally, Mr. Bodiford, not Defendant, controlled the time, method, and manner of AAA’s work.

Plaintiff argued that even if Defendant completely surrendered possession of the premises, its knowledge of the hazardous skylights rendered them liable. Georgia law provides that the crux of a premises liability case is the owner’s superior knowledge of the hazard. Thus, a plaintiff’s actual, subjective awareness of the hazard precludes a recovery under this theory. Here, there was no issue about either party lacking knowledge of the hazardous skylights and neither party’s knowledge was superior to the other.

As a result, the Court of Appeals affirmed the trial court’s grant of summary judgment to Defendant.

**PREMISES LIABILITY/ PARKING ACCESS AND OFF PREMISES INJURY: Where a property’s parking is interrupted, the landlord incurs no liability for an off premises injury when the landlord exercised no control over the off-premises site and breached no duty imposed by law.**

*Walton v. UCC X, Inc et al*, 282 Ga. App. 847, decided November 22, 2006.

Wendall Walton (“Plaintiff”), as administrator of the estate of Wallace David Abernathy (“Abernathy”), sued UCC X, Inc. d/b/a Cedar Heights Apartments (“Defendant”) for the wrongful death of Abernathy. Defendant received Department of Housing and Urban Development (“HUD”) rental assistance payments on behalf of its residents. On November 20, 2003, Defendant’s management notified residents that the parking lot was scheduled to be resurfaced and instructed the residents to park their cars across the street from the complex. On the evening of November 25, 2003, a motorist’s car struck and killed Abernathy as he crossed the highway that ran between the temporary parking lot and Defendant’s apartment complex. The

trial court granted Defendant’s Motion for Summary Judgment, and Plaintiff appealed.

Plaintiff claimed that Defendant was negligent per se in its actions toward Abernathy by failing to comply with HUD regulations. Negligence per se can arise from violations of federal statutes (or regulations) if: (1) the plaintiff falls within the class of persons the statute intended to protect; (2) the harm complained of was the same harm against which the statute sought to guard; and (3) the violation of the statute proximately caused the plaintiff’s injury.

Plaintiff first cited several HUD regulations, which require a landlord to maintain its property free of hazards and safe for tenants. However, under the common law, the Court of Appeals rejected this

argument. Finding that the HUD regulations did not intend to eviscerate common law principles, the Court relied upon the common law that an owner or occupier of land does not have a duty to protect against harms occurring on public roadways or premises owned by third parties when the owner or occupier had not exercised any control over the roadway or premises.

Plaintiff next argued that Defendant violated O.C.G.A. §30-5-8(a)(1), which makes it unlawful to neglect an elder person. O.C.G.A. §30-5-3(7.1) defines neglect as the absence or omission of an essential service, which includes protection from health and safety hazards. The appellate court refused to conclude that continuous and uninterrupted parking privileges are an essential service such that its negligent or intentional deprivation constitutes a violation of O.C.G.A. §30-5-8(a)(1).

Plaintiff further argued that Defendant breached a common law duty to not injure Abernathy. However, the Court of Appeals found that Defendant's duty to exercise ordinary care in keeping its premises and approaches safe did not

extend to the public highway where Abernathy was injured because it did not exercise any control over the highway or the manner in which Abernathy chose to cross the highway. Thus, Defendant did not breach any common law duty.

Plaintiff also asserted that Defendant breached Abernathy's contractual right to use the parking lot and its independent duty to avoid harming Abernathy. However, the Court of Appeals noted that Abernathy's lease agreement did not provide a right of parking. Further, even if a right of parking was implied, recovery in tort requires not only a breach of a contract term, but also a breach of some independent duty imposed by law. In this case, there was no general duty imposed by law for a landlord to provide uninterrupted parking to tenants.

For these reasons, the Court of Appeals affirmed the trial court's grant of summary judgment to Defendant.

*This case was successfully defended in the trial court and at the Court of Appeals by T. Jeffery Lehman of Goodman McGuffey Lindsey & Johnson, LLP.*

**FREE PUBLIC SERVICES DOCTRINE: A county cannot recover the costs and expenses associated with carrying out public services from a tortfeasor whose conduct caused the need for the services.**

*Walker County v. Tri-State Crematory, et al, 284 Ga. App. 34, decided March 7, 2007.*

After the discovery of numerous uncremated and unburied bodies located at the Tri-State Crematory site on February 15, 2002, Walker County ("Plaintiff") brought suit against the owners and operators of the crematorium as well as the funeral homes and funeral directors who did business with Tri-State Crematory ("Defendants") for subsequent removal by Plaintiff and other agencies. Plaintiff asserted a cause of action for negligence and public nuisance seeking to recover expenses incurred for recovering, identifying, and properly disposing of the human remains discovered at the Tri-State Crematory property. The lower court granted Defendants' Motion to Dismiss, and Plaintiff appealed. The Court of Appeals affirmed holding that Plaintiff's claims are barred by the Free Public Services Doctrine.

Plaintiff sought to recover in excess of \$2 million spent on equipment, facilities and employee labor costs for the disposition and identification of unidentified remains. There is a long-standing principle in Georgia and across the country that the "Free Public Services Doctrine" provides that absent specific statutory authority or damage to government owned property, a county cannot recover the costs of carrying out public services from a tortfeasor whose

conduct caused the need for the services. The general rationale behind this doctrine is that state legislatures establish local governments to provide core services for the public and pay for those services by spreading the cost to all citizens through taxation. Any decision to reallocate those costs necessarily implicates fiscal policy, a matter that is normally left to the legislature and its public processes rather than the courts.

In affirming the dismissal, the Court of Appeals relied upon the fact that Plaintiff was not seeking to recover costs associated with injury to its own property, and that there was no specific statutory authority for a county to recover damages for the cost of work performed as a public duty owed to its citizens. The Court of Appeals also rejected Plaintiff's argument that there should be an exception to the Free Public Services Doctrine when the costs are incurred as part of the abatement of a public nuisance. Likewise, the Court rejected Plaintiff's argument that there should be an exception to the Free Public Services Doctrine if the services were mandatory rather than discretionary.

While this case initially was entwined with the specific facts of the Tri-State Crematory

discoveries, the holding by the Court of Appeals should have broad reaching effects as it has solidified the “Free Public Services Doctrine” as a defense to suits brought by counties and municipalities against individual tortfeasors. Where counties and municipalities have an obligation to perform public

services, including fire and police services, they will not be able to recover the costs associated with those services absent direct statutory authority.

*This case was successfully argued for Defendants by Robert A. Luskin, Esq. of Goodman McGuffey Lindsey & Johnson LLP.*

**DUTY TO DEFEND/CONTRACTUAL INDEMNIFICATION/SUBROGATION: A general contractor and its insurer may be entitled to indemnification from a subcontractor and its insurers if the general contractor/subcontractor agreement contains an indemnification provision as well as requirement to be named as an additional insured.**

*BBL-McCarthy, LLC v. Baldwin Paving Company, 2007 WL 1053372 (Ga. App.), decided April 10, 2007.*

The property owners (“Owner”) hired BBL-McCarthy, LLC (“BBL”) as the general contractor in their effort to design and build an office park in north Fulton County. According to the owner/general contractor agreement, BBL was to design and construct the project as well as obtain general liability insurance.

BBL hired Baldwin Paving to build a deceleration lane that facilitated entry onto Owner’s property. The general contractor/subcontractor agreements required Baldwin Paving to obtain insurance that would protect Owner and BBL from liability that might arise from its operations. The agreement also required Baldwin Paving to defend, indemnify and hold harmless Owner and BBL from all claims arising from the performance of the work, regardless whether the claim was caused in part by the negligence of Owner or BBL. Baldwin Paving purchased a general liability policy and umbrella policies per the agreement.

Sometime thereafter, an automobile accident occurred which causes both injuries and deaths. The injured and the estates of the deceased brought suit against Owner, BBL and Baldwin Paving alleging they negligently constructed the deceleration lane that caused the automobile accident. Owner and BBL were also sued for negligently managing the construction project. Eventually, all of the underlying claims were settled by the separate carriers for Owner, BBL and Baldwin Paving.

BBL and its carrier subsequently sued Baldwin Paving and its carriers seeking reimbursement of its defense costs and settlement funds. The Complaint was filed alleging: (1) that Baldwin Paving’s insurance carriers failed to defend and indemnify BBL; (2) that Baldwin Paving breached its duty to contractually indemnify BBL; and (3) that Baldwin Paving was liable under common law theories of indemnification and contribution.

The Court of Appeals first addressed whether the policies’ additional insured endorsement limiting coverage to liability “arising out of” Baldwin Paving work precluded the carriers from owing a duty to defend and indemnify. The Georgia Court of Appeals stated that the term “arising out of your work” means “arising out of a business transaction.” “Arising out of” has also been construed to mean “had its origins in, grew out of or flowed from.” When the issue arises from an insurance contract, the additional insured is covered regardless whether the injury is attributable to the named insured or the additional insured. Therefore, the Court of Appeals decided that the carriers for Baldwin Paving owed BBL a duty to defend because BBL’s liability “ar[ose] out of” Baldwin Paving’s liability.

The Court of Appeals further determined that the contractual indemnification provisions between BBL and Baldwin Paving, even where the claim is caused in part by the liability of BBL, were valid. In Georgia, indemnification agreements are strictly construed against the party to be indemnified. The Court compared the language of the indemnification agreement to the “arising out of” language in the additional insured endorsement. The Court of Appeals decided contractual indemnification was appropriate as the claims at issue arose from Baldwin Paving’s work. Moreover, Baldwin Paving specifically agreed to indemnify even those claims where Owner or BBL might be a joint tortfeasor.

That said, the carriers that paid a settlement without the consent of their insureds could not subrogate because the insurer acted as an independent contractor. In Georgia, an insurance carrier is permitted to compromise the claims of an insured without the insured’s consent, but a relationship of independent contractor is created. O.C.G.A. §33-7-12(a). Where the insurance carrier is acting as an independent contractor, it cannot subrogate to recover funds it paid on behalf of its insured. Accordingly, those insurance carriers that may have been otherwise

able to recover on theories of indemnification could not in this case because the insured did not consent to

the settlement.

**CONTRACTUAL INDEMNITY/INDEMNITOR'S OBLIGATIONS IN THE EVENT OF INDEMNITEE'S SOLE NEGLIGENCE: Absent explicit language in the contract, an indemnitor is not required to hold an indemnitee harmless for the indemnitee's sole negligence. If an indemnity provision is unenforceable, the liability of the indemnitor extends only to the limits of any applicable insurance policy.**

*Ryder Integrated Logistics, Inc. v. BellSouth Telecommunications, Inc.*, 281 Ga. 736 (Ga. Supreme Court), decided March 19, 2007.

Ryder ("Plaintiff") entered into a contract to supply transportation and logistical services for BellSouth ("Defendant"). Under the contract, Plaintiff was obligated to indemnify Defendant for injuries arising from Plaintiff's negligent or willful acts and to carry insurance naming Defendant as an additional insured with respect to Plaintiff's work under the agreement.

Plaintiff's employee was injured at Defendant's facility and sued Defendant for negligence. Defendant tendered the defense to Plaintiff and Plaintiff's insurance carrier pursuant to the contract, but both Plaintiff and its carrier refused to defend or indemnify Defendant claiming that the employee's injury was due to Defendant's sole negligence. Defendant filed a third-party complaint against Plaintiff and its carrier.

Affirming the Court of Appeals' decision, the Supreme Court held that the indemnity provision

of the contract between Defendant and Plaintiff was unenforceable. Under Georgia law, an indemnity agreement must expressly state that the indemnitor will be responsible for the indemnitee's sole negligence. Absent this express language, the courts will not hold an indemnitor responsible for an indemnitee's sole negligence.

However, the Supreme Court reversed the Court of Appeals' finding that Plaintiff was responsible for the difference between the \$1 million of insurance coverage that Plaintiff agreed to provide and the amount of the settlement that the employee entered into with Defendant. The Supreme Court held that nothing in the contract created greater liability on Plaintiff's part. The Supreme Court also stated that had the indemnity provision been enforceable, Plaintiff's liability would not be limited by the \$1 million insurance coverage that it carried.

**UNINSURED MOTORIST COVERAGE: Umbrella insurance policies that provide automobile or motor vehicle liability coverage are subject to the provisions of the Georgia Uninsured Motorist Act (O.C.G.A. §33-7-11).**

*Abroahams v. Atlantic Mutual Insurance Agency*, 2006 WL 2507052 (Ga. App.), decided August 31, 2006.

On December 28, 2002, Richard Abroahams and his minor son David ("Plaintiffs") were injured in an automobile accident with an uninsured motorist. David Abroahams' permanent injuries led to a total claim of \$1,450,000. Plaintiffs were the named insureds on both an automobile policy and a personal umbrella policy issued by Defendant Atlantic Mutual. The umbrella policy provided \$1 million in excess liability coverage and covered Plaintiffs' house and two cars. After the accident, Plaintiffs made a demand for uninsured motorist (UM) benefits under both policies.

Defendant filed a declaratory judgment action contending the umbrella policy did not provide UM coverage. In fact, Defendant argued the policy specifically excluded it. Plaintiffs filed a

counterclaim alleging that the Georgia Uninsured Motorist Act, O.C.G.A. §33-7-11, required umbrella policies to provide UM coverage. Defendant filed a Motion for Summary Judgment on three grounds: (1) O.C.G.A. §33-7-11 does not apply to umbrella policies; (2) the umbrella policy specifically excluded UM coverage; and (3) even if O.C.G.A. §33-7-11 applied to umbrella policies, the umbrella policy was a renewal policy and exempt from the UM statute. The trial court granted summary judgment in favor of Defendant.

The Court of Appeals reversed the trial court's decision holding that umbrella policies are subject to the provisions of O.C.G.A. §33-7-11. The statute provides: "(a)(1) No automobile liability policy or motor vehicle liability policy shall be issued

or delivered in this state . . . unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle . . .” The Court of Appeals interpreted “automobile liability policy” and “motor vehicle liability policy” as any policy providing any coverage to an automobile or a motor vehicle. Therefore, an umbrella policy that provides coverage for an automobile, as Plaintiffs’ policy did, is subject to the provisions of O.C.G.A. §33-7-11.

The Court of Appeals then addressed the issue whether Plaintiffs’ umbrella policy was exempt from the provisions of the UM statute because it was a renewal policy. Under O.C.G.A. §33-7-11(a)(3),

UM coverage is not required (1) where the insured rejects the coverage in writing; or (2) where the policy is a renewal policy and the insured had previously rejected the coverage in a prior policy issued by the same insurer. An insurer does not have to increase UM coverage in a renewal policy from the amount shown on the declarations page if coverage existed prior to July 1, 2001. The Court of Appeals held that the renewal exceptions were not applicable in this case because Defendant had never previously offered UM coverage on its umbrella policy and Plaintiffs had never previously rejected UM coverage under the umbrella policy.

Finally, the Court of Appeals held that because umbrella policies are subject to the requirements of O.C.G.A. §33-7-11, Defendant could not exclude UM coverage from the policy.

## Florida Liability

### **PREMISES LIABILITY: Constructive notice of dangerous condition or defect may be inferred from circumstantial evidence.**

*Freeman vs. BellSouth Telecommunications*, 954 So.2d 45 (Fla. 1st DCA), decided March 16, 2007.

Plaintiff was injured when she fell into an open manhole. It was dark at the time of the accident, and Plaintiff had been walking along a grassy right-of-way to try to call for assistance because her car would not start.

Plaintiff and her husband filed suit against BellSouth, the owner of the manhole and easement. The jury awarded Plaintiff \$149,587 and her husband \$15,000. However, the trial court granted BellSouth's post-trial motion for directed verdict concluding that Plaintiffs failed to prove that BellSouth had constructive notice that the manhole cover had been removed.

On appeal, the First District Court of Appeal held that the question whether BellSouth had constructive notice was for the jury. The Court further stated that constructive knowledge may be proven by circumstantial evidence showing “defects which have been in existence so long that they could have been discovered by the exercise of reasonable care, and repaired.”

The First District Court of Appeal found that there was sufficient evidence in the trial court record

that BellSouth had constructive notice that the manhole cover had been dislodged. There was a photograph of the manhole area taken the night of the accident showing thick grass and weeds growing down into the manhole and over the edge of the cover where it lay. An employee of a company also testified that he had to replace the manhole cover in question twice before. Relying upon this evidence, the Court concluded the jury could have inferred that the cover had been off the manhole for more than a brief period of time. See *Hannewacker v. City of Jacksonville Beach*, 419 So.2d 308, 311 (Fla. 1982); *Leon v. City of Miami*, 312 So.2d 518 (Fla. 3<sup>rd</sup> DCA 1975).

In so ruling, the Court affirmed the existing rule that a property owner owes a public invitee a duty to maintain the premises in a reasonably safe condition, and to warn of any concealed peril of which it should have known through the exercise of reasonable care. Furthermore, circumstantial evidence may prove constructive knowledge of a dangerous condition on property if the evidence shows that the defects have been in existence for such a time that they would have been discovered if reasonable care had been exercised.

## The Valued Policy Law [VPL] pre and post THE 2005 amendment.

*Citizens Property Insurance Corporation v. Ueberschaer*, 2007 WL 906448 (Fla. 1st DCA), decided March 28, 2007.

Citizens Property Insurance Corporation (“Citizens”) is a statutorily created insurer of last resort pursuant to F.S. §627.351(6) (2004). The statute limits Citizens to provide wind-only coverage. Citizens issued a policy to Plaintiff, which provided coverage for damage caused by windstorm and other named perils for his house and detached pool house. Damage caused by flood was specifically excluded.

On September 15, 2004, Plaintiff’s property was extensively damaged by Hurricane Ivan. Thereafter, Santa Rosa County issued a Notice of Determination of Substantial Damage to the Plaintiff determining that the damage to the property exceeded 50% of its pre-damage value. As a result the National Flood Insurance Program (NFIP) required removal of the structures from the floodplain or elevation of the structures so the lowest floor was at or above the 100 year flood elevation.

Plaintiff filed suit against Citizens seeking the policy limits under Valued Policy Law (VPL), F.S. §627.702(1) (2004). Specifically, Plaintiff sought recovery of the full policy limits for the dwelling, pool house, and personal property as well as for additional living expense (Loss of Use) alleging the property was a total loss, which entitled him to policy limits.

Plaintiff filed a Motion for Summary Judgment claiming (1) the premises were insured for a covered peril, and (2) the damage to the premises had caused a constructive or actual total loss. The Court granted Plaintiff’s Motion and Citizens appealed.

The District Court of Appeal held that because a covered peril, wind in this case, *contributed* to the damage of a structure determined to be a total loss, Citizen’s was liable under VPL for the face amount of the policy.

Notably, however, VPL has now been amended. The changes are underlined:

(1)(a) In the event of the total loss of any building, structure, mobile home as defined in §320.01(2), or manufactured building as defined in §553.36(12), located in this state and insured by any insurer as to a covered peril, in the absence of any change increasing the risk without the insurer’s consent and in the

absence of fraudulent or criminal fault on the part of the insured or one acting in her or his behalf, the insurer’s liability under the policy for such total loss, if caused by a covered peril, shall be in the amount of money for which such property was so insured as specified in the policy and for which a premium has been charged and paid.

(b) The intent of this subsection is not to deprive an insurer of any proper defense under the policy, to create new or additional coverage under the policy, or to require an insurer to pay for a loss caused by a peril other than the covered peril. In furtherance of such legislative intent, when a loss was caused in part by a covered peril and in part by a non-covered peril, paragraph (a) does not apply. In such circumstances, the insurer’s liability under this section shall be limited to the amount of the loss caused by the covered peril. However, if the covered perils alone would have caused the total loss, paragraph (a) shall apply. The insurer is never liable for more than the amount necessary to repair, rebuild, or replace the structure following the total loss, after considering all other benefits actually paid for the total loss.

(c) It is the intent of the Legislature that the amendment to this section shall not be applied retroactively and shall apply only to claims filed after the effective date of such amendment.

The Pre-2005 VPL required payment of policy limits because a covered peril, wind, *contributed* to the damage of a structure determined to be a total loss. The Post-2005 VPL specifically

limits the extent of the insurer's obligation for payment to that portion of the loss caused by the covered peril. This should provide for a pro rata

apportionment of payment in most instances avoiding the result in *Citizens*.

**PIP: An insurer is not required to provide copies of its PIP payout logs pre-suit to its insured and/or its insured's assignee?**

*Southern Group Indemnity, Inc., vs. Humanitary Health Care, Inc., 2007 WL 1542019 (Fla. 3<sup>rd</sup> DCA), decided May 30, 2007.*

The insured was treated at Humanitary Health (HH) for injuries sustained in an automobile accident. At the time of the accident, she had personal injury protection (PIP) benefits under a policy issued by Southern Group Indemnity, Inc. (Southern Group).

The insured assigned her rights under the policy to HH. However, Southern Group denied benefits claiming that the medical expenses did not exceed the insured's \$2,000 deductible. HH's pre-suit request for Southern Group's PIP payout log to further investigate HH's entitlement to payment was denied.

HH filed suit against Southern Group seeking to collect PIP benefits and sought a declaratory judgment that it was entitled to pre-suit disclosure of Southern Group's PIP payout logs. HH asserted that F.S. §627.736(6)(d) (2006) requires an insurer, upon a request from the injured person, to furnish the PIP payout logs pre-suit.

The court granted HH's motion for partial summary judgment and denied Southern Group's motion for summary judgment, requiring Southern Group to produce the PIP payout logs. Southern Group appealed.

Affirming the trial court's opinion, the Circuit Court stated that while F.S. §627.736(6)(d) does not specifically identify the PIP log as a document that must be produced by an insurer pre-suit, the statutory language is broad enough to encompass the PIP log.

Southern Group filed a petition for writ of

certiorari to the Third District Court of Appeal. Not only did the Third District Court of Appeal disagree with the Circuit Court's interpretation of F.S. §627.736(6)(d), but also they concluded the statute cited was completely inapplicable.

The Third District Court of Appeal concluded that the Circuit Court applied the incorrect law inasmuch as F.S. §627.736(6)(d) relates only to the obligation of employers and health providers to provide information to insurers. The only obligation the statute places upon the insurer is to forward, upon request of the insured, all the information it received from the insured's employer and health care providers. The Court determined that the purpose of F.S. §627.736(6)(d) appears to be to provide some degree of oversight of healthcare providers to ensure that the treatment provided and the resultant costs are reasonable and necessary.

Accordingly, F.S. §627.736(6) does not provide for nor address the insured's right to access documents prepared internally by the insurer. The insurer's PIP payout log is a document generated by the insurer and is not a document the insurer obtained pursuant to F.S. §627.736(6). Therefore, while a PIP payout log may be discoverable after suit is filed, it is not discoverable before. The only obligation the statute places upon the insurer is to forward, upon request of the insured, all the information it received from the insured's employer and health care providers.

**INSURANCE: Privileged communications may be subject to the attorney client privilege in a bad faith action brought by the third party beneficiary in a subsequent bad faith suit.**

*Progressive Express Insurance Company vs. Scoma, 2007 WL 1296007 (Fla. 2<sup>nd</sup> DCA), decided May 4, 2007.*

Mr. Courtney was involved in an accident resulting in Ms. Barnett's death. At the time of the accident, he maintained an automobile liability insurance with Progressive with \$10,000.00 liability limits.

Ms. Scoma, as the personal representative of Ms. Barnett's estate, made a claim with Progressive alleging that Mr. Courtney was responsible for the accident and Ms. Barnett's wrongful death. When settlement negotiations were unsuccessful, Ms.

Scoma filed suit against Mr. Courtney, which resulted in a verdict against Mr. Courtney in the amount of \$1,050,000.

In Ms. Scoma suit against Progressive as a third-party beneficiary to the insurance contract, she claimed Progressive acted in bad faith in failing to settle the claim against Mr. Courtney. Ms. Scoma sought discovery of all documents in the possession of Progressive related to the initial claim asserting that attorney-client privilege did not apply to any communications between Courtney, Progressive and their respective counsel. Progressive objected to this request on grounds of work-product and attorney-client privilege.

The trial court concluded that the attorney-client privilege did not apply to protect confidential communications made by Progressive and Mr. Courtney with their counsel during the underlying tort suit. Progressive appealed.

The Second District Court of Appeal held that (1) privilege protected the insurer's communication with its individual counsel; and (2) privilege protected confidential communications with Mr. Courtney's counsel if the communications resulted from representation of a common interest. Mr. Courtney and Progressive, therefore, both have a clear and unambiguous privilege that was not waived. It stands to reason that a person does not waive or otherwise lose an attorney-client privilege merely because a third party is authorized to file a lawsuit against the person's insurance company.

The attorney-client privilege is not always available for all parties, however. Specifically, the attorney-client privilege generally will not exist for communications between a liability insurer, the insured, and the attorney hired to represent the insured in third-party claim because these parties agreed to a representation of common interests. Similarly, if the insured sues its liability insurer for a breach of the requirement to provide third-party benefits, the insured has available to him all communications between himself, the insurer, and the lawyer representing them. However, if the insured or insurer retained separate attorneys to represent only that party's specific interests, they should each be able to preserve their respective attorney-client privilege as to their communications with their own lawyers.

In summary, a court must review the application of the attorney-client privilege statute, F.S. §90.502 (2000), and the case law interpreting it to determine whether documents which an insurance company seeks to protect from disclosure are indeed protected by the attorney-client privilege. This will require an in camera inspection and an analysis as to whether the documents contain confidential communications and whether documents between the insurance company, the insured, and the insured's attorney were a result of representation of a common interest.

**COSTS: It is the party in whose favor judgment has been entered rather than the “prevailing party” who is entitled to all taxable costs.**

*Bessy vs. Difilippo, 951 So.2d 992 ( Fla. 1<sup>st</sup> DCA 2007) decided March 16, 2007.*

Plaintiff filed suit against the driver and the owner of a car that rear-ended his vehicle. Defendants admitted negligence on the day before the trial but denied Plaintiff suffered permanent injury or the damages claimed.

The trial court awarded past medical expenses, but found no permanent injury and awarded nothing for future medical expenses. The judgment was affirmed on appeal.

Plaintiff filed a motion to tax costs as the “party recovering judgment” pursuant to F.S. §57.041 (2005). Defendants opposed the motion arguing that the statute incorporated the “prevailing party” standard. As such, Plaintiff was not entitled to costs because he had not prevailed on the significant issues of permanent injury, future

medical expenses, future earning loss of earnings, and future pain and suffering.

The trial court awarded partial costs to Plaintiff for those costs that could be attributed to the issue of past medical expenses. The court further stated Plaintiff could not recover costs for the issues on which he did not prevail, like permanent injury.

On Plaintiff's appeal, the First District Court of Appeal reversed on the finding that Plaintiff was entitled to all taxable costs. When judgment was entered against Defendant, Plaintiff became the “party recovering judgment,” within the meaning of F.S. §57.041(1), such that Plaintiff was entitled to an award of all taxable costs reasonably and necessarily incurred in maintaining suit.

F.S. §57.041(1) does not authorize reduction or apportionment of costs on the grounds that the plaintiff recovered on less than all of the damages prayed for in the Complaint. Furthermore, the statute does not leave the award to the trial

court's discretion, but entitles the party in whose favor judgment is entered to an award of all taxable costs as a matter of law.

**PROPOSAL FOR SETTLEMENT AND ATTORNEY FEES: A court should look to the terms outlined in a proposal for settlement to determine whether the proposal meets the requirement that it state with particularity all relevant conditions and non-monetary terms.**

*Palm Beach Polo Holdings, Inc. vs. Madsen, Sapp, Mena, Rodrigues & Co., 2007 WL 1201744 (Fla. 4<sup>th</sup> DCA), decided April 25, 2007.*

Plaintiff, an accounting association, filed suit against Defendant seeking \$18,332.25 for services rendered. Prior to trial, Plaintiff filed "Plaintiff's Proposal for Settlement" offering to settle for \$16,000.00, stating, "[t]his offer, if accepted, will settle all pending claims in this action against Defendant, including claims for punitive damages, interest, costs and attorneys' fees (whether contractual or statutory)."

The trial court found for Defendant. However, on appeal, the Fourth District Court of Appeal reversed and entered judgment for Plaintiff. Then, pursuant to Plaintiff's Motion, the trial court entered a judgment against Defendant for attorney's fees and costs. Defendant appealed arguing that Plaintiff's settlement proposal was defective because it failed to provide information regarding whether, if accepted, the claims would be dismissed or Defendant would be released.

The Fourth District Court of Appeal affirmed the trial court's Order against Defendant for attorneys' fees and costs. Reviewing F.S. §768.79 (2005), the Court noted that an offer of settlement must only be in writing, state that it is being made pursuant to this section, name the party making it and the party to whom it is being made, state with particularity the amount offered to settle a claim for

punitive damages, if any, and state its total amount. The offer will be construed as including all damages which may be awarded in a final judgment, and the offer shall be served upon the party to whom it is made. However, the offer shall not be filed unless it is accepted or unless filing is necessary to enforce the provisions of this section.

Fla.R.Civ.P. 1.442 (c) provides for the "Form and Content of Proposal for Settlement." With respect to the requirements of a Proposal for Settlement as outlined above, the Florida Supreme Court has confirmed that the requirements that the offer state with particularity the relevant conditions and non-monetary terms are fundamental to the purpose underlying the statute and rule.

The Fourth District Court found no ambiguity in the present case. Plaintiff's proposal for settlement clearly stated that he was offering to settle all claims including claims for punitive damages, interest, costs and attorney's fees, whether contractual or statutory. The Court further stated that neither F.S. §768.79 nor Fla.R.Civ.P. 1.442 requires language expressing a willingness to dismiss all claims in a proposal for settlement. In this case, it was clear from Plaintiff's proposal for settlement that, if accepted, it would have ended the litigation and disposed of all claims.

**ARBITRATION AND THE NURSING HOME RESIDENTS ACT**

*The Place at Vero Beach, Inc. vs. Hanson, 953 So.2d 773 (Fla. 4<sup>th</sup> DCA), decided April 25, 2007.*

The Place at Vero Beach, ("The Place"), an assisted living facility, appealed an Order denying its Motion to Compel Arbitration and Stay Litigation in an action filed by the personal representative of the estate of the deceased, Albert Williams. Williams was a patient at the Place at the time of his death.

At the time Williams became a resident at The Place, the parties signed a Resident Admission

Agreement (the Agreement) as part of the admissions process. The Agreement had a dispute resolution clause listing arbitration as one of the methods of resolution. The Agreement designated the American Health Lawyers Association ("AHLA") as the arbitration administrators.

The trial court determined that the burden of proof required by the AHLA conflicted with the

Florida Nursing Home Residents Act (“FNHRA”). The AHLA rules required that intentional or reckless misconduct by the Place be proven by clear and convincing evidence, while the FNHRA rules required only proof by a preponderance of the evidence. Finding the clause designating the AHLA as the administrators of the arbitration not severable from the Agreement, the Trial Court denied the Motion for Arbitration.

On The Place’s appeal, the Fourth District Court of Appeal held that the arbitration clause was unenforceable because it was in conflict with the Nursing Home Residents Act (NHRA) and the provision in the arbitration clause could not be

severed.

Generally, in determining whether a dispute is subject to arbitration, three issues must be considered: (1) whether a valid written agreement to arbitrate exists; (2) whether an arbitrable issue exists; and (3) whether the right to arbitration was waived. Here, the arbitration clause providing that arbitration would be provided by Health Lawyers Association could not be severed from the rest of the clause where the arbitration clause was built around the facility’s intent that the specified association and its rules would control the arbitration.

## Georgia Workers' Compensation

**RIGHT TO APPEAL:** If the Superior Court fails to give the parties notice of a final judgment within the thirty-day period during which a party may file for a discretionary appeal, then the court, upon the losing party’s motion, should vacate and re-enter the award.

*Wal-Mart Stores, Inc. et al. v. Parker*, 642 S.E.2d 387, decided February 22, 2007.

On appeal to the Full Board, Wal-Mart Stores, Inc. (“Wal-Mart”) sought to reverse the ALJ’s Award of income benefits to the claimant. The Full Board amended part of the ALJ’s award, which Claimant appealed to the Superior Court. The Superior Court reversed the Full Board’s decision, but neither party received a copy of the Order.

Wal-Mart wanted to appeal the decision, but the time period for a discretionary appeal expired. Wal-Mart filed a motion requesting the Court vacate and re-enter the judgment so that it could pursue an appeal in a timely manner. The Superior Court held that the Court would lose jurisdiction if it vacated the decision.

On appeal, The Court of Appeals held that it was improper for the Superior Court to make a

judgment on the Motion based upon its determination that the employer knew or should have known that a judgment had been entered. The Court of Appeals stated the issue was whether the Superior Court had carried out its duty to give notice of an Order, and not whether a losing party had knowledge that the court entered a judgment.

The Court of Appeals further held that the Superior Court would not lose subject matter jurisdiction over the workers’ compensation case if it granted the Motion to Set Aside its order and re-entered the judgment. The thirty-day period within which Wal-Mart must appeal would begin to run from the date the Superior Court re-entered the judgment.

**SUBSIDIZED MEALS AS AN ECONOMIC BENEFIT: On site subsidized meals sold to the claimant at a discounted rate constitutes real economic gain and should be included in the claimant's wage computation for the purposes of average weekly wage and temporary disability benefits.**

*Caremore, Inc./Wooddale Nursing Home et al. v. Hollis*, 642 S.E. 2d 375, 07 FCDR 540, decided February 22, 2007.

Following Claimant's on-the-job accident, her Employer commenced medical and temporary total disability ("TTD") benefits. However, the Employer and Insurer failed to timely file Board forms, including an Employer's First Report of Injury, a Notice of Payment of Benefits, and a Wage Statement. The State Board of Workers' Compensation ("Board") assessed penalties against the Employer for a violation of Board Rules and increased the Claimant's income benefits. The Superior Court agreed with the Board and the employer appealed the decision.

The Administrative Law Judge ("ALJ") determined the employer willfully violated Board Rule 61(b)(6) when it failed to file its response to a WC-205 physician's request for advance authorization of an evaluation. Board Rule 205 requires an employer to respond within five days to a WC-205 form requesting authorization for treatment. The ALJ concluded that the violation of the Board Rule was willful because the Employer was made aware of the Rule when it received the form and chose to not respond timely. The ALJ imposed penalties, attorney fees, and increased the claimant's weekly wage by \$15.00 to include the economic benefit of the employer's meal subsidy program.

The Employer presented three arguments in support of its allegations of error on appeal. First, the Employer argued that Rule 205 is an invalid extension of statutory power not granted to the Board

by the legislature because it determines the compensability of a disputed medical procedure without Board review. The Court found that because the Employer approved the evaluation before the issue went before the ALJ, the validity of Board Rule 205 was not at issue.

Next, the Employer argued there was no evidence that it willfully failed to comply with Board Rules. The court found that the employer's failure to pay TTD benefits at an appropriate rate and failure to timely file the required forms was a conscious indifference to its duties under the Workers' Compensation Act and constituted willfulness.

Lastly, the Claimant challenged the Board's decision to increase the Claimant's weekly benefits to include the value of "on-site" partially subsidized meals sold to the Claimant for \$1.00 at work. The Employer argued that the Claimant was paying for the meals, and therefore they could not be considered a benefit "furnished without charge" and should not be included in wage computation pursuant to Board Rule 260(a). The Court disagreed and found the meal subsidy provided a net economic benefit to the Claimant of \$15.00 per week, and that such a benefit should be included in the calculation of the Claimant's average weekly wage and TTD benefits. The Court of Appeals agreed with the ALJ and upheld the assignment of penalties and an increase in the Claimant's TTD benefits.

**THIRD PARTY ASSAULT ON EMPLOYEE: To determine whether an employee's injury occurred for personal reasons or was an employment related accident, the court will consider whether the injuries arose out of and in the course of employment.**

*Burns Inter. Security Services Corp. v. Johnson, et al.*, 2007 WL 805915, decided March 19, 2007.

The parents of a deceased security guard filed a wrongful death action against Burns International Security Services Corporation ("Burns"), the decedent's former employer. The Superior Court denied the Employer's motion for summary judgment, which alleged that the parents' exclusive remedy was under the Georgia Workers' Compensation Act. The Employer premised its Motion on the argument that the decedent's death arose out of and in the course of her employment.

The Workers' Compensation Act is the exclusive remedy for an injury by accident arising out of and in the course of employment. Further, a third party assault against an employee is an accident as defined by the Workers' Compensation Act if the act is not against the employee for reasons personal to the employee. To determine whether the assault was personal to the employee, the Court considered evidence of whether the death arose out of and in the course of employment.

For the death to arise out of the decedent's employment, there must be some causal connection between the conditions under which the work is required to be performed and the resulting injury. The decedent, young and inexperienced, had been assigned to guard vacant hotel property that was in a high-risk area known to be inhabited by vagrants and transients. She was required to work alone, and at night, though she was not provided a weapon of any kind or other means of protection, or furnished with a radio or other form of mobile communication. The Court concluded that the conditions of the decedent's employment did not merely provide the time and place for the assault, but subjected her to a danger peculiar to the employment. The uncontested evidence showed that the circumstances of her death arose out of her employment.

An injury is in the course of employment when it occurs within the period of employment, at a

place where the employee is in the performance of her duties, or engaged in something incidental to those duties. The decedent in the present case was last seen working an evening shift, and her body was discovered in a secluded room on the property nearly three weeks later. Furthermore, her personal items remained after her disappearance. Given these facts, the Court of Appeals found the evidence proved the death occurred in the course of employment.

Based upon the factual support that this decedent's death arose out of and in the course of employment, the Court determined that the assault was not for reasons personal to the decedent. As a result, the decedent's parents were limited to the exclusive remedy under the provisions of the Georgia Workers' Compensation Act.

**DOCTRINE OF CONTINUOUS EMPLOYMENT: A continuous employee who is provided a residence by his employer to reside in near a job site/project and who is returning to the job site or to their employer-provided residence at the time of the accident is entitled to workers' compensation benefits.**

*Ray Bell Construction Co. et al. v. King, 2007 WL 878572, decided April 10, 2007.*

Howard King, a resident of Florida, lived in Fayetteville, Georgia, in an apartment provided to him by his employer to live in while he worked as a superintendent at a construction project in Jackson, Georgia. King was also provided with a company truck. He was killed in a motor vehicle accident while driving the company truck on his way back to the Fayetteville/Jackson from running a personal errand. The accident occurred in the "general proximity" of the Fayetteville/Jackson area. As a result of King's death, his widow filed a claim for death benefits on behalf of their minor child.

The ALJ found that King's death was compensable and awarded benefits based on the doctrine of "continuous employment." The Appellate Division, Superior Court and Court of Appeals all affirmed the ALJ's Award.

The Supreme Court of Georgia also affirmed the ALJ's award. In so finding, the Supreme Court held that King had returned to continuous employment coverage, after a personal mission, and returned to his general area of employment at the time of his accident, and therefore his death was compensable. The Court noted that there is generally broader workers' compensation coverage in the case of the traveling employee who is required by his

employer to lodge and work within an area geographically limited by the necessity of being available to work on the employer's job site. Workers' compensation coverage is not extended when an employee is engaged in a purely personal mission, but when the deviation ends, the employee is said to have returned to the employer's business, and therefore any injuries he/she sustain would be covered by workers' compensation.

The Court specifically held that King's death would have been compensable regardless of whether he was returning to his employer-provided housing, or to the job site.

Justice Melton wrote a strongly worded dissent in which he urged that King's injuries not be found compensable because they did not arise out of his employment, and that there was no casual connection between the employment and the accident. The dissent was joined by two other justices. Justice Melton distinguished King's case from the line of deviation cases, in which accidents occurring after one returns from a deviation are compensable, by pointing out that the entire trip made by King was a wholly personal deviation. Therefore, he argued his accident did not arise out of and in the course of his employment.

# Florida Workers' Compensation

**HEART ATTACKS: Where a claimant with a preexisting heart condition suffers a heart attack while at work, the judge must assess the claimant's daily work requirements over the term of his employment to determine whether the work required an unusual strain or over-exertion on the date of the heart attack pursuant to *Victor Wine*.**

*Coca-Cola Bottling Co. v. Perdue*, 2007 WL 103786, decided April 9, 2007.

This Claimant, who suffered from preexisting heart disease, suffered a myocardial infarction while delivering cases of soda for the employer. Although the judge applied the test from *Victor Wine & Liquor, Inc. v. Beasley*, 141 So.2d 581 (Fla. 1962), the Court found the judge applied the test incorrectly.

The test enumerated in *Victor Wine* requires an employee with a preexisting heart condition who suffers a heart attack at work to show he was subject to unusual strain or over-exertion not routine to the type of work he was accustomed to performing at the time of the heart attack. According to the Court, application of the *Victor Wine* test calls for an assessment of the claimant's work requirements for his least and most arduous days. Then, if the judge finds the claimant's work requirements on the date of the heart attack fell within this range, the claimant's activities on that day could not have been an unusual strain or over-exertion.

In this case, because there was no evidence in the record of the Claimant's daily work requirements, the Court reversed and remanded the case for further proceedings consistent with the Court's opinion.

This case clarified a longstanding debate over the "unusual exertion" requirement. Before this decision, the claimants' bar tried to argue that unusual exertion was measured from an average day such that anything above the baseline was an "unusual exertion". The Court now has clarified that there is no baseline. Instead, the analysis is based upon a spectrum of physical demand between the least and most strenuous periods of employment. To qualify as an "unusual exertion" for compensability in a heart attack case, the activity in question must be more arduous than the most strenuous regular job activity.

**OCCUPATIONAL DISEASE: In order to meet the statutory definition of an occupational disease, the claimant must suffer death or disablement. To prove disablement, a claimant must be able to show actual wage loss. An impairment, in and of itself, is not sufficient to meet this definition, without a showing of actual wage loss.**

*City of Port Orange v. Sedacca*, 2007 WL 1047397, decided April 10, 2007.

The claimant in this case, a firefighter, sought workers' compensation occupational disease benefits for hypertension relying on F.S. §440.151. Pursuant to F.S. §112.18(1), hypertension developed by a firefighter is presumed to have been accidental and sustained in the line of duty.

The Claimant passed a pre-employment physical with no signs of heart disease or hypertension. However, this firefighter later was diagnosed with hypertension on June 12, 2003,

though he did not lose any time from work due to the hypertension. Because what was being alleged was an occupational disease, the date of accident should have been the date of last injurious exposure giving rise to eligibility for coverage. He reached maximum medical improvement (MMI) on April 2, 2004, and was assigned a permanent impairment rating between one and ten percent to the body as a whole.

The Claimant argued that the fact that he was assigned a permanent impairment rating meant he had suffered a disability and therefore was injured by an accident, pursuant to the occupational disease section of the Florida Workers' Compensation Law. The judge ruled that the Claimant's permanent impairment rating for hypertension was sufficient to establish that he had a disability as defined by the Florida Workers' Compensation Law.

The Court's analysis began with the coverage provision of Florida Workers' Compensation Law, F.S. §440.09, requiring that a claimant's injuries stem from an accident, defined in F.S. §440.02(1) as "an unexpected or unusual event or result that happens suddenly." However, under F.S. §440.151(1)(a):

Where the employer and employee are subject to the provisions of the Workers' Compensation Law, the disablement or death of an employee resulting from an occupational disease as hereinafter defined shall be treated as the happening of an injury by accident.

This last provision effectively carves out an exception to the requirement of an injury by accident established in F.S. §440.09. The issue here was whether the Claimant in this case suffered a disability simply based on the fact that it was determined that he had some permanent physical impairment as a result of his occupational disease. Said another way, the issue was whether an impairment rating was equivalent to disablement.

The Court held that the term disablement is defined in F.S. §440.151(3) (2002) as "the event of an employee's becoming actually incapacitated, partially or totally, because of an occupational disease, from performing his work in the last occupation in which injuriously exposed to the hazards of such disease and 'disability' means the state of being so incapacitated." Based on the definition as enumerated above, the Court held that in order to meet the definition of disability and therefore be entitled to coverage under the Workers' Compensation Law, the claimant must be unable to perform work, resulting in actual wage loss. The Court also held that this definition of disablement applied to all dates of accident.

Because the Claimant had not missed any time from work and therefore had no wage loss, the Court held that the Claimant did not suffer a disability, despite the fact that he was assigned a permanent impairment rating. The Court specifically stated that an impairment was a medical assessment, while disability was a legal issue. Because the Court found that the Claimant was not disabled, the Court held that the Claimant's hypertension did not meet the statutory definition of an occupational disease. As a result, the Claimant was not exempt from showing an injury by accident as required by F.S. §440.09; and therefore, was not entitled to benefits under the Workers' Compensation Law.

While the ruling here was somewhat fact specific, the analysis of the definition of "disability" has potential far reaching application for categories of indemnity and medical benefits.

**ATTORNEY'S FEES: The JCC has exclusive jurisdiction as to the award of attorney's fees relating to a workers' compensation claim, even those based on liens for prior representation.**

*Francisco v. Espinosa, 2007 WL 1135654, decided April 18, 2007.*

Claimant was represented by two different attorneys over the life of his claim. After approximately nine months of representation, he fired his first attorney and retained his second. The first attorney filed a lien in the workers' compensation claim. Thereafter, the parties negotiated settlement of the workers' compensation claim, a term of which was for Employer/Insurer to indemnify Claimant for any prior attorney's fee liens.

Subsequently, the first attorney sued Claimant in circuit court under a breach of contract theory, requesting payment of his attorney's fees. Thereafter, the first attorney withdrew his lien in the workers' compensation action. Claimant then filed a Motion to Dismiss based on a lack of subject matter jurisdiction. (As an aside, Employer/Insurer

provided the claimant with an attorney in these proceedings given their agreement to indemnify him as part of the settlement.) Claimant argued that only a JCC has jurisdiction to award attorney's fees stemming from a workers' compensation claim. The Circuit Court judge agreed and dismissed the Complaint.

Thereafter, the first attorney filed another lawsuit in Circuit Court alleging unjust enrichment and quantum meruit. This second attempt was also dismissed after Claimant filed another Motion to Dismiss on the same grounds as noted above. The Court ultimately concluded that a JCC has exclusive jurisdiction to determine whether attorney's fees are owed, even if they are the result of a lien against the workers' compensation claim from prior counsel.

The holding in this case seems to be common sense. However, the interesting note is the first attorney's actions. The first attorney clearly was attempting to obtain a greater recovery than he was entitled to under workers' compensation law. Otherwise, he would have simply moved forward based on his lien filed in the workers' compensation matter. Instead, he attempted to circumvent the workers' compensation system, most likely based on

the belief that if he was awarded a fee through the Circuit Court, it would not be as limited of a fee as would be awarded based on his lien under the workers' compensation claim. Arguably, in the end, the first attorney robbed himself of obtaining any fee relating to his representation of this Claimant due to his withdrawal of his lien during his attempt to obtain a fee through the Circuit Court.

**FRAUD: An Employer/Insurer is not required to provide a claimant with benefits while waiting for adjudication of their fraud defense.**

*Alvarez v. UNICCO*, 2007 WL 1146453, decided April 19, 2007.

The Court's written opinion in this case is not very long. However, the Court's holding is important and very favorable from a defense perspective.

The Employer/Insurer asserted a fraud defense and prevailed at trial. Claimant appealed the JCC's denial of benefits, asserting that she was entitled to payment of benefits during the period from her date of accident through the date of the judicial finding of fraud. Finding that the judge did not commit error by failing to award the Claimant benefits for the period prior to entry of its order, the Court upheld the finding in favor of a total denial of all benefits.

In its decision, the Court specifically included the following language: "Further, neither this court's decision in *Horizons Painting v. Lessard*, 688 So.2d 941 (Fla. 1<sup>st</sup> DCA 1997), nor our decision

in *Pavilion Apartments v. Wetherington*, 943 So.2d 226 (Fla. 1<sup>st</sup> DCA 2006), require an award by the judge of compensation claims for a period preceding the determination of a violation of section 440.09(4)." This language is significant in light of the significant debate and controversy since the decision was rendered in *Wetherington*.

The Claimant's bar has argued that the Court's holding in *Wetherington* required an Employer/Insurer to provide benefits, despite the assertion of a fraud defense, until an official determination of fraud. **The Court in the present case verifies that *Wetherington* does not require such provision of benefits.** Accordingly, the law now seems to clearly state that an Employer/Insurer is not required to furnish benefits to a claimant for the period of time between the assertion of a fraud defense and an official decision of the issue.

**MISCONDUCT: If competent substantial evidence supports a determination that a claimant was terminated after committing multiple violations of an employer's policies, the claimant will be denied temporary partial disability benefits because his termination will be deemed to have been for misconduct. If only a single violation occurred, the same must be deliberate or intentional and egregious.**

*Thorkelson v. NY Pizza & Pasta Inc.*, 2007 WL 1459846, decided May 21, 2007.

This claim involved a request for temporary partial disability benefits that was denied by the JCC based upon his determination that the Claimant was terminated for misconduct. With a termination for misconduct, a claimant was not entitled to temporary partial disability benefits pursuant to F.S. §440.15(4)(e), (2004).

The rationale behind the Claimant's argument for entitlement to benefits was not clearly expressed in the written opinion. However, it appears that the Claimant alleged that since the termination occurred after her date of accident, it should not bar her from receipt of temporary partial

disability benefits despite her termination for misconduct.

The specific provision, referenced above, was written into the Florida Workers' Compensation Law as part of the 2003 amendments. F.S. §440.02(18), (2004), defines misconduct as:

- (a) Conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of the employee; or
- (b) Carelessness

or negligence of such a degree or recurrence as to manifest culpability, wrongful intent, or evil design, or to show an intentional and substantial disregard of an employer's interests or of the employee's duties and obligations to the employer.

On Appeal, the Court discussed the fact that the above cited language closely parallels the language utilized in Florida Unemployment Compensation Law defining misconduct. In its discussion, the Court specifically addressed what role prior unemployment cases play in a JCC's determination of whether a claimant was terminated for misconduct. The Court indicated that utilization of such similar language presumes that the legislature approved of the meaning that had been developed in unemployment case law.

The Court also addressed whether or not a JCC is bound by determinations made in an unemployment proceeding. The Court specifically indicated that although a JCC is not bound by same, a JCC also cannot ignore such decisions.

Regarding the issue on appeal of the claimant's entitlement to temporary partial disability benefits, the Court concluded that the issue of whether a claimant had committed misconduct was a question of law to be determined by the JCC after considering the facts before the Court. Although a single violation of an employer's policy might be

sufficient to meet the definition of misconduct, the Court indicated that repeated violations were generally required. This was supported by case law from prior unemployment compensation appeals. Unemployment cases where a single act was sufficient to establish misconduct involved deliberate or intentional actions against employers.

In this case, the Court indicated that the record evidence supported a finding that the Claimant was terminated after "multiple instances of willful insubordination." Unfortunately, the written opinion did not specify what the specific acts equating to misconduct were. Ultimately, the Court determined that competent substantial evidence was presented to the JCC to support a determination that the Claimant was terminated for misconduct. Furthermore, once misconduct was determined, application of F.S. §440.15(4)(e) required that the Claimant be denied temporary partial disability benefits.

This case emphasizes how important it is that Employers document all violations of a company's policies. In order to prevail on a defense based on termination for misconduct, it will be necessary to present multiple instances of same to a JCC, unless there is a single deliberate or intentional egregious violation of company policy. This is also one of the first times an appellate court has ruled in the favor of an employer and insurer on a temporary partial disability issue.

**WORK PRODUCT: Documents prepared by a consultant expert who is not anticipated (and specifically not listed) to testify at trial are protected under the work product privilege where the opposing party has an expert who has obtained the same findings.**

*Nevin v. Palm Beach County School Board, 2007 WL 1518269, decided May 25, 2007.*

In this case, the Claimant sought certiorari review of the JCC's order compelling Claimant to make their expert available for deposition. The Claimant's claim was based on pulmonary and bronchial injuries allegedly resulting from ongoing exposure to mold.

Claimant's attorney requested that the condition of the school where Claimant was working not be tampered until after an inspection could be performed. Both parties agreed to have their experts conduct an inspection of the school on the same day and the same occurred. Thereafter, the Employer/Insurer filed a request for production of various documents created by Claimant's expert. Claimant's attorney objected to the production of documents on the grounds they were protected by the

work product privilege. Claimant's attorney did not file a privilege log with the JCC.

Although the parties completed a pre-trial stipulation, which was approved by the JCC, Claimant did not list their expert as a witness. After the pre-trial stipulation was approved, Claimant's attorney filed a motion for protective order seeking to prevent the Employer/Insurer from deposing their expert. The JCC entered an order granting the Motion. Numerous other discovery events and Motion hearings were held, throughout which Claimant continued to argue that Employer/Insurer was not entitled to the requested documents nor were they entitled to depose their expert. Claimant continued to maintain the expert was a private consultant and was not anticipated to testify at trial.

Ultimately, Employer/Insurer scheduled Claimant's deposition again. This time, the JCC denied Claimant's Motion for Protective Order and issued an Order for Claimant to make his expert available for deposition within 30 days. This appeal followed.

Generally speaking, the work product privilege allows a party to avoid providing the opposing party with documents received by their attorney, if the records were gathered in anticipation of litigation. Where an expert has been specially employed in anticipation of litigation but is not expected to be called as a witness at trial, the facts known or opinions held by the expert are deemed to be work-product and are only discoverable "upon a showing of exceptional circumstances under which it is impracticable for the party seeking discovery to obtain facts or opinions on the same subject by other means." Fla. R. Civ. P. 1.280(b)(4)(B).

The Court found that no exceptional circumstances existed and specified that the Employer/Insurer were aware of the underlying facts that would be contained in Claimant's expert's

reports, just not his opinion itself. In that regard, the Court indicated that the only information of which Employer/Insurer were not in possession that could be obtained from discovery of Claimant's expert's records was how his opinions differed from Employer/Insurer's. "[M]ere inconsistency is not enough to establish the requisite need," noted the Court.

Ultimately, the Court determined that the work product privilege was properly asserted in this case and that the JCC committed error by compelling Claimant to produce her expert for deposition. This opinion may be significant support for the notion that peer review reports do not need to be provided to claimants' attorneys, nor do reports of any other experts consulted with by the parties in preparation for trial, but not intended to be produced at trial.