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DECISIONS

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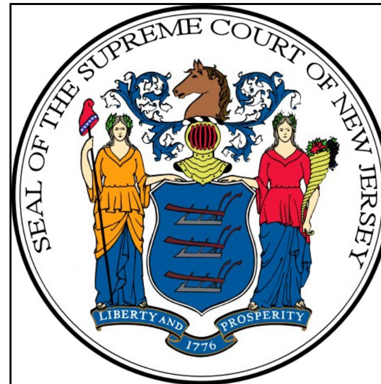
Special points of interest:

- Late Notice Defense under New Jersey Law
- Enforceability of Arbitration Provisions in Wrongful Death Cases Under CA and KY law
- Damages for Wrongful Pregnancy Claims in New Jersey
- Coverage for Ambulance Negligence under Auto and Professional Liability Policies
- Application of Prior Litigation Exclusion under California law
- Misrepresentations relating to one insured do not void coverage for other innocent co-insureds

New Jersey Supreme Court Holds That Prejudice Is Not Required To Prevail On Late Notice Defense Under a Claims Made Policy

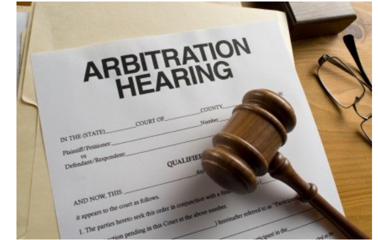
On February 11, 2016, the New Jersey Supreme Court ruled that an insurer disclaiming coverage under a claims made policy issued to a "sophisticated" insured is not required to show prejudice resulting from the delayed notice. Templo Fuente De Vida Corp. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 2016 WL 529602 (N.J. Feb. 11, 2016). In the unanimous decision, the court affirmed an appellate court's ruling that National Union is not responsible for a settlement entered after the insurer disclaimed coverage based on late notice. The insured, which operates a church and child day care center, accused First Independent Financial Group ("FIFG") of backing out of commitments to provide funding for a loan for it to buy property. FIFG, which was insured under a claims made directors and officers policy, waited more than six months after it became aware of the lawsuit before notifying National Union of the lawsuit. During that six month period, FIFG retained counsel and filed an Answer to the Complaint. Although the claim was made during the National Union policy period, National Union denied coverage for the lawsuit on the grounds that it did not receive notice of the claim "as soon as practicable" as required under the claims made policy. FIFG settled the case for $3.2 million and, to cover part of the settlement, assigned its rights against National Union to Templo. Templo filed a lawsuit against National Union to secure coverage for the settlement. The trial court determined that there was no coverage under the policy because FIFG failed to provide notice as soon as practicable. A panel of the state Appellate Division upheld the trial court's decision. During arguments before the Supreme Court, the insured argued that National Union was required to show prejudice to deny coverage. The Court disagreed, noting the insured's level of sophistication. The Court held that the policy was not a contract of adhesion or a policy where terms and conditions were set by the insurer with little to no room to negotiate. Writing for



the Court, Justice Lee A. Solomon wrote that "[w]e hold that because this directors and officers 'claims made' policy was not a contract or adhesion but was agreed to by sophisticated parties, the insurance company was not required to show that it suffered prejudice before disclaiming coverage on the basis of the insured's failure to give timely notice of a claim." Justice Solomon further noted that the plaintiff failed to present evidence as to why FIFG delayed in providing notice to National Union. In its ruling, the Court cited its 1963 decision in Zuckerman v National Union Fire Ins. Co., which held that an insurer does not have to show prejudice in order to avoid coverage for late notice under a claims made policy. Despite its ruling in favor of National Union, the Court declined to draw a "bright line" test for what constitutes timely compliance with an "as soon as practicable" notice provision. "We recognize that a different conclusion may have been reached in other jurisdictions, but our jurisprudence has never afforded a sophisticated insured the right to deviate from the clear terms of a 'claims made' policy," wrote Justice Solomon.

California Court Says Arbitration Agreement Does Not Apply to Wrongful Death Claimants

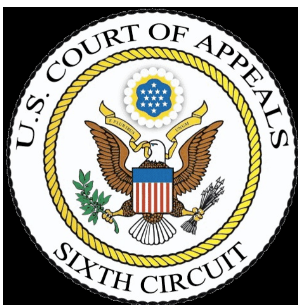
On January 29, 2016, the California Court of Appeal, First District, held that a wrongful death claim asserted by the personal representative of a woman who died allegedly as the result of an assisted living facility's negligence is not subject to compelled arbitration. Monschke v. Timber Ridge Assisted Living, LLC, 197 Cal. Rptr. 3d 921 (Cal. App. 2016). The personal representative signed an agreement with Timber Ridge, on behalf of the resident, when she entered the facility. The agreement contained an arbitration clause that applied to all parties to the agreement, including spouses, heirs, representatives, executors, administrators, successors and assigns. The resident was allowed to leave the facility without supervision. She subsequently fell and was left outside for approximately forty-five minutes. She suffered numerous injuries and died two weeks later. The personal representative filed suit against Timber Ridge and Timber Ridge moved to dismiss the action and compel arbitration. The trial court denied the motion and Timber Ridge appealed. The appellate court stated that the personal representative was not bound by the arbitration agreement in her capacity as a wrongful death beneficiary because she was not a party to the agreement in that capacity. The Court noted that a "party cannot be compelled to arbitrate a dispute that he has not agreed to resolve by arbitration." The Court further noted that "[w]hile the plaintiff signed the residency agreement, she did so as decedent's power of attorney, not in her capacity" and that the representative had not "stepped into the shoes" of the decedent because the representative was "asserting a wrongful death claim on behalf of the decedent's heirs, not the decedent." In so ruling, the Court noted that, unlike other jurisdictions, California does not consider wrongful death claims to be derivative of a decedent's claims. Instead, the California Civil Code "creates a new cause of action in favor of the heirs as beneficiaries, based upon their own independent pecuniary injury suffered by a loss of a relative" which is distinct from any the deceased might have had she survived. The Court further held that the representative was not the decedent's alter ego for purposes of the wrongful death action.



"A party cannot be compelled to arbitrate a dispute that he has not agreed to resolve by arbitration."

Sixth Circuit, Applying Kentucky Law, Refuses to Compel Arbitration

On January 15, 2016, the Sixth Circuit Court of Appeals, applying Kentucky law, concluded that wrongful death beneficiaries in Kentucky are not bound to arbitrate a dispute arising out of a wrongful death action filed against a long-term care facility. Richmond Health Facilities—Kenwood, LP v. Nichols, 811 F.3d 192 (6th Cir. 2016). At issue in the case was an arbitration provision contained in an admission document signed by the decedent when he entered the facility that stated he would arbitrate "any and all disputes arising out of or in any way related to" the care he received. After the decedent died at the facility, the executor of his estate filed a wrongful death action. The facility filed a motion to compel arbitration but the U.S. District Court for the Eastern District of Kentucky denied the motion. On appeal, the facility argued that the Kentucky Supreme Court's holding in Ping v. Beverly Enters., Inc., 376 S.W.3d 581 (Ky. 2012) applied. The court in Ping held that arbitration of a wrongful death claim by nonsignatories to the agreement cannot be compelled. The Court disagreed and concluded that Ping was dispositive. In Ping, the Court held that a wrongful death claim in Kentucky is independent of any claim held by the decedent. Relying on Ping, the Court held that the decedent had "no authority to make contracts … affecting the claims that belong to others." The Court also rejected the facility's argument that the Federal Arbitration Act ("FAA") preempted Ping. The Court noted that Ping does not categorically prohibit arbitration of wrongful death claims. The Court further noted that "federal law does not force arbitration on a party that never agreed to arbitrate in the first place."



Illinois Supreme Court Holds That Credentialing Documents Are Discoverable In Lawsuit Against Hospital

On January 22, 2016, the Illinois Supreme Court held that documents submitted to or obtained by a hospital in connection with a physician's application for medical staff privileges are not privileged and are subject to discovery in a negligent credentialing lawsuit filed against the hospital. Kaine v. Southern Ill. Hosp. Servs., 2016 WL 280553 (Ill. Jan. 22, 2016). The Court affirmed the lower court's decision holding that the materials, though designated as confidential by the Health Care Professionals Credentials Data Collection Act, 410 Ill. Comp. Stat. 517/1 et seq. ("Credentials Act), were nevertheless discoverable in the plaintiff's claim against the hospital. The Court noted that confidential is different than privileged. In the case, the plaintiffs filed a medical malpractice action against the hospital defendant alleging that they negligently granted medical staff credentials to a physician. In responding to plaintiffs' discovery requests, the hospital refused to produce materials submitted to or obtained by the hospital in connection with the physicians' application for credentialing or summaries or case histories related to patients treated by the physician. The hospital argued that the materials were privileged under state and federal law. With respect to the state privilege, the hospital argued that the records were confidential, and therefore privileged, under the Credentials Act. The Court rejected the argument and held that the documents were highly relevant and, nevertheless, that the Credentials Act did not create a blanket privilege for this information. With respect to federal privilege, the hospital argued that the documents were protected under the federal Health Care Quality Improvement Act ("HCQIA") or HIPAA. Specifically, the hospital argued that HCQIA provided a privilege for references in the

physician's applications to material provided to the National Practitioner Data Bank ("NPDB"). The Court rejected this argument as well and held that it is "clear that the information reported to the NPDB, though confidential, is not privileged from discovery in instances where, as here, a lawsuit has been filed against the hospital and the hospital's knowledge of information regarding the physician's competence is at issue." The Court also held that information regarding the physician's treatment of patients who were not parties to the action was not protected from discovery by HIPAA or by Illinois ' physician-patient privilege.

"Information, though confidential, may be highly relevant to matters at issue in a trial and, therefore, critical to the truth-seeking process. Consequently, the confidential nature of information does not prevent it from being discoverable unless the plain language of the statute so provides."

Damages for Sterilization Failure in Wrongful Pregnancy Case Limited Under New Jersey Law

On January 20, 2016, the United States District Court for the District of New Jersey issued an unpublished decision holding that the parents of a child born with Down syndrome cannot recover damages for the extraordinary costs of raising the child. Maliton v. United States, 2016 WL 270213 (D.N.J. Jan. 20, 2016). The wrongful pregnancy case arose out of allegations of malpractice by the mother's doctors who failed to perform tubal ligation following the delivery of her child in 2009. The mother became pregnant again and the child was subsequently born with Down syndrome. The parents alleged that she would not have become pregnant if not for the negligence of the medical defendants that led her to believe she could not become pregnant. The defendants filed a motion to dismiss all wrongful birth claims and to limit plaintiffs' damages to those for wrongful pregnancy only. The Court granted the motion and held that the New Jersey Supreme Court has not recognized a cause of action for wrongful life and that it has not authorized the award of such damages in a wrongful pregnancy case. The Court noted that, although New Jersey courts have recognized the cause of action of wrongful pregnancy, they have limited the damages to the medical expenses, pain and suffering, lost wages, and loss of consortium incurred during the pregnancy and delivery. In addition, although New Jersey also recognizes a cause of action for wrongful birth and permits the type of damages sought by the plaintiffs, plaintiffs did not assert this cause of action because they knew their child would have Down syndrome and proceeded with the pregnancy anyway. Thus, plaintiffs' damages were limited and the Court stated it was not authorized to expand state law.

New Jersey federal court refuses to expand damages recoverable in a wrongful pregnancy case

Automobile Liability Insurer and Professional Liability Insurer Are Both Obligated to Defend Ambulance Lawsuit

"Given the potential for a professional liability claim at the outset of the claim, we will divide the liability on the duty to defend and find both parties equally responsible for the defense."

In a decision issued on January 26, 2016, the United States District Court for the Eastern District of Pennsylvania held that a commercial auto insurer was obligated to indemnify an ambulance company for a settlement reached with a plaintiff who sustained injuries when he fell out of the back of a wheelchair accessible ambulance van. Knightbrook Ins. Co. v. Northfield Ins. Co., 2016 WL 344371 (E.D. Pa. Jan. 26, 2016). The Court also held that both the automobile insurer and the professional liability insurer had an equal responsibility for paying the defense costs incurred in the case. In Knightbrook, a wheelchair-bound plaintiff sustained injuries when an employee of the insured failed to secure him with a lap belt or straps. As a result, the plaintiff rolled off the back of the van and sustained injuries. The ambulance company tendered the lawsuit to its commercial auto insurer and to its general liability/professional liability insurer (Northfield). The auto liability insurer (Knightbrook) defended the lawsuit pursuant to a reservation of rights and settled the case. Knightbrook then sued Northfield to recover its indemnity and defense costs. The auto policy provided coverage for the ownership, maintenance, or use of a covered auto. The Northfield policy provided general liability coverage but contained an auto exclusion precluding coverage for bodily injury arising out of the ownership, maintenance, use (which included loading or unloading) or entrustment of any auto. The term "loading or unloading" was defined to include the handling of any person or property after, while in, or while being moved from an auto to the place where the person is finally delivered. The Court, in ruling on cross-motions for summary judgment, rejected Knightbrook's argument that the van was merely the "situs" of the injury and concluded that the claim was covered under the auto policy because the use of the vehicle constituted a "but for cause of the injuries." In addressing the broader duty to defend, the Court held that the allegations not only alleged negligence in the use of the auto but also potential professional negligence. In this regard, the Court noted that many of the allegations related directly to the insured's liability regardless of whether it occurred around the ambulance van. On balance, the Court noted that the allegations encompassed both professional liability and injury resulting from the operation of the vehicle. The Court concluded that "[g]iven the potential for a professional liability claim at the outset of the claim, we will divide the liability on the duty to defend and find both parties equally responsible for the defense."

New York Appellate Court Says Issues of Fact Exist As To Whether Pressure Ulcers Were "Unavoidable"

On December 3, 2015, the Supreme Court, Appellate Division, First Department, held that whether a nursing home departed from good and accepted medical practices was a material fact issue that precluded the entry of summary judgment. Pichardo v. St. Barnabas Nursing Home, Inc., 21 N.Y.S.3d 42 (1st Dept. 2015). In Pichardo, the plaintiff-decedent was an 81 year-old female who suffered from numerous medical conditions such as dementia, gastroenteritis, and heart disease. She was placed on a ventilator due to her respiratory failure. The plaintiff was admitted to St. Barnabas hospital and developed a stage II sacral ulcer during her admission. The ulcer decreased in size with treatment by the hospital. When she was eventually readmitted, the ulcer was characterized as Stage IV. Plaintiff filed an action against the nursing home alleging medical malpractice, negligence and violation of Public Health Law § 2801-d. Defendants' expert opined that whenever a person with severe preexisting illnesses experiences acute illness necessitating prolonged intensive care and artificial life support, the risk for further adverse outcome, like worsening of wounds, increases, even with the best of care. The plaintiff's expert opined that the nursing home should have continued the hospital's treatment protocol and highlighted the fact that the ulcer improved during the hospital admission. The court denied the defendants' summary judgment motion stating that, while the plaintiff's comorbidities played an "obvious role in her decline," it cannot be said that "the formation and worsening of skin ulcers was unavoidable as a matter of law." The court therefore found triable issues as to whether the nursing home violated Public Health Law § 2801-d.

California Court Holds That Insurer had No Duty to Pay Defense Costs Because DOJ Claim Involved Excluded Prior Litigation

On February 26, 2016, a California federal court reversed its September 30, 2015 decision holding that Millennium Laboratories' insurer owed it $5 million in coverage for a federal Health Insurance Portability and Accountability Act ("HIPAA") investigation under a directors liability policy issued by Allied World Assurance Company ("Allied"). Millennium Laboratories, Inc. v. Allied World Assurance Company, Inc., Case No. 12-cv-2280 (S.D.Cal. Feb. 26, 2016). At the time the Allied policy was issued, Millennium, a specialty diagnostics laboratory provider to the chronic pain market, faced private lawsuits from competitors and several whistle-blower actions. After the policy was issued, the DOJ issued broad subpoenas requesting a wide range of documents and listing a wide range of potential offenses. Millennium sought coverage in responding to the requests. The Allied policy contained a "related claims" provision stating that "[a]ll Related Claims shall be deemed to be a single Claim made on the date on which the earliest Claim ... was first made." The policy also contained a "Specific Claims Exclusion" that provided that "[n]o coverage will be available for Loss from any Claim based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving" prior or pending litigation. In the September, 2015 decision, the Court noted that Allied could not prove that the Department of Justice's investigation was related to several *qui tam* and private lawsuits alleging that Millennium had engaged in unlawful business practice to gain an unfair competitive advance. The DOJ subsequently released the settlement details that ended its probe and Allied moved for reconsideration based upon this new evidence. After considering the information contained in the unsealed Settlement Agreement, the Court held that all of the DOJ allegations in the Complaint and the Settlement Agreement were based upon, arose out of, resulted from, or were in some way involved with the three specified excluded private lawsuits filed prior to the issuance of the Allied policy. Accordingly, the Court held that the "Specific Claims" Exclusion applied to preclude coverage for the DOJ action.

"All of the DOJ allegations in the Complaint and the Settlement Agreement … are based upon, arising out of, directly or indirectly resulting from, in consequence of or are in some way involving [the three excluded actions]."

Fourth Circuit Holds That Imposter Doctor Does Not Void Entire Policy

On January 15, 2016, the United States Court of Appeals for the Fourth Circuit upheld a district court's refusal to completely void a professional liability policy that Evanston Insurance Company ("Evanston") issued to Agape Senior Primary Care Inc. ("Agape") after it was revealed that a doctor added to the policy was an imposter. Evanston Ins. Co. v. Agape Sr. Primary Care, Inc., 2016 WL 192748 (4th Cir. Jan. 15, 2016). In Agape, the medical facility discovered that the doctor it hired had stolen the identity of his friend, who was a real doctor and who was out of the country. Agape and several of its employees were later named as defendants in three class action lawsuits claiming, among other things, that they had been negligent in hiring the doctor. Evanston sought to rescind the entire professional liability policy based on the misrepresentations of the doctor. In an effort to vitiate coverage based upon the misrepresentation, Evanston filed suit in South Carolina federal court in 2013, seeking a declaration that it had no obligation to defend or indemnify Agape in the underlying litigation. In ruling on Agape's motion for summary judgment, the district court judge invalidated the policy's coverage as to the doctor, but left coverage for Agape and its other employees intact. The district court held that as an "innocent co-insured" under the Evanston policy, Agape was entitled to retain its portion of the insurance proceeds. In an unpublished opinion issued by a three-judge panel of the Fourth Circuit, the Court concluded that the lower court reached the correct conclusion. Based on South Carolina law and public policy, the Court held that the policy should not be rescinded, as the fraudulent acts of one insured should not deprive the other innocent insureds of coverage. The panel wrote that "South Carolina law and principles of equity demand that fraudulent misrepresentations on an application for medical malpractice insurance by a person posing as a doctor should not vitiate the insurance policy as to his or her innocent employer and fellow employees."

The Court of Appeals for the Fourth Circuit holds that misrepresentations of one physician does not void coverage for other innocent co-insureds

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Notable Verdicts/Settlements

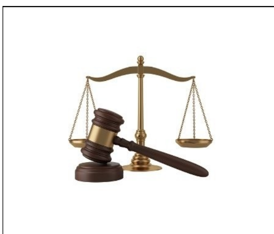
Cook County, IL—February, 2016. A Chicago family of a six-year old boy left permanently disabled and brain damaged as a result of twenty-five experimental procedures on the young boy have reached a $30 million settlement with the boy's physician and several hospitals. The boy was born in 2009 with a non-life threatening, correctible condition called esophageal atresia. During a 2011 surgery, the surgeon improperly used a surgical needle that severed the child's pulmonary artery and resulted in irreversible brain damage and cerebral palsy. The procedures were not authorized by the hospital or done pursuant to clinical trial protocols.

Howard County, MD—November, 2015. A Howard County jury returned a $397,000 verdict in favor of plaintiff who became pregnant several weeks after bilateral tubal ligation surgery performed by the defendant. The plaintiff, joined by her husband, filed suit alleging that the surgery was not performed properly. After a three day trial, the jury awarded plaintiffs $240,000 to compensate the plaintiffs for the costs of raising their child and $157,000 to cover costs of services to cope with his special needs.

Sussex County, New Jersey—October, 2015. A Sussex County jury awarded the plaintiff's estate $3.5 million for pain and suffering/loss of enjoyment of life and $3.5 million for loss of guidance and advice against a radiologist who failed to order an MRI or liver biopsy after an ultra sound showed a liver mass. Patient died after the liver cancer metastasized.

DeKalb County, GA—September, 2015. A DeKalb County jury awarded $20 million (later reduced to $12.5 million) to the mother of a twenty-five year old mentally disabled man with a history of cardiomyopathy and orthopnea, who died of a sudden cardiac death while undergoing a sleep study run by the defendants.

Notable Defense Verdicts



Recent Notable Defense Verdicts

Henrico County, VA — January, 2016 A Henrico County jury found for the defendant in a case alleging that plaintiff suffered a stroke as a result of negligently conducted atrial defect repair surgery. The defense was supported by two interventional cardiologists who testified that the surgeon complied with the standard of care. The forty-eight year old plaintiff sought $2.5 million in damages, including future medical expenses, past and future lost wages and ongoing life care costs. After a five day trial, the jury concluded that the defendant had not been negligent.

Fredericksburg City, VA— October, 2015. After a five day trial, a Fredericksburg City jury found for the defendants in a case in which an eighty-six year old woman who suffered from paraplegia after undergoing spinal decompression surgery to relieve weakness, gait instability, and difficulty balancing in her legs. The plaintiff alleged that the surgeon negligently touched her spinal chord during surgery. The defendants asserted that the care met and exceeded the standard of care and that the surgeon did not come into contact with the spinal chord. Plaintiff had sought $2 million in damages.

Riverside County, CA—July, 2015. A Riverside County jury, after a ten day trial, returned a verdict in favor of a physician defendant who was sued after the patient suffering from respiratory distress died. In the lawsuit, plaintiff alleged the physician was negligent in failing to timely perform surgery and failing to diagnose the patient with sepsis. The defendant maintained that there was no need to immediately operate on the patient, who presented with abdominal pain, and that she was not septic.

New Castle, DE—April, 2015. A New Castle County jury found in favor of the defendant in a case involving the alleged failure to rule out injury to his left internal carotid artery after the plaintiff presented with lacerations to his mouth sustained when a metal rod perforated the roof of his mouth. Defendant denied liability and argued that if plaintiff told the defendant that he was under the influence of marijuana at the time of the incident, he would have been able to determine that the injury was more severe.