LEGAL UPDATE

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The legislature convened this year with the understanding that this would be the most difficult budget since the Great Depression. A balanced budget totaling $17.9 billion was eventually passed, resulting in a reduction in annual spending of $3.3 billion less than just two years ago.

Some specific items that were maintained in the FY 2011 budget were $1.2 million to sustain the Moultrie and Columbus GBI crime labs and funds that if not available, would mean the reduction in classrooms in the Juvenile Justice system. Funding 1,000 days of personal services for senior judges in Superior Courts was also maintained in addition to guaranteeing funds for the Public Defenders and Juvenile Courts. In regards to legal issues, the 2010 legislative session accomplished many things, but as with all government action it left some key legislation undone. The most notable of what was left undone is HB 24, the comprehensive evidence re-rewrite. Right now, here are a few things whose last hurdle to becoming law is the Governor’s signature:

**BUSINESS LAW**

**HB 451 – UCC Article 7 Revision:** Like all other aspects of business transactions, Article 7 of the UCC needs to be dusted off and brought into the 21st Century. HB 451 allows for the transfer of commercial paper by electronic means. The Bill passed unanimously out of the House and Senate.

**HB 173 & HR 178 – Restraint of Trade:** The Georgia Constitution prohibits contracts that “have the effect of defeating or lessening competition.” As a result, Georgia courts take a very dim view of restrictive covenants in business and employment contracts and will void the entire contract if any portion is determined to be overly broad or restrictive. HR 178 would modify the constitution to specifically allow the General Assembly to create rules to allow for such contracts and require courts to “blue line” contracts to only void the portions it deems overly broad without voiding the entire contract. HB 173 is the enabling legislation that will only go into effect if the constitutional amendment passes voter approval in the 2010 November elections.

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.
DOMESTIC LAW AND COURT PROCEEDINGS

SB 367 – Informed Consent: This bill expands the list of persons who may consent to surgical or medical treatment for those unable to do so for themselves. It also helps those persons who are unable to consent to receive access to timely medical care should a guardian be needed. To achieve this, a newly defined term ‘adult friend’ was granted the authority to consent if no other person enumerated in the code is available to consent to surgical or medical treatment. The bill also provides immunity from civil and criminal liability for hospitals, health care facilities, health care providers, or other persons or entities that rely in good faith on the direction or decision of someone they reasonably believed to be authorized to consent.

SB 491 – Nonresidents in Domestic Relations Cases: This bill expands the State’s “long-arm” statute pertaining to the enforcement of proceedings that involve divorce, separate maintenance, annulments or other domestic relations action if one party to the marriage continues to reside in this state while the other party does not. This legislation is needed to ensure that Georgia court orders in domestic relation cases can be enforced against former residents of Georgia who have since moved to other states.

HB 567 – Crime Victim’s Bill of Rights: This bill is a comprehensive measure to enhance and strengthen Georgia law as it relates to crime victims. Many of the changes relate to what is known as the “Crime Victims’ Bill of Rights.” This bill clarifies certain rights to victims when the accused is a juvenile. It also provides opportunities and procedures to allow the victim to be heard in court, and establishes certain procedures by which the accused may interview the victim.

HB 1015 – Street Gang Prevention Act: This bill strengthens and clarifies the Georgia Street Gang and Terrorism Prevention Act. It expands and changes the provisions relating to what constitutes criminal gang activity, the offenses that can be used as evidence to prove the existence of a criminal street gang, bail-able offenses, and probation requirements for someone convicted under the “Georgia Criminal Street Gang Terrorism and Prevention Act.”

HB 1002 – Aggravated Assault on Court Officials: This bill increases the punishment for certain crimes committed against judges, attorneys, clerks and deputy clerks, court reporters, court interpreters, and probation officers. It also changes the provisions relating to terroristic threats or acts. Adding a new subsection to the list of what constitutes aggravated assault, any person who knowingly commits an offense of aggravated assault upon an officer of the court will be punished by imprisonment for no less than 5 and no more than 20 years.

HB 1022 – Fee Bill: This bill updates numerous fees throughout the Georgia code to ensure they accurately reflect the cost of providing various government services. Fees were increased that relate to annual registration for Limited Liability Corporations and Limited Partnerships. Various fees were also increased for filing operations within Superior Courts, Probate Courts, and Magistrate Courts. This bill also increased a couple of unique “per page” charges. Preparation of records and transcripts to the Supreme Court and Court of Appeals will be $10 per page from $1.50. Also, the preparation and furnishing of a copy of the record of appeal in criminal cases where the accused was convicted of a capital felony pursuant to Code section 5-6-43 will be $5 per page from $1.50. This bill was also amended to include a 1.45% increase in the hospital provider fee, a five-year phase-out of state taxes on passive income for Georgians 65 and older, and an elimination of the state portion property tax, a 0.25 mill assessment, over a 5-year period.
CIVIL PRACTICE

SB 131 – Trust Code Revision: This legislation brings the sections of the Georgia Code that deal with trusts in line with what a number of other states have enacted in recent years. The current trend is for states to enact the Uniform Trust Code (UTC) so there is uniformity amongst the states as it relates to trust law. This bill was drafted in cooperation with the Fiduciary Law Section of the State Bar of Georgia. Extensive discussions were held before the final version of the bill was produced.

SB 138 – Transparency in Lawsuits: This bill limits private rights of action to those expressly provided for within legislation. Courts will not be able to create implied causes of action based on their interpretation of legislative intent. The bill codifies more than 30 years of Georgia case law and the modern trend in federal cases. This is a measure that will help reduce needless litigation that overwhelms our court system.

SB 461 – Federal Estate Taxes; Generation Skipping Protection: This bill ensures changes to federal estate and generation-skipping transfer tax law do not invalidate wills or trusts executed in Georgia. It will act as a stopgap to ensure certain changes to federal estate and generation-skipping transfer tax law do not invalidate wills or trusts executed by Georgia law.

REAL ESTATE LAW

SB 346 – Property Tax Reform: This bill makes comprehensive changes to Georgia’s property tax code including valuation notices, hearing officers, and oversight for boards of equalization. The bill requires that a property owner’s valuation notices shall be sent by the appropriate board of assessors each year and it must contain an estimate of the current year’s tax assessment. These measures, and others, are meant to provide property tax payers with a clear understanding of their tax burden, and prevent property valuations from expanding beyond accepted, fair market value.

SB 371 – Real Estate Fraud Investigation: This bill gives the Georgia Bureau of Investigation the ability and certain tools to investigate residential mortgage fraud in order to provide assistance to local authorities. These types of cases are typically complicated and technical investigations, and the passage of this bill provides local prosecutors greater access to state resources to combat residential mortgage fraud.

TRAFFIC LAW

SB 360 – Texting While Driving: This bill makes it illegal for all drivers, regardless of there age, to write, send, or receive text-based messages on a mobile phone while driving. This is measure is an acknowledgement of the increasing tendency of today’s driver’s to “text” while they drive. It seems every day more and more evidence is provided to show just how dangerous this behavior is, and this bill seeks to address that behavior.

HB 23 – Cell Phone Usage While Driving: This bill makes it illegal for individuals under the age of 18 to use a mobile phone while driving. Similarly to texting while driving, this measure seeks to limit the number of potential distractions for young drivers. Your kids will hate it, but, if followed, more of them will make it safely to adulthood.
**SB 458 – Seatbelts in Trucks:** This bill eliminates the ability of drivers of pick-up trucks, vans, and sports utility vehicles to be exempt from wearing safety belts. When seatbelt laws were first passed some types of cars were exempted from the definition of vehicle, among those exceptions were pick-up trucks and SUV’s. This bill removes that exception, except for the very narrow instance for farmers while they are conducting normal farming business.

**INSURANCE LAW**

**HB 321 – Insurance Delivery Enhancement Act:** This bill allows for a market based option for small business to pool together under associations to offer health insurance to their employees. It also allows for the inclusion of independent contractors, 1099 employees, and their families for the first time. Additionally, it includes the prompt pay statutes for third party administrators, which makes Georgia the first state to pass such a sweeping “market based” or private funded health insurance reform bill.

**MISCELLANEOUS**

**HB 16 – Electronic Devices Placement without Consent:** This Bill would outlaw placing onto any automobile an electronic tracking device without the consent of the owner. The Bill allows for exceptions for law enforcement and parents of minors.

**SB 291 & SB 308 – Georgia’s Right to Carry:** These two bills bring Georgia’s firearm carry permits in line with citizens’ Second Amendment Rights under the U.S. Constitution. The bills streamline the permit renewal process and clarify Georgia’s laws as to where an individual with a permit may or may not carry a handgun when they have been issued a carry permit by a county probate judge.

**HB 514 – Use of Senior Judges:** This Bill restricts senior judges from presiding over cases in which the constitutionality of an act is challenged. The Bill bars the senior judge unless: (1) he or she was presiding over the case before he or she went to senior status; (2) an elected judge determines that the challenge is without merit; or (3) the challenge is raised after the entry of a pretrial order.

**HB 1236 – Limit Printed Volumes:** Because of the fall in state revenues and how those revenues are eventually appropriated to court systems, this bill is a way to allow those systems the flexibility to accommodate those revenue reductions.

**SR 277 – Trauma Funding:** This resolution is a Constitutional Amendment that will allow the voters in Georgia to decide if they wish to add a $10 trauma charge to their car tag fee. The fee will be collected at the same time as license tag and registration fees, on passenger vehicles designed to carry 10 or fewer passengers; it includes pickup trucks, motorcycles, sports utility vehicles and passenger vans. This charge will go into a dedicated fund exclusively for trauma care services throughout the state.
MEDICAL MALPRACTICE/NONECONOMIC DAMAGES: Georgia statute limiting non-economic damages in medical malpractice cases violates constitutional right to jury trial.


In January 2006, the defendant physician performed plastic surgery on Ms. Nestlehutt with subsequent complications. Ms. Nestlehutt sued and, after one mistrial, received a jury verdict of $1,265,000. The verdict included $900,000 in non-economic damages and $250,000 in loss of consortium damages for Mr. Nestlehutt. Because the award arose from medical malpractice, O.C.G.A. § 51-13-1 applied to limit the Nestlehutts’ damages award.

O.C.G.A. § 51-13-1, in part, caps noneconomic damages in a medical malpractice action against one or more health care providers at $350,000. The statute defines non-economic damages as damages for pain and suffering, loss of consortium, loss of enjoyment of life and all other non-pecuniary losses, among others. Thus, O.C.G.A. § 51-13-1 would have reduced the Nestlehutts’ award by $800,000 to the statutory limit of $350,000. Ms. Nestlehutt moved to have the statute declared unconstitutional. The trial court granted the motion, declaring the statute unconstitutional on several different grounds. The defendant appealed.

The Georgia Supreme Court first addressed the trial court’s holding that the statute violated the Georgia Constitution’s guarantee of the right to a jury trial. The Court noted that the Constitution guarantees the right to a jury trial only in cases where such a right existed at common law or by statute at the time of adoption of the Constitution in 1798. The Supreme Court reviewed case law and determined that such a right existed in medical malpractice cases, reaching as far back as a 1374 English case.

The Court also noted that the determination of damages rests with the jury, and that non-economic damages have long been an element of total damages in tort cases, including medical malpractice cases. The Court found that O.C.G.A. § 51-13-1 infringed on the right to a jury because it nullified a jury’s finding of fact regarding damages and thus undermined the jury’s basic function. “The very existence of the caps, in any amount, is violative of the right to trial by jury.” Because it violated the Constitution’s right to a trial by jury, the Court did not address the trial court’s other reasoning.

MEDICAL MALPRACTICE/GROSS NEGLIGENCE: The Georgia statute, which sets gross negligence standard of liability for emergency medical care in E.R., is general law that does not violate patient’s right to equal protection or due process.


The Gliemmos brought a medical malpractice action against Dr. Cousineau, his practice and St. Francis Hospital. The defendants answered the suit and raised the
defense that the Gliemmos failed to set forth an allegation sufficient to establish gross negligence as required by O.C.G.A. § 51-1-29.5. The Gliemmos challenged the constitutionality of O.C.G.A. § 51-1-29.5. The trial court rejected the challenge and the Gliemmos appealed.

Section 51-1-29.5 provides that no health care provider who provides emergency medical care in an E.R., obstetrical unit or surgical suite may be held liable for that care unless it is proven by clear and convincing evidence that their actions amounted to gross negligence. The Gliemmos challenged the gross negligence standard for three reasons.

First, the Gliemmos argued that O.C.G.A. § 51-1-29.5 violated the Georgia Constitution's uniformity provision. The Constitution's uniformity provision prohibits "special" laws, which are laws that deal with a limited activity in a special industry during a limited time frame. The Court noted that the statute did not contain any time restriction, and it was broad enough in scope. Thus, the Court found that O.C.G.A. § 51-1-29.5 was not a special law. The Constitution's uniformity provision also requires general laws to operate uniformly, which means that a law may operate upon persons of a designated class, provided that the classification is not arbitrary or unreasonable. O.C.G.A. § 51-1-29.5 operates on a designated class of health care liability claims arising from emergency medical care. The Court found that O.C.G.A. § 51-1-29.5 operates uniformly throughout the State and does not make an arbitrary or unreasonable classification. Thus O.C.G.A. § 51-1-29.5 complies with the uniformity requirement of the Georgia Constitution.

Second, the Gliemmos argued the statute violated their right to equal protection because it applied only to emergency medical care provided in specific places. Equal protection requires the state to treat similarly situated individuals in a similar manner. To survive an equal protection challenge, a statute cannot disadvantage a suspect class or interfere with a fundamental right, and need only bear a reasonable relationship to a legitimate state purpose. The Court determined that O.C.G.A. § 51-1-29.5 did not deprive the Gliemmos of a fundamental right. The Court also noted that the statute was reasonably related to the state's purpose of promoting affordable liability insurance for providers, thereby promoting the availability of quality health care services.

Finally, the Gliemmos argued that O.C.G.A. § 51-1-29.5 violated due process because it failed to define "gross negligence." The Court noted that gross negligence, however, has a commonly understood meaning and needs no specific definition. Based on the foregoing, the Court denied the Gliemmos' constitutional challenge.

**MEDICAL MALPRACTICE/AFFIDAVIT REQUIREMENT:** Failure to attach expert affidavits to medical malpractice action results in dismissal with prejudice unless properly amended complaint is filed within statute of limitation or complaint is dismissed and refiled.


Plaintiff Beatrice Roberson entered Candler Hospital on May 8, 2007 for removal of a bunion on her left foot. Just prior to the surgery, the anesthesiologist mistakenly placed an anesthetic block on her right ankle. The mistake was discovered before surgery began and a block was placed on the left ankle. Roberson filed a medical malpractice action in April of 2009, alleging injury to her right ankle, but she failed to attach the required expert affidavits to support her claims of negligence.

The defendants, including the hospital, nurses and the anesthesiologist, answered the complaint and simultaneously filed motions to dismiss based on Roberson's failure to support her suit with affidavits. Roberson filed a responsive brief opposing the motion, rather than dismissing her complaint and re-filing within six months under Georgia's renewal statute. By that time, the statute of limitation had run.

The trial court dismissed the complaint with prejudice and Roberson appealed,
contending that she should have been permitted to amend her complaint to attach the affidavits. In the alternative, she argued that the dismissal should have been “without prejudice,” permitting her to refile within six months.

The Court of Appeals affirmed the judgment of the trial court. Responding to Roberson’s argument that the trial court should have permitted her to amend her complaint, the Court pointed out that O.C.G.A. §9-11-9.1 does not permit such amendments. The Court further held that dismissal for failure to attach an affidavit to a malpractice action is the equivalent of a dismissal for failure to state a claim, resulting in dismissal on the merits and with prejudice.

OFFER OF SETTLEMENT: The offer of settlement provision codified in O.C.G.A. § 9-11-68 held constitutional.


The offer of settlement provision in O.C.G.A. § 9-11-68, as part of the 2005 Georgia Tort Reform Act, provides that if a plaintiff rejects a reasonable offer of settlement made by a defendant and subsequently does not collect at least 75% of the amount of the offer in a judgment, a defendant is entitled to collect reasonable attorney’s fees incurred subsequent to the offer’s rejection.

In this case, the plaintiffs, Salon and Cheryl Baptiste, filed a complaint against Chuck Smith and WQXI 790 AM alleging that Mr. Smith made defamatory remarks about the plaintiffs that were broadcast by WQXI. Pursuant to O.C.G.A. § 9-11-68 the defendants offered to settle the case for $5000. The plaintiffs failed to respond to the offer within 30 days, which is deemed a rejection under the statute.

Subsequently, defendants filed a motion for summary judgment as to all counts of the plaintiffs’ complaint, which was granted by the trial court. The defendants then sought attorney’s fees pursuant to O.C.G.A. § 9-11-68. After a hearing on the issue, the trial court denied the motion on the grounds that O.C.G.A. § 9-11-68 violated the Georgia Constitution. The defendants appealed.

On appeal, the Georgia Court of Appeals considered essentially three arguments by the plaintiffs as to why the statute was unconstitutional, rejecting each one in turn.

The plaintiffs asserted that the statute violated a constitutional guarantee that citizens have access to the court system. The Court held that the Georgia Constitution does not guarantee a right of access to the courts, but was intended to provide only a right of choice between self-representation and representation by counsel. The Court stated that the statute does not deny litigants access to the courts, but simply sets forth circumstances in which attorney’s fees are recoverable. Therefore, even if a “right of access to the courts” existed, it was not applicable to the case at hand.

The Court also held that the recovery of attorney’s fees is not limited to that which is available under O.C.G.A. § 9-15-14 or O.C.G.A. § 13-6-11, the two Georgia statutes relating to attorney’s fees. There is nothing in the Georgia Constitution that limits attorney’s fees to either of those two statutes. Therefore, as long as there is some statutory authority, here, O.C.G.A. § 9-11-68, attorney’s fees are recoverable.

The Court also rejected the argument that the statute violates constitutional guarantees that laws operate uniformly across the subjects regulated. The plaintiffs claimed the statute was not uniform because the statute only applied to tort claims and not all civil cases, such as contract cases. However, the Court stated that O.C.G.A. § 9-11-68 applies uniformly to all tort cases, and the legislature is free to regulate different classes of items separately.

Lastly, the Court refused to address the issue, for the first time on appeal, that the current version of O.C.G.A. § 9-11-68 became effective after the lawsuit at hand was filed, and that retroactive application of the statute to the case was unconstitutional. The issue was not
addressed by the trial court and therefore the Court of Appeals would not consider it.

The Court’s ruling was accompanied by very strong concurring and dissenting opinions. The effect of the Court’s ruling is to preserve a segment of tort reform that creates a strong incentive for plaintiffs (and defendants) to approach settlement negotiations more reasonably.

OFFERS OF JUDGMENT/SETTLEMENT: So long as essential terms of settlement offer are identified, it is not necessary that every term be expressed. Subsequent settlement offers after offer of settlement is rejected do not invalidate rejected offer pursuant to O.C.G.A. § 9-11-68.


On June 23, 2006, Bloomfield was fatally injured in a car accident. Her survivors and estate brought suit and all defendants made a collective offer of settlement pursuant to O.C.G.A. § 9-11-68. The offer was rejected in writing and a jury returned a verdict for the defendants. Defendants requested reimbursement of their attorney’s fees and expenses, which was denied without explanation by the trial court. The defendants appealed.

Bloomfield argued on appeal that the offer it received was not “stated with particularity” because a copy of the release was not attached, it did not identify the liens that needed to be satisfied, it did not recite the terms for indemnification and it did not attach an indemnification agreement.

The Court of Appeals rejected the argument and held: “Georgia enforces settlement agreements conditioned upon releases or other documentation even if the specific terms of those documents have not yet been established, so long as there is a meeting of the minds between the parties as to the essential terms of the settlement. Because the specifics concerning the settlement documents argued for by Bloomfield are not required by Georgia law to render a settlement agreement enforceable, such specifics also are not required by the offer of settlement statute.”

Bloomfield also argued that a subsequent offer made by defendants during trial invalidated the offer of settlement that was previously rejected. The Court of Appeals disagreed because once an offer is rejected, it is no longer capable of being superseded, withdrawn or amended by a later offer. Therefore, subsequent settlement offers do not invalidate a previously rejected offer of settlement pursuant to O.C.G.A. § 9-11-68.

SETTLEMENT AGREEMENT/REQUEST FOR ADMISSIONS: Attorney of record has apparent authority to enter into agreement on behalf of client and agreement is enforceable against client by other settling parties.


Horace and Jennifer Stephens filed a mold infestation claim under their homeowner’s insurance policy with Liberty Mutual Fire Insurance Company. To complete the remediation of the mold, Liberty Mutual hired Alan V. Mock Construction Company, which sub-contracted work to Ser-Clean, Inc.

After issues arose with the remediation work, the Stephens sued both Liberty Mutual and Mock Construction for breach of contract, negligence and conversion. Mock counterclaimed against the Stephens for the unpaid rental fees for storing all of their property during the remediation.

After discovery, the trial court found that the Stephens and Liberty Mutual had entered into a binding settlement agreement and dismissed the Stephens’ claims against Liberty
Mutual. After further discovery, the trial court also granted summary judgment to Mock Construction on all of the Stephens’ claims against it, as well as its counterclaim for unpaid rental fees.

On appeal, the Court of Appeals found that the trial court’s rulings were correct. The Appellate Court determined that counsel of record for the Stephens entered into a settlement agreement with Liberty Mutual on July 5, 2006, whereby the Stephens would receive $21,211.89 from Liberty Mutual in exchange for dropping the lawsuit and releasing all their claims against Liberty Mutual. Mr. Stephens signed the settlement agreement, but Mrs. Stephens refused to do so. As a result, Liberty Mutual asked the court to enforce the settlement agreement and to dismiss the Stephens’ lawsuit against it.

The trial court held a hearing to consider Liberty Mutual’s request to enforce the settlement; however, the Stephens did not attend. The trial court subsequently agreed with Liberty Mutual and enforced the settlement agreement. The Court of Appeals agreed with the trial court, finding that, “under Georgia law, an attorney of record has apparent authority to enter into an agreement on behalf of his client and the agreement is enforceable against the client by other settling parties . . . .” In other words, the Stephens were bound by the acts of their counsel.

The Appellate Court also determined that the Stephens failed to respond to Mock Construction’s requests for admission, which removed all genuine issues of material fact from the case. As the Court noted, “it is well-settled that a party’s failure to timely respond to requests for admission conclusively establishes as a matter of law each of the matters addressed in the requests.” O.C.G.A. § 9-11-36(a).

Accordingly, the trial court was correct in granting summary judgment to Mock Construction on all of the Stephens’ claims, as well as Mock Construction’s counterclaim for unpaid rental fees associated with the storage of the Stephens’ belongings during the mold remediation.

DRAM SHOP ACT: A social host will not be liable under Dram Shop Act in absence of evidence that guest was furnished or served alcoholic beverages while in state of noticeable intoxication.


On July 3, 2005, Seung Park (Park), after leaving a party hosted at the home of Ki Soo Shin (Shin), ran a red light, and crashed his van into a car driven by Stacey Camacho. Park was found to be intoxicated when the accident occurred. Camacho was killed and her minor son was injured. Shin was sued by the decedent’s family under the Georgia Dram Shop Act.

The Act, codified in O.C.G.A. §51-1-40(b) reads in relevant part, “[a] person who . . . knowingly sells, furnishes, or serves alcoholic beverages to a person who is in a state of noticeable intoxication, knowing that such person will soon be driving a motor vehicle, may become liable for injury or damage caused by or resulting from the intoxication of such . . . person when the sale, furnishing, or serving is the proximate cause of such injury or damage.”

The following facts were adduced in discovery: Shin and his wife hosted a barbeque at their house and Park drove to this party. During dinner, Park drank two bottles of beer and three to five servings of sake. Towards the end of dinner, Park got into an argument with another guest, which escalated to the guest pushing Park in the abdomen. After breaking up this argument, Shin concluded Park had become intoxicated. Shin then put all of the alcoholic beverages away and most of the guests left.

After the argument, Park testified that he drank two glasses of soju (a Korean liquor similar to vodka) because he was angry. Park did not remember who poured these drinks for him. Shin testified that he did not see Park drink the soju or any other alcoholic beverage after the fight.
Later in the night, Park began to help Shin’s wife clean up but he was urged to rest on the couch before driving home or allow her to take him home. Shin also offered for Park to sleep and sober up before driving home. After resting on the couch for between 45 and 90 minutes Park headed to his car to drive home. Shin’s wife tried to persuade Park not to leave. Shin asked Park if he was fine to drive and Park said he was. The accident occurred within 15 minutes of leaving the Shin’s house and his BAC at the time of the accident was 0.147.

The trial court denied Shin’s motion for summary judgment but his application for interlocutory appeal was granted. The issue before the Court of Appeals centered on the first portion of the Dram Shop Act – whether Shin knowingly furnished or served Park with an alcoholic beverage while he was in a state of noticeable intoxication.

Based on Shin’s testimony that he did not see Park drink the soju or any other alcoholic beverage after the fight (which coincided with the point in time when Shin determined he was intoxicated) the Court of Appeals determined the trial court erred in denying summary judgment. In arriving at this decision, the Court found an absence of evidence to support the first element of the Act; that is, there is no evidence in the record that Shin knowingly furnished alcoholic beverages when Park was in a state of noticeable intoxication.

Though the issue did not have any bearing on the ultimate decision, the Court also noted that Georgia law does not impose a duty on a provider of alcoholic beverages to prevent an intoxicated person from driving.

TORTS/PROXIMATE CAUSE: Even where violation of building code constitutes negligence per se, personal injury plaintiff may not recover where she had equal knowledge of alleged defect constituting violation.


Mandana Zeimaran hired Commercial Concepts to construct the Kobra Salon and Spa. Architectural firm Lyman Davidson Dooley prepared the architectural plans. The plans called for a storage space above the ceiling. The storage area surface was to be constructed of metal decking with plywood on top. This storage area did not cover the entire ceiling, however; the remainder of the area was covered with acoustical tile.

Zeimaran fired Commercial Concepts before work on the storage area was completed. Commercial Concepts sent a certified letter informing Zeimaran that, per her request, “Commercial Concepts, Inc. has removed itself from the above location. Also per your request, you agree to take over and complete any and all remaining construction items to your satisfaction. Commercial Concepts, Inc. does not and will not in the future, have any responsibility/warranty for the completion of such items as they relate to Kobra Salon and Spa.” Zeimaran did not do any further work on the storage area after Commercial Concepts stopped worked.

After Zeimaran had been operating the salon for approximately eight months, she accessed the storage area to organize some boxes when she fell to the floor below through the acoustical tile adjacent to the storage platform, injuring herself. Zeimaran sued Commercial Concepts and Lyman Davidson Dooley.

In her complaint, Zeimaran claimed Lyman Davidson Dooley was negligent for failing to include a guardrail in the storage area plans pursuant to applicable building codes. The complaint also alleged that Commercial Concepts was negligent for failing to install a guardrail, even though no guardrail was included in the plans.

Commercial Concepts moved for summary judgment, contending that the plans did not call for a guardrail and even if they had, Zeimaran assumed responsibility for finishing the construction when she removed Commercial Concepts from the job before it could finish construction of the storage area. Further, Zeimaran acknowledged that she had been in the
storage area several times prior to her fall and that it was obvious to her where the corrugated steel floor ended and the acoustical tile began. Lyman Davidson Dooley also moved for summary judgment, arguing that Zeimaran could not show any causal connection between the lack of a guardrail and her fall because she did not know how or why she fell and the lack of a guardrail was open and obvious. The trial court granted both defendants’ motions.

The Court of Appeals affirmed the trial court’s rulings on the grounds that, even if the lack of a guardrail constituted negligence per se as a violation of the building code, plaintiff’s claim was nevertheless barred by the “equal knowledge” rule, based on the fact that she had been in the storage area on several occasions and was aware of the boundary between the steel floor and acoustical tiled surface. Additionally, Zeimaran’s signature on the certified letter from Commercial Concepts, advising her that construction was not complete when it was removed from the job, relieved the contractor from any further liability for the allegedly unfinished storage area.

**TORTS/THIRD-PARTY PRACTICE/ CONTRIBUTION AND INDEMNITY:** Excessive, unexcused delay in bringing third-party complaint barred same, but did not bar separate action for contribution and indemnity.


In 2000, general contractor R. Larry Phillips Construction Company constructed a new automobile dealership in Columbus, Georgia. In 2004, the owners/lessors of the dealership sued Phillips for negligent construction after certain defects in the building allegedly revealed themselves. In 2007, after learning that the cost of repairs would exceed $5 million dollars, Phillips moved to add several subcontractors involved in the construction of the dealership as third-parties. The trial court denied Phillips's motion. In 2008, Phillips filed a separate lawsuit against those same subcontractors. Upon motion, the trial court dismissed Phillips’s contribution action for failure to state a claim upon which relief could be granted. Phillips appealed from both rulings.

O.C.G.A. § 9-11-4 provides that a third-party plaintiff may bring a third-party action without the need for leave of court if the third-party action is commenced within ten (10) days of the filing of the third-party plaintiff's original answer. After ten days have passed, the third-party plaintiff must seek leave of court to file a third-party action. Here, Phillips did not seek to file a third-party complaint until nearly three years after it had filed its answer. In affirming the trial court’s denial of Phillips’s motion, the Court of Appeals highlighted the fact that Phillips failed to explain or justify this excessive delay, including why, after learning the repairs would cost more than $5 million, it waited an additional eight months before seeking leave to bring a third-party action.

Although it agreed that the trial court had discretion to deny Phillips’s motion to file a third-party complaint against the subcontractors, the Court of Appeals disapproved of the lower court's dismissal of Phillips’s separate action for contribution and indemnity. Phillips appealed the trial court's dismissal of its contribution action on the following three grounds: (i) neither a judgment nor settlement is a prerequisite to the right to bring an action for contribution; (ii) the right to contribution is not limited by third-party practice under O.C.G.A. § 9-11-14; and (iii) dismissal of Phillips's contribution action in conjunction with the denial of its motion to bring a third-party complaint left Phillips with no remedy to enforce its right to contribution, in violation of the Due Process Clause of the Georgia Constitution and O.C.G.A. § 9-2-3.

Relying only on Phillips's first enumeration of error, the Court of Appeals reversed the trial court, holding that the 1972 amendment to Georgia's contribution statute, O.C.G.A. § 51-12-32, provided for the existence of an action for contribution without the necessity for either a judgment or settlement in the underlying action.
NEGLIGENCE: Georgia law does not impose duty on person – including owner or operator of hotel – to rescue another from situation of peril which former did not cause.


Virginia Rasnick brought a wrongful death action against Krishna Hospitality, Inc., the owner and operator of the Motel Jesup, where her husband Sidney died while a registered guest at Motel Jesup.

Mrs. Rasnick called her husband several times the night before he died, but there was no answer in his room. She then asked the front desk to go check on him, but was told that he was probably sleeping. No motel personnel ever checked on Mr. Rasnick that night. The next morning, a housekeeper found Mr. Rasnick lying on the floor conscious, but unable to move. He was rushed to a nearby hospital and died shortly thereafter. The autopsy revealed that he died from untreated coronary artery disease coupled with an enlargement of his heart.

The trial court granted summary judgment in favor of Krishna. The Georgia Court of Appeals affirmed the trial court's decision, finding that Mrs. Rasnick had failed to show any legal duty that Krishna allegedly breached in connection with the death of her husband.

Mrs. Rasnick based her argument on Section 314A of the Restatement (Second) of Torts, which places a duty on innkeepers to take reasonable action to give their guests first aid if they know or have reason to know that they are ill. The Court pointed out that while some states have adopted Section 314A of the Restatement, Georgia has not. Further, the Georgia Supreme Court has recently reiterated the long-established general rule that “[a] person is under no duty to rescue another from a situation of peril which the former has not caused.” The cited provision of the Restatement is actually inconsistent with the long-established rule as recognized by the Georgia Supreme Court.

In conclusion, the Court held that in the absence of any signal from the Supreme Court or from the General Assembly that, with respect to innkeepers, it is time for Georgia to retreat from its long held, common law general rule of no-duty, it would adhere to that rule and conclude as a matter of law that Krishna had no duty to comply with Mrs. Rasnick's requests to attempt to rescue her husband from his medical peril.

AVOIDABLE CONSEQUENCES: Driver could have avoided accident, so widower's recovery was barred.


This is a typical multi-vehicle wrongful death collision case, with an atypical result: summary judgment for all defendants. The decedent approached a stop sign at a T-intersection in Glynn County, expecting to make a left turn. Her view to the left was blocked by a stalled front-end loader. Witnesses saw her brake lights flash and then she accelerated into the left turn. Unfortunately that put her directly in the path of a tractor-trailer, which broadsided her car, killing her instantly.

There was evidence that the tractor-trailer was traveling below the speed limit and that an alternate route was available to avoid the stalled loader.

The plaintiff widower alleged that the negligence of the loader company, its maintenance company, and the trucking company combined to cause or contribute to the fatal accident. Plaintiff's version was that his wife had come to a stop, then inched forward, and then tried unsuccessfully to accelerate to get out of the path of the oncoming truck.
On appeal from the grant of summary judgment to all defendants, the Court of Appeals contrasted the legal doctrine of contributory negligence, which is usually a fact question incapable of being resolved at summary judgment, and the doctrine of avoidable consequences. “If the plaintiff by ordinary care could have avoided the consequences to himself caused by the defendant’s negligence, [the plaintiff] is not entitled to recover.” Under this doctrine, plaintiff’s negligence in failing to avoid the consequences of defendant’s negligence is deemed the sole proximate cause of the injuries, and is a complete bar to recovery, unless the defendant inflicted the injuries willfully and wantonly. This issue may be ruled on as a matter of law when it is clear and palpable.

The Court of Appeals concluded that the record demonstrated the elements of the affirmative defense, that plaintiff was familiar with the intersection and the right of way, that she could see the loader and knew it blocked her view of oncoming traffic from that direction. Further, there was no evidence of willful or reckless conduct by the defendants. Even assuming the defendants were each negligent, the court held that the trial court correctly ruled as a matter of law.

Plaintiff also made spoliation charges against defendants for moving the loader after the accident, and for failing to keep written logs regarding the loader. However, the Court of Appeals held that the ruling mooted these contentions.

Plaintiff is currently petitioning the Georgia Supreme Court for appeal by writ of certiorari. This opinion is interesting and seems very fact intensive for a ruling as a matter of law. The opinion states plaintiff “failed to come forward with any evidence that the decedent lacked knowledge of the danger she faced,” which is a curious statement since it seems to require proving a negative, and because the burden of proof of this affirmative defense is on the defendant, not the plaintiff.

JURISDICTION TO CONSIDER SUMMARY JUDGMENT: Trial court does not have jurisdiction to consider motion for summary judgment once trial has proceeded to point where court is under duty to make findings of fact.

The question before the Georgia Court of Appeals was whether the trial court had jurisdiction to consider the motions for summary judgment once the trial had been held. The Court followed its prior decision in Braselton Bros., Inc. v. Better Maid Dairy Products, 110 Ga. App. 515, 139 S.E.2d 124 (1964). In its holding, this court reasoned that here, as in Braselton Bros, the trial had proceeded to the point where the court was under a duty to make findings of fact; therefore, the court was without jurisdiction to entertain the insurers’ motions for summary judgment. Because contradictory testimony on key issues was presented at trial, the court was obligated in its role as fact-finder to weigh the credibility of the witnesses and reliability of the evidence to resolve the issues pending before it. Accordingly, it was without jurisdiction to entertain Canal and National’s now moot motions for summary judgment.

EMPLOYER LIABILITY/SCOPE OF EMPLOYMENT: Supreme Court held employer entitled to summary judgment where tortfeasor was merely an “on-call” employee.


A 4-3 decision of the Supreme Court held that several previous cases had misconstrued the law in suggesting that an employee’s on-call status always creates a jury issue regarding scope of employment.

The plaintiff was injured in an automobile collision with an on-call employee who was driving a company vehicle. The employee was the daughter of a company owner, and she performed as-needed clerical work for the company.

She gave uncontradicted testimony that, at the time of the accident, she was leaving school after an exam and was on a purely personal mission as she headed home. Beyond the fact that she was driving a company vehicle, the only evidence regarding scope of employment was her testimony that she was on call, subject to being called into work.

The Court held that the plaintiff established an initial presumption of scope of employment by showing that the employee was driving a company-owned vehicle at the time of the accident. This shifted the burden to the employer to overcome that presumption, which it attempted to do through the testimony of its employee.

The Court noted that, once the plaintiff has established the presumption, and the employer has provided uncontradicted testimony to the contrary, the plaintiff must present evidence (beyond the evidence creating the presumption in the first place) that the employee was within the scope of employment. If the plaintiff presents direct evidence of scope, then that creates a jury issue. If, however, the plaintiff presents only circumstantial evidence of scope, it must be sufficient to support a verdict, or the defendant is entitled to summary judgment.

The Court held that the evidence of the employee being on call was inconclusive on the issue of scope of employment and insufficient to avoid summary judgment. In order for the plaintiff’s circumstantial evidence to be sufficient to support a verdict, “the facts shown must not only reasonably support that conclusion, but also render less probable all inconsistent conclusions. In cases of circumstantial evidence a mere inconclusive inference . . . is not to be regarded as any evidence, so as to require the submission of its sufficiency to the jury.” Since being on call was entirely consistent with not actually being in the scope of employment, this fact did not render “less probable all inconsistent conclusions,” and the plaintiff did not carry her burden of disproving the employer’s testimony.

The majority rejected as *dicta* the statement in a previous case that an employee being subject to call at any time constitutes direct evidence of scope of employment.
ATTORNEY’S FEES: State Board has discretion to apportion attorney’s fee between multiple attorneys where total fees awardable under fee contracts exceed statutory maximum.


Martin Garcia was catastrophically injured on the job and hired Russell Keener to represent him, agreeing to pay Keener 25% of any recovery, 25% of any settlement offers made, or a fee based upon the time spent by Keener on the case at a reasonable hourly rate. Keener obtained a settlement offer of $650,000, plus funding of an MSA, but Garcia rejected the offer and dismissed Keener. Keener then filed an attorney’s lien for $162,500, which represented 25% of the employer’s offer, plus his expenses.

Garcia then hired Jorge Flores to represent him. His contract with Flores obligated him to pay Flores 25% of any monetary recovery that Flores obtained. Flores obtained a settlement offer of $657,500.00, plus funding of an MSA, eight days later. Under Georgia law, the maximum attorney’s fee that may be awarded is 25% of the value of the income benefits. Following the submission of the stipulation to the State Board for approval, Flores filed a motion to deny Keener’s lien and award the full 25% of the settlement allocated to attorney’s fees to him.

The Administrative Law Judge apportioned the fee between the two attorneys based upon the relative value of the offers; thus, he awarded Keener 25% of the $650,000 offer he obtained and awarded Flores 25% of the additional $7,500 he obtained.

Flores appealed to the Appellate Division. The Appellate Division rejected the ALJ’s approach to the division of the fee. The Appellate Division awarded 70% of the fee to Keener, based upon the time he had devoted to the case at his hourly rate of $225.00 per hour, and awarded the remaining 30% of the fee to Flores because he had achieved the settlement in only eight days.

The case was then appealed to the superior court, which vacated the Appellate Division award and remanded the case to the State Board. The superior court ruled that the State Board had failed to apply “the correct law.” Flores next appealed the superior court’s ruling to the Court of Appeals, which reversed. The Court of Appeals held that the Appellate Division is authorized to weigh the evidence in the record and assess the credibility of the witnesses who testified at the hearing. If the Appellate Division finds that the ALJ’s findings of fact are not supported by a preponderance of the credible evidence, it may then substitute its own findings, which the courts are bound to accept if those findings are supported by “any evidence.”

Under the contracts which Garcia signed, Keener was authorized to receive $162,500 and Flores was authorized to receive $162,875. However, state law limited the total award of attorney’s fees to $162,875. Therefore, the State Board had discretion to apportion the fees between the two attorneys, and Flores failed to show that the Board’s decision violated any grounds for a court to set aside the decision; i.e., the decision did not exceed the Board’s powers, was not procured by fraud, was supported by the facts found by the Board, the facts found by the Board were supported by competent evidence and the decision was not contrary to law.

The determination of a reasonable attorney’s fee, and the value of an attorney’s services, is a factual determination to be made by the State Board. The State Board’s finding will be upheld unless there is no evidence to support it. In Mr. Garcia’s case, the State Board exercised discretion to apportion the fee because of the statutory limitation on a claimant’s attorney’s fees. Because there was some evidence that supported its finding, the Court of Appeals upheld it.
STATUTE OF LIMITATIONS: Claimant’s filing of Form WC-R1CATEE constitutes application for additional TTD benefits under O.C.G.A. § 34-9-104(b), tolling two-year statute of limitations.


The claimant, Linda Hunnicutt, had a compensable accident in 1996. Following her injury, she received temporary total disability (“TTD”) benefits for the maximum period available under O.C.G.A. § 34-9-261 (i.e., 400 weeks from her date of injury). Within two years of exhausting her TTD benefits, she filed a Form WC-R1CATEE requesting catastrophic designation. The form, filed on July 27, 2005, did not specifically ask for additional TTD benefits. The employer and insurer requested a hearing, objecting to the catastrophic request. At the hearing, the Board found the claimant catastrophically injured, but did not specifically address whether she was entitled to additional TTD benefits.

Although the award was initially appealed, the appellants dismissed their appeal with prejudice. In doing so, they agreed to provide the claimant with rehabilitation benefits. However, on December 17, 2007, the claimant requested a hearing, because the employer and insurer had not reinstated her TTD benefits. In turn, the employer and insurer argued the claimant’s timely filing of a Form WC-R1CATEE did not constitute an application for additional TTD benefits under O.C.G.A. § 34-9-104. Therefore, they argued the claim for TTD benefits was barred due to the fact that Hunnicutt’s new hearing request was filed more than two years after her last receipt of TTD benefits.

The State Board, and ultimately the Court of Appeals, disagreed. Reading O.C.G.A. § 34-9-104 and § 261 together, the Court held that an application for catastrophic designation via WC-R1CATEE, even when it fails to explicitly request additional TTD benefits, is adequate to toll the applicable statute of limitations.

EXCLUSIVE REMEDY PROVISION: Workers’ Compensation Act is exclusive remedy for claim of heirs of temporary worker against contractor to whom temporary worker was assigned.


In April 2006, Boral Bricks, Inc. (“BBI”) hired Albert Painting, Inc. (“API”) to paint some of the buildings at its Smyrna, Georgia plant. In turn, API contracted with Labor Ready to supply temporary workers for the job. According to the contract, Labor Ready charged API a regular billing rate of $16.80 per employee, per hour, which included “all wages, withholdings, FICA, Medicare, payroll taxes, unemployment insurance and workers’ compensation insurance as required by law for supplied employees.” Richard Sabellona, Jr. was a temporary employee supplied to API by Labor Ready for the painting job at BBI’s plant. On August 14, 2006, Sabellona was on the roof of one of the plant buildings when he fell 35 feet through a skylight to his death.

Sabellona’s minor son and dependent, Brandon, filed a workers’ compensation claim against Labor Ready, which was settled for $160,000. Thereafter, Sabellona’s other two children, Richard III and Scott, and Ray Gary, Sabellona’s personal representative (collectively “appellants”), filed a wrongful death claim against API and BBI.

API moved for summary judgment, contending it was immune from suit under the Workers’ Compensation Act (“WCA”). The trial court granted the motion, finding that the immunity from suit granted by the WCA to Labor Ready extended to API because it is “a business using the services of a temporary help contracting firm” under O.C.G.A. § 34-9-11(c), and it elected WCA coverage through its contract with Labor Ready. Appellants appealed that
ruling, arguing that the WCA does not apply to API, which “has regularly in service less than three employees.”

Georgia law provides that the exclusive remedy provision of O.C.G.A. § 34-9-11 prevents an injured employee or his/her dependents from bringing a tort claim against the employer, a statutory employer, or a co-employee. In 1995, the legislature extended this tort immunity to businesses using the services of a temporary help contracting firm or an employee leasing company,” provided that workers' compensation benefits are furnished by either: (1) a temporary help contracting firm or an employee leasing company; or (2) a business using the services of either such firm or company. The record showed that Labor Ready qualified as a temporary help contracting firm and that API qualified as a business using its services. The record further reflected that Labor Ready paid workers’ compensation benefits to Sabellona’s dependent. Accordingly, pursuant to O.C.G.A. § 34-9-11(c), API was immune from suit, and the trial court properly granted summary judgment to API.

Fred R. Green, a partner in the Atlanta office of GMLJ, represented Boral Bricks Inc. and negotiated a very favorable settlement for Boral on the related premises liability claims.

Georgia Coverage

LIMIT OF LIABILITY: Where term “accident” is not expressly defined in policy, and distinct are made for multiple impacts by insured which occurred in close proximity and time to each other, liability insurance available is limited to single “per accident” limit set forth in policy.


A vehicle driven by State Auto’s insured struck a bicyclist, killing him, and then shortly thereafter, struck a second bicyclist, seriously injuring him. The insured’s policy with State Auto contained a limit of liability for “each accident” of $100,000 and provided that this limit is the “maximum limit of liability for all damages resulting from one auto accident . . . regardless of the number of . . . vehicles involved in the auto accident.” However, the policy did not expressly define the term “accident,” “each accident,” or “any one accident.”

State Auto contended that the incident constituted one accident such that it was responsible for only providing the single $100,000 limit of coverage. The claimants maintained that there were two separate accidents; therefore, State Auto was responsible for providing two $100,000 limits of coverage.

In a certified question to the Supreme Court of Georgia, the district court for the Middle District of Georgia asked the Supreme Court to determine if the insured’s striking the two cyclists amounted to one or multiple accidents. Specifically, the district court asked, “whether the liability insurance available for separate and distinct claims arising from an incident where the insured struck two claimants separately but in close temporal and spatial proximity to each other is limited to the single ‘per accident’ limit in the policy when ‘accident’ is not expressly defined in the policy.”

Viewing the policy as a whole, the Supreme Court held that the language showed a clear intent to limit liability in accidents involving multiple vehicles which occur closely in time and place: “by placing the term ‘accident’ in the limitation of liability section, manifestly, it was intended that the policy have monetary limits of coverage.” The Supreme Court went on to point out the fallacy in limiting the term “accident” to one impact in this type of situation, “because it is virtually impossible for multiple vehicles to collide truly simultaneously . . . [Further,] the policy’s [language limiting
liability] regardless of the number of vehicles involved would be meaningless in almost any collision involving multiple vehicles, as State Auto would have to pay . . . for each impact. That is plainly not the intent of the contract.”

Turning to the definition of “accident,” the Supreme Court analyzed three different theories employed by courts around the country: the “effect” theory, the “event” theory, and the “cause” theory. Viewing the policy as a whole and looking to Georgia tort law, the Supreme Court adopted the “cause” theory for application in Georgia to limit liability in accidents where all the injuries and/or damages resulted from “one proximate, uninterrupted, and continuing cause.” The Supreme Court looked to whether, after the cause of the initial collision, the driver regained control of the vehicle before a subsequent collision, so that it could be said that there was a second intervening cause, and consequently, a second accident.

UNDERINSURED MOTORIST COVERAGE: Loss of consortium claim combines with bodily injury claim combine to determine whether UIM limits have been exhausted.


Shirley Mullinax sued David English for personal injuries sustained in an automobile accident. James Mullinax, Shirley’s husband, sued Mr. English for loss of consortium. The complaint was also served on State Farm Mutual Automobile Insurance Company (State Farm), the Mullinaxes’ UM carrier. State Farm answered the complaint in its own name. The Mullinaxes eventually settled with English for his $25,000 per person liability policy limits, with $20,000 going to Mrs. Mullinax and $5,000 to Mr. Mullinax. A limited liability release was executed pursuant to O.C.G.A. §33-24-41.1. The Mullinaxes then dismissed their claims against only Mr. English with prejudice, with the intent of maintaining and pursuing their claims against State Farm.

State Farm moved for summary judgment, arguing that the Mullinaxes could not recover underinsured motorist (UIM) benefits since individually the Mullinaxes’ recoveries were less than the $25,000 liability limits of Mr. English’s policy. Further, State Farm argued that the dismissal with prejudice precluded the Mullinaxes from proceeding against State Farm because the Mullinaxes’ claim against State Farm was based on the negligence claim against English. In response, the Mullinaxes filed a motion to correct a clerical error, claiming they intended to file a dismissal without prejudice, not with prejudice. The trial court granted State Farm’s motion for summary judgment finding for State Farm on both issues.

The Mullinaxes appealed, arguing that, (1) the dismissal with prejudice was a clerical error; and (2) because a spouse is not entitled to recover damages for loss of consortium independent of the other spouse’s injury, single limits must be used to pay those claims. Thus, the Mullinaxes argued, they have exhausted Mr. English’s $25,000 policy limits with the $20,000 going to Mrs. Mullinax and the $5,000 to Mr. Mullinax.

The Georgia Court of Appeals reversed the trial court, citing the case of _Thompson v. Allstate Ins. Co., 285 Ga. 24 (2008)_ for the proposition that an insurer’s total available coverage for personal injury to one spouse and loss of consortium injury to the other is the total available per person limit of coverage ($25,000 in both this case and Thompson, supra). Further, the Court of Appeals found that the trial court abused its discretion in failing to allow the Mullinaxes to correct their clerical error in entering a dismissal with prejudice as opposed to a dismissal without prejudice. The Court found that State Farm would not be prejudiced by correcting this error and would gain a substantial windfall if the error were not corrected. The Court found that O.C.G.A. §9-11-60(g) is intended to allow clerical errors to be corrected at any time and the Mullinaxes should have been permitted to fix their error.
ATTORNEY FEES UNDER PROPOSAL FOR SETTLEMENT: Joint offer for settlement conditioned on mutual acceptance of multiple offerees is invalid and unenforceable.


Attorneys’ Title insured real property owned by both Joseph Gorka and Laurel Lee Larson. Gorka and Larson were sued in a dispute involving the property and Attorneys’ Title refused to defend them. Gorka and Larson then filed an action against Attorneys’ Title for a declaratory judgment and for damages because of breach of contract.

Before the trial, Attorneys’ Trial served a proposal for settlement on Gorka and Larson pursuant to Fla. Stat. 768.79 and Fla. R. Civ. P. 1.442. The proposal offered payment of $12,500 to each of them in full settlement of their claims, including attorney fees and costs. The offer was conditioned, however, upon the offer being accepted by both Gorka and Lason. The proposal specifically stated that “... the offer can only be accepted if both John W. Gorka and Laurel Lee Larson accept and neither Plaintiff can independently accept the offer without their co-plaintiff joining in the settlement.”

Neither plaintiff accepted the proposal for settlement, and the case proceeded to trial. At the bench trial the court entered final judgment in favor of Attorneys’ Title. On Attorneys’ Title’s motion for attorney fees and costs, both the trial court and the Second District Court of Appeals concluded that Attorneys’ Title’s Proposal for Settlement was invalid and unenforceable because it was conditioned upon both plaintiffs accepting the amounts offered, and did not allow either to independently accept the offer. By so doing, the court noted, if one plaintiff wanted to accept the proposal, its acceptance would be ineffective if the other plaintiff chose not to accept. Likewise, a plaintiff who wished to accept might still be exposed to the fee sanction if the conditional proposal were enforceable due to the conduct of the other plaintiff who rejected the joint offer rather than based on his/her own decision.

The Second District Court of Appeals certified its decision, however, it appeared in direct conflict with a decision from the First District Court of Appeal, Clements v. Rose, 982 So. 2d 731 ( Fla. 1st DCA 2008). The Florida Supreme Court accepted and reviewed the case in light of the conflict.

The issue presented to the Florida Supreme Court based on the conflicting decisions by the two appellate courts was whether a joint offer of settlement or judgment that is conditioned on the mutual acceptance by all of the joint offerees is valid and enforceable.

The court reviewed the general principles of the statute and rule governing proposals for settlement, noting that since they serve as a sanction by awarding attorney fees, both should be construed strictly. According to the language of the Rule and case law interpreting it, the court noted the principle has developed that, in order for a joint offer to be valid, it must: (1) state the amount and terms attributable to each party and (2) state with particularity any relevant conditions. This requires, the Court reasoned, that an offer of judgment must be structured such that either offeree can independently evaluate and settle his or her respective claim by accepting the proposal, irrespective of what the other party receiving the proposal does.

The court reviewed current precedence noting that: (a) an offer of settlement made by a defendant to multiple plaintiffs is required to specify the amount and terms attributable to each plaintiff; (b) joint offers made by two plaintiffs to one defendant must be apportioned, showing the amount attributable to each plaintiff; and likewise (c) an offer from one plaintiff to multiple defendants still must differentiate between the parties, even when one of the defendants is alleged to be only vicariously liable. The Court pointed out that the history of
case law instructs us that “an offer must be differentiated such that each party can unilaterally settle the action.”

The Florida Supreme Court held that the Second District Court of Appeal properly found that the proposal by Attorneys’ Title was invalid, because it violated the settlement rule and did not differentiate the offer such that each party could unilaterally settle the action or independently accept the offer it received.

NEGLIGENCE: Presumption of negligence for driver of rear vehicle is not applicable to passenger of rear vehicle in action against driver of lead vehicle that was rear-ended.

*Chardon v. Birge*, 35 Fla. L. Weekly D805 (Fla. 5th DCA 2010).

On February 25, 2007, William Smith, operating a motorcycle, and Warren Birge were involved in an accident. Crystal Charron was riding as a passenger on Smith’s motorcycle when the accident happened. Both vehicles were traveling on U.S. Highway 17-92. Birge came to a stop as he approached a street that merges into (and yields to) Highway 17-92. Smith was unable to stop in time and collided with Birge’s vehicle. As a result of the collision, both Smith and Charron were injured.

Smith and Charron filed a lawsuit against Birge for injuries sustained in the accident. The deposition testimony in the case showed that Birge came to a stop at a point on Highway 17-92 where traffic is not expected to stop.

Birge filed a motion for summary judgment, which the trial court granted, holding that Charron failed to overcome the presumption that Smith, as the rear/following driver, was negligent. On appeal the Fifth District Court of Appeal analyzed the presumption of negligence that attaches to the rear driver in a rear-end accident and considered whether such a presumption applies to bar the claim of a passenger of the following vehicle.

The Court discussed the history of the presumption of negligence that applies in rear-end collision accidents and noted that “the rebuttable presumption of negligence that attaches to the rear driver in a rear-end collision in Florida cases arises out of the necessity in cases where the lead driver sues the rear driver. The presumption bears only upon the causal negligence of the rear driver . . . .” The Court explained that the presumption clearly does not apply when a passenger of the following vehicle sues the driver of the lead vehicle for negligence. In cases such as this one, the Court held, the issue in the case is whether the lead or forward vehicle was negligent at all, not whether the passenger can rebut a presumption of negligence attached to the driver of the rear vehicle.

The Court further held that it was improper under the facts of this case and the evidence presented to enter summary judgment on the issue of whether the rear driver should have anticipated the forward vehicle stopping. The Court pointed to various Florida cases with diverging rulings on when and whether a following vehicle should have anticipated the vehicle in front of it stopping, depending on the facts presented. The Court ruled that there was evidence in the record supporting the position that a driver would not reasonably have expected to stop in that location on Highway 17-92. Since such a determination depends on the circumstances, however, and involved a question of fact, that issue should not have been determined by summary judgment.

The Appellate Court reversed the trial court’s entry of summary judgment in favor of the defendant and held that the proper issue to be determined in the case was whether there was evidence that Birge was negligent as the forward driver and caused the injuries of Charron, and that the evidence could support a verdict for negligence against Birge under the circumstances.
IMPAIRMENT INCOME BENEFITS: If claimant is earning less than his average weekly wage at time impairment income benefits become due, he receives 75% of his compensation rate per week, whether or not causal connection exists between claimants reduced wages and industrial accident.


This case concerns one of the changes to the Florida Workers’ Compensation Law made effective October 1, 2003. Specifically, Florida Statute Section 440.15(3)(c) was amended to reflect that when a claimant reaches maximum medical improvement (“MMI”) and is assigned a permanent impairment rating (“PIR”), he is entitled to impairment income benefits (IIB) paid out at 75% of the claimant’s compensation rate (“CR”) or one half thereof, depending upon whether or not the claimant is earning his average weekly wage (“AWW”) or greater when the benefits become due.

In this case, the claimant litigated the issue of payment of IIB at the full 75% rate. The parties stipulated that during the period that impairment income benefits were due, the claimant did not earn 100% of his AWW or greater. They further stipulated that the claimant’s failure to earn 100% of his AWW was unrelated to his compensable injury. As a result, the employer asserted that it was entitled to reduce the claimant’s IIB by 50%.

Florida Statute Section 440.15(3)(c) reads:

“Impairment income benefits are paid biweekly at the rate of 75 percent of the employee’s average weekly temporary total disability benefit...however, such benefits shall be reduced by 50 percent for each week in which the employee has earned income equal to or in excess of the employee’s [AWW].”

The Judge of Compensation Claims (“JCC”) determined that there was no causation requirement within the statute and awarded IIB at the full 75% rate.

The employer appealed the JCC’s determination. The First District Court of Appeal (“DCA”) agreed with the JCC’s interpretation of the statute and affirmed the JCC’s order. Specifically, the DCA determined that the language of 440.15(3)(c) is clear and unambiguous and therefore should be given its plain meaning.

AUTHORIZATION OF PHYSICIAN BY OPERATION OF LAW: When claimant is successful in establishing that physician should be deemed authorized by operation of law under Florida Statute Section 440.13(2), employer is not required to provide continued treatment with that physician, but can select physician of its choice within that medical specialty for continued treatment of claimant’s injuries.

Carmack v. State, Department of Agriculture, 34 Fla. L. Weekly D2357 (Fla. 1st DCA 2009).

This case deals with the issue of whether or not the Employer/Carrier is required to continue to provide treatment for a claimant with a physician deemed authorized by operation of law under Florida Statute Section 440.13(2)(c).
Here, the claimant requested to be treated for alleged psychiatric injuries. After this was not authorized, the claimant was sent to a psychiatrist by his attorney and started receiving psychiatric treatment. The JCC determined that the E/C was responsible for payment of the psychiatric treatment that the claimant had sought on his own. However, the JCC held that the E/C was not required to continue to provide the claimant with psychiatric treatment with that same physician, but instead was “entitled to select and authorize a psychiatrist of its choosing to provide ongoing psychiatric care.”

On appeal, the claimant asserted two arguments. First, the claimant argued that the JCC’s order should be reversed because it was premised on case law not cited by either party. The First District Court of Appeal (“DCA”) indicated that a JCC is free to conduct its own independent legal research and rejected this argument with little discussion.

Secondly, the claimant argued that the E/C should have been required to provide continued treatment with the same physician that the claimant sought treatment from on his own. This is the more interesting issue and is worthy of greater discussion.

In addressing the second issue, the DCA focused on the language of 440.13(2)(c), as amended by the legislature effective October 1, 2003. Specifically, the term “initial” was inserted before the phrase “care and treatment.” Furthermore, the DCA referred to its prior decision in Parodi v. Florida Contracting Co., 16 So.3d 958 (Fla. 1st DCA 2009), wherein the Court determined that a JCC can authorize a physician under 440.13(2)(c) during “the period of wrongful denial.”

Taken together, unauthorized treatment can later be deemed authorized and the E/C required to pay for same only until the E/C begins furnishing the claimant with the medical and treatment determined to be medically necessary. In fact, to avoid any further confusion on the topic, the DCA specifically stated, “[w]e now make equally clear that ‘the period of wrongful denial’ ends when the JCC finds the employee entitled to the previously denied medical treatment.”

This is a tactic being utilized more and more often by claimants’ attorneys. Fortunately, the DCA continues to acknowledge that an E/C generally has the ability to control the selection of the claimant’s treating physicians. However, if the treatment that is retroactively determined to be reasonable and medically necessary is of such a unique characteristic that no similar physician can be identified, a JCC could determine that the specific physician should remain authorized.

**DEFINITION OF WAGES:** In order to be considered wages, claimant’s income must be reported by him to IRS.

*Rene Stone Work Corporation v. Gonzalez, 35 Fla. L. Weekly D230 (Fla. 1st DCA 2010).*

This case involves a claimant who was a non-resident alien who had never utilized a Social Security number. The claimant denied having ever been required to complete any tax forms for his employer or having ever received a W-2.

After a final hearing, the claimant was awarded indemnity benefits and the claimant’s AWW was established at $290 per week. The latter was determined based upon the testimony of the claimant and his CPA who prepared various tax forms on the claimant’s behalf and testified that the claimant “ha[d] reported his income to the federal government as the term ‘reported’ is generally understood in the accounting and tax-preparing community.” The claimant acknowledged that he reported his earnings to the IRS for the sole purpose of obtaining workers’ compensation benefits.

On appeal, the E/C asserted that the JCC incorrectly awarded indemnity benefits to the claimant since the only issue before the JCC at the time of the final hearing was a correction of the claimant’s AWW. The First District Court of Appeal (“DCA”) agreed and reversed this award.
The E/C argued that the JCC should be reversed for failing to grant the E/C’s post-hearing motion to amend its pre-trial stipulation to include a misrepresentation defense. The basis of the purported defense was the fact that the claimant and his CPA testified that the forms completed by the claimant for tax purposes only listed his wages earned while working for the employer, rather than all of his employers during 2008. The E/C asserted that they were unable to raise this issue until after the claimant and his CPA testified at the final hearing. The DCA determined that if the E/C had done their due diligence, they could have known of this potential defense prior to the final hearing. As a result, the DCA determined that the JCC did not abuse her discretion in denying the E/C’s motion.

Lastly, the E/C asserted that the JCC’s determination of the claimant’s AWW should be reversed for two reasons. They first argued that the JCC erroneously indicated in her order that the claimant’s testimony was “unrefuted.” While this was identified by the DCA as a misstatement, the DCA determined that the JCC’s determination of the claimant’s AWW was based upon competent substantial evidence and consequently the error was harmless, as the DCA would be bound by the JCC’s determination on the issue.

The E/C next argued that the JCC’s determination that the claimant had complied with the reporting requirements of 440.02(28) was incorrect because the claimant did not complete the correct tax documents. The DCA also rejected this argument, holding that the plain language of 440.02(28) only requires that, in order to be considered wages, the claimant’s earnings must be “reported for federal income tax purposes.” The DCA relied on its holding in Fast Tract Framing, Inc. v. Caraballo, 994 So.2d 355 (Fla. 1st DCA 2008), wherein the Court determined that the statute requires a claimant to report his earnings to the IRS. Since the DCA determined that the claimant and his CPA’s testimony constituted substantial competent evidence that the claimant had, in fact, reported his earnings to the IRS, the JCC’s determination of the claimant’s AWW was affirmed.

**ONE TIME CHANGE:** Claimant will be deemed to have utilized his one and only change in treating physicians where claimant has attended appointment with new physician, even if new physician was not identified within 5 days of claimant’s election of his right to one-time change.

*Pruitt v. Southeast Personnel Leasing, Inc.*, 35 Fla. L. Weekly D933 (Fla. 1st DCA 2010).

In this case, the claimant became dissatisfied with his authorized treating physician after the physician determined that no further treatment was reasonable and medically necessary, despite the claimant’s continued subjective complaints of pain. He then filed a petition requesting that he be provided with an alternate treating physician, as well as other ancillary issues not mentioned in the body of the appellate case. A response to the petition was filed, but no specific response was listed regarding the issue of the claimant’s one-time change. After several months, the parties attended mediation and the E/C agreed to provide the claimant with a new, unnamed, authorized treating physician. Shortly thereafter, the claimant was notified that he had an appointment scheduled with a new specific physician. The claimant treated with this physician on multiple occasions. Ultimately, this second physician determined that the claimant’s industrial injury was no longer the major contributing cause of the claimant’s need for further treatment and the E/C filed a Notice of Denial cutting off further care and treatment.

The matter then proceeded to a final hearing. At the final hearing, the claimant argued that he was still entitled to an alternate physician because the E/C failed to respond to his initial request for same and therefore he, rather than the E/C, was entitled to choose his new treating physician. The JCC concluded that the claimant was not entitled to treatment with a new physician.

The issue raised by the claimant on appeal was whether the JCC erred as a matter of law because she determined that the claimant had already been provided his one-time change, despite the fact that the parties agreed that the E/C did not provide a new physician within five
days of the claimant’s request for a new physician.

The First District Court of Appeal ("DCA") focused on the language of 440.13(2)(f) wherein it states that if the E/C fails to timely authorize a new physician within five days of the claimant’s request, “the employee may select the physician...” The DCA concluded that, although the claimant’s right to a change in treating physicians is absolute, the right to select the physician is not absolute. Since this right is not absolute, it can be waived by failure to exercise it. Thus, since the claimant failed to select an alternate physician and instead acquiesced to the E/C’s selection, the claimant was deemed to have waived the right to select his one-time change physician. Accordingly, the DCA concluded that the claimant was properly denied another change of his treating physician.

**Florida Coverage**

STACKING OF UNINSURED MOTORIST COVERAGE: Anti-Stacking provision in Delaware personal auto policy did not apply where insurer also issued policy to Florida residents covering vehicles principally garaged in Florida.


In 2005 John Rando, a resident of Florida, was involved in an accident in which he sustained permanent serious injuries. At the time of the accident, Rando and his wife had two automobile insurance policies with GEICO: one Florida policy covering two vehicles registered and principally garaged in Florida; and a Delaware policy covering one vehicle that was registered and principally garaged in Delaware (where Rando's daughter lived). The Delaware policy was issued and delivered in Florida.

At the time of the accident, Rando carried uninsured motorist coverage on each of his three vehicles. GEICO paid the full extent of the coverage under the Florida policy, but denied any coverage applied for the Delaware vehicle, citing the “anti-stacking” provision in the Delaware policy, which stated:

If separate policies with us are in effect for you or any person in your household, they may not be combined to increase the limit of our liability for a loss.

The Randos filed a lawsuit against GEICO for UM benefits and the case was removed to federal court. The district court granted summary judgment for GEICO, holding that the anti-stacking provision in the Delaware policy was enforceable because the vehicle insured on that policy was not registered or principally garaged in Florida. The Randos appealed the case to the Eleventh Circuit Court of Appeals, which certified the following as a question of Florida law for which it appeared there was no controlling precedent:

Whether, under Florida Law, an automobile insurance policy—which was executed, issued and delivered in Florida to the named insureds residing in Florida for a car that is registered and garaged in Delaware—may validly provide that uninsured motorist coverage under that policy may not be combined with uninsured motorist coverage provided by a separate automobile policy also issued by the insurer to the named insureds in Florida.

Because the Delaware policy was executed, issued, and delivered in Florida, the Court determined that Florida law applied for the interpretation of the parties’ rights and obligations in the case, and as such, the Court applied Florida’s uninsured motorist law.

The Court looked to the Florida Statute governing UM benefits and held that since §627.727(9) requires an insurer obtain informed consent by the insured in order to provide non-
stacking UM coverage (or any reduced benefits), this provision also applied to the Delaware policy issued in Florida. If GEICO included an anti-stacking provision in the Delaware policy issued to the Florida insureds, in Florida, GEICO needed to follow the dictates of § 627.727 and inform the insureds of the required information and obtain the insured’s written consent.

Noting that the purpose of UM benefits is to cover the insured (person) rather than the car, and also noting the public policy favoring UM coverage, the court rejected GEICO’s argument that subsection (9) of §627.727 (requiring insured’s acceptance when lesser UM coverage is provided) applies only to vehicles registered or principally garaged in Florida. While part of the statute compelling UM insurance coverage refers to vehicles registered or principally garaged in Florida, since GEICO’s policy was issued to named insureds in Florida, and issued and delivered in Florida, the requirements of the statute applied to GEICO’s issuance of UM coverage.

The Florida Supreme Court answered the Eleventh Circuit’s certified question in the negative, ruling that GEICO’s anti-stacking provision in its Delaware policy was unenforceable under Florida law.

BAD FAITH: Excess insurer may bring action for bad faith against primary insurer even when no excess judgment was entered against insured and claim ended in settlement.

**Vigilant Ins. Co. v. Continental Cas. Co., 35 Fla. L. Weekly D750 (Fla. 4th DCA 2010).**

Joe Hutchinson was injured while using equipment manufactured by Garden Way and sued Garden Way for products liability and negligence. At the time of the accident, Garden Way had primary liability insurance with Continental Insurance Company in the amount of $1 million, subject to a $500,000 self-insured retention, and carried excess liability coverage with Vigilant Insurance Company in the amount of $25 million.

According to Vigilant, Continental advised Vigilant that its policy provided $1 million of coverage after the $500,000 SIR was met, that the claim was within Continental’s limit of liability and Vigilant could close its file. During the litigation, Hutchinson made demands for settlement that were within the SIR and Continental’s limit of liability but Continental rejected such demands without notifying Vigilant. After three years of litigation, Continental contacted Vigilant when Hutchinson demanded an amount in excess of Continental’s coverage and the SIR. After several letters to Vigilant where Continental failed to advise Vigilant of its exposure, Continental advised Vigilant that there was not enough coverage remaining under its policy and the SIR to cover settlement of the claim and suggested Vigilant take over the defense of the case.

Following settlement of the claim for $1.7 million (Continental paying its remaining limit of liability and Vigilant paying the rest of the settlement), Vigilant sued Continental for bad faith, alleging Continental should have settled the claim at the time when it could have been settled within Continental’s limit of liability. Continental moved for summary judgment, arguing that Vigilant, as an excess insurer, had no claim for bad faith against Continental, the primary insurer. The trial court agreed and entered summary judgment, holding that Vigilant had no claim because: (1) Garden Way (the insured) was released without paying any portion of the settlement, and (2) there could be no bad faith claim where the underlying claim ended in settlement.

Vigilant appealed the ruling and the Fourth District Court of Appeal reviewed the case. The issue the Appellate Court considered was whether an excess insurer could bring a bad faith claim against the primary insurer where no excess judgment was entered against the insured and the claim was resolved by settlement.

The Appellate Court noted that Florida case law permits a bad faith action by an excess insurer against the primary insurer for the bad faith refusal to settle a claim against the insured. The Court reiterated that an excess is essentially in the same position as an insured when a primary insurer refuses to settle a claim and the excess insurer steps into the shoes of the insured in these circumstances.
The court found that it did not matter that an excess judgment had not been entered against Garden Way or that Garden Way had been released. Vigilant paid the settlement that was in excess of the primary insurer’s limit as a consequence of Continental’s alleged bad faith conduct. Therefore, the Fourth DCA held that an excess insurer may bring a bad faith claim against a primary insurer, even where there is no excess judgment, and the claim may be based upon a settlement executed by the excess insurer.

COMMERCIAL AUTOMOBILE COVERAGE: Exclusion in automobile policy for bodily injury of employee of insured arising out of or within course of employment applied to employee’s claim against estate of co-employee who was driver of company truck involved in accident with plaintiff passenger.


Mercury Insurance Company insured Charlie’s Tree Service, Inc., under a commercial automobile policy. The policy included an exclusion, stating that Mercury’s duty to defend did not apply to:

bodily injury to an employee of an insured . . . arising out of or within the course of employment . . . This exclusion applies whether the insured may be liable as an employer or in any other capacity and to any obligation to share damages with or repay someone else who must pay damages because of the injury.

Valentin Bautista-Bautista and Elias Caballero, who were both employees of Charlie’s, were involved in an accident in a company truck while they were on the job. Caballero was driving and Bautista was a passenger. Caballero was killed in the accident and Bautista sustained injuries. Bautista settled with Charlie’s for workers’ compensation benefits and brought an action against Caballero’s estate.

Mercury brought a declaratory judgment action seeking a determination that the exclusion under its policy precluded coverage for Bautista’s personal injury claim against the estate of Caballero.

On appeal from the circuit court ruling finding that Mercury’s policy must provide coverage, the appellate court analyzed Mercury’s policy exclusion and reversed the judgment.

The appellate court pointed out that there was no dispute that Charlie’s was “an insured,” that Bautista was an employee of Charlie’s, and that Bautista’s injuries arose out of or within the course of his employment. The court rejected Bautista’s argument that the term “an insured” as used in the exclusion refers only to the co-employee driver Caballero, because Caballero was the only “insured” who was a defendant in the action. The court pointed out that, in determining whether or not a given exclusion applies, the insurer must consider not only the particular allegations of the lawsuit, but all of the facts surrounding the accident, as well.

The court also cited earlier Florida case law, agreeing that exclusions such as the one at issue are put in business policies for the benefit of an employer, who is required to protect its employees through workers’ compensation insurance. Otherwise, insurance premiums would necessarily be higher. The court held that judgment in favor of Mercury should have been entered and that there was no coverage for the Plaintiff’s claim against the co-employee driver.
APPEALS/NOTICE OF APPEAL: Failure to comply with requirements of North Carolina Rules of Appellate Procedure is grounds for dismissal of appeal of summary judgment order dismissing claim.


On March 7, 2008, the plaintiff lot owners filed a complaint against multiple defendants regarding modifications to the Declaration for Winget Pond Subdivision. On November 13, 2008, all plaintiffs voluntarily dismissed several, but not all, of the defendants from the action with prejudice. Each of the remaining defendants filed a motion for summary judgment.

On February 4, 2009, the trial court granted defendants' motions for summary judgment. Counsel for one of the plaintiffs filed a notice of appeal, and subsequently withdrew his appeal as to one of the defendants. The remaining defendants thereafter filed a motion to dismiss the appeal. The basis of the defendants' motion was that the appellant did not serve the notice of appeal on all parties, having failed to serve both the non-appealing plaintiffs, as well as the remaining defendants.

The first issue before the Court of Appeals was whether the case could be dismissed on the grounds that the plaintiff failed to serve his appeal on the non-appealing plaintiffs. The Court of Appeals cited to Rule 3 of the North Carolina Rules of Appellate Procedure, stating that a failure to follow the requirements of the Rule required a dismissal of the appeal. Even though the defendants waited more than six months to file their motion to dismiss, the Court held that since the dismissal presented a question of jurisdiction, the Court could address the issue at any time, regardless of whether defendants properly preserved it for appellate review. As a result, the Court rejected the plaintiff's argument that the defendants either did not have standing to bring their motion or that they effectively waived any arguments they may have had regarding standing to consider whether the plaintiff complied with the Rules of Appellate Procedure.

The next issue the Court addressed was whether the notice of appeal must be served on all parties including those who have not chosen to appeal. The Court cited the Rules of Appellate Procedure, which require service upon all parties within the time frame prescribed by the Rule. Therefore, since the plaintiff-appellant did not serve the notice of appeal on all parties, the appeal was properly dismissed under the Rules of North Carolina Appellate Procedure. The Court noted that the appellant's non-compliance with the Rules impaired the Court's task of review and that review on the merits would frustrate the adversarial process. The Court noted that notice to all parties is not a mere formality, but a fundamental requirement of the Rules of Appellate Procedure. The Court also cited to the principles of due process as supporting the finding that a failure to serve the notice of appeal upon all parties is a violation of the Rules of Appellate Procedure, subjecting the appeal to dismissal.
ACCIDENTAL INJURY: Where no unusual or unforeseen circumstance interrupted plaintiff's work routine, even if incident causes plaintiff's injury, it is not “accident” within meaning of Workers’ Compensation Act.

Gray v. RDU Airport Authority, _____ N.C. App. _____, 692 S.E.2d 170, decided April 20, 2010.

On November 20, 2007, Allen Gray was working as a traffic control officer for the RDU Airport Authority. On that date, he was standing outside of a terminal in an adjacent parking lot next to a pedestrian crosswalk, which also served as a speed bump for oncoming traffic. The speed bump was roughly 6 feet wide and 6 inches taller than the surrounding pavement. From the top, the crosswalk sloped downward to the pavement of the roadway. Gray was standing in the crosswalk stopping vehicular traffic to allow pedestrians to use the crosswalk when he stepped backward onto the section of the crosswalk that sloped down to the roadway. He felt a popping sensation in his left leg near his ankle. Ultimately as a result of this injury, Gray underwent surgery to repair his Achilles' tendon and was out of work for several weeks. He also required several months of medical treatment. Gray filed a claim for workers’ compensation benefits.

After conducting an evidentiary hearing in May 2008, the Deputy Commissioner entered an Opinion and Award denying Gray's claim. Gray appealed his case to the full commission, which found that there was no unusual or unforeseen circumstance that interrupted Gray’s work routine and that, although the incident of November 20, 2007 was the cause of the injury, the incident was not an “accident” within the meaning of the Workers’ Compensation Act. Thus, the commission upheld the denial of benefits.

On appeal before the North Carolina Court of Appeals, Gray's attorney argued that unknowingly stepping backward from the flat surface of the crosswalk onto an uneven, angled surface was not part of Gray's normal work routine, but rather was an unexpected event. The employer argued that Gray's normal work routine involved standing, walking and directing traffic. Rejecting this argument, the Court of Appeals noted that Gray himself testified that he routinely had to step backward off the flat portion of the crosswalk as part of his normal work routine. Thus, the Court held the evidence supported the decision that there was no unusual or unforeseen circumstance interrupting his normal work routine when he sustained his injury and, accordingly, upheld the denial of benefits.

COMPENSABLE INJURY: Fall caused by idiopathic condition or physical infirmity is not compensable because injury did not result from accident arising out of claimant’s employment.


On May 8, 2007, while in the scope of his employment, Mr. Watkins sat down on a pallet of feed bags. At one point, Mr. Watkins got up from the pallet, stretched, straightened up and turned left, then walked maybe a half dozen steps before falling on his left hip. Watkins later told the insurance adjuster that his left leg just “gave way” on him somehow or
another and he hit the floor. Watkins was taken to the hospital where he was diagnosed with a hip fracture. Medical tests also revealed that he suffered from chronic blocked coronary arteries. Subsequent testimony revealed that Watkins did not fall as a result of a heart attack, as the condition of his coronary arteries was not consistent with a recent heart attack. Watkins remained in the hospital for several weeks and did not return to work after his fall.

Watkins filed a request for hearing seeking benefits related to his fall. His employer denied the claim on the basis that Watkins’ injuries were the sole result of an idiopathic condition and were not related to his employment. At the hearing, the Deputy Commissioner found that Watkins suffered a compensable injury by accident and awarded him disability and medical benefits. The employer appealed the matter to the full commission, which issued an Order reversing the Deputy Commissioner’s decision on the basis that the fall was due to an idiopathic condition or physical infirmity that caused Mr. Watkins’ leg to give way. The commission further found that Mr. Watkins’ injuries did not result from an accident arising out of his employment with the defendant. Mr. Watkins’ appealed the decision to the North Carolina Court of Appeals.

The Court of Appeals was presented with the issue of whether the commission erred by finding that Mr. Watkins’ fall was not the result of an accident arising out of his employment. The Court noted that there was no dispute that the plaintiff had an accident. The Court further noted that, while Watkins was clearly within the course of his employment at the time of his fall, he was also required to establish some causal connection between the injury and his employment.

The Court noted that the word “idiopathic” has two definitions: (1) arising spontaneously or from an obscure or unknown cause and (2) peculiar to the individual. The commission used the term “idiopathic” in the first sense: plaintiff’s fall was spontaneous and “due to an unknown physical infirmity.” The Court found that there was no evidence in the record explaining a cause for the fall other than the fact that Watkins’ leg “gave way” and he fell. Since there was no evidence to establish a causal connection between the work being performed and the injury sustained, the court upheld the conclusion that his fall was due to an idiopathic condition and upheld the denial of benefits.

HOLDOVER COMMISSIONER: The Industrial Commission correctly denied defendant’s motion to vacate award made during holdover period by panel on which holdover commissioner was member of two-to-one majority.


On February 5, 2007, by a two-to-one majority, a panel of the full commission filed an Opinion and Award ordering defendant Danny Nicholson, Inc. to pay plaintiff Robert Baxter workers’ compensation benefits, including total disability benefits, medical expenses, a 10% penalty on all unpaid installments of compensation, the standard attorney fee award in such cases, and additional attorney fees for the time spent by plaintiff’s counsel on the matter.

The full commissions’ Opinion and Award was filed on February 5, 2007. However, the document was signed and dated by the panel on February 2, 2007. On that same date, then Governor Michael Easley sent a letter to Commissioner Thomas Bolch, a member of the two-person majority of the panel, informing him that his service as a commissioner was at an end and that his successor had been appointed. Commissioner Bolch’s term had actually expired in 2004 and he had been holding over in his position since that time. The Governor sent another letter, also dated February 2, 2007, to the replacement commissioner, Danny Lee McDonald, notifying him that his appointment was “effective immediately.” Commissioner McDonald did not take the oath of office until February 9, 2007.
According to an affidavit from a member of the Governor’s staff, Commissioner Bolch was authorized to hold over in this position until the date of the swearing in of Commissioner McDonald, which took place on February 9, 2007. The affidavit went on to state that one of the important reasons for Commissioner Bolch being specifically authorized to hold over until McDonald was sworn in was to give the Industrial Commission time to issue and file any decisions which had already been heard on oral argument by panels involving Commissioner Bolch, but which were pending the filing of a formal opinion and award. Based upon the filing of the Opinion and Award after the date that Commissioner Bolch’s successor had been appointed, Danny Nicholson, Inc. filed a motion to vacate the decision and for reconsideration and rehearing.

Although there was a dispute with respect to the nature of plaintiff’s trial return to work, and the defendant alleged unilateral termination of plaintiff’s benefits, the main issue before the North Carolina Supreme Court was whether the term of an appointed public officer ends immediately upon the appointment of his successor by the Governor or when the successor takes the oath of office. The Supreme Court relied on the plain meaning of the statute and concluded that the authority of an appointed office continues until the date on which the successor takes the oath of office in question and thereby becomes duly qualified to begin performing the duties of that office.

APPEALS: In order to preserve right to appeal to full commission, appealing party must timely file and serve Form 44 and brief within 25 days of receipt of official hearing transcript.


On August 30, 2006, the plaintiff’s claim was heard before Deputy Commissioner George Glenn, II. Deputy Commissioner Glenn ruled in favor of the defendants on August 28, 2008, concluding that the plaintiff had failed to establish that he developed an occupational disease as a result of his employment with the defendant-employer. Plaintiff appealed to the Industrial Commission.

The Industrial Commission issued a notice that the matter was scheduled for hearing on the February 9, 2009 docket. Defendants filed a motion to dismiss plaintiff’s appeal on December 17, 2008, stating that plaintiff failed to timely file and serve his Form 44 and his appellant’s brief within 25 days of the receipt of the transcript pursuant to Rule 701(2) of the North Carolina Industrial Commission. Plaintiff submitted a response dated December 29, 2008, entitled “Plaintiff’s Response in Opposition to Defendant’s Motion to Dismiss, Motion for a Continuance of Hearing and Motion to Deem Brief in Full Commission as Timely Filed.” Plaintiff also filed his Form 44 and his appellant’s brief with the Industrial Commission on December 29, 2008.

The issue before the Court of Appeals was whether the Industrial Commission committed reversible error by granting defendants’ motion to dismiss citing abuse of discretion and insufficient evidence to support defendants’ motion. The Court of Appeals held that where a party fails to file any documents whatsoever setting forth the grounds for appeal, the appeal is deemed abandoned. The Court noted that plaintiff failed to timely file a Form 44 and an appellant’s brief setting forth the grounds for appeal, thereby abandoning his appeal. As a result, the Court found the Industrial Commission’s interpretation of the Rule to be proper.

The Court of Appeals noted that plaintiff conceded in his brief that the defendants received a copy of the plaintiff’s brief and Form 44 approximately 21 days after the appropriate filing date. The Court rejected the plaintiff’s argument that, since the brief and Form 44 were received 44 days prior to the date set for oral argument, he had essentially complied with the Rule. The Court noted that Rule 801 allows the Commission to waive a violation of the rules in
the interest of justice, but that such a waiver is discretionary. The Court found that there was no abuse of discretion allowing it to overturn the determination of the Industrial Commission.