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ALL-RISKS POLICY

Florida Supreme Court resolves dispute over damage from concurrent causes

The Florida Supreme Court has ruled that coverage may exist under an all-risks policy when an insured risk is a cause of the loss, even though a concurrent cause of the loss is excluded from the policy.

Sebo et al. v. American Home Assurance Co. Inc., No. SC14-897, 2016 WL 7013859 (Fla. Dec. 1, 2016).

The 6-1 decision resolves a split between two intermediate appellate courts over whether to apply the "efficient proximate cause" or "concurrent cause" doctrine.

Under the EPC doctrine, "where there is a concurrence of different perils, the efficient cause — the one that set the other in motion — is the cause to which the loss is attributable," Justice James E.C. Perry wrote in an opinion authored for the majority.

"The CCD provides that coverage may exist where an insured risk constitutes a concurrent cause of the loss even when it is not the prime or efficient cause," he explained.

REUTERS/Tami Chappell

Florida Supreme Court building

PROPERTY DAMAGE

According to the majority opinion, John Sebo bought a four-year-old house in Naples, Florida, in April 2005.

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Leaks and dismissals under the False Claims Act: *State Farm v. Rigsby*

By Nicole Schneider, Esq.
Cohen & Cohen

Any complaint filed under the False Claims Act must remain sealed for 60 days to allow the government to fully investigate the claim. Circuit courts split on whether a leak of the complaint during this 60-day period warrants, or even mandates, dismissal.

The U.S. Supreme Court recently decided this split in *State Farm Fire & Casualty Co. v. United States ex rel. Rigsby et al.*, No. 15-513, 2016 WL 7078622 (U.S. Dec. 6, 2016), and provided guidance as to how future FCA claims should be treated.

Since the purpose of the seal requirement is to allow the government to thoroughly investigate before deciding whether or not to pursue a claim, the court decided that a leak that does not hinder the government's investigation — regardless of the reasons for the leak — should not alone warrant dismissal and the decision whether to dismiss the claim lies within the sound discretion of the district court.

HISTORY AND REQUIREMENTS OF THE FCA

To understand why a mandatory dismissal is not appropriate, the history and purpose of the FCA must first be considered.

The concept of allowing the government to recover for fraudulent claims against it dates back to the Middle Ages, and the FCA has a long history in the United States.

In 1863, Congress first passed 31 U.S.C.A. § 3729 because of fraud concerns during the Civil War. The FCA created a cause of action against any person who knowingly submitted a false claim to the government, caused another to submit a false claim to the government, or knowingly made a false record or statement to get a false claim paid by the government. Although the FCA has been amended numerous times, its goal has remained the same.

> State Farm allegedly misadjusted federal flood claims in Mississippi by claiming that wind damage to insureds' homes was caused by flooding.

Most FCA claims are not initiated by the government. Instead, they are brought by private individuals who sue for violations on behalf of the government. A person bringing an action under the FCA is referred to as a "relator," and the suit is known as a qui tam action. If the relator is ultimately successful in the suit, he is awarded a percentage of the recovered funds.

An important feature of a qui tam action is confidentiality. Initially, the complaint and written information must be filed under seal and served on the U.S. attorney for the jurisdiction where the alleged fraud was committed. It must also be served on the U.S. attorney general. The seal provision prohibits the relator from publicly discussing the filing of the complaint while the government is investigating.

The purpose of the seal is to allow the government to consider the complaint before deciding to proceed with a civil case, and without notifying the target of the claim until the investigation is complete. The seal also allows the government to bring or complete any potential overlapping criminal investigation based on the facts stated in the claim.

The government typically has 60 days to complete its investigation, although it may seek an extension.[1] If the government declines to pursue the claim action, the relator may proceed with the claim individually.

The question presented in *State Farm* was whether a violation of the seal requirement mandated dismissal of the claim.

In interpreting the FCA's seal requirement, five federal appeals courts considered the question and split three different ways.

The 6th U.S. Circuit Court of Appeals held that a violation of procedural requirements mandates dismissal regardless of whether

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the government's investigation was hindered.[2]

The 2nd Circuit and 4th Circuit held that dismissal is required only if the violation incurably frustrates the congressional goals served by the seal requirement.[3]

The 9th Circuit applied a balancing test and said dismissal is required only if the violation causes actual harm to the government.[4] The key factors the 9th Circuit considered in the balancing test are the harm suffered by the government, the relative severity of the seal violation, and whether there is evidence of bad faith or willfulness.[5]

The 5th Circuit followed the 9th Circuit's approach in deciding *State Farm*.[6]

STATE FARM V. RIGSBY

The relators in *State Farm Fire & Casualty Co. v. United States ex rel. Rigsby et al.* were sisters Cori and Kerri Rigsby, two independent claims adjusters who provided services to State Farm after Hurricane Katrina.

The Rigsbys alleged that State Farm misadjusted federal flood claims in Mississippi by claiming that wind damage to their insureds' homes was caused by flooding. While wind damage would have been covered by State Farm's insurance, flood damage fell under the federal government's National Flood Insurance Program. State Farm allegedly filed claims for coverage under the federal government's program instead of paying for damage that was covered under its policies.

A two-week bellwether trial was held concerning one particular house in Mississippi, and it was determined that State Farm submitted a fraudulent claim of $250,000 to the government when it should have paid for wind damage.

Prior to trial, State Farm filed a motion to dismiss, claiming that the relators violated the seal requirement. Specifically, it alleged that the relators leaked the complaint to the media and to a Mississippi congressman in an effort to help their claim and smear State Farm's name.

The government acknowledged that the seal requirement was violated during the 60-day investigation period. However, it claimed the disclosure was made by counsel without the Rigsbys' assistance or knowledge and that it did not impact the government's investigation.

The U.S. District Court for the Southern District of Mississippi denied State Farm's motion. The 5th Circuit affirmed the District Court's opinion, but it noted the conflict among the circuits.

On May 31 the U.S. Supreme Court granted certiorari to consider the seal requirement and resolve the split.

State Farm argued that the balancing test used by the 5th Circuit and 9th Circuit is contrary to established law regarding statutory prerequisites to suit.

State Farm said the Rigsbys should be sanctioned with the dismissal of their claim because they used their complaint to paint State Farm as an insurance company that took advantage of those devastated by Hurricane Katrina.

It also claimed the balancing test contravenes the statutory objective of the seal requirement — namely, that it is extremely difficult to prove there was actual harm to the government as a result of the disclosure. Therefore, State Farm argued that relators may be encouraged to disclose the complaint when it might help their case to do so because there is no real penalty for violating the seal requirement.

State Farm encouraged the high court to adopt the 6th Circuit's mandatory dismissal standard. State Farm said the Rigsbys should be sanctioned with the dismissal of their claim because they used their complaint to paint State Farm as an insurance company that took advantage of those devastated by Hurricane Katrina.

The government argued that the disclosure violations did not actually inform the public about the complaint until after the 60-day period. It also said the disclosure failed to tip off State Farm to the investigation. The government claimed that State Farm admitted it had not heard of the lawsuit until it was served, and consequently, the violations could not have impaired the government's ability to investigate.

Additionally, the government said dismissal would be inappropriate because the violations were not severe. The confidential materials were kept under seal for a substantial period of time, and the disclosure was made by counsel, not by the Rigsbys.

In addition to the briefs filed by State Farm and the government, numerous amicus briefs were filed on behalf of interested groups, such as the American Tort Reform Association, the U.S. Chamber of Commerce and the National Whistleblower Center.

The high court heard oral argument Nov. 1, and issued its opinion Dec. 6.

HOW THE COURT RULED

The Supreme Court considered two important factors when considering which circuit's test should apply and whether the 5th Circuit ruled appropriately: the wording of the disclosure requirement, and the purpose behind keeping these types of complaints under seal.

Unfortunately, the text of the FCA fails to provide much clarity. It does state that complaints "shall" remain under seal, which the court recognized is a mandatory requirement, but does not explain what the sanction should be for violating this requirement. Nowhere does it state that violations compel dismissal, and it does not provide the court with guidance as to how it should treat a disclosure.

While State Farm pointed to other procedural requirements that the Supreme Court has determined warrant dismissal, the court did not find these arguments to be persuasive and distinguished those circumstances from the FCA.

The most important argument to the court was the purpose of the FCA and that a mandatory dismissal because of a disclosure violation would be counterproductive to that purpose. This type of sanction would pit the government's interests against each other, because it would make it harder for the government to recover for fraudulent claims, and would deter qui tam relators from initially coming forward.

The government is more interested in recovering for fraudulent claims than it is in secrecy. The seal requirement was included because of the government's interest in pursuing claims.

Using the requirement to block meritorious claims runs directly counter to the reason

for the requirement in the first place. State Farm's interpretation would allow those who commit fraud to avoid punishment or repayment based on a technicality, and would keep the government from furthering the act's purpose.

As the court noted, "it would make little sense to adopt a rigid interpretation of the seal provision that prejudices the government by depriving it of needed assistance from private parties."

One question the high court did not elaborate on in its opinion is whether the 9th Circuit's balancing test should be directly applied.

The high court stated that while the factors considered by the 9th and 5th circuits "appear to be appropriate, it is unnecessary to explore these and other relevant considerations."

Rather than providing guidance on what factors should be considered in deciding whether to dismiss a claim, the court merely left the decision up to the sound discretion of the lower courts and review should only be for an abuse of discretion.

The FCA has played an important role in helping the government identify fraud and recover from those who attempt to unlawfully take from the government.

The high court's decision may have an impact on how relators and the targets of their claims approach the 60-day seal period.

Perhaps relators will be more likely to leak their complaints since there is not a high risk of dismissal. Targets of FCA claims may also become more proactive in trying to uncover complaints filed against them during the confidentiality period.

While there is potential for some disruption during the investigation period, ultimately the goals of the FCA will continue to be met through the process already in place.

As long as the purpose of the FCA is not impaired by a disclosure, regardless of the reasons or the circumstances, courts will likely allow claims to proceed rather than dismiss them on a technicality.

The court also left open the possibility that lower courts could use other sanctions short of dismissal for violations, even though that type of remedy was not requested in this specific case.

The court's decision solidifies district courts' discretion to decide whether sanctions are appropriate based on the circumstances rather than instituting mandatory dismissals. WJ

NOTES

[1] 31 U.S.C.A. § 3730(b)(3).

[2] *United States ex rel. Summers v. LHC Grp.*, 623 F.3d 287 (6th Cir. 2010).

[3] *United States ex rel. Pilon v. Martin Marietta Corp.*, 60 F.3d 995 (2d Cir. 1995); *Smith v. Clark/Smoot/Russell*, 796 F.3d 424 (4th Cir. 2015).

[4] *United States ex rel. Lujan v. Hughes Aircraft Co.*, 67 F.3d 242 (9th Cir. 1995).

[5] *Id.*

[6] *United States ex rel. Rigsby v. State Farm Fire & Cas. Co.*, 794 F.3d 457 (5th Cir. 2015).

Washington court further delineates defense counsel's role in ROR situations

By Steven Plitt, Esq., and Jordan R. Plitt, Esq.,
Cavanagh Law Firm

Under Washington law, insureds do not have the right to hire independent counsel when an insurer defends the insured under a reservation of rights.[1] Under that state's law, a conflict of interest does not automatically arise when an insurer defends under an ROR because insurer-retained attorneys owe a fiduciary duty of loyalty when defending insureds in that situation.[2]

Insurer-retained attorneys owe a "duty of full and ongoing disclosure to the insured" under Washington law.[3]

There are three aspects to the duty of disclosure. The first requires defense counsel to fully disclose — and resolve in favor of the insured — any potential conflicts of interest between the insurer and the insured.

Second, the defense lawyer must communicate to the insured all information relevant to the insured's defense, including a realistic and periodic assessment of the insured's chances to win or lose in the pending lawsuit.

Third, the defense lawyer must disclose to the insured all offers of settlement, and the insured must be fully apprised of all activity involving settlement irrespective of whether the settlement offers or rejections come from the injured party or the insurance company.[4]

In *Arden v. Forsberg & Umlauf*, the Washington Court of Appeals found that insureds were not entitled to independent counsel merely because the insurer-retained attorney, defending the insureds, had a significant ongoing business relationship with the insurance company pursuant to which the attorney received defense and coverage matters.[5]

> The Washington Supreme Court found that under the Rules of Professional Conduct there was no obligation for the attorneys to disclose to the insured their relationship with the insurer.

The insureds argued that the attorney defendants breached their duty of loyalty to the insureds by representing them despite the law firm's and the attorneys' long-standing relationship with the insurer, which included representing the insurer in coverage cases. The court rejected this argument, finding that the relationship did not create a conflict of interest.

The court began its analysis by recognizing that the parties had submitted declarations from competing experts who expressed disagreement on the issue. Even commentators on Washington insurance law have acknowledged this disagreement over whether a conflict of interest is automatically created in these situations.

The court in *Arden* found that the insurance company's interests were not directly adverse to the insureds' interests with regard to the defense of the lawsuit. While the insurer and the insureds had adverse interests with regard to coverage issues, a letter the insureds received from the insurance defense lawyers made it clear that the lawyers and their firm did not represent either the insurer or the insureds on the coverage issues.

Regarding the defense aspects of the claim, the court noted that the insurer's interests and the insureds' interests were aligned, as both were interested in winning or settling the case.[6] Additionally, as long as the defense attorneys followed the criteria outlined by the Washington Supreme Court, there was no significant risk that the attorneys' representation of the insureds would be materially limited by the attorneys' representation of the insurance company in other cases.

The court noted that defense attorneys that handle ROR cases know that under Washington law the attorneys represent only the insured, not the insurer, and owe a duty of loyalty to the insured that has no exceptions.[7]

Next, the insureds argued that the attorneys breached their fiduciary duty of loyalty by failing to give the insureds notice of the long-standing relationship with the insurer. The court rejected this argument. It found that under the Washington Rules of Professional Conduct there was no obligation for the attorneys to disclose to the insured their relationship with the insurer.[8]

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The court also said the decision in *Tank v. State Farm Fire & Casualty Co.*[9] did not require defense attorneys to disclose their relationship with the insurer. The *Tank* decision requires a defense attorney to follow the dictates of Rule 1.7 by disclosing any conflict of interest between the insured and the insurer defending under an ROR.[10] However, the court in *Arden* found that neither Rule 1.7 nor the *Tank* decision imposed a requirement that a defense attorney disclose its relationship with that insurer.[11]

The court in *Arden* advised that the "better practice for attorneys handling an ROR defense may be to inform their clients if they have a long-standing relationship with the insurer and represent the insurer in other cases."[12] The court found, as a matter of law, that the attorneys had no fiduciary duty to provide that notification/disclosure to the insureds they were defending.

The insureds in *Arden* also argued that the defense attorneys breached their fiduciary duty of loyalty by not attempting to "persuade" the insurer to fund the settlement demand made by the claimants. The court rejected this argument as well.

First, it noted that defense attorneys are under an obligation to communicate an insured's request to settle to the insurer. However, it said there is no authority to support imposing a duty on defense attorneys to attempt to persuade an insurer to settle the case.[13]

Under the facts presented to the court, the insured had personal counsel actively involved in the case. Therefore, there was no reason for defense counsel to become further involved in persuading the insurer to settle. The insured's personal counsel was in a better position to advocate for settlement with the insurer.

Therefore, the court declined to impose a fiduciary duty on the defense attorney to attempt to persuade the insurer to settle for the amount the insured demanded. The defense attorney's duty was to give a fair evaluation of the liability and damages aspects of the case without regard to the coverage issues.[14] WJ

NOTES

[1] *See, e.g., Johnson v. Cont'l Cas. Co.,* 57 Wash. App. 359, 788 P.2d 598 (Wash. Ct. App., Div. 2 1990). In *Johnson* the insured argued that a conflict of interest automatically arises from an ROR defense situation and that the insured was entitled to independent counsel. However, the Washington Court of Appeals rejected the argument that a conflict of interest automatically arose when an ROR defense was provided. There was no conflict of interest because Washington law imposes enhanced obligations of fairness on the insurer in an ROR situation. *Id.*, citing *Tank v. State Farm Fire & Cas. Co.,* 105 Wash. 2d 381, 715 P.2d 1133 (Wash. 1986).

[2] *Tank,* 105 Wash. 2d at 388, 715 P.2d 1133. A duty of loyalty to the insured/client was determined to be consistent with Rule 5.4(c), which demands that counsel represent only the insured, not the insurance company.

[3] *Id.*

[4] *Id.* at 388-39, 715 P.2d 1133.

[5] 193 Wash. App. 731, 373 P.3d 320 (Wash. Ct. App., Div. 2 2016).

[6] *Id.,* 193 Wash. App. 731, 373 P.3d at 328-29.

[7] *Id.*

[8] *Id.* at 749, 373 P.3d at 330.

[9] *Tank,* 105 Wash. 2d 381, 715 P.2d 1133.

[10] *Id.* at 388, 715 P.2d 1133.

[11] *Arden,* 193 Wash. App. at 751, 373 P.3d at 330.

[12] *Id.*

[13] *Id.* at 753, 373 P.3d at 331-32 ("Such a duty would be inconsistent with the defense attorney's role in a reservation of rights defense. When coverage is disputed, an insurer's decision to settle necessarily involves an evaluation of the strength of its coverage defenses. Imposing a duty on defense counsel to attempt to persuade an insurer to settle would require that attorney either to argue the insured's position on coverage or advise the insurer on coverage issues, both of which would give rise to actual conflicts of interest.").

[14] *Id.* at 754, 373 P.3d at 332, citing *Tank*, 105 Wash.2d at 388-89, 715 P.2d 1133.

Dispute over professional services exclusion in day care policy ordered to trial

An Arkansas federal judge has ruled that a trial is needed to decide whether a professional services exclusion in an insurance policy issued to a day care center was part of the policy when a child was hurt.

Penn-Star Insurance Co. v. New Edition Early Learning Academy LLC et al., No. 15-cv-104, 2016 WL 6963044 (E.D. Ark. Nov. 28, 2016).

Penn-Star Insurance Co. conceded in a motion for summary judgment filed in the U.S. District Court for the Eastern District of Arkansas that $100,000 in coverage exists under a policy issued to New Edition Early Learning Academy LLC.

The insurer contended, however, that an additional $300,000 in coverage is barred by a "professional services" exclusion.

U.S. District Judge D.P. Marshall Jr. concluded the exclusion would apply, but found a factual dispute over whether it was part of the policy when Monica Cervantes' then-4-year-old son was injured at the day care center.

According to Judge Marshall's order, Cervantes arrived at New Edition on Jan. 27, 2013, to pick up her son and his sister. She signed out the children and began talking with others inside the facility.

During the conversation, Cervantes' son turned his attention to some pine cones on a television cart, the order said.

A day care employee and Cervantes told the child to stay away. He went for them anyway, according to the order, and the cart and television fell on him. He allegedly suffered severe injuries.

Cervantes sued New Edition and its owner, Jacqueline Stanback, in Arkansas state court. Her complaint includes claims related to the allegedly dangerous nature of the premises, the failure to remove objects and devices that are dangerous to children, and the failure to employ sufficient staff trained to supervise children, the order said.

Penn-Star, the liability insurer for New Edition, is defending the day care center in the state court case. It also filed a declaratory judgment action in the District Court, seeking a determination about its coverage limit.

According to the order, the policy has a $300,000 per-occurrence limit for damages because of bodily injury. The order said that coverage is subject to a "professional services" exclusion for "injuries from an act, error, or omission in the use or failure to use special skills, experience, and knowledge."

The policy also provides up to $100,000 in liability coverage for day care-related risks, the order said.

Penn Star admitted the incident triggered the coverage for day care-related risks, meaning there is at least $100,000 available. It argued in a motion for summary judgment, however, that the $300,000 in coverage is excluded.

Cervantes countered in her own motion that the exclusion was not part of the policy when the incident happened. She argues that even had it been, it does not apply because New Edition does not provide "professional services."

Judge Marshall found the language of the exclusion is clear and unambiguous.

He noted that Cervantes' claims center on New Edition's alleged lack of due care in arranging the cart and television, securing play things, maintaining the facility, and hiring and training staff.

"All these things are an important part of running a safe place for parents to take their children each day," Judge Marshall said. "Decisions about them involve professional judgment about day care operations, and require the skills, experience, and knowledge of running that business."

The court concluded, therefore, that if the exclusion were in place at the time of the incident, it applies and the coverage available under the policy is $100,000.

Judge Marshall then found that a genuine issue of fact exists over whether the exclusion was in the policy when the child was injured.

The judge cited competing evidence from the parties, including Penn-Star's copy of the certified policy that includes the endorsement adding the exclusion and an affidavit from the underwriter that the endorsement was part of the policy all along.

Cervantes notes, among other things, that the endorsement is dated about one month after the incident.

Judge Marshall, thus, concluded that a jury must decide whether the exclusion was part of the policy when the incident occurred, saying the decision "will make a $200,000 difference in coverage." WJ

Related Filing:
Order: 2016 WL 6963044

See Document Section B (P. 25) for the order.

Insurer says no coverage for seller of allegedly explosive e-cigarette

Atlantic Casualty Insurance Co. is asking a Washington state court to rule it does not owe coverage against a lawsuit claiming a woman suffered disfiguring injuries when an electronic cigarette exploded in her face.

Atlantic Casualty Insurance Co. v. Bellinger et al., No. 16-cv-422, complaint filed (E.D. Wash. Dec. 1, 2016).

The insurer claims in a declaratory judgment action filed in the Spokane County Superior Court that the policy it issued to Brad Bellinger, the operator of Lilac City Vapor, excludes coverage under the circumstances. Furthermore, Atlantic says, the defendant in the underlying lawsuit — the vape shop itself — is not an insured under the policy.

THE UNDERLYING LAWSUIT

Marlene Rubertt filed a lawsuit in Washington state court in October against Lilac City Vapor LLC, a sole proprietorship located in Spokane County. *Rubertt v. Lilac City Vapor LLC*, No. 16-2-03995-7, *complaint filed* (Wash. Super. Ct., Spokane Cty. Oct. 13, 2016).

She alleges she sustained disfiguring injuries in January 2016 when an e-cigarette she was smoking in her home exploded in her face, according to Atlantic's complaint.

Lilac City Vapor's attorney tendered the lawsuit to Atlantic on Oct. 21, according to the insurer. Atlantic agreed about two weeks later to provide a defense, subject to a reservation of rights.

POLICY EXCLUSIONS

Atlantic acknowledges its policy covers damages from bodily injury caused by an occurrence within the coverage territory.

REUTERS/Christian Hartmann

The insurer says the policy excludes coverage for a customer's injuries after an electronic cigarette allegedly exploded. An e-cigarette is shown here.

But under a "products completed operations hazard" the policy excludes coverage for injuries sustained off the insured's premises and that arise out of the insured's product, according to Atlantic's complaint.

Both conditions apply to Rubertt's injuries, which she sustained at home using products she bought from Bellinger's business, the complaint says.

The insurer further asserts Lilac City Vapor LLC is not named in the policy as an insured.

"The Who Is An Insured provision provides that no person is an insured with respect to the conduct of any limited liability company that is not shown as a named insured in the declarations," Atlantic says.

The complaint seeks declarations that Atlantic owes no duty to defend or indemnify the LLC or Bellinger, doing business as Lilac City Vapor, in connection with Rubertt's lawsuit.

The insurer also asks for permission to withdraw from the reservation of rights defense it is providing to the LLC. WJ

Attorney:
Plaintiff: Mary R. DeYoung, Soha & Lang, Seattle, WA

Related Filing:
Complaint: 2016 WL 7042746

See Document Section C (P. 28) for the complaint.

California panel reverses insurer's win in fire damage dispute

A trial court erred in granting summary judgment for an insurance company that declined to defend a chimney installer against a lawsuit over a house fire, a California appeals court has ruled.

Tidwell Enterprises Inc. et al. v. Financial Pacific Insurance Co., No. C078665, 2016 WL 6962291 (Cal. Ct. App., 3d Dist. Nov. 29, 2016).

"[T]here was a possibility that the damages ... fell within the coverage provided by the terms of the general liability policies," a three-judge panel of the state's 3rd District Court of Appeal said.

Financial Pacific Insurance Co. had convinced the Calaveras County Superior Court that it did not owe coverage because the fire giving rise to the suit against its insureds did not occur until after its policies had expired.

The insureds, Greg Tidwell, Tidwell Enterprises Inc. and Tidwell Enterprises Fireplace Division, are collectively referred to in the 3rd District's opinion as "Tidwell."

HOUSE FIRE CLAIM

Tidwell participated in the construction of a home in Copperopolis, California, in 2006 or 2007 by installing a fireplace, according to the opinion.

A fire damaged the home in November 2011.

State Farm General Insurance Co., which insured the home, notified Tidwell by letter that the cause of the fire may have been related to, among other things, the manufacture, design or installation of the fireplace, the opinion said.

Tidwell forwarded the letter to Financial Pacific Insurance Co., which issued policies to Tidwell between 2003 and 2010 that covered property damage that occurred during the policy period.

FPIC agreed to investigate the claim subject to a reservation of rights.

SUBROGATION ACTION

State Farm sued Tidwell in February 2012, alleging negligence related to its installation of the fireplace system.

FPIC declined Tidwell's defense tender because the fire had occurred in November 2011 after its policies had expired, the opinion said.

Tidwell's attorney subsequently provided a report to FPIC prepared by an expert Tidwell retained.

> "[W]e conclude only that under the allegations of State Farm's complaint and the facts known to [FPIC] this is what might have happened," the panel said.

The insureds took the position, based on that report, that fires over the course of six years, some of which occurred during the time they were insured by FPIC, each caused damage to the chimney system and resulted in the November 2011 fire, according to the opinion.

FPIC reiterated its denial in September 2013.

Tidwell sued FPIC the following year, seeking damages for alleged breach of contract and a declaration that FPIC owed a duty to defend.

The Superior Court granted FPIC summary judgment in December 2014, reasoning that State Farm is seeking recovery for a fire that occurred after coverage had expired.

REVERSAL

The 3rd District panel, citing *American States Insurance Co. v. Progressive Casualty Insurance Co.*, 180 Cal. App. 4th 18 (Cal. Ct. App., 3d Dist. 2009), explained that "to prevail on a motion for summary judgment premised on a claim that the insurer had no duty to defend, 'the insurer ... must present undisputed facts that eliminate any possibility of coverage.'"

The appeals court agreed with Tidwell that FPIC did not meet that burden.

"Even though State Farm did not seek to recover from Tidwell damages directly attributable to physical injury to the ... house that predated the November 2011 fire, there was a possibility that the damages State Farm *did* seek to recover occurred *because of* earlier physical injury to the house for which Tidwell [allegedly] was responsible," the panel said.

The appeals court found a possibility of coverage based on allegations that Tidwell might have negligently installed a custom top on the chimney that restricted air flow.

It reasoned that the restricted air flow may have then resulted in excessive heat every time a fire burned in the fireplace, reducing the temperature at which the wood framing in the chimney structure would ignite.

"Of course, we need not and do not conclude that this is what happened; we conclude only that under the allegations of State Farm's complaint and the facts known to [FPIC] this is what *might* have happened," the panel said.

The appeals court, thus, reversed the entry of summary judgment in FPIC's favor and remanded the case with instructions to deny the insurer's motion. WJ

Related Filing:
Opinion: 2016 WL 6962291

Illinois firefighter hurt in 'nonemergency' response loses bid for health premiums

A firefighter who was injured while moving a person with multiple sclerosis from the floor back into bed is not entitled to payment of health insurance premiums under Illinois' Public Safety Employee Benefits Act, a state appeals court has ruled.

Wilczak v. Village of Lombard, No. 2-16-0205, 2016 WL 7079555 (Ill. App. Ct., 2d Dist. Dec. 5, 2016).

The statute mandates that the employer of a full-time firefighter who suffers a catastrophic injury must pay the premium of the employer's health insurance plan for the injured employee, but only when the injury resulted from the firefighter's response "to what is reasonably believed to be an emergency."

A three-judge panel of the 2nd District Appellate Court agreed with a lower court's conclusion that the dispatch call that resulted in Kenneth Wilczak's injury was not an emergency.

THE DISPATCH

Wilczak served as a firefighter/paramedic for the village of Lombard, Illinois.

He and another firefighter, Tony Sally, received a dispatch call in August 2009 to an address in the village to assist a resident with getting back into bed.

Wilczak knew the resident, who suffered from multiple sclerosis and weighed about 250 pounds, because he had been dispatched to the address at least 10 previous times, the appeals court's opinion said.

According to the opinion, when they arrived, Wilczak and Sally found the resident stuck between his bed and a wall. They decided to move the person off the floor and into bed.

During their initial attempt, the resident became hung up on the side of the bed. Wilczak and Sally then "kind of lunged and swung him onto the bed," the opinion said.

Wilczak says he felt significant pain in his left shoulder during the lunging motion.

According to the opinion, he received treatment for the injury, but complications left him unable to continue working. He applied for a "line of duty" disability benefit in April 2010.

The Lombard Firefighters' Pension Fund granted the application in June 2012.

About two months later, Wilczak petitioned the village for health insurance benefits under the Public Safety Employee Benefits Act, 820 Ill. Comp. Stat. Ann. 320/10(b).

After the village declined the request, Wilczak filed a lawsuit in the DuPage County Circuit Court. He requested a declaratory judgment that he is entitled to the requested health insurance benefits.

Wilczak alleged that his catastrophic injury occurred in response to what he reasonably believed was an emergency.

The parties had agreed that a person who obtains a line-of-duty disability pension is considered as a matter of law to have suffered a catastrophic injury, the opinion said.

REUTERS/Shaun Best

Both sides moved for summary judgment.

The Circuit Court granted the village's motion.

The court acknowledged that Wilczak was injured while responding to a 911 call, but concluded that no person would reasonably believe the incident was an emergency.

The 2nd District panel affirmed.

The appeals court said Illinois case law defines an emergency under the Public Safety Employee Benefits Act to be "an unforeseen circumstance involving imminent danger to a person or property requiring an urgent response."

The panel concluded the evidence showed Wilczak's injury did not occur while responding to what was reasonably believed to be an emergency.

The dispatch report for the call at issue, for instance, shows the dispatcher indicated the resident needed help into bed, the panel said. The dispatcher also classified the call as a "priority 2," which meant it was not a life-threatening incident, it said.

The panel acknowledged that Wilczak subjectively believes he responded to an emergency because, among other things, he did not know the condition of the resident until he arrived at the house.

"Nonetheless, even if the plaintiff subjectively believed that he was responding to an emergency, what he learned when he arrived confirmed that it was not an emergency," the panel said, adding that Wilczak "testified that, after an initial assessment, he determined that the disabled citizen was not injured and did not require medical attention." WJ

Related Filing:
Opinion: 2016 WL 7079555

Staffing agency nurse is 'employee' for insurance purposes, court says

(Reuters) – A nurse employed by a staffing agency who worked at a Maryland hospital counts as an employee of the hospital for the purpose of the hospital's malpractice insurance, a federal appeals court has ruled.

Interstate Fire & Casualty Co. v. Dimensions Assurance Ltd., No. 15-1801, 2016 WL 7099822 (4th Cir. Dec. 6, 2016).

A unanimous panel of the 4th U.S. Circuit Court of Appeals on Dec. 6 vacated a lower court decision dismissing a lawsuit brought by Favorite Healthcare Staffing's insurer, Interstate Fire & Casualty Co, against Dimensions Assurance Ltd., the captive insurer of Maryland's Dimensions Healthcare System.

The dispute stems from a 2012 medical malpractice lawsuit brought against Dimensions Healthcare's Laurel Regional Hospital and several of its doctors and nurses by a former patient.

One of the defendants was a nurse, identified in court papers only by her last name, Cryer, who was employed by FHS and worked for the hospital under an agreement between FHS and the hospital.

Chicago-based Interstate defended Cryer in the lawsuit, eventually settling it for $2.5 million and incurring close to $500,000 in defense costs, according to the Dec. 6 opinion.

In December 2013, Interstate sued Dimensions Assurance in the U.S. District Court for the District of Maryland, seeking to recover the entire cost of the case. It said Cryer was an employee of Dimensions, and thus covered by its liability insurance policy.

In June 2015, U.S. District Judge George Hazel in Greenbelt, Maryland, granted summary judgment to the hospital. *Interstate Fire & Cas. Co. v. Dimensions Assurance Ltd.*, No. 13-cv-3908, 2015 WL 3917402 (D. Md. June 24, 2015). He cited the staffing agreement between FHS and the hospital, which said FHS was "solely responsible for the actions or omissions of any practitioner" it provided, and that FHS practitioners were not hospital employees.

Interstate appealed.

The 4th Circuit, in reversing, first said that Dimensions' own insurance policy for the hospital implicitly extended coverage to agency employees. The general liability portion of the policy explicitly excluded agency employees, but the professional liability portion did not, said Circuit Judge William Traxler, who wrote the opinion.

That difference "must be understood as an intentional decision," Judge Traxler said.

Even apart from the policy, Judge Traxler said, Cryer must be considered an employee under the state's common law "right-to-control test," laid out by the Maryland Court of Appeals in 1985 in *Whitehead v. Safway Steel Products*, 497 A.2d 803 (Md. 1985), a workers' compensation case. Under that test, a worker who can be hired, fired, paid and disciplined by an employer is generally considered an employee.

Judge Traxler rejected Dimensions' argument that the court must defer to the language of the staffing agreement stating that FHS workers are not hospital employees.

Judge Traxler said that, under Maryland law, that meant only that Cryer had two employers — a "general" employer, FHS, and a "special" employer, the hospital. He cited the Maryland Court of Appeals' 2001 decision in *Lovelace v. Anderson*, 785 A.2d 726 (Md. 2001), which concerned employer liability for an employee's actions.

Circuit Judges Dennis Shedd and Henry Floyd joined Judge Traxler in the opinion. The panel remanded the case to the District Court for further proceedings.

Robert Ferguson, an attorney for Dimensions, declined to comment. An attorney for Interstate could not immediately be reached. WJ

(Reporting by Brendan Pierson)

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Defendant: Robert Ferguson Jr., Ferguson Schetelich & Ballew, Baltimore, MD

Related Filings:
4th Circuit opinion: 2016 WL 7099822
Lovelace opinion: 785 A.2d 726
Whitehead opinion: 497 A.2d 803

Firm's California 'nerve center' trumps Vermont board meetings for diversity purposes

An insurer that is incorporated in Vermont but has its business "nerve center" in California is not an out-of-state citizen for diversity purposes, according to a San Francisco federal judge who remanded a judgment creditor's lawsuit to state court.

Derosier v. Global Hawk Ins. Co., No. 16-cv-6069, 2016 WL 6888280 (N.D. Cal. Nov. 23, 2016).

Plaintiff Brittney Derosier wants Global Hawk Insurance Co. to pay her a $100,000 default judgment on behalf of trucking company Victory Transportation Inc. Derosier won the judgment in July 2015 after a Victory driver rear-ended her vehicle and injured her the previous June.

According to a complaint Derosier filed in the Alameda County Superior Court, a Global attorney acknowledged that Victory is covered under one of the insurer's policies, but the insurer has in bad faith refused to pay. *Derosier v. Global Hawk Ins. Co.,* No. RG1634665, *complaint filed*, 2016 WL 7046513 (Cal. Super. Ct., Alameda Cty. Oct. 11, 2016).

Derosier's state court complaint alleges that Global, upon closer inspection, is not an actual insurance company. Rather, it appears to be a risk retention group — an association of up to 20 unknown investor-owners identified as "Does 1-20" — who collectively promise to pay claims by insureds.

'A MERE SHELL'

Derosier claims the "Does" are using Global Hawk as "a mere shell and sham" to escape individual liability for matters and substitute Global — which she claims is financially insolvent — in their places.

Global Hawk removed the suit to the U.S. District Court for the Northern District of California in October on diversity-of-citizenship grounds. The insurer said the case belongs in federal court because Derosier is a Nebraska resident and Global is a Vermont corporation that merely does business in California.

The insured driver is not named in the suit.

Derosier sought to remand the action to the state court, asserting that Global's principal place of business is in Livermore, California.

'NERVE CENTER'

U.S. Magistrate Judge Kandis A. Westmore granted partial judgment to Derosier and sent the case back to state court. She relied on a 2010 U.S. Supreme Court opinion that said a company's principal place of business is its "nerve center," where officers and directors co-ordinate its activities. *Hertz Corp. v. Friend*, 559 U.S. 77 (2010).

The nerve center is largely considered to be the corporation's main place of business and is not just a location where it conducts board meetings, the opinion said.

Under those parameters, Global failed to prove Vermont is its nerve center simply because it is incorporated in that state and its director meetings originate there, Judge Westmore said.

She also noted that Global's contact address on its website is in Livermore, and CEO Jasbir S. Thandi also is located in that town.

Judge Westmore granted Derosier's remand motion but denied her bid for attorney fees for the cost of the venue battle.

No one was immediately available at Global to comment on the litigation. WJ

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Defendant: Dominic G. Flamiano, Norcal Logistics Lawyers Group PC, Livermore CA

Related Filings:
Order: 2016 WL 6888280
State court complaint: 2016 WL 7046513

NEWS IN BRIEF

CALIFORNIA INSURANCE DEPARTMENT PENALIZES ZENEFITS $7 MILLION

Zenefits, a San Francisco-based provider of online human resources services, has agreed to resolve an investigation by the state's Department of Insurance over allegations that it allowed unlicensed employees to transact insurance business and circumvented agent education requirements. California Insurance Commissioner Dave Jones said in a Nov. 28 statement that the $7 million penalty imposed on Zenefits is one of the largest the DOI has ever assessed. Jones says his office began investigating Zenefits in 2015. The company then announced that it was not complying with insurance laws and regulations, Jones' statement said. The settlement includes a $3 million penalty for licensing violations and a $4 million penalty for subverting licensing education and study-hour requirements for agent and broker licensing, Jones said. Because of Zenefits' self-reporting and remedial actions, half the total penalties will be suspended unless the company fails to meet compliance requirements, according to the statement.

NEW YORK MAN ACCUSED OF INSURANCE FRAUD

An Ulster County, New York, grand jury has indicted a local man on insurance fraud, larceny and other charges, according to a Dec. 6 statement from the county's district attorney, D. Holley Carnright. Robert Bari, 37, of Milton, New York, is alleged to have defrauded Aflac Inc. by submitting fraudulent disability forms between January 2012 and December 2013, and obtaining benefits to which he was not entitled, according to the statement. He also is accused of submitting fraudulent policy applications to Aflac between December 2012 and September 2013 that allegedly resulted in Aflac paying him commissions that he was not entitled to receive, according to the statement.

NORTH CAROLINA WOMAN FACING CHARGES OVER ALLEGED ARSON SOLICITATION

A North Carolina woman has been charged with several offenses related to her alleged solicitation of people to burn and damage their property in an attempt to collect insurance payments, according to a Dec. 2 statement from the state Insurance Commission. Tina Huong Nguyen, 58, of Charlotte, North Carolina, allegedly solicited people to present claims on insured properties so she could profit, the statement says. Nguyen was arrested Dec. 1 and placed under a $45,000 bond, according to the statement. She is facing one count of solicitation, second degree arson; two counts of misdemeanor solicitation, insurance fraud; and five counts of misdemeanor solicitation, burning one's own dwelling, according to the statement.

All-risks policy

CONTINUED FROM PAGE 1

American Home Assurance Co. Inc. issued him a homeowners policy at the time of purchase that insured against "all risks."

The policy insured the house and other permanent structures for more than $8 million, and provided additional coverage for loss of use of the home, according to the opinion. It covered weather perils such as rain, but excluded losses caused by defective planning, design and construction.

Soon after the purchase, water began to intrude during rainstorms, the opinion said. The house sustained further damage in October 2005 during Hurricane Wilma, it said.

Sebo reported water intrusion and other damage to AHAC in late December 2005, the opinion said.

The insurer denied coverage in April 2006 for most of the claimed losses, but tendered $50,000 for mold damages, according to the opinion.

The house eventually was demolished and Sebo sued numerous defendants in January 2007. His claims included negligent design and construction.

Sebo later added AHAC to the case, seeking a declaration that its policy covered his damages.

Sebo settled with most of the defendants, but proceeded to a trial against AHAC.

The jury found in favor of Sebo, and the Collier County Circuit Court entered a judgment in his favor of about $8 million, according to court records.

The state's 2nd District Court of Appeals reversed. *Am. Home Assurance Co. v. Sebo*, 141 So. 3d 195 (Fla. 2d Dist. Ct. App. 2013).

The appeals court found no dispute that there was more than one cause of the loss, including rain, wind and defective construction, according to Justice Perry's opinion.

The panel then departed, however, from the 3rd District Court of Appeals' holding in *Wallach v. Rosenberg*, 527 So. 2d 1386 (Fla. 3d Dist. Ct. App. 1988), that "[w]here weather perils combine with human negligence to cause a loss, it seems logical and reasonable to find the loss covered by an all-risk policy even if one of the causes is excluded from coverage."

The 2nd District rejected *Wallach*'s use of the concurrent-cause doctrine and ordered a new trial with Sebo's loss being examined under the efficient-proximate-cause doctrine.

> "We conclude that when independent perils converge and no single cause can be considered the sole or proximate cause, it is appropriate to apply the concurring-cause doctrine," the majority said.

The state Supreme Court resolved the appellate court split by siding with the 3rd District's use of the CCD.

"We conclude that when independent perils converge and no single cause can be considered the sole or proximate cause, it is appropriate to apply the concurring-cause doctrine," Justice Perry wrote.

The high court noted that it would not be feasible under the circumstances to apply the efficient-cause doctrine because "there is no reasonable way to distinguish the proximate cause of Sebo's property loss — the rain and construction defects acted in concert to create the destruction."

Justice Charles T. Canady concurred in the result.

Justice Ricky Polston wrote in dissent that the issue was not properly before the court for consideration. WJ

Related Filing:
Opinion: 2016 WL 7013859

See Document Section A (P. 17) for the opinion.

CASE AND DOCUMENT INDEX