

# NEWSLETTER

## FLORIDA LAW UPDATE

### CAN I GET A JUDGMENT FOR ATTORNEY FEES AGAINST THE PLAINTIFF, OR WILL I HAVE TO PAY THEM UNDER THE PROPOSAL FOR SETTLEMENT RULE?



**Steven Sundook, Esq.**  
Vernis & Bowling of  
Southwest Florida, PA

If your lawyer does a great job for you and you won your case, what are the chances of enhancing that victory with an award of attorney fees following the successful litigation? If you were not successful in litigating a claim, will it get worse with an award of fees being entered against you? These are the happy and fearful questions to ponder under Florida's Proposal for Settlement (PFS) rule and Offer of Judgment statute. The answer to these questions has become clearer as appellate decisions regarding enforcement of Proposals for Settlement have been rendered. Under the rule a Plaintiff who obtains a judgment for 125% of the amount of a PFS, or a defendant who obtains a judgment for 75% or less, may seek a judgment for attorney fees.

The rule requires a proposal for settlement to be as specific as possible

leaving no ambiguities so that the recipient can fully evaluate its terms and conditions; if ambiguity within the proposal could reasonably affect the offeree's decision, the proposal will not satisfy the particularity requirement.

A general release is a "relevant condition" or "nonmonetary term" that must be described with particularity in an offer of judgment because when an offeror insists that an offeree sign a general release, the release becomes a stipulation or prerequisite of the contract. A summary of the proposed release can be sufficient, however, to satisfy the rule requiring an offer of judgment to state with particularity any relevant conditions and all nonmonetary terms. Thus, in order to satisfy the particularity requirement of the offer-of-judgment rule, a proposal for settlement can contain either the proposed release or a summary of the terms of the proposed release, provided that the summary eliminates any reasonable ambiguity about its scope.

In Lyons v. Chamoun, 96 So.3d 456 (Fla. 4th DCA 2012), the plaintiff sued the owner and driver of a car for

Continue Reading p.14

## GEORGIA LAW UPDATE

### PREMISES LIABILITY AND TORT UPDATE



**J. Scott Bell, Esq.**  
Vernis & Bowling  
of Atlanta, LLC

Every day of our professional lives, we are confronted with claims which span the gamut of human activity. In assessing those claims, we must make informed decisions on how those claims are likely to be addressed should they make their way before a jury. In the realm of premises liability and tort litigation, the interpretation of the law is at least as important as the operative statute itself. Following are some of the more interesting recent cases which show how Georgia courts are interpreting Georgia's premises liability and tort laws.

In Bruce v. Georgia-Pacific LLC, \_ Ga.App. \_ (April 22, 2014), the Court of Appeals dealt with a slip/trip and fall off of a flatbed tractor trailer by its driver while he was securing a load in another company's loading dock. Immediately prior to the slip/trip and fall, the driver was in the midst of applying shrink wrap and a tarp to his load of wood paneling obtained at a Georgia-Pacific facility.

Continue Reading p.9

#### THIS NEWSLETTER ISSUE INCLUDES:

Florida Law Update	p.1	Alabama Law Update	p.3	Client Feedback	p.13
Georgia Law Update	p.1	Company Spotlight	p.4	Firm Announcements	p.15
North Carolina Law Update	p.2	Verdicts & Dispositions	p.5	Office Locations	p.16

## NORTH CAROLINA UPDATE

## HOW NORTH CAROLINA RULE 414 HAS CHANGED THE LANDSCAPE IN EVALUATING MEDICAL EXPENSES IN LIABILITY CASES



**Thomas G. Nance, Attorney**  
Vernis & Bowling of Charlotte

On October 1, 2011, a new rule of evidence went into effect in North Carolina, affecting the admissibility of medical expenses. The new law dramatically changes how medical expenses are calculated and presented to a jury in personal injury cases. Attorneys and insurers have been trying figure out how to deal with it ever since. The absence of any appellate decisions interpreting the new rule has led to a wide variety of interpretations of the rule, as well as strategies to use it, and get around it.

Unlike the majority of jurisdictions that allow plaintiffs in personal injury cases to claim and present evidence of the full amount of their medical bills, North Carolina now restricts evidence of medical expenses to the amounts “actually paid” to satisfy the medical bills or “actually necessary” to satisfy unpaid bills. This new rule in calculating medical expenses is commonly referred to as “billed v. paid”.

### 1. What it does and how it works.

Rule 414 of the North Carolina Rules of Evidence, enacted October 1, 2011, states as follows:

*Evidence offered to prove past medical expenses shall be limited to evidence of the amounts actually paid to satisfy the bills that have been satisfied, regardless of the source of payment, and evidence of the amounts actually necessary to satisfy the bills that have been incurred but not yet satisfied. This rule does not impose upon any party an affirmative duty to seek a reduction in billed charges to which the party is not contractually entitled.*

The primary effect of the new rule is that any adjustments or reductions to the medical bills due to the application of health insurance, Medicare, Medicaid and other third party sources acts to reduce the amount of medical expenses that are admissible at trial. This can drastically reduce the value of a case.

As an example, take the theoretical case of a personal injury plaintiff who suffered serious injuries in an accident of some kind (motor vehicle, slip & fall, construction accident, etc.). The person was hospitalized for a few days, had multiple CT scans and MRIs, required spine surgery, as well as rehabilitation and physical therapy. This plaintiff has medical expenses of \$80,000. However, the plaintiff has health

insurance. The health insurer has agreements in place with all of the medical providers, including approved rates and pricing for all providers and procedures. As a result of these contractual rates, the medical bills are adjusted down and the total amount of the bills suddenly drops from \$80,000 to only \$35,000. The plaintiff pays the deductible and co-insurance and the insurer pays the balance. All of the medical bills have now been paid in full for \$35,000.

Prior to Rule 414, the plaintiff would be able to claim the full \$80,000 in medical bills and present that amount to the jury at trial. Now, under Rule 414, the plaintiff can only present evidence of \$35,000 in medical expenses.

Right away, this new rule dramatically impacts the value of the case and has major implications for how a liability insurer, third party administrator or self-insured entity is going to evaluate the case for settlement purposes. The value of the case has now dropped by \$45,000, at a minimum, and likely more.

Rule 414 also applies to more than just health insurance adjustments and reductions. The broad language of the rule makes it applicable to Medicare and Medicaid adjustments, Workers’ Compensation adjustments, uninsured discounts, self-pay discounts, prompt payment discounts, etc. The focus is no longer on what the bill says is being charged. The focus is on what is actually paid to satisfy those bills. If the provider takes less than the full amount as payment in full for services, the reduced amount is what is admissible.

The same is true for bills that have been incurred but not yet paid. However, it is often harder and more time consuming to determine the actual amount necessary to satisfy unpaid bills.

Rule 414 does not affect the Collateral Source Rule. Defendants are still not permitted to introduce evidence that the bills were paid by some third party such as health insurance, Medicare or Medicaid. Rather, the rule simply affects the amount of expenses that can be introduced. A party cannot introduce evidence that the bills were actually higher and were reduced or introduce evidence of how or why they were reduced or who paid the bills. At trial, rather than introducing the bills themselves, which normally will not reflect the amounts actually paid, the attorneys are frequently stipulating to a document that summarizes and lists the amounts actually paid for the services of each medical provider.

[Continue Reading p.11](#)

ALABAMA LAW UPDATE

## RECENT INTERPRETATIONS OF THE FORUM NON CONVENIENS STATUTE PROVE FAVORABLE FOR CORPORATE DEFENDANT



**James "Jay" Potts, Esq.**  
Vernis & Bowling of Birmingham, LLC

The tort reform package passed in 1987 brought sweeping changes to the practice of civil law in the state of Alabama. Included in these changes was the enactment of Alabama Code 6-3-21.1, otherwise known as the *forum non conveniens* statute. Alabama law allows for an individual to bring a personal injury lawsuit against a corporation in the county where the corporation has its principle office, or in the county where the plaintiff resides, if the corporation “does business by agent or otherwise” in that county. However, under the *forum non conveniens* statute, even if an action is filed in a proper forum, upon motion by the defendant, the trial court **shall** transfer a case to a county that is more convenient for the parties and witnesses or, in the interest of justice, to a county that has a stronger connection to the litigation than the county where the action was filed.

For many years after its enactment, the appellate courts were reluctant to enforce the *forum non conveniens* statute. However, in the last ten years, there have been several Supreme Court opinions which have given new life to the statute. Citing the “interest of justice” prong, a clear message has been sent that a case should be litigated in the county in which the events giving rise to the lawsuit occurred. The rationale is that the citizens of that county, who will serve as jurors at trial, have a strong interest in determining the outcome of a case that is based upon events that occurred in their home county (Example: if an automobile accident occurs on a public road located in “County A,” the citizens of County A who travel on this road have a vested interest in determining the outcome of the case). As stated many years ago by the United States Supreme Court, “There is a local interest in having localized controversies decided at home.” Gilbert v. Gulf Oil Corporation, 330 U.S. 501 (1947).

In a 2006 Alabama Supreme Court opinion that dealt with the *forum non conveniens* statute, the Court held that “litigation should be handled in the forum where the injury occurred.” Ex parte Fuller, 955 So. 2d 414, 416 (Ala. 2006). That doctrine has been cited and applied in several subsequent opinions dealing with the *forum non conveniens* statute. See Ex parte Indiana Mills & Mfg., Inc., 10 So. 3d 536 (Ala. 2008); Ex parte Autauga Heating & Cooling, LLC, 58 So.3d 745 (Ala. 2010); Ex parte Wachovia Bank, N.A., No. 1100645, 2011 Ala. LEXIS 79 (May 27, 2011). In Wachovia, the Supreme Court expounded upon this by stating, “the fact that the injury

occurred in the proposed transferee county is often assigned considerable weight in an interest-of-justice analysis.”

Ex parte Waltman, 2013 WL 135735 (Ala. 2013) is a prime example of a recent Supreme Court opinion on this topic. John Owens was injured when a utility trailer that was being towed by James Waltman became disconnected from Waltman’s vehicle and subsequently struck Owens’s truck. As a result of this incident, Owens brought claims for personal injuries against Waltman. Additionally, because Owens was operating a vehicle in the line and scope of his employment, he brought claims for workers’ compensation benefits against his employer, Griffin Wood Company, Inc. The incident occurred in Tuscaloosa County. Owens was a resident of Hale County and Waltman was a resident of Tuscaloosa County. Owens filed the action in Perry County where Griffin Wood had its principal place of business. Waltman filed a motion to transfer the case to Tuscaloosa County, which was denied at the trial court level. The Supreme Court reversed the trial court’s decision, and ordered the case to be transferred to Tuscaloosa County. The Court reasoned that under the “interest of justice” analysis, Tuscaloosa County had a stronger connection to the claims than Perry County because the accident occurred in Tuscaloosa County.

This office is currently defending a catastrophic personal injury case with facts similar to those presented in Waltman. The plaintiff, who was working at the time of the accident, filed the case in the county where his employer has its principle place of business, rather than in the county where the incident made the basis of the lawsuit occurred. We filed a motion to transfer venue to the county where the incident occurred pursuant to the *forum non conveniens* statute and its recent interpretations from the Supreme Court. Although the original venue was technically proper, the trial court agreed that the *forum non conveniens* statute mandated a transfer of the case to the county where the incident occurred. This development was of great benefit to the client, not only because the new venue was more appropriate to litigate the matter, but also because the suit is now pending in one of the more conservative venues in Alabama.

The *forum non conveniens* statute has developed into a potent shield against the “forum shopping” which tort reform was meant to curtail. The present interpretation of the statute limits the plaintiff’s ability to choose a favorable venue which has little interest in the case. As counsel and insurers for corporate defendants, we should always be mindful of this statute and the opportunity it may provide for the transfer of an action to a more favorable venue for the client. ❖



## COMPANY SPOTLIGHT

## THE CLOUD'S GOT YOU COVERED

BizTech

Kym Gilhooly, Author  
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Feeling under the weather when it comes to disaster recovery? Three businesses tap into hybrid cloud strategies to keep their systems and data healthy.

Within many C-suite offices, the mere mention of “disaster recovery” conjures up images of arduous data restoration in the aftermath of devastation wrought by tornados, hurricanes and floods.

Ironically, this perception can hinder DR planning if senior management becomes so focused on severe weather and other natural events that they overlook everyday threats that can bring systems — and businesses — to a complete standstill.

As a result, even some large businesses have ineffective or, worse, no documented DR strategies in place. So where does that leave small and midsized businesses?

In an ever-improving position, actually — with a growing number of cloud backup and recovery options at their disposal. Options range from plain-vanilla online backup to managed services, including disaster recovery.

Ideally, experts suggest, small businesses should take a hybrid approach, backing up all data, applications and servers both locally and off-premises in the cloud.

Combining local with cloud backup is a smart business practice, enabled by appliances that run on-premises to facilitate the hybrid process, says Dave Simpson, senior analyst at 451 Research.

“If you have a server failure rather than a site failure, you can recover locally, and that’s always faster,” Simpson says. “This hybrid approach covers most disasters, as it’s typically not a bomb or a flood that causes service disruptions.”

Businesses can mix and match backup tools and options with myriad cloud services. IT teams can scale tools and use their cloud arrangements to expand storage as necessary while also providing resiliency, Simpson notes.

That’s the approach taken by Vernis & Bowling, a Florida-based law firm, with 16 offices across the Southeast U.S.

## WILMA’S WAKEUP

“When you’re based in the Southeast, you never know what might bring operations down,” says IT Director John

Klarmann, whose staff of four supports 350 employees. “It can be anything from a brief power outage or employee error to fire or water damage caused by tornados or hurricanes.” The power outage caused by 2005’s Hurricane Wilma, which struck around the time Klarmann was hired, took the network offline for several days.

“We back up servers locally, but we also needed something offsite to ensure full disaster recovery,” he says.

The team uses Veeam Backup & Replication Enterprise Plus to cross-replicate virtual servers running accounting software in Miami and Palm Beach. This provides some recovery assurance, but the sites are too close in proximity for high-availability protection. Following an extensive review process, Klarmann chose Barracuda Networks’ Barracuda Backup to supplement his local virtualized replication.

Vernis & Bowling’s automated backup process is multilayered: A workgroup solution locally backs up the server at each site to its own external hard drive for rapid restoration purposes. Then, a Barracuda agent on each local server backs up all changed files to the network-attached storage system at the Miami site, where the Barracuda appliance runs. When that process is complete, the appliance, whose software incorporates 256-bit AES encryption, backs up everything to the Barracuda Cloud.

For data protection, Barracuda operates redundant, geographically dispersed data centers. Other services in place to provide business continuity assurance include overnight appliance replacement as well as a LiveBoot option. If virtual servers fail, IT staff can boot them through Barracuda and run them as if they were live on-premises.

“If our data center goes down and the appliance is damaged, or it just needs general repairs, Barracuda ensures we will have a new unit with all our data on it the next business day,” Klarmann says.

Given the sensitivity of Vernis & Bowling’s legal files, the IT team does full server backups so that it can quickly provide access to lost or corrupted files and perform complete bare-metal restores if necessary. The only servers the firm doesn’t run on-premises are email servers, which they colocate with Rackspace.

51%

Percentage of IT pros who cited more frequent backups as the reason they incorporate public-cloud services in their DR strategies\*

\*SOURCE: Forrester Consulting, “Cloud Backup and Disaster Recovery Meets Next-Generation Database Demands,” March 2014

**VERDICTS & DISPOSITIONS**

**Tom Paradise and Belinda Scott (Broward/Hollywood, FL) (General Liability)** obtained a summary judgment in the case styled Marie Corinne Doudeau v. Target.

Plaintiff brought an action against Target Corporation for Negligence stemming from a slip and fall incident. The Plaintiff, Marie Doudeau, age 54, slipped and fell as a result of a clear substance that she presumed to be water. Plaintiff alleged that as a result of the incident she suffered a cervical disk herniation (C5-6) and subsequently had an anterior cervical discectomy and fusion at this level. Plaintiff incurred \$155,000.00 in medical bills which were all under a letter of protection.

Target filed a Motion for Final Summary Judgment with the Court on the basis that the undisputed facts indicated that its inspections of the subject store were reasonable and timely, and that the substance was not on the floor for a long enough time for Target to be charged with notice of same. In support of its Motion, Target provided images from the store surveillance video, which showed that an undercover Target Asset Protection Specialist walked through the area where the Plaintiff subsequently slipped and fell 3 minutes and 45 seconds prior to the incident. This Target employee testified that had he observed something on the floor at that time, he would have had it cleaned up. Additionally, Target argued that based on the description of the substance the Plaintiff could not prove that the water on the floor had been there for a length of time by which notice could be imputed to Target, as required by Florida Statute 768.0755.

In opposition to Target's motion, the Plaintiff contended that the proximity of her fall to the entrance of the store (an area that water is known to accumulate when it rains outside) suggested that Target should have foreseen that water would be present in the location of her fall since it was raining outside at the time of the incident. In her response she included several quotes from the testimony of Target employees wherein they admitted that water could accumulate by the store entrance (where the carpet meets the tile).

Target rebutted this contention, pointing out that the location of Plaintiff's incident was, in fact, some distance away from the entrance of the store, and closer to the One-Stop area and the main aisle. Therefore, Target argued, any evidence about water which may have been by the entrance was misleading and irrelevant.

In its eleven page ruling, the Court explained that Plaintiff's mischaracterization of the location of her fall did not create a material issue of fact to defeat Target's Motion. The Court ruled that there was no evidence which would establish that Target had notice of the substance on the floor and granted

final summary judgment in favor of Target. Plaintiff is currently appealing.

**Matthew Francis (Florida Keys) (Liability/Governmental)** obtained a summary judgment in a bicycle accident case involving a collision with a road sign installed as part of a roadway and sidewalk reconstruction project in Key West Florida. Plaintiff filed suit against the Florida Department of Transportation and numerous contractors and sub-contractors involved with the reconstruction project. Plaintiff alleged the sign involved was not installed in accordance with plans and specification and further constituted a hidden dangerous condition. As a result of the accident Plaintiff suffered a broken hip that required surgical intervention. Plaintiff's medical bills totaled over \$100,000.00. Following discovery a motion for summary judgment was filed on behalf of FDOT. The Court ruled the subject sign was an open and obvious condition and one for which FDOT was afforded the protections of Sovereign Immunity. Following the entry of summary judgment a settlement was reached as to the taxable costs and plaintiff agreed to waive appellate remedies. Tolien v. The Florida Department of Transportation, et al, 16th Circuit, Monroe County, FL 44-2011-CA-754-K.

**Scott Black and Theron Simmons (Florida Keys) (Liability/Education)** obtained a summary judgment in a negligent supervision case filed against the School Board of Monroe County Florida. Plaintiffs, individually and as parents of a minor child, brought suit against the school board for an injury to their child stemming from an altercation with a fellow student. Plaintiff suffered a fractured elbow requiring surgery after being pushed to the ground by a fellow 8th grader. Plaintiff claimed the teacher involved was negligent in his supervision of the class because he stayed behind to answer a student's question and lock his class room door. The incident took place without prior notice or warning to the teacher and lasted for approximately 6-7 seconds. Plaintiff's medical expenses totaled just over \$25,000.00 and the last offer to settle was for \$125,000.00. Based on the age of the students, lack of notice, and the short duration of the altercation the Court entered summary judgment in favor of the School Board. Charles v. The School Board of Monroe County, FL 44-2008-CA-446-K.

**R. Gregory Lewis (Charlotte, NC) (Insurance Defense – Motor vehicle negligence)** obtained a defense directed verdict in the case styled Yanka Castro, by her Guardian Ad Litem vs. Heather & Zachary Taylor (Guilford County, Greensboro, NC). Tried March 31 – April 2, 2014, Guilford County Superior Court, Greensboro, NC.

**Verdicts & Dispositions, Continued**

Plaintiff brought suit against Defendants, alleging that on 2/15/12, the 13 year-old minor Plaintiff pedestrian was injured when she was struck by a vehicle operated by 16 year-old Defendant Zachary Taylor, and owned by his mother, Defendant Heather Taylor. The evidence at trial showed the minor was crossing a residential street 29 feet from the closest intersection, outside a marked/unmarked crosswalk, at night in a dimly lit residential neighborhood, and that she was wearing dark clothing. Plaintiff's evidence also showed that she was wearing a strobe-light safety armband, observed by the investigating officer at the scene. Without objection, defense counsel elicited testimony from the investigating officer that the speed of Defendants' vehicle was not an issue in terms of contributing factors to the accident, and that Defendant had made a left turn onto the roadway at a speed of 15 mph and could not see the Plaintiff crossing the street before impact. There were no tire marks or other determinative physical evidence at the scene, and Plaintiff impacted the front right corner of Defendants' vehicle, scratching the right hood and knocking off the right side mirror, as she crossed the road from Defendant's left to his right, having crossed 2/3 of the roadway before impact. All the evidence elicited on cross-examination of Plaintiff's witnesses showed the minor was aware of the responsibilities of a reasonably prudent pedestrian, and dangers of failing to keep a lookout. Plaintiff alleged abrasions and contusions requiring EMS transport, ER treatment, 2 follow-up visits with her PCP, and at 4 months post-accident (after middle school was recessed for the summer), a 6 week course of chiropractic care. She continued to complain of objectively unverifiable back, neck and leg complaints at trial, despite discharge from treatment in late 2012. Medical expenses totaled approximately \$12,000.00. Plaintiff's lowest demand was \$30,000.00 at mediation. Defendants' top offer was approximately \$10,000.00 – the expenses related to ER and PCP treatment. At trial, upon the conclusion of Plaintiff's evidence and upon Motion of defense counsel, Superior Court Judge Susan Bray (Guilford County, NC) **directed a verdict in favor of Defendants**, finding insufficient evidence of negligence on the part of the Defendant driver, and contributory negligence as a matter of law on the part of the minor Plaintiff, for crossing a street at night, outside a crosswalk, with the permission of her aunt to whom she had been entrusted and who was watching other children nearby and not keeping a proper lookout. \*\*It is significant to note that in NC, which follows contributory negligence as opposed to comparative, at common law, a minor between the ages of 7 and 14 is rebuttably presumed to be incapable of negligence. The court therefore found that the presumption had been rebutted by the defense as a matter of law. Informal

discussions with discharged jurors after the dismissal suggest the outcome would have been the same had the issues been submitted to the jury.

**Carl Bober and Donna Waters Romero (Hollywood/Broward) (Commercial First Party Property)** obtained a defense verdict after a 5 day jury trial in a Hurricane Wilma breach of contract action filed against Citizens Property Insurance Corporation in Miami, Florida. Plaintiff, a 96 unit condominium association, brought a breach of contract action seeking damages in excess of \$2.6 million dollars alleging that its insurer failed to pay for structural and interior damages due to windstorm that were covered under its Commercial Property policy of insurance. Plaintiff's expert engineer testified that the Association's building showed a classic pattern of windstorm damage that could only have been caused by Hurricane Wilma. Plaintiff's public adjuster testified that the Association's insurance claim, which was not reported until June 2010, was promptly made once it was confirmed that the damages were actually due to Hurricane Wilma. For the defense, it was argued that the Plaintiff failed to timely report its loss and that Plaintiff's numerous intervening repairs to the property prejudiced Citizens' ability to fairly investigate and evaluate their claim. Additionally, it was also argued that the inspections of the property did not demonstrate any evidence that the property sustained damages caused by Hurricane Wilma. While the trial judge directed a verdict on the question of late notice at the end of the Plaintiff's case in favor of Citizens, the Court sent the question to the jury of whether the Association had overcome the presumption of prejudice due to its late reporting of the claim. The jury deliberated for 1 hour and returned a verdict in favor of Citizens in the case of The Horizons West Condominium No.8 Association Inc. v. Citizens Property Insurance Corporation, 10-51970 CA 10. Post-trial, the Association did not appeal the judgment entered against it, and the trial judge also granted Citizens' Motion for Entitlement to Attorney's Fees and Costs.

**Steven Sundook (Fort Myers/Southwest Florida) (Negligence)** obtained a summary final judgment in a personal injury case filed by an expert pool cage rescreener, against a homeowner who hired a contractor to replace three screens on his lanai pool cage. The Plaintiff was the helper of a contractor whom the homeowner was about to hire to do the job. While the contractor was writing up a contract for the work, the plaintiff placed a ladder against the pool cage and began to climb it. He fell off the ladder and landed on the concrete pool deck, several feet below. He was diagnosed with an intraarticular displaced fracture of right distal radius and ulnar and significant dorsal comminution,



not in a position amenable to closed treatment. The Plaintiff underwent open reduction and internal fixation right distal radius intraarticular fracture and right open carpal tunnel release, as well as significant physical therapy for three months. Medical bills totaled \$36,787.45. The Plaintiff also had a significant lost wages claim. The last demand for settlement was \$301,000.00 (liability policy limits + \$1,000.00 medical payments coverage).

The Plaintiff argued that pool cage anchors were negligently maintained by the homeowner were the cause of his fall. Attorney Sundook argued, and the court agreed, that The Plaintiff was attempting to impose liability on his supervisor's customer for dangers inherent in the pool cage rescreening job, the contractor might have been hired to do, had they ever entered into a contract to perform the work. The court determined, as a matter of law, that the homeowner owed no duty whatsoever to the Plaintiff. The case was styled Raynor vs. Konczal, Sarasota Circuit Court case no 13-CA-6323-NC. It is expected that the Plaintiff will appeal from the summary final judgment.

**Chelsey Edgerly (Birmingham, Alabama) (General Liability)** obtained summary judgment on behalf of the insured grocery store, Food Giant. The plaintiff filed suit in the Bessemer Division of Jefferson County Circuit Court, typically a plaintiff-friendly venue, asserting negligence and wantonness. She claimed injuries to her right arm and shoulder after tripping and falling over an allegedly defective rug at the store's entrance. Chelsey argued that the plaintiff failed to offer any evidence to establish that the mat in question affirmatively caused the plaintiff's fall. She further argued there was no evidence of actual or constructive notice to the defendant of the allegedly dangerous condition. Summary Judgment was granted in favor of the defendant, and the plaintiff quickly filed a Motion to Alter, Vacate or Amend. Upon rehearing, the plaintiff argued that the defendant was not required to have notice of this defect because notice is presumed under the "affirmative-creation" rule, whereby constructive knowledge is imputed to a defendant whose employees actively create a dangerous condition in an otherwise safe environment. In contest, Chelsey argued that the placement of the mat was not the sort of affirmatively created defect contemplated by the case law. Plaintiff's Motion was denied and final judgment was entered in favor of the defendant. Warren v. Food Giant, Circuit Court of Jefferson County, Bessemer Division, CV-2012-900736.

**Thomas G. Nance (Charlotte, NC) (Insurance Defense – Automobile Liability)** Defense verdict obtained in the case styled Elaine Templeton v. Sandra McGill.

The case involved a high-speed T-bone collision at an intersection that resulted in serious injuries to Plaintiff,

Defendant and the occupants of a third vehicle struck in the accident. Both Plaintiff and Defendant claimed they had a green light and the other had run the red light. Plaintiff filed suit in the Superior Court of Union County and Defendant responded with a counterclaim. Attorney Thomas Nance represented the Defendant, along with co-counsel retained to pursue the counterclaim. The parties stipulated to damages and the case was tried solely on liability. 3 independent witnesses testified favorably for Defendant, but none was in a position to see the color of the light for either Plaintiff or Defendant. Plaintiff's 2 adult sons were passengers in her car and testified in favor of Plaintiff. Both parties brought in traffic engineers to testify to the complex signal pattern of the lights at the intersection. A total of 10 witnesses testified during the 2 day trial. After 1 hour of deliberation, the jury returned a favorable defense verdict, finding Plaintiff negligent and Defendant not negligent. The verdict had implications beyond the immediate case. The injured occupants of the third vehicle had filed a separate lawsuit against both Plaintiff and Defendant. By prior agreement of all parties, the jury's verdict also applied to determine liability in the other lawsuit, obligating Plaintiff to pay the claims of the occupants of the third vehicle and relieving the client of any liability in that case. The client's insurer was also able to recover payments it had made for the property damage claim of the third vehicle.

**Thomas G. Nance (Charlotte, NC) (Insurance Defense – Automobile Liability)** Obtained a defense verdict in the case styled Shelton Prentice Rankin v. James Nelson Brady.

Plaintiff brought suit in the Superior Court of Guilford County alleging Defendant ran a red light, resulting in a significant T-bone collision that flipped Defendant's car on to its roof. Defendant counterclaimed, alleging that it was plaintiff who ran the red light and caused the collision. In addition to the parties, there were 4 witnesses to the accident. 2 witnesses claimed Defendant ran the light. The other 2 witnesses claimed it was Plaintiff that ran the red light. Both Plaintiff and Defendant alleged personal injuries and property damage. Each party was represented by both plaintiff's counsel and defense counsel who divided the presentation of witnesses and evidence equally. Counsel Thomas Nance represented Plaintiff in defense of the counterclaim asserted by the Defendant. The parties stipulated to damages and tried the case to a jury solely on the issue of liability. Following a 2 day trial, the jury returned a defense verdict against of both parties, finding that neither proved who had the red light and awarding no damages to either party. ❖

## THE CLOUD GOT YOU COVERED

## Company Spotlight, Continued from p.4

“The lifeblood of a law office is communication, and today, communications throughout the court system are done through email,” Klarmann says. “We keep that offsite because tens of thousands of emails flow through our offices daily. We can’t afford any downtime.”

Once an IT team completes the initial backup of data it wants to store offsite, only changed or new files subsequently need to be backed up to the cloud. “You’re not backing up every terabyte of your production data every day — only what’s changed,” says Dave Simpson, senior analyst at 451 Research.

Typically, a business need back up only a few terabytes (or even gigabytes) in the cloud daily, he says. Though the Internet isn’t a good vehicle for migrating petabytes of data, it’s well suited to most businesses’ ongoing backup and recovery needs, further aided by deduplication and other WAN optimization features incorporated in backup appliances and services.

If a business does its initial backup over hard-wired network links, it can take weeks or even months, depending on upload speed and data volume. With 100-megabit-per-second download speeds and a fiber network, law firm Vernis & Bowling had the throughput to do its main backup to its Barracuda appliance over the Internet, says IT Director John Klarmann.

“The initial backup took several days, but once it was done, our nightly backup, which includes all our SQL databases, was very fast,” he says.

If a company doesn’t have the sufficient network capabilities to go this route or doesn’t want to wait for an extended period, it can take advantage of seeding services offered by some cloud service providers. With these services, providers send the customer an appliance or drive to make a full initial backup, before beginning any data replication.

## A DOSE OF DR

With years of experience managing IT operations, Ken Johnson “learned the hard way that backup isn’t something you take lightly.” When he joined the Rose City Urgent Care and Medical Practice as IT director two years ago, his first task was to map the Portland, Ore., startup’s IT topology.

“I knew the kind of system we needed because I’d dealt with crashes, where I had to go through tapes to restore data, and I wasn’t going there again,” says Johnson, who has since become part-owner of the practice which has 50 employees in four offices.

Johnson wanted a solution that was cost-effective but also robust. He considered optical jukeboxes, “but the initial cost

outlay for a hard solution was ludicrous, exceeding the cost of my servers and entire infrastructure.”

After researching cloud options for offsite backup, he chose Carbonite Server, which also met his need for a service compliant with the Health Insurance Portability and Accountability Act. For local backup, he uses the folder redirection option in the Windows Server 2012 machines in each office to store files from client devices in a single share and then backs up the servers to the Carbonite cloud.

“I’m a huge fan of Carbonite because I’ve already recovered from two major crashes through a simple click-and-restore process,” Johnson says. “In terms of cost and the lean infrastructure we can run, the return on investment of cloud solutions is beautiful.”

## CONFIDENCE BUILDER

For its part, Garrand, a marketing and ad agency in Portland, Maine, opted to deploy a cloud-based enterprise backup tool. The solution backs up the firm’s business data and creative files to a 12-terabyte server array onsite. As soon as the local process completes, the data then replicates in a private cloud hosted on an offsite server in another Garrand office.

“Every 15 minutes, any changes to data on all our servers and workstations are automatically backed up locally and then offsite,” says Bill Smith, a consultant who manages Garrand’s IT operations. The cloud solution “is multideestination, and that’s a very powerful feature. You can back up locally onsite, offsite in your own private cloud or in the solution’s public cloud.”

An automated backup process is a major improvement over Garrand’s earlier approach, Smith says. Previously, at the end of each week, managers took turns toting home the hard drive storing that week’s data. They swapped that drive with the one holding even older data, and then repeated the process.

“It was a pain because the swap-outs were not only error-prone, but if we did suffer a failure, the most recent data was a week old,” Smith says.

Smith works closely with Garrand CFO Susan Brown, who handles some backup administration tasks, including onboarding new notebooks to ensure they automatically back up regardless of employee location and monitoring endpoint status through the software’s management console.

“Backup might not be glamorous, but it’s critical,” Brown says. More and more clients “want us to specify in contracts how we protect their data. I think it’s smart on their part, and we’re proud to show them what we have in place to ensure all data is secure and available.” ❖



## PREMISES LIABILITY AND TORT UPDATE

### Georgia Law Update, Continued from p.1

In the process of covering the load, the driver stepped into an uneven gap in the load, lost his balance and fell to the ground. In affirming the trial courts grant of summary judgment in favor of Georgia-Pacific, the Court of Appeals rejected the plaintiff's argument that Georgia-Pacific was not entitled to summary judgment because it had not implemented OSHA regulations requiring fall protection for workers applying protective plastic sheeting to loads on trailers in or next to a building, as the undisputed evidence showed that Georgia-Pacific employees were forbidden to climb on or secure loaded trailers. Because Georgia-Pacific had no obligation to provide fall protection for its own workers, the Court held that it owed no such duty to employees of other companies working at the facility. The Court also held that the grant of summary judgment to Georgia-Pacific was proper because the undisputed facts showed that the plaintiff had knowledge of the hazard posed by the uneven load surface that was equal or superior to any knowledge Georgia-Pacific may or should have had.

In Double View Ventures LLC v. Polite, \_ Ga.App. \_ (April 15, 2014), the Court of Appeals dealt with the application of the apportionment statute in a premises liability case. In this case, the Plaintiff, Polite, was attacked by unknown assailants on the grounds of an apartment complex after coming from a bordering Chevron gas station. Evidence introduced at trial established many violent crimes and robberies had occurred on the Chevron station property, and Polite was attacked shortly after he walked through the wooden fence on Chevron's property, and the defendants had previously contacted the Chevron station owners regarding replacement of the wooden fence but received no response. The defendants had sought to have the jury instructed on the apportionment of the Plaintiff's damages amongst all potentially responsible parties, including the owners of the Chevron gas station. However, the trial court granted Plaintiff's motion for a directed verdict as it related to any liability being apportioned to the owner(s) of the Chevron gas station because the Defendants failed to produce any evidence creating a jury question as to whether the Chevron station was responsible for any of the repairs or had knowledge of the existing condition of the fence and because the defendants could not establish exactly who owned the Chevron station. However, the Court of Appeals reversed the trial court's grant of the directed verdict because it found that the past history of criminal activity created a jury question on the Chevron gas station's potential liability for the Plaintiff's attack. Furthermore, for purposes of apportionment, the precise identities of the owners were not required for them to be placed on the verdict form. In so holding the Court of

Appeals stated that although establishing the exact identity of the Chevron station owner(s) would be necessary to subject that owner(s) to legally enforceable liability, to apportion fault to a non-party, the Defendants were only required to designate the non-party's identification as much they could under the circumstances.

In Reed v. Carolina Cas. Ins. Co \_ Ga.App. \_ (April 10, 2014), the Court of Appeals dealt with the issue of apportionment of damages in the context of a fatal automobile collision. The undisputed evidence established that at approximately 2:00 a.m. on August 26, 2008, a driver parked his tractor-trailer alongside a metal guardrail in the right side emergency lane on Interstate 285 westbound just past the entrance ramp to that highway from Interstate 75 South. The tractor trailer driver did so because he was tired and because he had driven the maximum number of hours allowed by applicable regulations. He proceeded to go to sleep in the sleeper berth of his tractor. About one hour later, another driver was driving a Ford Explorer southbound on Interstate 75 approaching the intersection with Interstate 285 in wet and rainy conditions. Sometime earlier, the Ford Explorer driver had been drinking alcohol, and he had a blood alcohol content of .095 as determined by a postmortem examination. This driver entered the right hand curve to transition onto Interstate 285 westbound at a rate of speed too fast for the curve and rainy conditions. He lost control of the Ford Explorer and struck the parked tractor trailer. The impact caused a rupture of the gas tank and a fire ensued which consumed the Ford Explorer. Both the driver and his passenger were pronounced dead at the scene. The tractor-trailer driver was cited for improper parking in a prohibited area.

Prior to trial, the trial court granted summary judgment in favor of the defendants on the ground that the undisputed facts show the plaintiff's decedent was at least 50 percent responsible for his own death due to the decedent's driving while intoxicated and for driving too fast for the conditions and for his failure to maintain his lane of travel. However, the Court of Appeals reversed the grant of summary judgment on the basis that the apportionment of fault remained a jury function except for in those instances when the fault is plain and palpable and on the basis that it was reasonably foreseeable that another motorist might negligently lose control of his vehicle at night in wet conditions and strike a tractor-trailer parked in emergency

[Read Client Feedback](#)

[Go to p.13](#)

## PREMISES LIABILITY AND TORT UPDATE

**Georgia Law Update**, Continued from p.9

lane on interstate highway and that striking a tractor-trailer possibly might cause fire thereby exacerbating injuries resulting from such an event.

In *Goins v. The Family Y*, \_ Ga.App. \_ (April 10, 2014) the Court of Appeals considered the grant of summary judgment in favor of a health club on the Plaintiffs' negligence and fraud claims arising out of their 16-year old son's death after her collapsed while exercising with a certified personal trainer at the defendant's facility. On the day in question, Brant Goins had been working with a certified personal trainer and was walking on the treadmill for a short time when he collapsed. An employee who saw him fall, immediately called 911. This employee was trained in CPR, but stated that she did not go over to Brant because there were two "paramedics" with him. One of the two men was a deputy sheriff who had been a first responder for eight years, was trained in advanced CPR, first aid, and also had life saving training in the Marine Corps. The deputy said that he checked for a pulse and saw that Brant was still breathing. The other man who went over to Brant after he collapsed was an EMT who testified that the deputy was with Goins when he went over to see if he could help. He stated that Brant's airway was open and he saw him take a breath, but then Brant appeared to stop breathing. The deputy also testified that he saw Brant take a large breath and then stop breathing. At that point, the deputy and the EMT began CPR. Simultaneously, the ambulance and EMTs arrived on the scene. Unfortunately, Brant never recovered and subsequently died.

The Court of Appeals first found that no "special relationship" existed because the only duty the Y undertook was to provide the son with a personal trainer to help him lose weight, which it did. Next, the Court found that the Goinses could not show a causal connection between the certified personal trainer's or any other employee's lack of CPR training and their son's death. An emergency medical technician and a deputy sheriff, who was trained as a first responder, were both present and both administered aid; the Court found that there would have been no reason for a Y employee to interfere with the care they were providing. Finally, the Court held that, even if the Goinses could establish the other elements of their fraud claim, they could show no damage as a result of their claim that the Y falsely represented to them that adequate well-trained employees would be on hand at all times, would have access to life saving equipment and would know how to use it. Neither the EMT nor the deputy the most highly trained people present called for a defibrillator, which was locked away, and both testified that they would not have used a defibrillator since the Goinses' son was still breathing and had a pulse at that time. ❖



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## HOW NORTH CAROLINA RULE 414 HAS CHANGED THE LANDSCAPE IN EVALUATING MEDICAL EXPENSES IN LIABILITY CASES

North Carolina Update, Continued from p.2

### 2. Rule 414 and its application in liability claims handling.

After the enactment of Rule 414, one of the first things that liability insurers, third party administrators and self-insureds started doing in their handling of pre-suit claims was to request that the claimant or claimant's attorney provide information on the amounts actually paid in satisfaction of the medical bills, i.e. information and documentation on health insurance, Medicare and Medicaid eligibility, explanations of benefits (EOBs), etc. This is also where they hit their first obstacle.

Rule 414 is a rule of evidence. It is not a substantive law of damages. This means that the rule only applies to the admissibility of evidence at a trial. Nothing about the rule requires a claimant, pre-suit, to disclose the amounts actually paid to satisfy the medical bills or produce documents of third party payments, adjustments, reductions, etc. Nothing in the rule gives an adjuster or self-insured any tools for compelling or obtaining that information. Plaintiffs' attorneys have continued to submit the medical bills, showing the full value of the charges. They routinely omit any references to reductions or the existence of health insurance, Medicare or Medicaid. This has left insurers, TPAs and self-insureds in a bind as to how to evaluate pre-suit claims without complete information on the amount of the medical expenses.

Adjuster and risk managers have begun using a variety of strategies to deal with the lack of information in pre-suit claims handling. These have included requesting the information directly from the medical providers, or evaluating the claims by making their own across-the-board reductions to the medical bills (with or without a formula) based on the assumption that the claimant had health insurance or some other third party source. Particularly if the claimant is 65 or older, it is reasonable to assume the claimant had Medicare coverage. Some have shifted to making very conservative evaluations and settlement offers on the assumption that the admissible medical expenses will be substantially less than the face amounts of the bills. Others have refused to extend settlement offers, or only make nominal offers, without the information, leading to a spike in litigation.

The issue of how to evaluate pre-suit claims where the claimant won't provide amounts actually paid is still in flux. Equilibrium has not yet been reached and both sides continue to employ different strategies in pre-suit claims handling as a result of the new rule.

### 3. Strategies of personal injury attorneys and how to respond to them.

Personal injury attorneys have been struggling to deal with Rule 414 since its enactment. They have been employing both collective and individualized strategies to try to circumvent the rule.

It has become routine for injury attorneys to decline to provide information or documents on amounts actually paid in pre-suit demand packages and claims handling unless it is to show that the claimant had no third party sources and that the full amount of the bills remains due. There have been instances where the claimant has voluntarily chosen not to submit the medical bills for third party payment, even though the claimant is eligible for such payment. Doing so prevents any reference to health insurance or other third party payment sources from showing up on the bills. It is assumed that that strategy is to present the claim as one where the full amount of the bills are due and then submit the bills to the third party source for payment after the case has been settled. This is a very dangerous strategy for multiple reasons.

First, if the claim is not settled in time, or if it goes into litigation, the claimant could wait too long to submit the bill and lose their ability obtain coverage and payment for those bills, leaving the claimant truly stuck paying the full value of the bill, out-of-pocket. Woe be unto the personal injury attorney who advises their client along those lines. Second, the rule states that it "does not impose upon any party an affirmative duty to seek a reduction in billed charges to which the party is not contractually entitled". It seems that the clear implication of this sentence is that a party **does** have an affirmative duty to seek a reduction in charges to which the party **is** contractually entitled. In other words, if the claimant is eligible for a reduction or payment from a third party source, the claimant must pursue it. It should be argued to the court that the amount actually paid or necessary to be paid is the amount the plaintiff was entitled to under applicable health insurance, Medicare, Medicaid or other third party sources, even if the plaintiff chose not to submit the bills to those sources. Proving the actual amounts of the expenses in that circumstance would be difficult. The

Read Firm  
Announcements  
Go to p.13



question is which side would bear the burden. It would seem the burden should fall on the plaintiff.

Another trend since the enactment of Rule 414 is for medical providers to refuse to submit the medical bills to those third party payment sources if the provider learns that the medical treatment relates to a liability claim. In some instances, this is done with the acquiescence of the claimant. Other times, the provider does it of their own accord, regardless of the claimant's position. There have been instances where medical bills actually show a provider reversing uninsured discounts, third party reductions and third party payments, once the provider learns that a liability claim is pending.

So far, there has been no reaction or position taken from any federal, state or other official source regarding this increasing practice of medical providers.

In the litigation arena, plaintiffs' attorneys have taken to routinely including allegations and Motions in the Complaint that Rule 414 is unconstitutional and seeking to preclude its application in the case. However, counsel have not been pursuing these claims and Motions so far. There have been rumors of the plaintiffs' bar filing a separate lawsuit seeking to have the rule declared unconstitutional but so far, this has not occurred.

In Discovery, plaintiffs' counsel are frequently, but not universally withholding information on third party payments and amounts actually paid for medical expenses. However, most choose to provide the information rather than face a hearing on a Motion to Compel. In the long run, defense counsel are getting the necessary information, albeit after jumping through some hoops. At trial, plaintiffs' counsel have, so far, been reluctantly following the new rule and not actively pursuing the arguments and strategies discussed above.

#### 4. Defense strategies for Rule 414.

In the Discovery phase of litigation, the most effective strategy is to simply keep the pressure on plaintiffs' counsel to provide the necessary information on amounts actually paid for medical expenses. Filing Motions to Compel Discovery normally will persuade counsel to give up the information. The greater difficulty has been in cases where either the plaintiff withholds submission of the bills to available third party sources, or where the providers themselves are refusing to submit the bills and insisting on charging the full value despite the availability of third party payment sources.

In order to obtain Discovery regarding amounts necessary to actually pay outstanding, unpaid medical expenses, particularly in situations where the plaintiff has not submitted the bills to an available third party source, it may

be necessary to pursue a court Order to send to the medical provider, accompanied by a Subpoena, requiring the provider to disclose and produce documentation as to what the approved amount for the medical treatment in question is or was, pursuant to the provider's contract with the third party. Providers are often resistant to providing such information. Alternatively, it may be necessary to take the depositions of the billing office of the medical provider to obtain such information.

At trial, the parties typically agree on stipulations as to the amounts actually paid or necessary to be paid, where such information has been disclosed. In those cases where the parties come to trial and the information still is not known, defendants should move *In Limine*, to preclude the plaintiff from introducing any evidence of medical bills at trial unless the plaintiff can affirmatively show that no third party payments, adjustments, reductions, etc. are available for the bill and that the face value of the bill is, in fact, the amount actually paid or necessary to be paid.

Under Rule 414 and the substantive law of North Carolina, the burden of proof should be on the plaintiff to prove the amounts actually paid or necessary to be paid for medical expenses. The plaintiff should be required to affirmatively prove that no health insurance, Medicare, Medicaid, etc., is or was available, and further, where such third party sources are available, plaintiff should be required to provide what adjustments and reductions apply by virtue of those third party sources in order to arrive at the amounts actually paid or necessary to be paid. The failure of the plaintiff to disclose the information in Discovery should work to the detriment of plaintiff, not defendant.

NCGS § 8-58.1 permits an injured party to testify and present evidence as to the amounts of the medical expenses actually paid or to be paid, but only if the records and bills showing the amounts actually paid or to be paid accompany such testimony. If the defendant has any evidence to indicate that the bills presented do not accurately reflect the amounts actually paid or required to be paid, counsel should move *In Limine* to preclude such documents from being introduced and/or object to their introduction. Absent such documents, the plaintiff should not be allowed to testify as to the amounts of the bills.

Where the plaintiff has chosen not to submit the bills to third parties, defendant should again argue that under the implied language of the rule, the plaintiff is obligated to seek a reduction to which the plaintiff is contractually obligated. Therefore, the plaintiff's choice to delay or forego such reduction by failing to submit the bills is irrelevant and plaintiff should still bear the burden of showing what the reductions would have been had the plaintiff sought the reduction to which they were entitled. In the absence of

doing so, the plaintiff should be prohibited from introducing evidence of those medical expenses.

Unfortunately, the absence of any legal precedent on the application of Rule 414 leaves local trial judges with very little guidance on these issues, both in terms of Discovery and trial, and these strategies will likely have varying degrees of success depending on the local venue and the disposition of the local presiding judge.

In summary, the enactment of Rule 414 has dramatically affected the handling of personal injury litigation in North Carolina. It is certainly a positive advancement for liability insurers and self-insureds in reducing case values.

However, the lack of legal precedent on its interpretation and application has left the attorneys on both sides, as well as the trial courts and liability insurers, grappling with its implications and its effect on evaluating claims for settlement or presenting the case at trial. If you are liability insurer, claims professional or self-insured entity, this issue will continue to have a direct impact on you for the foreseeable future.

I hope this information is of assistance to you. If you or your company would like more information on this issue or other issues in North Carolina litigation, please contact Tom Nance at [tnance@ncarolina-law.com](mailto:tnance@ncarolina-law.com). ❖

## CLIENT FEEDBACK

“Thank you for all your efforts on this case — without which we would more than likely not have resolved as we did. I look forward to working with you in the future.”

— **Judith Rosenblatt**, Sr. Claims Adjuster, *North American Risk Services*, in reference to **Terry Lavy**, SW FL/Ft. Myers office

“Michelle did a great job here. I need more defense counsel in the panhandle that can ‘tippy toe’ through these very difficult cases.”

— **Lori Hammer**, Adjuster at *Allstate Insurance*, referring to **Michelle Hendrix**, Liability Department Head, Pensacola office.

“Frankly, I should have you ‘teach’ other defense attorney’s how to provide a litigation strategy.”

— **David Boyd**, Complex Claims Manager, *Liberty Mutual*, referring to **Alisa Ellenburg**, Managing Attorney Atlanta office

“I have been very impressed with the law firm’s aggressive and proactive handling of our files. I definitely see a long working partnership with Sky Chefs & Vernis & Bowling.”

— **Jacob Romero**, Manager of Workers’ Compensation, *LSG Sky Chefs* ❖

## CAN I GET A JUDGMENT FOR ATTORNEY FEES AGAINST THE PLAINTIFF, OR WILL I HAVE TO PAY THEM UNDER THE PROPOSAL FOR SETTLEMENT RULE?

**Florida Law Update**, Continued from p.1

injuries sustained in an auto accident. The plaintiff served only **the owner** with a proposal for settlement for \$40,000, which provided for the execution of “a full release of liability in favor of Defendant, and his insurance company, and a Stipulation for Voluntary Dismissal. The plaintiff did not attach a release or describe its terms. Following a jury verdict in favor of the Plaintiff, judgment was entered for \$186,796.20.

The Defendant moved to strike the PFS due to the ambiguity of the release terms. The court held that if the release is not attached, then the PFS must satisfy the requirements of Rule 1.442 and eliminate any reasonable ambiguity about its scope. The PFS did not state whether the driver was covered by the release. This term was determined to be essential for the owner because he is responsible for the driver's negligence under the dangerous instrumentality doctrine. Even if the owner's insurer is the unnamed insurance company in the release, it remained unclear whether “a full release of liability” included a release of **the driver**. The court found the proposal for settlement to be too ambiguous to satisfy Florida Rule of Civil Procedure 1.442.

In Alamo Financing, L.P. v. Mazoff, 112 So.3d 626 (Fla 4th DCA 2013), the defendant served a PFS for \$13,335.00 to resolve “all Claims made in the present action by the party to whom this proposal is made including any claims that could be made against Defendant ALAMO FINANCING, L.P., which arise out of the same occurrence or event set forth in this action.” One of the conditions of the proposal was that the plaintiff would execute a release in favor of Alamo Financing. Specifically, that condition stated:

*“(4) Plaintiff shall execute a general release of the Defendant, ALAMO FINANCING, L.P., in the form general release attached as Exhibit “A”. The general release attached to the proposal for settlement provided that the plaintiff would release Alamo Financing and “their parent corporations, subsidiaries, officers, directors, and employees” from any and all claims.”*

The Defendant obtained a summary judgment after the PFS had expired. Plaintiff argued that the release was ambiguous

due to the fact that the car involved in the accident was actually rented by a subsidiary of the named defendant, and he wanted to be able to continue the claim against it. The court in enforcing the defense PFS, held that, “The rule does not demand the impossible. It merely requires that the settlement proposal be sufficiently clear and definite to allow the offeree to make an informed decision without needing clarification. Therefore, parties should not ‘nit-pick’ the validity of a proposal for settlement based on allegations of ambiguity unless the asserted ambiguity could ‘reasonably affect the offeree's decision’ on whether to accept the proposal for settlement.”

If there are multiple claims, the rule require that settlement proposals “identify the claim or claims the proposal is attempting to resolve” and “state with particularity any relevant conditions.” Our supreme court has held that “[t]he rule does not demand the impossible. It merely requires that the settlement proposal be sufficiently clear and definite to allow the offeree to make an informed decision without needing clarification.” Palm Beach Polo Holdings, Inc. v. Stewart Title Guar. Co., 132 So.3d 858 (Fla 4th DCA 2014).

The net result of the current case law is that Plaintiffs often do not make a release a condition of acceptance of a PFS, and Defendants always attach a copy of a proposed release to all PFS's served.

A PFS can be a powerful tool to encourage settlement of a claim, when faced with a possible judgment for attorney fees, in addition to losing a case. In determining whether to serve or accept a PFS, Its enforceability is crucial. Determining whether the terms of a PFS are ambiguous, is crucial to being able to collect, or having to pay, attorney fees, following the conclusion of a case. ❖

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- Vernis & Bowling was presented with the Target Corporation's Law Department Excellence in Diversity & Inclusion Award.
- **Karen Nissen (Palm Beach, FL)** has been selected as a member of the United States Liability Insurance Company's attorney advisory panel.
- **Robert C. Bowling (Managing Partner, Miami, FL)** and **G. Jeffrey Vernis (Managing Partner, Palm Beach, FL)** were selected as Power Leaders in Law and Accounting by the South Florida Business Journal.
- **Cassius Borel (Ft. Myers, FL), Kenneth E. Amos, Jr. (Clearwater, FL)** and **Jose Font (Broward/Hollywood, FL)** have been selected to the 2014 Florida Super Lawyers list & Rising Stars list.
- The January 2014 issue of Florida Trend Magazine lists Vernis & Bowling as one of the Top 25 Law Firms in Florida.
- **Ian N. Matthes, Esq., Regional Managing Attorney (Atlanta)** Has Earned The Highest Possible Martindale-Hubbell® Peer Review Rating™ AV® Preeminent™.
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