LEGAL UPDATE
November 2012

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Hurdling The Collateral Source Rule

By: Robert M. Darroch and Adam C. Joffe

The complexities of health care pricing structures make it difficult to determine whether the amount paid, amount billed, or an amount in between represents the reasonable value of medical services. Historically, hospitals billed insured and uninsured patients similarly. Mark A. Hall & Carl E. Schneider, Patients as Consumers: Courts, Contracts and the New Medical Marketplace, 106 Mich. L. Rev. 643, 663 (2008). With the advent of managed care, some insurers began demanding deep discounts, and hospitals shifted costs to less influential patients. Id. Along with health insurance came the advent of “UCR” fees (Usual Customary Reasonable), and these fees gave health insurers consistency and objectivity in determining the reasonableness of fees charged. Id. Health insurers now generally pay about forty cents per dollar of billed charges and hospitals accept that amount in full satisfaction of billed charges. Id.

In many states, the tort system has adapted to the way business is done in the medical profession. All too often, defense lawyers, attorneys, judges and juries accept medical bills as a true reflection of the reasonable value of the service provided. A plaintiff may be billed $100,000 for medical services and may pay a $1,000 deductible, leaving $99,000 for the health insurer. The health insurer then pays $40,000 of the $99,000. The hospital writes off the difference. Should the jury know of the discount? Was the $100,000 a reasonable charge if the hospital knew it would never receive payment for the amount billed?

For example, in Georgia, medical bills are considered an item of a plaintiff’s special damages. “In all cases, necessary expenses consequent upon an injury are a legitimate item in the estimate of damages.” O.C.G.A. § 51-12-7. “As to medical expenses, such as hospital, doctor, and medicine bills, the amount of the damage would be the reasonable value of such expenses as was reasonably necessary.” Allen v. Spiker, 301 Ga. App. 893, 895 (2009)(emphasis added); See Council of Superior Court Judges, Suggested Pattern Jury Instructions, Vol. I: Civil Cases, § 66.040 (5th ed. 2007).

While a plaintiff is permitted to recover only the “reasonable value of ... expenses as was reasonably necessary,” it begs two questions given the complexities associated with the pricing of medical services: (1) “What is reasonable value?” and (2) “How do you prove it?”
Assume that the plaintiff is involved in an accident and suffers injuries ultimately resulting in surgery and other medical care. In most cases, the plaintiff has private health insurance or qualifies for a Medicaid or Medicare program. Immediately following the care a bill or invoice is generated showing the amount billed per procedure. On the bill, a contractual adjustment is generally noted and the bill is reduced in some cases to an amount less than 50% of what was actually billed.

During the litigation, the plaintiff claims he or she has medical bills totaling $500,000. However, the bills were adjusted downward by the healthcare providers and ultimately $200,000 was accepted in full satisfaction of the bills by the healthcare providers and the remaining balance of $300,000 is written off by the provider.

What is the reasonable value of the medical services? Are the $500,000 in total invoices the reasonable value of the expense even though the hospitals, doctors and other healthcare practitioners accepted $200,000 for those same services? Is $200,000 the reasonable value of the services or procedures where the rates were set by volume based discounts from health insurance carriers? Is there some other measure as to the actual reasonable cost of the medical service that is performed that is not reflected on the bills or invoices?

In some states, there is a clear answer. In others, there is none. In 40 states, the defendant may be allowed to introduce evidence of the collateral source, offset collateral source payments, or limit the plaintiff to proof of the amount paid. Some of the states that modify the collateral source rule include:

Alabama: Ala. Code § 6-5-545 permits the admissibility of evidence of collateral source payments.

Alaska: Alaska Stat. § 9.17.070 permits the admissibility of evidence of collateral source payments. Provides for awards to be offset, less any amount paid by the claimant to secure the benefit, e.g., insurance premiums.

Arizona: Arizona Revised Statutes § 12-565 permits the admissibility of evidence of collateral source payments in all civil liability cases.

Colorado: Colo. Rev. Stat. § 13-21-111.6 permits the admissibility of evidence of collateral source payments. Provides for awards to be offset with broad exclusions.

Connecticut: Conn. Gen. Stat. Ann. § 52-225a permits the admissibility of evidence of collateral source payments. Provides for awards to be offset by the amount paid by collateral sources less any amount paid by the claimant to secure the benefit.

Florida: F.S.A. § 768.76 requires that judges reduce the amount awarded for past medical or lost wages by the amount that any health or disability insurance company for which there is no right of reimbursement.

Illinois: 735 Ill. Comp. Stat Ann. § 5/2–1205 Provides for awards to be offset for benefits over $25,000, as long as the offset does not reduce the judgment by more than 50%.

Maine: Maine Revised Statute § 2906 provides for awards to be offset by collateral source payments, where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff.

Minnesota: Minn. Stat. Ann. § 548.36. Permits the admissibility of evidence of collateral source payments only for the court’s review. Provides for awards to be offset by collateral source payments, unless the source of reimbursement has a subrogation right.
Missouri: Missouri Revised Statute § 490-715 modifies the collateral source rule to allow the actual amount of paid medical expenses to be introduced into evidence rather than the amount billed.

Ohio: Ohio Revised Code § 2323.41 provides that collateral source benefits can be introduced into evidence, except under certain circumstances.

Oklahoma: Permits the admissibility of evidence of collateral source payments, unless the court determines the payment is subject to subrogation or any other right of recovery.

Oregon: Or. Rev. Stat. § 18.580 permits a judge to reduce awards for collateral source payments, excluding life insurance and other death benefits, benefits for which plaintiff have paid premiums, retirement benefits, disability benefits, pension plan benefits, and federal social security benefits.

Pennsylvania: Prohibits a patient from suing a health care provider for damages that were paid by a health insurer.

Why aren’t more southeastern states on the list? What can be done to ensure that juries know the true value of health care services?

1. **How Do Plaintiffs Prove Their Expenses?**

   In Georgia, the plaintiffs have it easy. O.C.G.A. § 24-7-9 deals with the evidentiary foundational requirements to prove the value of a medical bill at trial. According to O.C.G.A. § 24-7-9:

   (a) Upon the trial of any civil case involving injury or disease, the patient or the member of his family or other person responsible for the care of the patient shall be a competent witness to identify bills for expenses incurred in the treatment of the patient upon a showing by such witness that the expenses were incurred in connection with the treatment of the injury, disease, or disability involved in the subject of litigation at trial and that the bills were received from:

   (1) A hospital;
   (2) An ambulance service;
   (3) A pharmacy, drugstore, or supplier of therapeutic or orthopedic devices; or
   (4) A licensed practicing physician, chiropractor, dentist, orthotist, podiatrist, or psychologist.

   (b) Such items of evidence need not be identified by the one who submits the bill, and it shall not be necessary for an expert witness to testify that the charges were reasonable and necessary. However, nothing in this Code section shall be construed to limit the right of a thorough and sifting cross-examination as to such items of evidence.

   The plaintiff or member of his or her family, as a matter of law, regardless of their background or expertise, is considered a competent witness to “identify bills for expenses incurred in the treatment of the patient,” and to testify the expenses were incurred in connection with the treatment of injury or disease involved in the subject of the litigation at trial.

   O.C.G.A. § 24-7-9 (b) further states that “it shall not be necessary for an expert witness to testify that the charges were reasonable or necessary. The Georgia legislature completely obviated a plaintiff's need to present any testimony by a nurse, doctor, healthcare professional or medical billing expert.
Applied practically during a trial, the plaintiff is handed his or her bill, he or she says “yes this is the bill, I received it, incurred the cost and it was incurred as a result of this accident.” The plaintiff has met the threshold requirement to tender the medical bills into evidence and they go to the jury.

The defendant or opponent has a much tougher road to challenge the reasonableness of the bill. O.C.G.A. § 24-7-9(b) permits the defendant or opponent to “cross examine” the evidence. On cross examination the plaintiffs generally admit they don’t know why or even how the healthcare practitioners generate the charge. The same is usually true for the medical providers that generated the charge. Most don’t know why or how the charge is calculated or even whether the charge for the procedure is reasonable. In most cases it is simply what the insurance companies agree to reimburse for the procedure.

The intuitive approach would be to cross examine the plaintiff with the amount of the write off to get into evidence that the medical provider accepted 50% less than what was billed. Unfortunately, this type of evidence in Georgia is barred by the collateral source rule.

“The common law rule in Georgia bars the defendant from presenting any evidence as to payments of medical, hospital, disability income, or other expenses of a tortious injury paid for by a plaintiff, governmental entity, or third party and taking credit towards the defendant’s liability in damages for such payments, because a tortfeasor is not allowed to benefit by its wrongful conduct or mitigate its liability by collateral sources provided by others.” Olariu v. Marrero, 248 Ga. App. 824, 549 S.E.2d 121 (2001). In Olariu, the defendant attempted to introduce the hospital bill showing the write off; however, the trial court refused to permit evidence of the write off and considered it a collateral source. The Georgia Court of Appeals agreed the write off was collateral source evidence and not admissible.

Most recently, this issue was raised as it related to estimated future medical expenses in Mallette v. Nash, 2011 WL 720201 (M.D.Ga., Feb. 22, 2011) where the defendant intended to introduce evidence that the plaintiff’s physician had a pre-arranged agreement to accept a reduced fee for future medical treatment. The trial judge found the pre-arranged agreement, i.e. health insurance, was a collateral source and therefore inadmissible at trial to contest the reasonableness of the future medical expenses.

2. How do Defendants Circumvent the Collateral Source Rule?

Given the strength of the collateral source rule, a defendant must be creative. For a jury to fairly understand the plaintiff’s damages, circumventing the collateral source rule is necessary. How is it done?

a. Impeachment

The age old way of introducing collateral sources was impeachment. The plaintiff says something like “I couldn’t afford that treatment” or “I didn’t continue to follow up with Dr. Smith because I couldn’t afford the time off work” or “those physical therapy treatments cost too much and so I quit going.” After that testimony, the defense attorney goes “gottcha!”

In those circumstances many states that rigidly prohibit evidence of collateral source payments will allow the evidence for purposes of impeachment. For case law examples, see:


b. Reasonableness of the Bills

A second approach is to challenge the reasonableness of the bills. For example, the Indiana Supreme Court addressed the issue in Stanley v. Walker, 906 N.E.2d 852, (Ind. Sup. Ct. 2009). In that
decision the Court determined the defendant had the right to admit evidence of the discounted amounts of the plaintiff's damages without reference to insurance or the actual collateral source. The Court reasoned that this information was crucial to the jury's award, which is limited to reasonable medical bills actually incurred. The actual value of medical services is not exclusively based on the actual amount paid or the amount originally billed, though these amounts are evidence as to the reasonable value of medical services.

One approach we use in large cases is to hire an expert solely to address the reasonableness of the medical bills, not the reasonableness of the treatment. What foundation is required for the expert's testimony? Obviously, they need experience in billing and collections (and possibly coding) in the health care industry. The expert must have unique knowledge of the value of the medical care provided to the plaintiff possibly without any regard for discounts, health insurance or any other third party payer agreement.

With the right experience, the expert may be able to testify concerning their experience with the difference between the bill and the amount accepted by the health care provider or about the amount the provider contractually agreed to accept under a particular health care plan. Another approach is to use the workers' compensation fee schedule as a basis for a "reasonable" charge. Still another is to cross examine the plaintiff's treating physician's testimony about reasonableness by showing the amount his office regularly accepts as payment as opposed to the amount billed.

Care should be taken to hire the correct expert. For example, did the expert take the national board examination in medical coding? Is the expert a Registered Medical Coder? See, State Farm Mut. Auto. Ins. Co. v. Bowling, 81 So.3d 538 (Fla.App. 2 Dist., 2012).

c. Reduction of the Recovery to the Amount Paid by the Collateral Source

Florida may have reached the most interesting compromise. Section 768.76, Florida Statutes (2009), requires that the damages awarded to compensate a claimant for losses sustained be reduced by the total amounts paid for the benefit of the claimant, or otherwise available to the claimant, from all "collateral sources."

"Collateral sources" are defined, in part, as:

(a) "Collateral sources" means any payments made to the claimant, or made on the claimant's behalf, by or pursuant to:

1. The United States Social Security Act, ... any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits....

2. Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the claimant, whether purchased by her or him or provided by others. . . .

3. Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.

§ 768.76(2)(a)(1, 2 and 4), Fla. Stats.

The jury is informed of the full amount charged but the judge reduces the amount of the verdict by the amount paid by the collateral source. That leads to an even different anomaly.
In our example above, the plaintiff is billed $100,000. The plaintiff pays $1,000. The health insurer pays $40,000 and the health care provider writes off $59,000. The jury is told the reasonable bill was $100,000. After the verdict, the trial court judge reduces the verdict by $40,000 because that is the amount paid by the health insurer as a collateral source. If the jury awarded the entire $100,000 bill, then the plaintiff ends up “ahead” $59,000, the amount written off by the health care provider.

**CONCLUSION**

Even though often unfair, the collateral source rule is entrenched in case law in the Southeast. Some states have legislatively modified the rule or carved exceptions to it. Even in those states, care should be taken to challenge the unfairness where a plaintiff has arbitrary and inflated initial invoices. An aware defendant can attack the reasonableness of the plaintiff’s medical bills with the right expert. As the discrepancy between what is billed versus what is paid continues to increase, we expect to see the involvement of experts on the issue of reasonableness of medical expenses to become even more common in personal injury litigation.
DAMAGES: Consequential damages for total vehicle loss do not include loan deficiency.


After their vehicle was damaged in an automobile accident on November 25, 2008, Michelle and Timothy McIntire filed a lawsuit against Misty Perkins to recover the amount of money owed on the car above the fair market value (i.e. the “loan deficiency”).

The McIntires’ vehicle was deemed a total loss and they received $23,000.00 for the fair market value of their vehicle. At the time of the accident, the McIntires had a loan on the vehicle through Honda Financial Services and owed $32,294.90. After receiving the insurance proceeds, the McIntires still owed a deficiency of $9,924.90.

The McIntires argued they were entitled to recover the loan deficiency from Perkins. Perkins moved for partial summary judgment, and the trial court agreed that the McIntires could not recover the $9,924.90 from Perkins.

The Georgia Court of Appeals affirmed finding that “the measure of damages for the total loss of a vehicle is limited to the difference in the fair market value immediately before and after the accident.”

A plaintiff cannot recover more than the fair market value of the vehicle because such an award would put the plaintiff in a better position following the accident. Thus, if the McIntires could recover for the loan deficiency, then they would be placed in a better position after the accident than they were before the accident, because they would be able to recover $32,294.90 in damages for a vehicle only worth $23,000.00.

The Court of Appeals further reasoned that the loan deficiency could not be recovered as consequential damages. “Consequential damages are those which are the necessary and connected effect of a tortious act . . .” Where the damages are not the legal and natural consequence of the accident, then the damages are too remote to be recovered as consequential damages. Where other circumstances “preponderated” [a greater cause] in causing the injury, then the damages are too remote to recover.

At the time of the accident, based on the contract the McIntires entered into with Honda, they owed more money on their loan than the vehicle was worth. Accordingly, the Court of Appeals reasoned that even if the deficiency could be deemed a result of the accident, other circumstances “preponderated” in causing the deficiency. As a result, the loan deficiency is too remote and contingent to be recovered as consequential damages.

Accordingly, because the McIntire’s claim for the loan deficiency was not supported by Georgia law, the trial court was correct in finding for Perkins.

*Summary prepared by James T. Hankins, III, jhankins@qmlj.com.*
TORTS/IMPUTED NEGLIGENCE/VICIOUS ANIMALS: Plaintiff in a dog bite case cannot recover against the dog's owner without evidence of a dog's propensity to bite and an owner's knowledge of such propensity.


Maureen Stennette filed a lawsuit against Robin Miller after she was bitten multiple times by Miller's dog. Stennette was providing nursing services to Miller's elderly mother at Miller's house when she was bitten. On the day of the incident, as part of her routine practice, Stennette called Miller on her way to her house and asked Miller to confine her dogs before Stennette arrived.

Miller put her dogs in her fenced backyard and left to run some errands, leaving only her mother and the housekeeper at home. Somehow the dogs got into the house through the back door and, when Stennette walked in the house, one of them bit her more than 20 times, causing her to sustain significant injuries.

The trial court granted Miller's motion for summary judgment as to Stennette's claims of liability based on 1) the dangerous animal liability statute (O.C.G.A. § 51-2-7), 2) the premises liability statute (O.C.G.A. § 51-3-1) and 3) her alleged negligent performance of a voluntarily-undertaken duty. Stennette appealed the trial court's decision on all three claims.

The Court of Appeals held that "a plaintiff in a dog bite case [under O.C.G.A. §§ 51-2-7 and 51-3-1] must show that the owner had knowledge that the dog had a propensity to commit the act that caused the injury." This burden cannot be satisfied through evidence of a dog's menacing behavior alone; in order "to infer the requisite knowledge, there must be at least one incident that would cause a prudent person to anticipate the actual incident that caused the injury."

In this case, there was no evidence that Miller's dog had ever bitten anyone. In fact, in her deposition, Stennette testified that she did not have any information about any of Miller's dogs ever biting anyone, other than her. As such, the Court of Appeals agreed with the trial court's decision on both of those claims.

However, the Court of Appeals reversed the trial court's decision in granting summary judgment to Miller on Stennette's negligence claim. The Court of Appeals found that under Georgia law, “[w]hen one undertakes an act that he has no duty to perform and another person reasonably relies upon the undertaking, the act must generally be performed with ordinary or reasonable care” and the “person assuming such responsibility may be held liable for negligently performing the duties so assumed.”

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

TORTS/SLIP AND FALL: Plaintiff cannot recover for injuries sustained from a slip and fall where she cannot prove, beyond mere conjecture or speculation, what caused her fall.


Rosemary Hiner filed a lawsuit against El Ranchero Mexican Restaurant after she slipped and fell while walking to the bathroom. Hiner argued she noticed an area of tile in front of the kitchen door that was slippery. She further testified she did not look down to determine why the floor was slippery, but when she returned from the restroom, she took careful steps to prevent herself from slipping.

Hiner fell and broke her leg when crossing the same area. She testified that after the fall she did not look to see what caused the fall; she did not know if any substance was on her clothing; she did not notice any defect in the floor and did not observe any substance on the floor; but she did believe there was a film on the tile.
Hiner further testified that she had been to the restaurant on several occasions and sometimes “slipped a little bit” because the ceramic tile had a film on it. El Ranchero filed a motion for summary judgment which was subsequently denied by the trial court.

On appeal, the Court of Appeals found that: (1) based on Hiner’s admissions, she had knowledge of the allegedly slippery condition that was at least equal to the knowledge of El Ranchero; and (2) El Ranchero’s reasonable cleaning and inspection procedures precluded any liability for the restaurant. The Court noted that the threshold point of inquiry into a slip and fall case is the existence of a hazardous condition on the premises and that proof of a fall, without more, does not create liability on the part of a proprietor or landowner.

The Court of Appeals further held that when a plaintiff does not know of a cause or cannot prove the cause of her/his fall, there can be no recovery because an essential element of negligence (causation) cannot be proven. The mere possibility of causation is not enough, and such speculation or conjecture makes summary judgment appropriate.

Hiner was therefore required to prove more than just the fact that the floor was slippery. She needed to prove the condition of the floor constituted an unreasonable hazard and that El Ranchero had superior knowledge of that hazard.

Hiner could not prove she lacked equal knowledge of the hazard. On the contrary, on several occasions, including just before her fall, she was aware of the slippery conditions in that area of the restaurant, had actual knowledge of the condition at the time of her fall, and failed to exercise due care for her own safety.

Finally, the Court of Appeals found the daily cleaning and inspection procedures (degreasing every morning and requiring employees to report or fix any problems) prevented liability on the part of El Ranchero for the alleged hazard at the time of Hiner’s fall. Accordingly, the Court of Appeals reversed the trial court and granted El Ranchero’s motion for summary judgment.

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

INSURANCE COVERAGE: Tractors with attached bush hogs are “motor vehicles” for purposes of statute providing that governmental entity’s purchase of insurance for loss arising out of negligent use of motor vehicle waived its immunity to the extent of amount of insurance purchased.


Jonathan Glass and Tony Smith, inmates at the Troup County Correctional Institution, were operating tractors with attached bush hogs when one tractor got stuck in a ditch. While pulling the tractor out of the ditch, the bush hog was engaged, which caused a rock to hit Glass in the throat. Glass bled profusely and died. Glass’ minor son and the executor of his estate brought suit against the county and Glass’ supervisor for wrongful death.

The county sought summary judgment, claiming plaintiffs’ claims were barred by sovereign immunity because the tractor and bush hog are not “motor vehicles.”

O.C.G.A. § 33-24-51(a) provides in relevant part that a county is authorized to secure and provide insurance to cover liability for damages for bodily injury or death arising from use of any motor vehicle by the county,
whether in a governmental undertaking or not. Section (b) provides that governmental immunity for a state officer is waived to the extent of the amount of the insurance purchased. O.C.G.A. § 36–92–1 defines motor vehicle narrowly as “any automobile, bus, motorcycle, truck, trailer, or semitrailer, including its equipment, and any other equipment permanently attached thereto, designed or licensed for use on the public streets, roads, and highways of the state.”

The Supreme Court found the broader definition of “motor vehicle” should be applied under O.C.G.A. § 33-24-51 and therefore, the tractor with a bush hog was a motor vehicle. The Court had previously determined that “any motor vehicle” refers to a vehicle that (1) can be driven on public roadways and (2) is covered by liability insurance policy purchased by a governmental agency. Because the tractor and bush hog could be driven on a public roadway and the county had purchased a liability policy providing coverage for the operation of the bush hog, the county had waived sovereign immunity to the extent of the liability policy.

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

BREACH OF DUTY TO DEFEND: An insurer cannot both deny a claim outright and attempt to reserve the right to assert a different defense to the claim in the future.


On October 20, 2004, James Hoover, an employee at Emergency Water Extraction Services, LLC (“EWES”), was instructed by his supervisor to deliver a ladder to an independent roofing contractor. Hoover’s job duties did not include using ladders or making roof repairs. At the request of the contractor, Hoover agreed to assist him in carrying repair materials from the job-site up to the roof of the building. While Hoover was descending the ladder, he fell to the ground and suffered a serious brain injury.

On September 22, 2006, Hoover filed a personal injury lawsuit against EWES, who was insured by Maxum Indemnity Company (“Maxum”), and later obtained a $16.4 million dollar verdict against EWES. In the interim, Maxum denied coverage because of the Employer Liability Exclusion. Maxum also tried to reserve its right to claim other defenses, such as a failure to comply with the notice provision of their policy. Additionally, Maxum filed a declaratory judgment action against EWES, but this action did not refer to a failure to comply with the notice provisions at all. After receiving an assignment of claims from EWES, Hoover then filed his lawsuit against Maxum, asserting a breach of the duty to defend.

Both Hoover and Maxum filed summary judgment motions with the trial court regarding the duty to defend and the notice provision. The trial court partially granted Maxum’s motion for summary judgment as to the notice provision, because EWES did not provide Maxum timely notice. The trial court also partially granted Hoover’s motion concerning the duty to defend.

The Court of Appeals agreed with the trial court’s decision involving timely notice, but reversed the trial court’s ruling on the duty to defend. The Supreme Court of Georgia agreed to review the case to determine (1) whether Maxum waived its right to assert a defense based on untimely notice and (2) whether timely notice was a prerequisite to having a duty to defend in the underlying lawsuit.

The Supreme Court found that an insurer is not permitted to deny a claim and attempt to reserve the right to assert a different defense in the future. The proper course of action is entering a defense under a reservation of rights and then proceeding with a declaratory judgment action. In this case, a reservation of rights was unavailable because Maxum had already denied coverage to EWES. Further, the reservation was defective because it did not unambiguously inform EWES that Maxum intended to pursue a defense on untimely notice of a claim. As a result, the Court of Appeals was not correct in finding that Maxum was able to deny the claim and issue a reservation of rights.
The Supreme Court further stated that Georgia law does not favor denying insurance coverage, and that courts of this state tend to construe these policies in favor of the insured. When Maxum filed its declaratory judgment action, it did not mention a defense based on untimely notice and focused exclusively on the liability exclusion. This action constituted a failure to fairly inform EWES; therefore, Maxum breached its duty to defend EWES. Accordingly, the Supreme Court reversed the decision of the Court of Appeals in all respects.

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

AUTOMOBILE INSURANCE COVERAGE: Sexual assault taking place in a vehicle does not arise out of the ownership, maintenance or use of a vehicle for insurance coverage purposes.


State Farm filed a declaratory judgment action seeking to clarify its obligations under insurance policies issued to Jesse Johnson, wife of Kenneth Johnson. Kenneth Johnson used a minivan covered under his wife’s policy to drive Medicaid patients to and from medical appointments. On February 20, 2008, Kenneth Johnson drove DeAnna Myers and her adult ward, D.M., to a medical appointment. Also present in the vehicle, was Kenneth Johnson’s brother, Dondi. On the return trip, Dondi sat in the backseat with D.M. When Myers fell asleep, Dondi proceeded to inappropriately touch D.M. without her consent. Dondi later plead guilty to sexual assault.

Myers subsequently brought suit for damages on behalf of D.M. against Kenneth Johnson. State Farm brought a separate declaratory judgment action that its policy issued to Jesse Johnson did not cover damages alleged by Myers. State Farm and Myers filed cross motions for summary judgment in the Declaratory Judgment Action. State Farm asserted that the damages alleged in the underlying suit did not arise out of the ownership, maintenance, or use of the car, as required for coverage under the policy. The trial court granted summary judgment in favor of Myers and denied summary judgment to State Farm. State Farm appealed.

The Court of Appeals reversed the trial court’s grant of summary judgment in favor of Myers, reasoning that there must be more of a connection between the use of the vehicle and the resulting injuries. Mere presence in the vehicle when the injury was sustained was not enough to show that the injuries arose out of the vehicle’s use.

Myers argued that the use of the car was causally connected to D.M.’s injuries because without the use of the car, it was unlikely that Dondi would ever have been able to assault D.M. Myers argued further, that the smaller size of the vehicle and presence of seat belts prohibited D.M. from avoiding her attacker. Finally, Myers argued that D.M.’s injuries arose out of Kenneth Johnson’s negligent operation (inattentiveness) of the vehicle. The Court of Appeals rejected all three of Myers’ arguments.

As to Myers’ first argument, the Court stated that the proximity of the attacker and victim within the confines of a moving vehicle did not present the causal connection required for the injuries to be covered under the policies. The Court rejected Myers’ second and third arguments because previous cases had already rejected arguments based on opportunities afforded an assailant by the structure of the vehicle or the inattentiveness of the driver. Thus, the Court held that D.M.’s alleged injuries did not arise out of the use of the vehicle because the minivan was nothing more than the loosely connected site of the attack.

Summary prepared by Neil T. Lyons, nlyons@gmlj.com.
SETTLEMENT OFFER AND ACCEPTANCE: Response to settlement offer that indicates liens must be satisfied constitutes a counteroffer, rather than an acceptance, when the offer was silent on the existence and satisfaction of liens.


Torres and Elkin were involved in a car accident which resulted in Torres incurring over $500,000 in medical expenses. Torres offered to settle with Elkin's liability insurer in exchange for the $25,000 policy limits, verification of the policy limits, a certified copy of the policy, and a limited liability release that did not contain any language that Torres had not relied upon any representations by the Elkin's insurer.

Two weeks later, the insurer wrote to Torres' counsel advising that it was preparing a response to his settlement offer and asked whether Torres would agree to satisfy any medical liens arising from the accident. The insurer never received a response.

The next day, the insurer wrote to Torres' counsel in response to the settlement offer. The letter noted that Torres' counsel had already received the $25,000 check and requested documents. The letter enclosed a proposed limited liability release that included indemnification language. The insurer explained that it included the indemnification language in the release because it had received notice of hospital liens and had not received a response as to whether Torres would satisfy the liens. The letter to Torres' counsel went on to emphasize that the insurer "trust[s] that your office will satisfy any liens arising out of this matter."

Torres' counsel responded that his client would not accept the insurer's counteroffer and would not protect against hospital liens. The next day, the insurer sent Torres a release that did not contain the indemnification language.

Torres filed suit against Elkin who moved to enforce the settlement agreement. The trial court found that the insurer had accepted Torres' settlement offer and a binding settlement agreement had been reached.

The Court of Appeals reversed, finding that the insurer's response to the offer was a counteroffer, not an acceptance. At issue was whether the insurer's statement that it “trust[s] that your office will satisfy any liens arising out of this matter” constituted an additional term of the settlement or mere confirmation of a term of the agreement.

The Court concluded that the insurer's statement regarding liens was a counteroffer because it imposed an additional requirement that Torres satisfy his medical liens. The Court contrasts this to a simple inquiry as to whether Torres would agree to satisfy any liens or a statement of the insurer's understanding of the matter which likely would not constitute a counter-offer.

Torres' offer did not offer to satisfy hospital liens and made no representations regarding the existence of any liens. Consequently, the insurer's statement that it trusted Torres to satisfy any liens imposed an additional settlement term. As a result, the insurer's response was a counteroffer rather than an unconditional and unequivocal acceptance of the offer, so no settlement agreement was reached.

*Summary prepared by R. Tyler Bryant, tbryant@gmlj.com.*
SUBSEQUENT INJURIES WHILE OBTAINING MEDICAL TREATMENT FOR A COMPENSABLE INJURY: Unless the Employer schedules the appointment and mandates that the employee attend, injuries while traveling to and from treatment are not compensable.


Juarez worked on Decostar’s production line moving automobile bumpers from the floor to a chest-level bench, cutting two holes in them, sanding them, and moving them to another work station. Juarez reported pain in her right shoulder and arm to the Employer, but no medical treatment was offered. She went to her personal physician, who referred her to Dr. Colpini, an orthopedist.

Juarez reported neck and bilateral shoulder pain to Dr. Colpini. An MRI showed mild to moderate neuroforaminal stenosis at C5-6, which Dr. Colpini believed was the cause of her pain. He also diagnosed tendinosis, shoulder impingement, and a pre-existing C6-7 fusion that may have made the C5-6 condition worse. He concluded that her work activities aggravated her pre-existing conditions.

After quitting her job, Juarez went to Dr. Karsch, who diagnosed rotator cuff tendinopathy and impingement syndrome that he felt caused, rather than aggravated, the injury. Juarez then went to Dr. Wells, who agreed with Dr. Karsch.

After a hearing, the ALJ accepted Dr. Colpini’s opinion that Juarez’s job duties aggravated her pre-existing condition, denied TTD benefits as she had been released to light duty and suitable work was available, and designated Dr. Colpini as her authorized treating physician. The Appellate Division adopted the ALJ’s decision.

The superior court reversed, finding no evidence that Juarez had a pre-existing condition, requiring that Dr. Karsch be designated as her authorized treating physician, and requiring the employer to pay Dr. Karsch’s bills.

The Court of Appeals reversed the Superior Court. The State Board makes determinations about the credibility of witnesses and the weight to be given to testimony, not appellate courts. Although Dr. Colpini’s testimony differed from that of Dr. Karsch and Dr. Wells, the Board was entitled to believe Dr. Colpini, and his testimony and Juarez’s records were “some evidence” to support the finding that Juarez’s work aggravated a pre-existing condition. Therefore, the superior court was obligated to uphold that ruling.

The standard of review from a decision regarding a change in physicians is whether or not the Board acted arbitrarily or in excess of its powers. Given that the Board believed Dr. Colpini’s diagnosis, it was not arbitrary or capricious to designate him to provide treatment rather than Dr. Karsch, whose diagnosis the Board had rejected.

Because Dr. Karsch was not Juarez’s authorized treating physician, his treatment was unauthorized, and the employer was therefore not responsible for payment of his bills.

Summary prepared by Neal B. Childers, nchilders@gmtj.com.
DEFERENCE TO FACTUAL FINDINGS MADE BY STATE BOARD: The State Board makes determinations about the credibility of witnesses and the weight to be given to testimony, not appellate courts. When there is “some evidence” to support the finding, the superior court must uphold the Board’s ruling.


Flores sustained a work-related injury to his back. The employer accepted the claim and provided both income and medical benefits. Flores scheduled an appointment with the authorized treating physician. He requested the insurer provide transportation to the appointment, which it did. On his way home from the appointment, the vehicle was hit from behind by another vehicle. Flores struck the dashboard and lost consciousness. He was diagnosed with trauma to his chest, abdomen, and pelvis, a neck sprain, and contusions to both knees.

Flores’ doctor had diagnosed herniated discs in his cervical spine and lumbar spine prior to the vehicle accident, and that diagnosis did not change. Nevertheless, the employer suspended medical benefits on the ground that the intervening accident had potentially left Flores permanently disabled.

Flores requested a hearing. The ALJ concluded that the motor vehicle wreck was work-related and ordered the Employer to continue to provide treatment for the initial injury and provide treatment for the injuries Flores sustained.

On appeal, the Appellate Division found that the motor vehicle wreck did not break the chain of causation from the original injury. Without analyzing the motor vehicle wreck, the Appellate Division adopted the Administrative Law Judge’s conclusions.

The superior court reversed the Appellate Division’s ruling, finding that the Board had misapplied the law concerning accidents occurring on the way to or from medical appointments. Flores then appealed to the Court of Appeals.

Whether or not injuries sustained while traveling to or from medical treatment of a work-related injury are compensable depends upon whether or not the particular trip during which the injuries were sustained was “voluntary.” If the trip was voluntary, then the injuries from the motor vehicle wreck are not compensable. If the trip was not voluntary, then the employer is responsible.

A trip is voluntary if: 1) the treatment is not a prerequisite to a return to work; 2) the employer did not set up the appointment or provide the transportation; and 3) the employee was free to use his time for his own affairs. In this case, the office visit was not a prerequisite to a return to work. Flores scheduled the appointment at his own convenience, and thus was free to use his time for his own affairs.

The ALJ apparently found the injuries to be compensable because the employer provided transportation to the appointment. However, the Court of Appeals reasoned that because the transportation was provided only at Flores’ request, that alone was insufficient to characterize the treatment as mandatory. Therefore, the Court of Appeals upheld the decision of the superior court and affirmed that the employer was not responsible for treatment of those injuries.

Summary prepared by Neal B. Childers, nchilders@gmlj.com.
**SCOPE OF HEARING:** The State Board can only decide the compensability of an injury within the scope of the hearing request, and for which the parties have received proper notice.


Harris filed a workers’ compensation claim after she was kicked in the knee by a resident at the Eastman Youth Development Center (“Eastman”). The injury kept her out of work for six weeks, after which she returned on light-duty. Harris continued working for five months while the pain in her knee worsened, and she developed low back pain. The treating physician determined Harris’ low back pain was related to an alteration in her gait as a result of the knee injury. Thereafter, Harris stopped working and underwent two knee surgeries before the ATP determined a total knee replacement was necessary.

Harris requested Eastman cover the knee replacement. The ALJ denied her request, instead suggesting the parties enter into an agreement as to a weight loss program for Harris, who was obese. Nevertheless, the ALJ did find Harris’ low back pain developed as a result of her altered gait and authorized treatment. Thereafter, Harris entered a weight-loss program and Eastman approved the knee replacement.

Prior to having surgery, Harris sought catastrophic designation based on her knee and back issues. The ALJ denied the request, citing the approval of the knee replacement surgery. Following surgery, Harris continued to experience deterioration in her lower back. She again sought catastrophic designation, as well as continued payment for her weight loss program. Both of Harris’ requests were denied by the ALJ, who determined that any degeneration in Harris’ back as a result of the knee injury had been resolved by the knee surgery and that Eastman was no longer responsible for her low back pain. The ALJ further determined that her continued pain was caused by Harris’ morbid obesity and thus unrelated to her knee injury.

The Appellate Division vacated the ALJ’s order, agreeing with Harris that the compensability of her back should not have been addressed by the ALJ when it was not an issue for hearing, and Harris was not given notice or an opportunity to be heard. Accordingly, the Appellate Division instructed the ALJ that when determining whether or not Harris’ claim should be considered catastrophic, the ALJ should make her findings and conclusions based on the Appellate Division’s opinion that Harris’ back condition was not an issue properly before the ALJ when her previous decision was rendered.

However, without holding a new hearing, the ALJ again denied Harris’ request for catastrophic designation, and again finding her back pain was attributable to her morbid obesity. Harris again appealed; however, this time the Appellate Division adopted the ALJ’s finding. Harris appealed to the superior court which affirmed.

The Court of Appeals agreed with Harris that the ALJ erred as a matter of law in determining her low back pain was unrelated to her work injury because Harris did not have notice or an opportunity to be heard on that issue. The Court of Appeals found that the issue before the ALJ was clearly whether Harris’ injuries were sufficiently severe to warrant catastrophic designation and not whether they were compensable in the first place. The Court further found nothing in the record that suggested compensability was at issue.

Therefore, because the issue was not before the Board, the ALJ should not have made any determination as to the compensability of her back, unless Harris was given notice and an opportunity to be heard on that issue or she had given express or implied consent that the issue be heard. The Court of Appeals found that neither occurred. Therefore, it remanded the case to the ALJ commanding her to make a determination as to whether Harris’ claim met the criteria for catastrophic injury without addressing the issue of compensability of Harris’ lower back pain.

*Summary prepared by Neal B. Childers, nchilders@gmlj.com*
CHANGE OF CONDITION VS. FICTIONAL NEW ACCIDENT: If income benefits are paid, after which the claimant resumes work but later stops work due to a gradual worsening of her condition, the date she stops working is a change in condition and not a fictional new injury if the employee continued working for the same employer.


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

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

Scott sought payment of TTD benefits as of September 2009, which Shaw denied on the grounds that her disability was the result of a change of condition and thus barred by the statute of limitations provisions of O.C.G.A. § 34-9-104. The Administrative Law Judge conducted a hearing on her claim and awarded income benefits finding a fictional new injury. Although both the Appellate Division and the Superior Court affirmed the ALJ’s Award, the Georgia Court of Appeals reversed. See *Shaw Industries v. Scott*, 310 Ga. App. 750, 713 S.E.2d 917 (decided July 12, 2011).

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

Shaw appealed, and on July 2, 2012, the Supreme Court of Georgia unanimously clarified the scope of the application of the “fictional new injury” concept unique to Georgia. The Georgia Supreme Court confirmed the decision is controlled by *Central State Hosp. v. James*, 147 Ga. App. 308, 248 S.E.2d 678 (1978). In *Central State Hospital*, the Court of Appeals set forth three common scenarios to give guidance in determining the difference between a new injury and a change in condition. The third scenario is where the claimant sustains a compensable injury for which she receives compensation during disability, subsequently returns to work performing her normal duties or ordinary work, and later again becomes disabled as a result of a gradual worsening of her condition from the wear and tear of ordinary life and the activity connected with performing her normal duties. This gradual worsening or deterioration would constitute a change in his condition and not a new accident.

The Supreme Court concluded that Scott’s circumstances fell within this third scenario outlined in *Central State Hospital*. Scott sustained an injury and was awarded compensation. She subsequently returned to work in a new position that required no strenuous activity, but developed knee and gait problems as a result of the wear and tear of ordinary life. That gradual worsening, as set forth in *Central State Hospital*, supra, constitutes a change of condition, not a new accident.

The Supreme Court disagreed with Scott’s contention that the Court of Appeals’ recent decision in *R.R. Donnelley v. Ogletree*, 312 Ga. App. 475, 718 S.E.2d 825 (2011), demands a different result. In *R.R. Donnelley*, the worker suffered an injury, received benefits, returned to work in several positions that were strenuous and exceeded his light-duty work restrictions, and, thereafter, had to cease work again due to worsened conditions. In *R.R. Donnelley*, the ALJ found that the worker suffered a new accident as a result of the new and more strenuous work he was required to perform. The Supreme Court distinguished Scott’s circumstances since she returned to work at Shaw Industries in a less strenuous position.
Claimants’ attorneys will try to narrow the scope of the ruling just as some defense attorneys may try to expand its scope. We believe all can agree, however, that this case clarifies the seminal ruling dating back to 1978 in *Central State Hospital* that when the claimant returns to work doing the same or less strenuous duties, if the claimant subsequently goes out of work, it is a change in condition and not a new injury.

*Summary prepared by Fred R. Green, fjgreen@gmlj.com.*

**WORKERS’ COMPENSATION:** “Any evidence” standard of review applies to superior court review of State Board’s decision in Maloney job search case, and if any evidence supports Board’s decision, it must be upheld by Superior Court.


Maughon was injured in a compensable accident while working for Brown Mechanical Contractors. He was subsequently laid off for reasons unrelated to his injury. At the time he was laid off, Maughon was under work restrictions that prevented lifting, pushing, pulling or carrying more than 40 pounds with his right arm or hand, as well as any overhead work with his right arm or hand.

After he was laid off, Maughon sought work with “well over 100 employers” in the six months between his termination and the hearing. He received three job offers during that time period, but all three were rescinded when he informed the prospective employers of his work restrictions.

Maughon requested payment of TTD benefits subsequent to his termination on the ground that he had made a diligent but unsuccessful search for employment within his restrictions. The Administrative Law Judge (ALJ) agreed with Maughon’s arguments and awarded TTD benefits.

Brown Mechanical appealed the ALJ’s decision to the Appellate Division, which vacated the ALJ’s Award and denied Maughon’s claim for income benefits. The Appellate Division found that Maughon’s search did not meet the *Maloney* standard because: 1) Maughon only sought work at 110 places over 144 “work days” (not counting holidays and weekends); 2) Maughon looked for work an average of less than one time per day; 3) Maughon failed to follow-up with 22 potential employers; 4) there were periods of 27 and 18 days during which Maughon did not look for work at all; 5) Maughon lost out on two possible jobs due to a pending surgery which had not been scheduled; 6) Maughon’s search only focused on jobs involving heavy physical labor, when he had experience doing other kinds of work; and 7) Maughon’s failure to seek work in less physical jobs supported an inference that he was trying to avoid being hired in order to bolster his claim for indemnity benefits.

Maughon appealed to superior court, which reinstated the ALJ’s decision. The superior court concluded that the correct standard of review was *de novo* since the Appellate Division erred in applying the law and specifically the holding in *Maloney*. The superior court further stated that the Appellate Division established a “heightened burden of proof not required by *Maloney*.”

Brown Mechanical appealed to the Court of Appeals, which reinstated the Appellate Division’s Award and the denial of benefits to Maughon. In so ruling, the Court of Appeals noted that the Superior Court applied an improper standard of review and that the “any evidence” standard of review applies. Since there was evidence to support the Appellate Division’s decision that Maughon had not met the *Maloney* burden, the Court of Appeals found that the Appellate Division’s Award should be reinstated. The Court specifically rejected Maughon’s argument that he met his burden simply by showing evidence that three employers rescinded possible job offers due to his
restrictions. The Court noted that such evidence was certainly probative, but not dispositive.

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

Florida Liability

COOPERATION WITH POLICY CONDITIONS: The insured must comply with all conditions (EUO, Proof of Loss, etc.) prior to demanding appraisal.

Citizens Property Insurance Corporation v. Mango Hill Condo Assoc., 54 So.3d 578 (Fla. 3d DCA), decided February 9, 2011; and Citizens Property Insurance Corporation v. Gutierrez, 59 So. 3d 177 (Fla. 3d DCA), decided March 2, 2011.

In Florida, plaintiffs' attorneys routinely file motions to compel appraisal. Some trial judges were granting those motions without any consideration of the insurance carriers' affirmative defenses related to an insured's failure to comply with the policy's post-loss obligations.

In 2011, the Third District Court of Appeal further clarified that trial courts, as a condition precedent to appraisal, must conduct an evidentiary hearing to determine whether the insured has complied with his or her post-loss obligations.

While many Florida property insurance policies now require mutual consent before a claim may proceed to appraisal, for years, most policies contained the following provision: "If you and we fail to agree on the amount of loss, either may demand an appraisal of the loss." If the policy contains this language or something similar, the parties will likely be required to proceed with a hearing.

These two cases illustrate this issue. Mango Hill held that as a preliminary, a request for appraisal is not ripe unless and until the policy's post-loss duties have been met. For example, EUOs must be complete, proof of loss submitted, etc.

In Gutierrez, the Third District held that the trial court must conduct an evidentiary hearing to determine [i.e. the scope] whether the insured complied with the policy's post-loss conditions. The court was clear: "[t]he insured must comply with all of the policy's post-loss obligations before the appraisal clause is triggered." Despite what appears to be self-evident, plaintiffs attorneys continue to insist that because the hearing is the result of their motion to compel, the post-loss duties are a secondary issue.

Those hearings also provide the insurer with an opportunity to shape the issues for appraisal.

Summary prepared by Robert M. Darroch, rdarroch@gmlj.com.
EVIDENCE: Don’t play your cards too early or Plaintiff may be entitled to withdraw claims and bar defendants from introducing evidence of the withdrawn claims.

*Health First, Inc. v. Cataldo*, 92 So.3d 859, (Fla. 5th DCA), decided June 29, 2012.

Cataldo sued the operator/employee and owner/employer of the vehicle that struck her. Cataldo went to the emergency room later in the day and was diagnosed with a cervical sprain. Approximately five months later she had surgery for three herniated discs in her cervical spine. In her suit she claimed brain and dental injuries, along with neck and back injuries.

Just before trial, Cataldo withdrew her claims for brain and dental injuries and requested that the defendants be prohibited from introducing any evidence related to these claims.

The defendants asserted that the plaintiff had been caught in lies and misrepresentation relating to those claims. While the defendants recognized that Cataldo was entitled to voluntarily drop any of her claims, they claimed they would be prejudiced if they were prohibited from bringing up those claims. Defense counsel argued that Cataldo’s injury claims were intertwined, including false medical histories Cataldo gave her providers relating to the dropped claims. The trial court prohibited Defendants from using any evidence relating to the dropped claims to impeach the plaintiff.

On appeal the First District agreed that introduction of any evidence relating to the dismissed claims was improper because it would involve impeachment on a collateral issue.

In his closing argument, Cataldo’s attorney made references to religion or a higher power, suggesting God favored a verdict in favor of the plaintiff. He further asked the jury to punish the defendants who had not “repented.” The jury returned a verdict in favor of Cataldo in excess of $2,000,000.

The appellate court held that Cataldo’s counsel’s closing argument was replete with improper statements and “strongly disapprove[d]” of his tactics. However, again the court did not find that the trial judge abused his discretion in refusing to grant a new trial because Defense counsel failed to object to any of the closing statement at trial. The standard for granting a new trial based on allegedly improper, but unobjected-to, closing argument requires meeting four requirements. The court held that the fourth requirement, that the argument “so damaged the fairness” of the trial as to require a new trial, was not met. The result may have been different if the defendants had objected to the statements during the closing argument, but the court did not address the issue.

Summary prepared by Robert M. Darroch, rdarroch@gmlj.com.

**PROPOSAL FOR SETTLEMENT:** Attach the proposed release to avoid ambiguity as to the parties to be released.


Plaintiff served the owner of the vehicle with a Proposal for Settlement (“PFS”) for $40,000. The PFS required the plaintiff to “execute a full release of liability in favor of Defendant, [owner], and his affiliated insurance company. . .” The plaintiff did not attach a release or describe its terms.

Since the PFS was not accepted in thirty days, it was deemed rejected. At trial the jury awarded the plaintiff over $186,000 and the plaintiff moved for attorneys’ fees under Fla. Stat. 768.79. The owner filed the typical Motion to Strike the PFS arguing that it failed to state the relevant conditions and non-monetary terms of the PFS with particularity as required by Section 768.79, and Fla.R.Civ.P. 1.442

The appellate court explained that if a release is required but is not attached to a PFS,
then the PFS must satisfy the requirements of Rule 1.442 and eliminate any reasonable ambiguity about the scope of the release. If ambiguity within the proposal could affect the offeree’s decision to accept a PFS, then the proposal will not satisfy the particularity requirement.

In this case, the Court of Appeals found the critical ambiguity was the failure to define the parties who were included by the release, i.e. the PFS did not state whether the driver was covered by the release. If the proposed release had been attached, that question would have been answered. The missing information created an ambiguity in the terms of the PFS and the appellate court found it was not valid.

Summary prepared by Robert M. Darroch, rdarroch@gmlj.com.

NEGLIGENCE/AUTO LIABILITY: Presumption of negligence in rear-end accidents may lead to summary judgment.


Shirley filed suit for injuries sustained in a four car wreck. She was the fourth car in line. State Farm argued that a presumption of negligence applied to rear drivers in rear-end collision accidents and absent evidence of any negligence by the other drivers, summary judgment should be entered finding Shirley liable. According to State Farm the evidence was uncontroverted that vehicles 1, 2, and 3 all slowed down gradually, and that Shirley slammed into vehicle 3.

As set forth in earlier cases, Florida recognizes a presumption of negligence on the rear driver of a rear-end collision accident. That presumption can be overcome by establishing the lead-driver stopped abruptly and arbitrarily.

In opposition to summary judgment Shirley submitted testimony of a traffic expert in order to show that the lead drivers stopped abruptly and arbitrarily. The expert offered testimony that the phantom turning vehicle and other vehicles in front of Ms. Shirley slowed using “maximum braking.”

In review of the evidence, however, the court concluded that there was no material evidence of negligence on the part of the lead drivers. In fact, the court noted, but for Shirley’s own negligence in failing to maintain a safe distance from the vehicles in front of her and apply the appropriate braking under the circumstances, no accident would have occurred. The court affirmed summary judgment against Shirley.

Courts are often hesitant to enter summary in negligence cases. This case shows, however, that it is possible, especially when there is no evidence of negligence. The court further declined to revisit the rule establishing the presumption of negligence on the rear driver in a rear-end collision.

Summary prepared by Robert Darroch, rdarroch@gmlj.com.
FIRST PARTY BAD FAITH: A claim for breach of implied warranty of good faith and fair dealing against insurer is essentially a first party bad faith claim. Florida’s statutory requirements for policy size, type, and language do not create a private cause of action or provide for penalties for non-compliance.

*QBE Ins. Corp. v. Chalfonte Condominium Apartment Assoc., Inc.*, 94 So.3d 541 (Fla. Supreme Ct.), decided May 31, 2012.

This action arose out of a declaratory judgment brought by Chalfonte Condominium association in the U.S. District Court for the Southern District of Florida. After Hurricane Wilma damaged property owned by Chalfonte, it filed a claim with its insurer, QBE Ins. Corp. (“QBE”). Dissatisfied with QBE’s investigation and processing of its claim, Chalfonte filed suit. Chalfonte’s claims against QBE included breach of contract – failure to provide coverage; breach of contract – breach of implied warranty of good faith and fair dealing; and violation of Florida’s mandatory language and type-size requirements statute for hurricane insurance deductibles.

The district court dismissed Chalfonte’s claim for violation of Florida’s mandatory type-size statute. The jury awarded damages to Chalfonte on the other claims. QBE appealed.

The U.S. Court of Appeals for the Eleventh Circuit certified the following questions to the Supreme Court of Florida: (1) does Florida Law recognize a claim for breach of implied duty of good faith and fair dealing for an insurer’s failure to investigate the insured’s claim within a reasonable period of time? (2) If Florida law recognizes such a claim, is the claim subject to bifurcation? (3) May an insured bring a claim against an insurer for failure to comply with the language and type-size requirements established by Fla. Stat. § 627.701(4)(a)? (4) Does an insurer’s failure to comply with language and type-size requirements established by § 627.701(4)(a) render a noncompliant hurricane deductible provision in an insurance policy void and unenforceable?; and (5) Does language in an insurance policy mandating payment of benefits upon “entry of final judgment” require an insurer to pay its insured upon entry of judgment at the trial level? The Supreme Court answered all of those questions: No (finding question 2 to be moot).

As to the first question, the Florida Supreme Court found that a claim for breach of an implied duty of good faith and fair dealing is nothing more than a first party claim for bad faith. The Court reasoned that Florida courts had never recognized common law claims for first-party bad-faith. Rather, Chalfonte’s claim must be brought under § 624.155 of the Florida Statutes. As a result, question two was moot.

As to the third and fourth questions, the Court found that the legislative intent of § 627.701(4)(a) was not to create a private cause of action or to impose penalties for non-compliance. The Court stated that the statute mandating size, type, and language for deductible notice was created to ensure that the notice served its purpose of informing insured’s of higher deductibles and was a byproduct of the legislature’s intent to increase availability of homeowner’s insurance at an affordable rate through higher hurricane deductibles. The statute was never intended to establish civil liability or to impose penalties on the insurer for non-compliance, such as voiding the policy provision.

Finally, the Court held that a contractual provision mandating payment of benefits upon “entry of final judgment” does not waive the insurer’s procedural right to post a bond to stay execution of a money judgment pending resolution of the appeal. Regardless of the policy language, posting a “good and sufficient bond” results in an automatic stay of an adverse money judgment pending the resolution of the appeal.

*Summary prepared by Neil T. Lyons, nlyons@gmlj.com.*
INSURANCE COVERAGE/POLICY CONDITIONS: An insured’s failure to comply with policy provisions requiring timely notice and submission of proof of loss creates a presumption of prejudice, which if not rebutted, extinguishes an insurer’s obligation under the policy as to that claim.

Kramer v. State Farm Florida Ins. Co., 95 So.3d 303 (Fla. 4th DCA), decided July 18, 2012.

The Kramers, State Farm insureds, allegedly sustained damage to their roof following Hurricanes Frances and Jeanne in September, 2004 but did not give any notice to State Farm. Four years later they had a leak in their roof. The Kramers again did not give notice of the alleged loss or submit a sworn proof of loss to the insurer. Rather, they decided that the cost to repair the leak was below their deductible and not to involve their insurance.

In May 2009, a roof inspector advised the Kramers that the hurricanes may have caused damage to their roof. Later that month they filed a claim with State Farm for the estimated cost to replace the roof.

State Farm’s insurance policy provided that “[a]fter a loss ... [the insureds] shall ... give immediate notice to [the insurer]” and shall “submit to [the insurer], within 60 days after the loss, [the insureds’] signed, sworn proof of loss.” The policy further provided that: “No action shall be brought unless there has been compliance with the policy provisions.”

State Farm denied the claim, citing failure to immediately report the loss and claiming that its ability to independently evaluate the claim had been compromised, quoting the conditions in the policy requiring immediate notice and submission of a sworn proof of loss.

The Kramers then sued State Farm for breach of contract for failure to pay the claim. In the lawsuit State Farm moved for summary judgment, arguing that the Kramers’ material breach of their duties under the policy, by failing to timely provide notice of the loss and submit a sworn proof of loss, relieved the insurer of its obligation under the policy.

The Kramers argued that they complied with the policy by giving immediate notice of the loss as soon as they became aware in May 2009, that there was damage which involved the policy. The insureds further argued that their delayed notice did not prejudice State Farm and therefore was not a ground for denying coverage. In support of their argument that State Farm was not prejudiced, the insureds attached an affidavit of a structural engineer who stated that he had knowledge of claims where State Farm had relied on engineers to determine the cause of damage to property years after a storm. He further stated that damage resulting from hurricanes is noticeably different from other causes of loss.

The trial court granted summary judgment in favor of State Farm. On appeal the Fourth DCA agreed with the circuit court’s interpretation of the policy conditions requiring prompt notice and proof of loss as conditions precedent to bringing suit for coverage, because of the policy language stating: “no action shall be brought unless there has been compliance with the policy provisions.”

Pointing to the rule set forth by Florida’s Supreme Court, the court noted that an insured’s failure to comply with such a policy provision results in a presumption of prejudice to the insurer. That presumed prejudice, however, may be overcome by showing the insurer was not prejudiced by untimely notice or proof of loss. In the present case, the court found that the insured failed to submit any evidence showing the insurer had not been prejudiced. The Affidavit of the insured’s own expert did not support the insured’s argument that State Farm had not been prejudiced. The Affidavit of the insured’s own expert did not support the insured’s argument that State Farm had not been prejudiced, because the expert stated it was difficult to determine the cause of the loss with certainty so long after the hurricanes. Because the insured did not rebut the presumption of prejudice, the court upheld judgment in favor of the insurer.

Summary prepared by Robert M. Darroch, rdarroch@gmlj.com.
TIMELY NOTICE AS A CONDITION PRECEDENT TO COVERAGE: Unjustified twenty-one month delay in notifying insurer of lawsuit precluded coverage as a matter of law.


OneBeacon brought a declaratory judgment action seeking a determination that there was no coverage under its policy due to the insured’s failure to give timely notice of a lawsuit. The underlying lawsuit was filed against the Catholic Diocese of Savannah (CDS), on April 6, 2006. CDS filed an answer to that suit on May 12, 2006. CDS did not notify OneBeacon of the lawsuit until January 23, 2008. OneBeacon issued a reservation of rights to CDS in September 2009 and participated in CDS’ defense. The underlying lawsuit was settled in October 2009.

OneBeacon filed the declaratory judgment action shortly thereafter, claiming CDS was not entitled to indemnification for the settlement because it failed to give timely notice of the lawsuit to its insurer. CDS claimed the delay in notice was because it could not locate the policies for the time period covering the events giving rise to the underlying suit. CDS claimed it provided notice as soon as it discovered the policies, which were over twenty-six-years-old at the time of the underlying suit. The trial court found CDS’ purported justification was unreasonable and awarded summary judgment in favor of the insurer based on the insured’s failure to give timely notice.

The Eleventh Circuit Court of Appeals affirmed, finding that CDS’ twenty-one month delay in notice was unreasonable as a matter of law. The Court found CDS failed to offer any reasonable justification for its delay. Though CDS submitted an affidavit of its attorney averring that OneBeacon was notified as soon as the policies were discovered, the affidavit lacked critical details, such as specific dates, to support CDS’ contention that it acted in a timely manner. The Court clarified that a twenty-one month delay is not always unreasonable, but becomes unreasonable as a matter of law when it is unexcused or unjustified.

The Court also rejected CDS’ contention that OneBeacon was required to show it was prejudiced by the delay in notice. It is well-settled under Georgia law that an insurer is not required to show it was prejudiced by an insured’s delay in notice. Though an insurer’s failure to show prejudice is a factor that may be considered in determining coverage, it is not dispositive. Accordingly, the Eleventh Circuit ruled the trial court did not err in not requiring OneBeacon to show prejudice and affirmed summary judgment in favor of OneBeacon.

Summary prepared by R. Tyler Bryant, tbryant@gmlj.com.
MEDICAL BILL REIMBURSEMENT DISPUTES: A carrier’s jurisdictional defense that services or products billed were provided by an authorized medical provider for compensable injuries is a binding concession that waives any challenge to the medical necessity of such care and stipulates to the payment of the medical bills.


Bergstein, through counsel, filed a Petition for Benefits seeking payment of outstanding bills for medical care that was received as part of her compensable industrial accident. The employer/carrier responded that the services or products billed were provided by an authorized provider for compensable injuries, and the Judge of Compensation Claims (JCC) did not have jurisdiction for reimbursement disputes pursuant to § 440.13(11)(c). Further, the employer/carrier’s defense asserted that some of the medical bills had been paid, some were duplicative, and still others had not been properly submitted to the carrier for payment.

The JCC agreed there was no jurisdiction for reimbursement disputes. Bergstein filed a timely appeal on the jurisdictional issue.

The First District Court of Appeal affirmed the JCC’s ruling and held that when an employer/carrier asserts the jurisdictional defense in § 440.13(11)(c), it is a de facto concession that the services or products billed were provided by an authorized provider for compensable injuries in accordance with or pursuant to § 440, Florida Statutes, so as to insulate a claimant from financial liability for such charges.

Therefore, the employer/carrier’s representation was a binding legal concession, by operation of § 440.32(3), Florida Statutes, and waived any challenge to the medical necessity of the care. Therefore, the employer/carrier’s stipulation made them financially responsible for the payment of the disputed medical bills and completely insulated the claimant from any financial responsibility.

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

ATTORNEY’S FEES: A JCC cannot dismiss a petition for benefits for lack of good faith effort when an attorney represents to court that he complied with the statute.


Blake-Watson sustained a compensable accident in October 2008, received treatment and returned to work in the same capacity until April 2010. In July 2010 she filed the first of three Petitions for Benefits (PFB), all of which sought attorney’s fees. In response to the first PFB, the employer/carrier provided some benefits, then moved to dismiss for lack of good faith to resolve the matter by Blake-Watson pursuant to § 440.192(4), Florida Statutes. During that dispute, the next two PFBs were filed in November 2010 and January 2011. The second PFB requested a psychiatrist and more tests. The third PFB listed claims identical to those in the first PFB. In response, the employer/carrier provided all benefits requested, but did not pay attorney’s fees.

The Judge of Compensation Claims (JCC) granted the employer/carrier’s motion to
dismiss the first PFB, without prejudice, allowing Blake-Watson leave to amend the pleadings. Blake-Watson moved for reconsideration of that ruling and also requested attorney’s fees based on obtaining the benefits requested in the first and second PFBS. The employer/carrier argued that no fees were due on the first PFB because that PFB did not comply with § 440.192(4). The employer/carrier also argued no fees were owed for the second PFB because the employer/carrier had provided the benefits requested within thirty days. The JCC declined to revisit dismissal of the first PFB but determined it was amended by the third PFB and awarded fees at a lower rate than requested. The JCC also denied fees for time spent defending against the motion to dismiss the first PFB.

On appeal, the employer/carrier asserted two primary arguments: first, that fees awarded from the first PFB are precluded under § 440.192(7), which prohibits the JCC from awarding fees payable by the carrier prior to the filing of a petition that do not comply with said section; secondly, attorney’s fees based on the second PFB never attached under § 440.34(3) which prohibits attorney’s fees from attaching until thirty days after the date the carrier or employer, if self-insured, receives the petition.

The Court of Appeals held the JCC erred in dismissing the first PFB, both because § 440.192 did not give the JCC authority to “go behind” counsel’s representations of good faith effort to resolve the dispute. Further, the Court stated that other remedies would allow the employer/carrier to seek sanctions. Therefore, the employer/carrier did not meet procedural requirements to do so under that rule. The Court also ruled that the JCC erred in excluding fees for the hours spent on the motion to dismiss and reversed the JCC’s order. The Court, however, affirmed the JCC’s finding as to the reasonable hourly fee rate.

Finally, the Court found that the employer/carrier was diligent by sufficiently establishing authorization as of the date of the letter by contacting several physicians in efforts to find one willing to accept Blake-Watson. The Court then reversed the award of the fees based on the third PFB.

Summary prepared by Justin G. Hausler, jhausler@gmlj.com.

**NOTICE OF INJURY:** Notice of injury to an officer of company is sufficient notice to be imputed to the carrier.


Gomez, and his wife own Gomez Lawn Service, Inc. Mr. Gomez, served as president, while his wife served as chief operating officer. Gomez never exempted himself from chapter 440 for purposes of workers’ compensation.

On July 13, 2010, Gomez was involved in a motor vehicle accident resulting in back injuries while driving a company vehicle and performing duties of the company. When Mrs. Gomez learned of her husband’s accident she reported it to the company’s motor vehicle insurer and a personal injury protection (PIP) claim was opened. Gomez treated under PIP insurance until November 2010. While being treated, Gomez was told by his doctor that he may need surgery. After the PIP benefits reached their limits, Gomez contacted an attorney. On December 1, 2010, Mrs. Gomez notified the company’s workers’ compensation carrier, The Hartford, of the claim. By January 26, 2011, The Hartford had not yet activated a claim and Gomez filed a petition for benefits.

The Hartford denied the claim, citing lack of timely notice pursuant to § 440.185. The Judge of Compensation Claims (JCC) denied the claim, finding that Gomez and Gomez Lawn Service were, in effect, the same party, and had not timely notified The Hartford of the work injury until approximately ninety days after the accident.

The Court of Appeals held that the plain language of § 440.185(1), provided that Gomez would be required to report his injury to his employer within thirty days of its occurrence. Since § 440.41(1) imputes notice to the employer
as notice to the carrier, Gomez gave proper notice to The Hartford by notifying an officer of his company, and therefore fully satisfied the notice requirement in §440.185(1).

The Court held that the JCC had no authority to expound on the thirty day requirement in § 440.185(1). It also held that nothing in § 440.185 required an injured employee to notify the carrier of an injury, nor did the section permit a JCC to deny entitlement to benefits if the carrier is not timely notified. Under § 440.185(2), the employer has the obligation to notify the carrier of a reported injury and that must occur within seven days.

Investigator prepared by Justin G. Hausler, jhausler@gmlj.com.

STATUTE OF LIMITATIONS: The response to a Petition for Benefits is the “initial” responsive pleading to a claimant’s Petition for Benefits for determination of waiver pursuant to § 440.19(4).

Miami-Dade County School Board and Gallagher Bassett Services, Inc. v. Russ, 88 So.3d 1038 (FLA 1st DCA), decided May 29, 2012.

The employer/carrier appealed an order of the Judge of Compensation Claims (JCC) rejecting its statute of limitations defense and awarding benefits to Russ. The JCC found the employer/carrier’s “initial response” to Russ’ Petition for Benefits (PFB) was various documents dated November 9, 2009 consisting of a notice of appearance, request for production, letter of representation, notice of deposition, and letter to the mediator, none of which asserted a statute of limitations defense. The JCC held that the employer/carrier waived the defense.

The First District Court of Appeal agreed with the employer/carrier that their Response to the Petition for Benefits dated November 10, 2009 should have been considered its “initial response.” The Court held that the “initial response” which denied “the claim in its entirety” evinces the need for an initial response to explicitly state a position either denying or conceding the particular claims therein. All of the documents relied on by the JCC did not represent a response addressing any of the claims raised by the claimant within the PFB.

As such, § 440.192(8), Florida Statutes, requires an employer/carrier to raise a statute of limitations defense within their first responsive pleading to a PFB. The response to a petition for benefits must list all benefits requested by a claimant not paid and explain its justification for nonpayment.

Further, the First District Court of Appeal found error in the JCC’s determination of the initial response as it was based upon the “preponderance of the evidence” standard of proof instead of “clear and convincing evidence” pursuant to § 440.185 and § 440.055.

The Court opined that § 440.19(4) would place a potentially heightened burden on a claimant to prove estoppel, where the burden was always on the employer/carrier to show it asserted the statute of limitations defense in its initial response.

The Court went on to state that it has ruled to the contrary of the JCC’s finding that the employer/carrier’s failure to respond to the petition for benefits within 14 days, pursuant to § 440.192(8), waived the statute of limitations defense. Finally the Court declined to rule on the employer/carrier’s argument that Russ’ assorted estoppel arguments lacked merit because the JCC did not rule on that issue.

Summary prepared by David M. Havlicek, dhavlicek@gmlj.com.
OCCUPATIONAL CAUSATION: The employer/carrier must establish evidence of a competing cause or preexisting condition to support the affirmative defense that the major contributing cause of the injury did not arise out of a work-related activity within the course of employment.


Valerie Walker was a receptionist at Broadview Living. Walker said she was asked to drop off a package for shipping at UPS. Walker placed the package in her car in anticipation of performing the requested task. However, a UPS driver arrived at Broadview Living, so Walker left her desk to go retrieve the package from her car to give it to the UPS driver. After Walker gave the package to the driver, she was returning to her desk when her right foot slipped causing her to fall and land in the hallway. It was undisputed that Walker sustained a left rotator cuff tear as a result of her fall and had prior problems with her left shoulder.

The Judge of Compensation Claims (JCC) found that Walker had no pre-existing conditions that may have caused her to fall. The JCC denied compensability of the claim as Walker’s accidental injury on Broadview Living’s premises did not arise out of her employment because her work activity at the time of the incident was not the major contributing cause of her fall or injury.

The First District Court of Appeal found that the JCC erred because the ruling was based on case law that had preexisting conditions which contributed to the accident or injury. Most importantly, the cases relied upon made it necessary for claimants to establish that the employment itself created the hazard of the risk.

In this case, Walker’s accident or injury was not impacted by a preexisting condition. The Court previously held that if there was only one cause of the claimant’s injuries, rather than competing causes, the claimant was not required to present additional evidence going to the issue of whether the work-related accident was the major contributing cause of the injuries.

Therefore, since it was undisputed that Walker was actively engaging in a work related activity at the time of the accident, and since the JCC found that there were no competing causes of the accident and injury, Walker’s work activity was *de facto* the major cause. The Court found that the JCC erred in finding that Walker failed to establish that work performed within her employment caused her left shoulder injury.

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

PRODUCTS LIABILITY/ALTERATION OR MODIFICATION: Modification of the seatbelt in the back seat of the car is a defense to a product liability claim.


On April 28, 2003, the Stark family was driving in a 1998 Ford Taurus. The family made a stop at a convenience store and then proceeded back toward the highway. As Mrs. Stark attempted to cut through the parking lot of a neighboring restaurant, her vehicle began to accelerate rapidly. The vehicle went up and over a small curbed island and slammed into the concrete base of a light pole at 26 miles per hour. Both Mr. and Mrs. Stark suffered injuries.
in the crash, as well as their three children riding in the back seat. The three children required lifesaving surgery as a result of their injuries, including injuries to their spines and abdomens believed to have been caused by the seatbelts. The Starks filed suit against Ford Motor Company (Ford) alleging that the defective seatbelt system enhanced their injuries. They argued that the seatbelts did not fit them properly and did not hold them in place during the accident resulting in abdominal and spinal injuries.

In defense of the claim, Ford argued that its vehicle was improperly used. Specifically, Ford’s expert testified that the seatbelt worn by one of the children had been “modified” because the shoulder belt was placed behind the child’s back instead of over her chest. Ford argued that the child’s failure to use the seatbelt as instructed and intended was a “modification” of the vehicle’s intended purpose barring the claim.

North Carolina’s Products Liability Act states that “no manufacturer or seller of a product shall be held liable in any product liability action where a proximate cause of the personal injury, death, or damage to property was either an alteration or modification of the product by a party other than the manufacturer or seller, which alteration or modification occurred after the product left control of such manufacturer unless: “the alteration or modification was in accordance with the instructions or specifications of such manufacturer or seller; or the alteration or modification was made with the express consent of such manufacturer or seller.”

The Products Liability Act states that alteration or modification includes changes in the design, form or function or use of the product from that originally designed, tested or intended by the manufacturer.

The Starks argued that the Act only relieved Ford of liability when the alteration or modification of the product was made “by another party to the litigation.” Following a jury trial, it was determined that the parents of the child plaintiffs had altered or modified the vehicle by allowing their children to misuse the seatbelt. On appeal, the Court of Appeals held that use of the word “party” in the Products Liability Act requires that the modification of the product be done by a party to litigation. However, in the opinion of the Supreme Court of North Carolina, there is no requirement that the person who modified the product be a party to the litigation. The Supreme Court further held that the failure of the Starks to properly seatbelt their children into the vehicle served as a “modification” of its intended purpose and thus serve as a complete bar to recovery from Ford.

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

NEGLIGENCE/VOLUNTARY UNDERTAKING: University did not voluntarily undertake a duty to protect students off-campus by regulating Greek organizations on campus.


John Mynhardt, was a student at Elon University who went out with his friends to a local bar. When the bar closed at 2:00 a.m., Mynhardt and his friends began walking to an off-campus party. Before arriving at their intended destination, the group stopped at a different off-campus party held by the members of Lambda Chi fraternity. Mynhardt and his friends entered the party despite being uninvited. The house hosting the event was not owned by Elon University, but the university exercised control over aspects of “Greek” organizations on campus, including protocols and regulations regarding the use of alcohol at on-campus events.

After Mynhardt arrived at the house party, he locked himself in a bathroom with one of his female friends and the two refused to open the door despite the knocking of the home’s occupants. When Mynhardt finally emerged from the bathroom, one of the defendants put him in a chokehold from behind and forced him toward the kitchen door exit. Before the group made it out the door, the defendant forcefully pushed Mynhardt to the floor. Upon striking the
floor, Mynhardt could not move his limbs. Mynhardt was dragged out of the door by his legs by two of the defendants. As a result of the incident, Mynhardt suffered permanent paralysis.

Suit was filed against the homes’ occupants, the Lambda Chi Alpha Chapter and Elon University for Mynhardt’s injuries. The trial court granted summary judgment in favor of Elon University as to the negligence claim, and Mynhardt appealed.

At the Court of Appeals, Mynhardt argued that Elon University owed him a duty of care because the university voluntarily undertook a duty to him by regulating Greek life at the university. Mynhardt argued that Elon University knew of the specific dangers involved with open fraternity parties and undertook to regulate these activities directly. Mynhardt pointed to evidence that the university voluntarily undertook to provide services, impose supervision, regulation and enforcement of the regulations against students participating in Greek organizations.

Elon argued that, despite the university’s proactive attempts to regulate Greek life on its campus, it did not voluntarily undertake a duty to protect students from harm while at off-campus events. In upholding summary judgment for Elon, the Court of Appeals held that the university’s regulation of Greek organizations on its campus does not transform it into an insurer of every student, member, or guest who might participate in off-campus activities. The Court of Appeals further held that Mynhardt voluntarily attended an off-campus party to which he was not invited, and which Elon University had no knowledge.

As a result, the Court of Appeals held there was no special relationship between Elon University and Mynhardt as was required to establish a voluntary undertaking. Judgment for Elon University was affirmed.

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

PREMISES LIABILITY: Apartment complex owed no duty to maintain a fence preventing children from exiting through the fence and entering upon a neighboring property.


On January 15, 2010, four year-old Jada Marie Lampkin was playing on a playground in the common area of an apartment complex when she exited the apartment complex through a hole in the chain link fence. Lampkin wandered onto a neighboring property which contained a frozen pond and fell through the ice and suffered permanent brain injuries. The apartment complex owned and maintained the chain link fence surrounding the property, and there was evidence that the owner of the adjacent property notified the apartment complex that children-residents were coming through the fence toward the pond.

Lampkin filed a negligence action against the apartment complex and Lampkin appealed.

At the Court of Appeals, Lampkin argued that the apartment complex owed a duty of reasonable care, including the duty to keep the children on its land from accessing the potentially dangerous neighboring property owned by a third party. Lampkin further argued that the apartment complex was on notice that the neighboring property was an “attractive nuisance” to children and owed a duty to protect those children from injury by the dangerous condition.

The Court of Appeals affirmed holding that it was against public policy to burden a landowner with the obligation of correcting unsafe conditions on property it does not control. Specifically, the Court of Appeals held that where a neighboring landowner retains both the benefits and exclusive right to control its
own land, the burden to prevent injury from conditions on the land must be retained by the party with control. As a result, the Court of Appeals held the law of North Carolina is that a landowner has a duty to exercise reasonable care in keeping his premises safe, but is not an insurer of the safety of his premises, nor an insurer of the safety of persons off the premises. The landowner is not obligated to protect against injury from dangerous conditions over which it has no control.

In a separate theory, Lampkin alleged that the apartment complex assumed a duty of care to the minors by erecting a perimeter around the apartment complex to contain children residing within. The Court of Appeals rejected Lampkin’s argument on the basis that there were insufficient allegations that the apartment complex affirmatively erected the fence for the purpose of containing children within its perimeter.

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

PRODUCTS LIABILITY/BREACH OF IMPLIED WARRANTY: Plaintiff’s claim for breach of implied warranty of merchantability against a restaurant was properly submitted to the jury when he testified that his food had a bad aftertaste and caused him illness within several hours.


Williams ate dinner at an O’Charley’s restaurant on March 18, 2008. He believed the chicken he ordered had a bad aftertaste, stuck to his plate, and was dry. By 8:00 a.m. the next morning, Williams suffered from severe diarrhea and vomiting and was admitted to the local emergency room for seven days. Williams filed an action for negligence and breach of implied warranty of merchantability on July 22, 2009.

Following a jury trial, a verdict was rendered in favor of the restaurant as to the negligence claim, but in favor of Williams on the claim for breach of an implied warranty of merchantability. Williams was awarded $140,000 in damages for his injuries. O’Charley’s filed a motion for judgment notwithstanding the verdict, which was denied. O’Charley’s appealed.

At the Court of Appeals, O’Charley’s argued that Williams failed to present adequate evidence of a defect in the chicken. The Court of Appeals affirmed the trial court on the basis that Williams had produced adequate circumstantial evidence of a defect necessary to carry his burden of proof. In its holding, the Court of Appeals held that circumstantial evidence of a defect necessary to prove a breach of implied warranty of merchantability may include: (1) the malfunction of the product; (2) expert testimony as to a possible cause; (3) how soon the malfunction occurred after the plaintiff first obtained the product; (4) similar incidents, when accompanied by proof of substantially similar circumstances and reasonable proximity and time; (5) elimination of other possible causes of the accident; and (6) proof tending to establish that such an accident would not occur absent a manufacturing defect.

The Court of Appeals noted that there was an absence of case law on the issue of food poisoning and the implied warranty of merchantability in North Carolina and looked to other jurisdictions for guidance. The Court of Appeals determined that the presence of a peculiar taste in food followed shortly thereafter by an illness is sufficient circumstantial evidence of a defect in food to warrant submission of the case to jury on the issue of breach of implied warranty of merchantability.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.
PREMISES LIABILITY: Baseball park discharges its duty to protect patrons from wildly thrown and batted baseballs by making available seating options with protective netting.


Bryson attended a baseball game in Gastonia, North Carolina. He purchased a general admission ticket, allowing him to sit anywhere in the park. The park offered seats in a beer garden which were not screened by protective nets, as well as seats that were shielded by protective nets. Bryson and his companions chose to sit in the unshielded beer garden.

As Bryson sat in the beer garden, he was struck in the face by a wild pitch thrown by a visiting pitcher causing injuries. Bryson filed suit against the baseball team, the league and the municipality who operated the stadium for personal injury. The trial court granted the defendants’ motion for summary judgment and Bryson appealed.

The Court of Appeals relied upon North Carolina’s extensive case law to determine that owners and operators of baseball parks owe a duty to exercise reasonable care in the maintenance of their premises for the protection of lawful visitors. However, with respect to wildly thrown or batted balls, operators are held to have discharged their full duty owed to spectators by providing adequately screened seats for patrons who choose to use them.

While Bryson argued to the Court of Appeals that his case was distinguishable from prior binding authority because he was injured by a wild pitch rather than a batted ball, the Court of Appeals held that wildly thrown baseballs are also a hazard incident to the game of baseball. As a result, the Court of Appeals held that the team, baseball league and park owner discharged the duty owed to the Plaintiff because they provided adequate amount of screened seating for Bryson’s use.

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

UNINSURED MOTORIST/HIT-AND-RUN: The Financial Responsibility Act requires physical contact between the phantom hit-and-run vehicle and the claimant’s vehicle to recover uninsured motorist benefits.


Prouse was a passenger in a truck owned by his employer and operated by a coworker. The truck was struck by a tire which fell from a passing vehicle. The tire collided with the truck causing Prouse’s coworker to lose control. The truck overturned and Prouse was injured. The vehicle from which the tire fell was not identified.

After Prouse’s uninsured motorist (UM) claim was denied, he filed suit against the insurer affording UM coverage to his employer’s truck, in addition to his personal vehicle, alleging that he was entitled to uninsured motorist coverage due to the hit-and-run accident. Both UM insurers denied the claim and defended the civil action arguing that there was no coverage for the accident because there was no physical contact between the employer’s truck and an uninsured vehicle. The trial court granted the insurers’ motion to dismiss and Prouse appealed.

Prouse argued that he satisfied the “physical contact” requirement of the Financial Responsibility Act because the tire that struck his employer’s truck fell from a moving vehicle and struck the truck in one continuous motion. The Court of Appeals refused to extend the reach of the Financial Responsibility Act beyond the precedent set forth in prior decisions which require physical contact between vehicles. Judgment for the UM insurers was affirmed.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.
SUIT AGAINST INSURER/CONDITION PRECEDENT: Insurer correctly defended claim by policyholder seeking damages for breach of contract and bad-faith based upon the policyholder's failure to comply with the requisite, pre-litigation appraisal process.


Patel owned a motel located in Tarboro, North Carolina. In 2008, Patel purchased an insurance policy insuring the motel against losses caused by fire. In 2009, the motel was destroyed by a fire, and Patel filed a claim with his insurer. Based on the insurer's investigation, it concluded that the cost to repair the motel exceeded its market value; therefore, the insurer issued payment to Patel equal to the motel's market value. Patel disagreed with the insurer's estimate.

Patel filed a civil action against the insurer seeking compensatory and punitive damages for breach of contract and unfair and deceptive trade practices. The insurer moved for summary judgment on the basis that Patel failed to comply with the terms of the insurance policy which required the parties to participate in an appraisal process prior to instituting a civil action against the insurer.

The policy provided: “If we and you disagree on the value of property or the amount of loss, either may make written demand for an appraisal of the loss. In this event, each party will select a competent and impartial appraiser. The two appraisers will select an umpire. If they cannot agree, either may request that selection be made by a judge of court having jurisdiction. The appraisers will state separately the value of the property and the amount of loss. If they fail to agree, they will submit their difference to the umpire. A decision agreed to by any two will be binding.”

Further the policy states: “We will pay for covered loss or damage within thirty days after we receive the sworn proof of loss, if you have complied with all the terms of this Coverage Part and (1) we have reached an agreement with you on the amount of loss; or (2) an appraisal award has been made.”

The trial court granted summary judgment in favor of the insurer, and Patel appealed. The Court of Appeals held that the insurer's interpretation of the insurance contract was correct, and participation and completion of the appraisal process was a condition precedent to the commencement of litigation against the insurer.

Rather than affirming the trial court's order granting summary judgment, the Court of Appeals remanded the case to the trial court so the parties could resume the appraisal process necessary to initiate a civil action. The Court of Appeals held that the trial court lacked authority to enter judgment for the insurer and the action should have been stayed pending completion of the appraisal.

Summary prepared by Michael A. Cannon, mcannon@gmlj.com.
EFFECTIVE CANCELLATION OF WORKERS’ COMPENSATION: Third-party financing company allowed to cancel policy due to insured’s failure to pay premium.


Jerry Smith, owner of Smith’s Home Repair, obtained a worker’s compensation insurance policy with Travelers Insurance Company. Smith financed the premium through a third party known as Monthly Payment Plan, Inc. (“MPP”). MPP’s financing agreement included a power of attorney provision authorizing MPP to cancel Smith’s policy if he failed to make timely payments.

In January 2007, Smith failed to make his premium payment to MPP. Thereafter, MPP sent Smith a letter advising him that his workers’ compensation policy would be cancelled if payment was not received within ten days. MPP sent copies of this letter by regular mail to Smith’s correct address, as well as to Smith’s insurance agent. After MPP did not receive payment from Smith, on January 15, 2007, MPP sent a “Notice of Cancellation” to Smith, his insurance agent and Travelers, notifying them of MPP’s intent to cancel his policy through the power of attorney provision in the finance agreement. Travelers then sent a Notice of Cancellation to Smith’s last known address for an effective cancellation date of January 25, 2007.

Diaz began working for Smith in April 2007 as a framer and roofer. In July 2007, Diaz fell from a roof on which he was working and sustained a fractured left humorous and dislocated his left elbow. Diaz filed his claim for workers’ compensation benefits in September 2007 and the carrier denied the claim for lack of coverage.

The Court of Appeals ruled that N.C. Gen. Stat. § 58-35-85 sets out the procedure for cancellation of an insurance policy by an insurance premium finance company. Pursuant to the statute, MPP was required to (1) provide the insured with written notice of its intent to cancel their insurance contract unless an installment payment was received, and (2) at the expiration of ten-day waiting period, send Travelers a request for cancellation of the policy while providing notice to the insured. The Court concluded that MPP was authorized by the power of attorney clause of the financing agreement to cancel Smith’s policy with Travelers and that they properly did so via the “Notice of Cancellation” sent on January 15, 2007.

Summary prepared by Rosetta Davidson, rdavidson@gmlj.com.

AWARD OF ATTORNEY’S FEES: Two-part analysis for determining whether attorney’s fees should be awarded.


While working as a truck driver for McGhee Brothers, Burnham sustained an injury which left him paralyzed. Although the parties agreed that Burnham’s injuries were compensable, they did not agree about the extent, if any, to which the employer and insurer should contribute to the ongoing rental costs of a two-bedroom handicapped accessible apartment for Burnham.

While Burnham sought compensation for the additional rental cost of a two-bedroom apartment, the employer and insurer asserted that they had no obligation to contribute to
Burnham’s ongoing rental expenses. The Deputy Commissioner granted Burnham’s request for housing assistance and the Full Commission affirmed.

The Full Commission found that for rehabilitation, safety and good health purposes, it is reasonably necessary for Burnham to have a place to store his medical equipment, supplies and devices close enough for him to have easy access. The Full Commission also found that a two-bedroom apartment which allowed Burnham to have a separate bedroom from his general living quarters to store and have easy access to his medical equipment was reasonably required to lessen his disability. Therefore, the additional cost Burnham incurred to rent a handicapped accessible two-bedroom apartment was the direct and natural result of and causally related to his compensable work injury.

The ultimate issue raised by Burnham’s appeal was whether the Commission erred in denying his motion for the imposition of attorney’s fees pursuant to N.C.G.S. § 97-88.1. The statute states that if the Industrial Commission determines that any hearing has been brought, prosecuted, or defended without reasonable ground, it may assess the whole cost of the proceedings including reasonable attorney’s fees.

The Court of Appeals analyzed the issue, using a two-part analysis. The Court stated that reviewing an award of attorney’s fees, the court must first determine whether the party has a reasonable ground to bring the hearing. Second, if the court determines that the party lacked reasonable grounds, it then reviews the Industrial Commission’s decision whether to award attorney’s fees and the amount.

Here, the Court indicated there was no decision that directly addressed an employer’s obligation to pay ongoing rental expenses that were attributable to a plaintiff’s disability such as the cost of an additional bedroom. Therefore, the Court concluded that the Commission did not err in ruling that the employer and insurer had a valid basis for resisting Burnham’s claim.

Summary prepared by Rosetta Davidson, rdavidson@gmlj.com.

TOTAL AND PERMANENT DISABILITY: The possibility of future drugs and their potential to improve plaintiff’s condition are too speculative when determining permanent disability.


Pait suffered from a compensable occupational lung disease resulting from her exposure to formalin in the course and scope of her employment with Southeastern General Hospital on March 9, 1994. Pait received weekly compensation and was unable to return to any employment due to her condition. In September 2004, the North Carolina Insurance Guaranty Association (NCIGA) assumed the responsibility for paying Pait’s benefits and determined that Pait was totally and permanently disabled. NCIGA proffered to Pait a Form 26 Agreement stipulating to her entitlement to total and permanent disability compensation. When Pait refused the Form 26, the employer and insurer requested that the claim be assigned for hearing to determine the extent of Pait’s disability.

Following a hearing the Deputy Commissioner concluded that the Pait was totally and permanently disabled based on the medical evidence presented. The Full Commission entered its opinion and award reversing the Deputy Commissioner and denied the employer and insurer’s request to have Pait deemed permanently disabled. The Full Commission relied on the testimony of a pulmonary medicine physician who had treated Pait since 1992. The physician testified that while he believed Pait was totally disabled, he could not say to a reasonable degree of medical certainty that Pait’s condition was going to be permanent because of the possibility that new drugs may be introduced to the market to treat her condition.

The Court of Appeals ruled that testimony as to the “possibility” of future drugs was entirely speculative. The testimony relied upon by the Commission did not address the
circumstances of Pait’s condition and available medical treatment as it presently existed. The Court pointed out that Pait’s treating physician, on two different occasions, opined that Pait was permanently disabled. Additionally, a second physician concurred with Pait’s treating physician in that Pait would not return to full-time gainful employment. The Court concluded that aside from the speculative and anticipatory testimony cited by the Commission, there was no competent evidence to support a determination that Pait’s condition was temporary in nature.

Summary prepared by Rosetta Davidson, rdavidson@qmlj.com.

EXPERT TESTIMONY OF PHYSICIAN: The opinion of a physician is not rendered incompetent merely because it is based wholly or in part on statements made to him by the patient in the course of treatment or examination.


Hutchens was employed as a truck driver for Lee, and was responsible for unloading food items at customers’ business locations. On December 12, 2006, while picking up a box of frozen turkeys, Hutchens injured his lower back. He was diagnosed with a lumbar strain and released to work on December 15, 2006 with no restrictions and no permanent partial disability rating. Hutchens did not seek any further medical treatment for his back until he re-injured it on April 10, 2007.

In May 2007, Dr. Albert Osbahr completed a medical questionnaire noting that Hutchens’s December 2006 back injury had completely resolved as of December 15, 2006, and that the new back symptoms were unrelated to the workplace injury. On June 1, 2007, Hutchens saw Dr. Adams, orthopedic surgeon, who noted that Hutchens’ back pain from December 2006 had continued to radiate down Hutchens’s leg until April 7, 2007. The surgeon further stated that Hutchens’ 2007 symptoms likely related back to the December 2006 injury.

Following a hearing on May 15, 2009, the Deputy Commissioner concluded that Hutchens’ December 2006 back injury had resolved and that Hutchens had experienced the onset of a different back condition in April 2007. The Full Commission entered its opinion and award concluding that Hutchens sustained a compensable injury to his lower back in December 2006 and that the medical treatment Hutchens sought beginning in April 2007 was casually related to the December 2006 injury.

The Court of Appeals ruled that although the employer acknowledged that Dr. Adams gave testimony that would support contested findings of fact, the employer asserted that Dr. Adams’ testimony was based on speculation and the “faulty” history Hutchens provided to him. The Court further ruled that in cases involving complicated medical questions far removed from the ordinary experience and knowledge of laymen, only an expert can give competent opinion evidence as to the cause of the injury. However, when such expert opinion testimony is based merely upon speculation and conjecture, it is not sufficiently reliable to qualify as competent evidence on issues of medical causation.

In this case, the Court concluded that the opinion of a physician is not rendered incompetent merely because it is based wholly or in part on statements made to him by the patient in the course of treatment or examination. A physician’s diagnosis often depends on the patient’s subjective complaints, and this does not render the physician’s opinion incompetent as a matter of law.

Summary prepared by Rosetta Davidson, rdavidson@qmlj.com.
COMPARATIVE NEGLIGENCE AND APPORTIONMENT OF FAULT: Retail store not liable for negligent acts of security company employee that departed from company policy and pursued a shoplifter’s getaway vehicle, when the pursuit resulted in an auto accident and death of the getaway driver.


The estate of Alice Hancock (Hancock) filed a negligence complaint against Wal-Mart, U.S. Security, and U.S. Security’s employee, Jones, after Hancock, the driver of a getaway car, was killed in an automobile accident while fleeing the store.

At trial, the judge granted Wal-Mart a directed verdict. The jury then determined that Hancock was 65% at fault and that Jones was 35% at fault for her death. Hancock appealed the directed verdict for the store, and the Court of Appeals affirmed.

Evidence at trial showed that Wal-Mart employees recognized that the shoplifter was attempting to exit the store with stolen merchandise. A greeter stopped the shoplifter near the exit and asked for her receipt. The shoplifter said that her sister had the receipt in the car, so she put her bags down and walked out the store. Outside the store, Jones, spoke to the shoplifter briefly before she ran and jumped into the getaway vehicle driven by Hancock. Hancock sped off the premises. Jones entered his vehicle and pursued Hancock off the premises.

Jones testified at trial that a Wal-Mart employee instructed him to follow the vehicle off of the store premises and to make sure that he got the tag number. Such an instruction from the Wal-Mart employee was a violation of Wal-Mart’s policy for investing and detaining suspected shoplifters which provided: “Never pursue a fleeing Suspect more than approximately 10 feet beyond the point you are located when the Suspect begins to run to avoid detention. Ten feet is about three long steps . . . NEVER pursue a Suspect who is in a moving vehicle.”

Conflicting testimony showed that Jones pursued Hancock’s vehicle for two miles before Hancock’s vehicle either swerved off the road and crashed, or Jones bumped Hancock’s vehicle, causing it to lose control and crash. Hancock died at the scene.

The estate of Hancock argued on appeal that Hancock did not have a fair trial because the jury was not allowed to apportion any fault to Wal-Mart, they were only allowed to apportion fault between Hancock, U.S. Security and Jones. Hancock argued that if the jury could have apportioned fault against Wal-Mart, it may have reduced Hancock’s proportion of fault to the point that her negligence was not greater than that of all the defendants.

The Court of Appeals rejected the argument and held that because Wal-Mart’s liability was derivative of Jones’ liability, and the jury found that Jones was only 35% at fault, such a finding foreclosed any liability of Wal-Mart.

Summary prepared by Sean B. Cox, scox@qmlj.com.
UNINSURED MOTORIST COVERAGE: Employee pinned against employer's manure truck after being struck by another vehicle was ‘upon vehicle’ within meaning of UIM provision and was entitled to employer’s UIM benefits.


Henry Kennedy was sent by his employer in his employer's truck to Wise Barbeque to tell Mr. Wise that the employer had some feed for him to pick up. When he arrived at Wise Barbeque, Kennedy left the keys in his employer's truck and went into the restaurant to deliver the message. As Kennedy left the restaurant, he saw his brother and engaged in a conversation while walking towards the employer's truck.

Kennedy and his brother finished their conversation near the rear of the truck when an accident occurred on a nearby highway between two pickup trucks. The impact of the collision knocked one of the pickup trucks, driven by George Counts, into the restaurant's parking lot where it struck Kennedy and his brother as they attempted to escape the careening vehicle. Kennedy sustained a broken right femur as well as head, neck, and back injuries. His combined medical expenses and lost wages exceeded the liability coverage on Counts' truck.

Kennedy's employer had a Commercial Auto Policy with Farm Bureau that covered its truck, and provided UIM coverage of $50,000 per individual per occurrence. Kennedy sought UIM coverage under his employer's liability but Farm Bureau filed a declaratory judgment action seeking a determination as to whether Kennedy was entitled to UIM benefits under the policy. Part II of the policy concerning UIM coverage provided that it would pay UIM benefits to a "covered person" as follows:

We will pay damages for **bodily injury** or **property damage** a **covered person** is legally entitled to collect from the owner or operator of an **underinsured motor vehicle**. The **bodily injury** or **property damage** must be caused by an accident arising out of the operation or ownership of the **underinsured motor vehicle**.

A "covered person" was defined as "a person **occupying your** [the insured's] **covered auto**." “Occupying” was defined as "having actual physical contact with an **auto** while in, upon, entering, or alighting from it."

Kennedy argued that in considering whether he was “upon” his employer's truck, it should not matter when the physical contact occurred, i.e., whether he was touching the insured vehicle at the time he was crushed by another vehicle, or whether he was touching it, then ran away for his safety before being pinned back upon it. Farm Bureau contended that the physical contact must occur while the individual is “occupying” the vehicle, and that Kennedy was not in physical contact with his employer's truck when Counts’ truck initially hit him, and the fact that he was pushed into the vehicle as a result of the accident does not mean that he “occupied” the employer's vehicle.

The trial court ruled in favor of Kennedy, but the decision was reversed by the Court of Appeals. The Supreme Court of South Carolina ultimately reversed, and held that there was UIM coverage and that Kennedy was “occupying” the employer's vehicle.

The Supreme Court relied on an earlier decision for the proposition that the temporal continuum of an accident necessarily includes more than the point in time of initial impact. It also includes the events immediately surrounding the initial impact and the point in time that the last injury was inflicted.

The Supreme Court held that even though Kennedy may have let go of his employer's truck in an attempt to avoid being hit by Counts’ truck, he was still “upon” and “occupying” the vehicle at the time of the accident, and was therefore entitled to UIM coverage under the Farm Bureau policy.

Summary prepared by Sean B. Cox, scox@qmlj.com.
PRODUCTS LIABILITY AND FEDERAL PREEMPTION: A state law action for allegedly defective contact lenses is preempted and barred by federal approval of contact lenses.


Weston filed suit for damages allegedly suffered from defective prescription contact lenses. Weston purchased a pair of decorative colored prescription contact lenses without a prescription, from Defendant Kim’s Dollar Store, an unauthorized seller. Defendant CIBA Vision (“CIBA”) manufactured the lenses. Weston subsequently developed an eye infection which led to the loss of vision in one eye.

Weston contended CIBA Vision knew these types of lenses were frequently sold without a prescription and by unauthorized sellers, yet CIBA Vision failed to take steps to ensure customers received lenses by prescription only and with appropriate warnings and instructions. CIBA Vision moved for summary judgment on the basis that the claims were preempted by federal law. The trial court granted partial summary judgment in favor of CIBA Vision as to the claims based on “warning, labeling, design, marketing, mis-branding, or similar claims.” The South Carolina court of appeals affirmed.

Federal law, 21 U.S.C. § 360k(a), provides:

[N]o State or political subdivision of a State may establish or continue with respect to a device intended for human use any requirement—

(1) which is different from, or in addition to, any requirement applicable under this chapter to the device, and

(2) which relates to the safety or effectiveness of the device or to any other matter included in a requirement applicable to the device under this chapter.

The first step to determine whether state law claims are barred by federal law preemption is to determine whether the federal government has established requirements applicable to the device through the pre-market approval (“PMA”) process. If so, the next step is to determine whether the state claims parallel the federal requirements (then, the state claim is not preempted) or whether the state common-law claims are “different from, or in addition to” the federal requirements (then, state claim is preempted).

Prior to Weston purchasing the lenses, CIBA Vision received a PMA letter from the FDA which approved the inclusion of UV protection in these particular lenses. Therefore, the Supreme Court held that these lenses had been subject to FDA approval, and the first prong had been met. Express preemption was triggered.

The next question was whether Weston’s claims are different from or in addition to the lenses’ specific federal requirements. Only state requirements that are “different from, or in addition to” the requirements imposed by the PMA process are preempted. State law claims premised on a violation of FDA requirements that “parallel,” rather than add to, federal requirements are not preempted. Weston claimed CIBA Vision knew or should have known that its lenses were being marketed and sold unlawfully. Because those claims were premised on requirements beyond those required by the FDA, they were preempted and barred as a matter of law.

Summary prepared by Sean B. Cox, scox@gmlj.com.
WORKER'S COMPENSATION/COMPENSABLE INJURY: Post-traumatic stress disorder arising after police officer shot a suspect is not a compensable mental injury.


Bentley, a deputy sheriff, alleged that he developed Post Traumatic Stress Disorder (PSTD) and depression after he shot and killed a suspect who attempted to assault him. After an Appellate Panel of the Workers' Compensation Commission unanimously found that Bentley failed to meet his burden of proof in establishing a compensable mental injury that arose out of an “unusual or extraordinary condition” of employment for a deputy sheriff, Bentley appealed, and the South Carolina Supreme Court affirmed.

Following the incident where Bentley shot and killed a suspect who threatened to assault him, Bentley began to suffer psychological symptoms including anxiety and depression and sought mental healthcare treatment. Based on his psychological symptoms, his psychiatrist and psychologist concluded that Bentley was unable to work. Bentley subsequently filed a Form 50 to claim workers' compensation benefits. After a hearing, the Single Commissioner found that the event was not an unusual or extraordinary condition of Bentley's work, and that he had not suffered a compensable mental injury by accident arising out of his employment. The Commissioner noted that deputies received training on the use of deadly force and that Bentley admitted he knew he would sometimes be required to use deadly force in the course and scope of his employment. Bentley appealed.

S.C. Code Ann. § 42–1–160, which sets forth South Carolina's standard for recovering benefits for mental injuries caused by mental stimulus, i.e. a mental-mental injury, provides:

- (B) Stress, mental injuries, and mental illness arising out of and in the course of employment unaccompanied by physical injury and resulting in mental illness or injury are not considered a personal injury unless the employee establishes, by a preponderance of the evidence:
  - (1) that the employee's employment conditions causing the stress, mental injury, or mental illness were extraordinary and unusual in comparison to the normal conditions of the particular employment; and
  - (2) the medical causation between the stress, mental injury, or mental illness, and the stressful employment conditions by medical evidence.

The Supreme Court was critical of this standard on policy grounds, but held that it was constrained to follow the statutory law. In applying the “extraordinary and unusual” standard it held that the standard “refers to conditions of employment and not the frequency of an event occurring during the course of employment.”

Bentley admitted he knew that as a deputy, part of his job was potentially utilizing deadly force. The Court found that using deadly force was a potential in every law enforcement job. Therefore, it was a normal condition of employment and did not satisfy the extraordinary and unusual test. Bentley was therefore not entitled to benefits for a purely mental-mental injury.

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

Collins was hired by West to drive a delivery van. Seko contracted with West for a delivery of parts from a company in Spartanburg, South Carolina, to Wauwatosa, Wisconsin. On September 7, 2007, Collins picked up the parts and delivered them to Seko’s customers in Wisconsin. While driving back to South Carolina on September 8, Collins was killed in an automobile accident.

Seko’s manager testified that Seko is a transportation company providing transportation services. Its drivers made deliveries within a hundred miles of Charlotte, but subcontracted longer trips to companies such as West. West provided delivery services which are required when a customer needs immediate delivery.

Seko did not have a written contract with West. Seko paid West $1.20 per loaded mile, one way. Seko utilized West’s services approximately two to three times per month and contracted with other similar companies. Seko contended that once a delivery was made, its agreement with West ceased. Here, Collins had no cargo in the van during the return trip, and Seko accordingly maintained he was no longer its statutory employee. He admitted that if Collins had been Seko’s employee at the time of the injury, he would have a valid workers’ compensation claim against Seko and conceded that the Seko drivers were covered by Seko’s workers’ compensation insurance on their entire trips, rather than just on the way to the delivery site. Seko admitted it knew West’s drivers would return to South Carolina because they were based here.

A single commissioner found Seko was Collins’ statutory employer. Seko appealed to the Commission which found Collins was Seko’s statutory employee during his trip to Wisconsin, but Seko did not maintain the degree of control over Collins during the return trip to continue the employment relationship. Furthermore, the Commission found Collins was no longer Seko’s employee within the “going and coming rule.” It concluded Collins was not Seko’s statutory employee at the time of the accident.

Statutory employment is an exception to the general rule that coverage requires the existence of an employer-employee relationship. The effect of the statutory employment provisions when brought into operation is to impose the absolute liability of an immediate employer upon the owner and/or general contractor although it was not in law the immediate employer of the injured workman.

When any person ... undertakes to perform or execute any work which is a part of his ... business ... and contracts with any other person for the ... performance by or under such subcontractor of the whole or any part of the work undertaken by such owner, the owner shall be liable to pay to any workman employed in the work any compensation... S.C. St. § 42–1–400.

The Court of Appeals found that once the Commission determined Collins was an employee of Seko’s subcontractor, West, the Commission should have looked to whether Collins’ activities were part of Seko’s trade, business, or occupation. South Carolina has applied three tests and concludes the statutory requirement is met if the activity: (1) is an important part of the owner's business or trade; (2) is a necessary, essential, and integral part of the owner's business; or (3) has previously been performed by the owner's employees. If the activity meets any of those three criteria, the injured employee qualifies as a statutory employee. In this case, Seko admitted deliveries like the one Collins made were an important and necessary part of Seko's business. We agree that Seko's utilization of West’s services two to three times per month for “express hot deliveries” is an important part of Seko’s delivery business. Accordingly, the Court of Appeals found Collins was Seko’s statutory employee during the entire trip and was therefore entitled to benefits.

Summary prepared by Sean B. Cox, scox@gmlj.com.
WORKERS COMPENSATION: Speculative evidence may not be used to deny wage loss claim.


Hutson was working as a crane operator for the State Ports Authority when he sustained an injury to his lower back and legs while attempting to remove a container from a ship. He was diagnosed with a disc bulge, and his treatment included steroid injections, physical therapy, and use of a back brace. After reaching maximum medical improvement, Hutson filed a Form 50 with the workers' compensation commission for continued benefits alleging permanent and total disability or, alternatively, a wage loss awarded in a lump sum.

The Ports Authority admitted the accident and the back injury, but disputed the claims to his legs and argued he should receive only permanent partial disability benefits. It also objected to Hutson's request that his benefits be paid in a lump sum.

According to a vocational expert, Hutson's earning ability post injury was slightly less than $14,000 per year compared to the approximately $90,000 per year he earned as a crane operator.

Hutson testified he was interested in opening a restaurant, which is why he requested the award in a lump sum. Hutson admitted he had never previously run a restaurant and acknowledged that doing so would require him to stand at the register and in the kitchen as well as sit for periods of time. Hutson could not respond with any specificity when asked how much money he expected to make. He informed the commissioner, “It depends on how many people I get coming in there. My food’s good.”

The single commissioner found Hutson sustained a 30% loss of use to his back, but did not award any benefits for a leg injury. The commissioner denied the wage loss claim finding that because Hutson testified he could work as a restaurateur he did not show a wage loss. Therefore, the Commissioner found Hutson did not suffer any loss of earning capacity. The full commission and circuit court affirmed. Hutson appealed his claim for lost wages.

The Supreme Court reversed the Court of Appeals' decision that Hutson did not show a valid claim for wage loss. It found that Hutson's testimony that he could work as a restaurateur was entirely speculative and based on conjecture. Therefore, it provided no probative value and could not be used as a basis to deny his lost wages claim. The only evidence in the record bearing on Hutson's future earning capabilities was from the vocational expert, who offered uncontradicted testimony that Hutson's present earning potential was approximately $14,000 per year.

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