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LITIGATION UPDATE

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Donegal Mutual Insurance Company v. Baumhammers, Pa., 938 A.2d 286 (2007)

Baumhammers went on a shooting spree, killing five people and wounding a sixth. Baumhammers was sued for the shootings and his parents were sued for failure to take a handgun away from him, failure to secure mental health treatment for him, and failure to advise the police about the handgun. The parents had homeowner's coverage with Donegal Mutual with a $300,000 liability limit. The issues on appeal: did the claims against the parents constitute an "occurrence" and, if so, how many "occurrences?" The Supreme Court rules that whether an injury is the result of an accident (and thus an "occurrence") is determined from the viewpoint of the insured seeking coverage, not from the viewpoint of the one that committed the act causing injury. Baumhammers' shooting spree, from the viewpoint of his parents, was unexpected, an accident, and thus an "occurrence," triggering coverage for the parents. For Baumhammers himself, the shooting spree was an intentional act, thus beyond coverage. With regard to the number of "occurrences," the Supreme Court rules the proper focus is on the conduct of the insured rather than on the number of victims. Since all of the victims claimed injury because of a single set of negligent acts by the parents, there was only a single "occurrence."

QBE Insurance Corporation v. M&S Landis Corporation, Pa. Super., 915 A.2d 1222 (2007)

QBE insured M&S Landis, a nightclub. The CGL policy had an "assault and battery" exclusion which eliminated coverage for claims arising from assault and battery or any act or omission in connection with preventing same. M&S Landis was sued after a patron was smothered to death during a confrontation with bouncers at the nightclub. The complaint included allegations that the bouncers negligently restrained the victim, that the nightclub negligently failed to train the bouncers, and that the nightclub and bouncers negligently failed to timely render first aid. The Superior Court rules that, although intentional conduct may have been a cause of the patron's death, negligent conduct other than assault and battery was also alleged to have caused the death. As a result, the underlying complaint alleged an "occurrence" that did not arise from assault and battery but rather arose from other negligent acts for which coverage had not been excluded. QBE was required to provide a defense in the underlying tort action.

Millers Capital v. Gambone Brothers, Pa. Super., - A.2d - (2007)

Gambone built housing developments while Millers Capital was its CGL carrier. Homeowners sued Gambone for alleged deficiencies in completed homes. Some suits claimed water leaks due to construction defects and product failures in vapor barriers, windows, roofs, and stucco exteriors. Other suits alleged Gambone used defective stucco, resulting in delamination, peeling, disfigurement, compromise of structural integrity, infiltration by the elements, mold, cracking of the exterior, and moisture penetration. Millers Capital denied coverage for the suits. The Superior Court affirms, citing *Kvaerner v. Commercial Union Insurance Company*, Pa., 908 A 2d 888 (2006). Claims premised on allegations of faulty workmanship are not covered under CGL policies. Although exterior faulty workmanship allegedly caused damage, the damage was simply to the interior of the larger product – the home itself. For instance, damage caused by rainfall seeping through faulty exterior work to damage the interior of a home is not a fortuitous event that triggers coverage.

Gambone argued that denial of coverage rendered some policy provisions meaningless or surplusage. Disagreeing, the Superior Court gives hypotheticals where coverage might exist. The subcontractor exception to the "Damage to Your Work" exclusion, for instance, allows coverage where a subcontractor confuses job orders and works on part of a project for which it had no contract, giving rise to an "occurrence." As another example, a subcontractor using job materials not contemplated by the contract, thus causing harm, also gives rise to an "occurrence."

Gambone also argued the policy "your work" definition included "warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of your work" – the very warranties and representations cited in the suits – and denial of coverage rendered that definition meaningless. Again disagreeing, the Superior Court notes coverage might exist when a contractor warrants subcontractor work on a portion of a project on which the subcontractor was not contracted to work, in short, a warranty pertaining to erroneously rendered performance or work. The warranty, therefore, fits the definition of "your work," yet still qualifies for the subcontractor exception to the "your work" exclusion.

Finally, the Superior Court rejects Gambone's alleged reliance on "reasonable expectations" in purchasing the policies. If policy limitations are clear and unambiguous, an insured may not complain that reasonable expectations have been frustrated. The policy limitation raised by Millers Capital (i.e. that the homeowners' allegation of faulty workmanship did not constitute an "occurrence") was unambiguous as a matter of law.

Plasticert v. Westfield Insurance Company, Pa. Super., 923 A.2d 489 (2007)

Westfalia contracted with Plasticert for the latter to provide thermoplastic wheels for use in a gravity-flow product line. Later, Westfalia received complaints from customers that the wheels in the gravity-flow products were breaking, cracking, and shattering. Westfalia sued Plasticert for resulting damages. Westfield, the CGL carrier for Plasticert, denied coverage for the lawsuit. In a coverage DJ action, the trial court found that coverage was properly excluded under the "sistership" exclusion, usually found as exclusion (n) in a standard CGL policy. On appeal, the Superior Court affirms, although relying, instead, on the "damage to your product" exclusion, usually found as exclusion (k) in a standard CGL policy. Since the underlying complaint alleged that Plasticert's wheel failed to perform according to specifications but did not allege that the failure of the wheels resulted in personal injury or damage to any property other than the wheels themselves, exclusion (k) applied to eliminate coverage.

Atlantic Mutual Insurance Company v. Gula, Pa.Super., 926 A.2d 449 (2007), allocatur denied, Pa., – A.2d – (2007)

After an injury at work, Gula alleged that her injury was compounded because Novaeon, the employer's healthcare management administrator, delayed authorization of needed surgery. On appeal, the issue was whether Atlantic Mutual, Novaeon's CGL carrier, provided liability coverage for Gula's allegations. The trial court granted summary judgment to Gula, but the Superior Court reverses and instead enters judgment in favor of Atlantic Mutual.

Citing the Pennsylvania Supreme Court *Kvaerner* decision (which denied CGL coverage for poor workmanship which causes injury to the work product itself), the Superior Court rules that Novaeon's CGL policy was not designed to insure the quality of the medical case management service provided. Other coverage (i.e. professional liability coverage) can be purchased for that risk. The alleged failure to authorize medical care was not an "occurrence" under the CGL policy. The Superior Court further notes that the professional services exclusion in the CGL policy was also triggered. A CGL policy would cover a slip and fall in the Novaeon office but would not cover Novaeon's failure to do the job it was paid to do. Novaeon was hired to coordinate patient and healthcare options to provide healthcare in a cost-effective manner, a job that necessarily suggests levels of training, weighing of factors, and use of judgment which are hallmarks of a professional service. Such work stands in contrast to routine administrative functions of stamping paperwork and processing payments.

Greene v. USAA, Pa. Super., 936 A.2d 1178 (2007).

Greene alleged damage to the roof of his residence. After investigating, USAA, the homeowner's carrier, determined that some damage, not covered, was due to simple wear and tear, while other damage, caused by windstorm and thus covered, was limited in scope to a small section on one of the twelve slopes on the roof. Since exact replacement shingles were no longer manufactured, Greene argued that USAA was required to pay the cost of replacing the entire roof, not just the small section. At a non-jury trial, the court awarded only a small amount for minor repairs. The Superior Court affirms. The "like construction" provision in the USAA policy did not require USAA to fund replacement of the entire roof. Although USAA contracted to pay "the replacement cost of that part of the building damaged," the Superior Court rejected as "unreasonable and absurd" Greene's argument that the entire roof was an indivisible "part of the building damaged." The Superior Court adopts the trial court analysis that Greene's argument "would necessitate replacing all siding when one piece of siding is damaged, or an entire door when a doorknob is damaged." The Superior Court similarly rejected Greene's argument for full roof replacement based on the inability to find exact replacement roof shingles. Shingles similar to the damaged shingles in function, color, and shape meet the requirements of the "like construction" language in the policy.

ACE American Insurance Company v. Underwriters at Lloyds, Pa. Super., 939 A.2d 935 (2007)

ACE had claims made E&O coverage through Lloyds. ACE owed $37,200,000 in bad faith damages to an ACE insured. Lloyds denied E&O coverage based on untimely notice. The E&O policy had two separate notice provisions, a general provision and a specific provision. The general provision required that claims first made against ACE within the policy period be reported to Lloyds during the policy period. The specific provision applied to claims reasonably likely to exceed a loss of $4,000,000. In those cases, notice was required "as soon as practicable." For the bad faith claim at issue, ACE gave timely notice under the general reporting section but not under the specific notice section. Lloyds prevailed at a jury trial. The Superior Court affirms. In a claims made policy, notice is a condition precedent to coverage, not a limitation of coverage. The insured in such cases has the burden of proving compliance and the insurer had no burden to establish a breach. In addition, although PA generally requires an insurer to establish prejudice, that rule applies only in occurrence-based policies, not in claims made policies.

Wall Rose Mutual Insurance Company v. Manross, Pa. Super, 939 A.2d 958 (2007)

While visiting Manross, Cafaro was injured by an ornamental dagger. Cafaro sued Darr, Manross' grandson. Wall Rose, Manross' homeowner's carrier, denied coverage to Darr, who, though related to Manross, was not resident in the Manross household. In affirming the denial of coverage, the Superior Court notes:

1. Darr had been living at a friend's house for up to two months before the incident.
2. Darr came to the Manross house to do laundry and visit.
3. Darr did not have a key to the Manross home.
4. Whenever Darr stayed over at the Manross house, he slept on a couch, except once when he slept in his brother's room.
5. Full time residents occupied the Manross house bedrooms.
6. Darr never offered to pay rent to Manross.
7. Darr had an ID card with his mother's address but never had an ID card with the Manross address.
8. Darr received some of his mail at the Manross address.
9. Darr owned little, keeping only a toothbrush and some clothing at Manross' home, and remaining possessions elsewhere.
10. Manross stored Darr's clothing in her bedroom where she also kept clothing of other relatives and friends of relatives.
11. Darr was at the Manross residence at the time of Cafaro's injury to "visit for a little while and see his brother."

The term "resident," though not defined in the policy, is not ambiguous. "Residence" is a factual place of abode evidenced by physical presence in a particular place. "Residency" requires some minimum measure of permanency or habitual repetition. Since resident status is a question of physical fact, intention is not relevant. Darr, a drifter, did not visit the Manross home with any regularity. While he received some mail and did laundry at the Manross home, he did so for convenience and not because he physically lived there.

Erie Insurance Exchange v. Weryha, Pa. Super., 931 A.2d 739 (2007)

While living with his mother, Weryha was killed in a car accident. After the liability carrier and the mother's UIM carrier paid limits, the father's UIM carrier denied coverage. Weryha's parents were separated. The legal issue of whether a child subject to a joint custody order is a resident of both parents' households remains unsettled. At the father's house, Weryha did not have a room, did not receive mail, did not regularly eat meals, did not have a key, did not attend school nearby, and did not spend the night on any regular basis. Since his contacts with the father's home lacked any measure of permanency or habitual repetition, Weryha was not a "resident in the household" under either the MVFRL or the policy language, so coverage was properly denied.

Southcentral Employment Corporation v. Birmingham Fire Insurance Company, Pa. Super., 926 A.2d 977 (2007)

Southcentral Employment Corporation is a non-profit employment services company which expends funds made available to it by certain federal and state authorities. A state audit identified and disapproved several expenditures made by Southcentral, resulting in an order that Southcentral reimburse the state almost $600,000 from non-federal funds. Birmingham, the insurance carrier for Southcentral, refused coverage for the claim. The Superior Court affirms, ruling that the amounts Southcentral was required to reimburse the state did not constitute an insurable loss, but rather were restitutionary funds not recoverable under an insurance policy even in the absence of an exclusion. Southcentral did not suffer any "loss" of $600,000. Since it was never entitled to that money, it could not have "lost" it.

BAD FAITH

Ash v. Continental Insurance Company, Pa., 932 A.2d 877 (2007)

After a fire loss, Ash submitted a property claim to Continental which denied same on the basis of concealment or fraud. Twenty two months after the fire, Ash filed a breach of contract suit against Continental. Continental sought summary judgment based on the policy one year suit limitation provision. More than a year later, Ash sought to amend his Complaint to include a bad faith claim. Continental opposed the amendment as beyond the two year limitation period for bad faith claims. The Superior Court affirmed the trial court grant of summary judgment to Continental on the property claim and the trial court denial of Ash's request to amend the Complaint to add a bad faith claim. The property claim was barred by the policy one year limitation provision and the bad faith claim was barred by a two year statute of limitations. The Pennsylvania Supreme Court also affirms, noting that the statutory bad faith action is akin to a tort claim and is accordingly governed by the two-year statute of limitations.

Toy v. Metropolitan Life Insurance Company, Pa., 928 A.2d 186 (2007)

Toy purchased a life insurance policy allegedly misrepresented to her by the sales agent as a retirement plan. Toy later cancelled the policy and sued Metropolitan for bad faith and for damages under the Unfair Trade Practices and Consumer Protection Law. Only five Supreme Court Justices eventually participated in resolution of the appeal. All five Justices agreed that the Actions on Insurance Policies bad faith statute did not apply to alleged unfair or deceptive practices in soliciting the purchase of a policy. Since an existing policy is required for an action under statute, conduct before the existence of a policy is not covered. All five Justices also agreed that a Consumer Protection Law plaintiff alleging fraud in the execution of a contract is not precluded as a matter of law from proving justifiable reliance on oral misrepresentations. On two remaining issues, only three Justices agreed. A plurality held that a Consumer Protection Law plaintiff must prove the common law fraud element of justifiable reliance. A plurality also held that a Consumer Protection Law plaintiff is not under a duty to read a contract in order to allege and prove justifiable reliance.

Zappile v. AMEX Assurance Company, Pa. Super., 928 A.2d 251 (2007), allocatur denied, Pa., 940 A.2d 366 (2007)

Zappile was struck by an automobile while walking his dog. He settled the liability claim for the $15,000 policy limit. He then sought stacked UIM benefits of $150,000 from AMEX, his carrier. Zappile never officially demanded less than policy limits. AMEX never officially offered more than $32,000. While each party at times hinted that movement in negotiations was possible, no further specific negotiations took place. At arbitration, the arbitrators awarded Zappile $95,000 plus $10,000 to his wife for loss of consortium. Zappile thereafter filed a bad faith suit against AMEX. The trial court awarded $75,000 in bad faith damages finding:

1. AMEX failed to make a partial payment.

2. AMEX told its counsel that plaintiff would not accept less than policy limits.

3. AMEX undervalued the claim.

4. AMEX never raised its initial offer.

The Superior Court notes, as it has previously, that UM/UIM proceedings are adversarial in nature and should not be considered typical "first party" claims. The Superior Court also again notes that no heightened duty is owed a "first party" claimant as opposed to a third party claimant. Insurance carriers must at all times act in good faith towards all claimants. As to the specific bases cited by the trial court in awarding bad faith damages, the Superior Court finds there was no obligation to make a partial payment, the carrier never told defense counsel Zappile refused any offer under policy limits, the carrier did, in retrospect, undervalue the claim, but by no more than Zappile overvalued the claim, and, finally, failure to raise the initial offer was not unreasonable under the circumstances. The award of bad faith damages was vacated.

SUBROGATION

Universal Underwriters Insurance Company v. A. Richard Kacin Inc., Pa. Super., 916 A.2d 686 (2007)

Kacin did construction work for Watson Chevrolet under a standard AIA (American Institute of Architects) contract. A wall collapsed, allegedly due to Kacin's negligent construction. Universal Underwriters paid Watson Chevrolet's property loss, then pursued subrogation against Kacin. The AIA contract had a waiver of subrogation clause. Citing the waiver of subrogation, the trial court dismissed Universal's subrogation suit. The Superior Court affirms. Unlike indemnification agreements, waiver of subrogation clauses are not disfavored in the law and are not subject to the same strict scrutiny. A waiver of subrogation does not seek to transfer liability for negligence away from a tortfeasor but rather arranges for insurance to pay any losses. Waiver of subrogation clauses do not violate any public policy. Universal Underwriters, however, argued it received no prior notice of, and did not consent to, the Watson Chevrolet/Kacin waiver of subrogation. In a ruling of first impression in PA, the Superior Court held insurer issues of notice and consent not relevant. Insurers can protect against waivers of subrogation by:

1. Putting an exclusion in the policy that permits a carrier to deny coverage if an insured waives the carrier's subrogation rights.
2. Raising premiums to offset losses caused by the waiver of subrogation clauses.
3. Investigating whether a potential insured has already waived any subrogation rights by contract.
4. Requiring insureds to warrant at the time a policy is issued that the insured has not and will not waive subrogation rights, and
5. Obtaining reinsurance to cover any losses related to waiver of subrogation.

Jalapenos, LLC v. GRC General Contractor, Pa. Super., 939 A.2d 925 (2007)

Jalapenos and GRC entered into a standard AIA construction contract. GRC's subcontractor caused a fire, damaging the property. Jalapenos had not purchased, or advised GRC it had not purchased, the property coverage required under the contract. Jalapenos sued GRC, but the trial court, citing the AIA contract "waiver of subrogation" clause, granted summary judgment to GRC. Affirming, the Superior Court upholds the validity of the "waiver of subrogation" clause, even in the absence of property insurance for the loss. Such clauses do not offend public policy, since it is economically inefficient for both parties to insure against the same risk. When Jalapenos failed to buy coverage, and did not advise GRC of its failure, the AIA contract provided that any losses attributed to that failure would be borne by Jalapenos.

Valora v. Pennsylvania Employees Benefit Trust Fund, Pa., 939 A.2d 312 (2007)

Valora had health insurance through PEBTF, a coverage provided to retired state employees. Valora's son was born with severe disabilities, for which a medical malpractice action was brought and eventually settled. Valora did not advise PEBTF of either the lawsuit or the settlement. The health plan eventually learned of the malpractice action and sent notice of a subrogation claim more than three years after the malpractice suit had started, more than a year after trial, ten months after the matter had already settled, and six months after the court had approved and sealed the settlement. Valora contended that PEBTF's subrogation claim was waived by the plan's failure to pursue its subrogation rights in a timely fashion.. The Supreme Court determines that PEBTF had a contractual right to subrogation. Even when a subrogation right is based in contract, rather than general equitable principles, equitable principles continue to apply. Whether a carrier timely pursues subrogation is an equitable consideration. The PEBTF knew it was paying substantial benefits for a child who suffered a severe birth injury that was likely to give rise to litigation. The health plan's failure to investigate and then pursue subrogation until the medical malpractice action was concluded waived any subrogation rights.

Ario v. Reliance Insurance Company, Pa. Cmwlth., 939 A.2d 1004 (2007)

The Commonwealth Court, acting as a court of original jurisdiction, addressed whether a subrogation claim held by an insurance company against an insolvent insurance company is properly assigned class (d) or class (g) priority. Since claims are honored in alphabetical class order, a class (b) claim would more likely be paid from the insolvent estate than a class (g) claim. In the underlying case, Pocket Rocket, a harness racing horse, broke loose from its sulky, escaped the racing venue, and ran into traffic, causing an accident and injuries to Davis, a Farm Bureau insured. Farm Bureau settled the Davis claim and then sought to subrogate against Pocket Rocket's owners, insured by Reliance. Reliance agreed to reimburse Farm Bureau in full but, before paying, was placed in rehabilitation and, thereafter, liquidation. Had Davis pursued Reliance to recover on claims against Pocket Rocket's owners, she would have been relegated to class (g) since other coverage (i.e., Farm Bureau's coverage) was available to pay the loss. When Farm Bureau, having paid Davis, pursued the claim against Reliance, Farm Bureau had no other insurance source to which it could turn for payment. Farm Bureau was accordingly entitled to class (b) status. This issue of proper class priority assignment of a subrogation claim was one of first impression in Pennsylvania.

John T. Gallaher Timber Transfer v. Hamilton, Pa. Super., 932 A.2d 963 (2007)

Following a work injury, Cummings filed a Claim Petition against Hamilton. Hamilton joined Gallaher as an additional defendant, asserting that Gallaher was Cummings' employer. The Workers' Compensation Judge found Hamilton to be the employer (and thus primarily liable for WC payments) and Gallaher to be the statutory employer (and thus secondarily liable for WC payments in the event Hamilton fails to pay). Hamilton did not appeal the WCJ decision but also did not pay the WC benefits. Gallaher as statutory employer then paid the WC benefits and sued Hamilton for reimbursement. Following Judgment on the Pleadings for Gallaher, Hamilton appealed, arguing that it was entitled in the court action to relitigate employment issues and to pursue other defenses based on Gallaher's alleged negligent supervision of the jobsite and Cummings. The Superior Court affirms the judgment against Hamilton. The doctrine of collateral estoppel is not unavailable simply because administrative procedures are involved. Where the administrative agency is acting in a judicial capacity (as in the case of hearings before a WCJ), disputed issues of fact resolved in the administrative proceeding are subject to preclusion principles.

Kalker v. Moyer, Pa. Super., 921 A.2d 21 (2007).

Kalker was involved in a Philadelphia County accident involving defendants Moyer and Rosario. Seven months later, Kalker was involved in a Berks County accident involving defendant Ingrams. Kalker alleged right arm injury from both accidents. Kalker sued all the defendants from both accidents in a single suit in Philadelphia. The Berks County defendant objected. Although defendants may be joined in a single suit for claims arising out of the same transaction, occurrence, or series of transactions or occurrences, Kalker could not prove any such "series" in this case. The accidents occurred at different times and places under different circumstances with different liability issues. Kalker's allegations of similar or overlapping injuries did not constitute a "series of transactions" for purposes of the rule permitting joinder of claims. The Superior Court acknowledges that trying claims separately, one in Philadelphia County and the other in Berks County, could result in proper payment, double payment, or no payment to Kalker, potential inconsistencies the Superior Court dismisses as "not an unusual situation" because "juries are asked to make this kind of distinction between current and pre-existing injuries all the time."

Attix v. Lehman, Pa.Super., 925 A.2d 864 (2007)

When Lehman failed to answer Attix's complaint, Attix sent the appropriate Notice of Intent to Default. When Lehman still did not answer, Attix entered Judgment by Default. Within ten days, Lehman filed a Motion to Open Default, attaching a proposed Answer to the Complaint. Since Lehman did not seek to explain or justify the earlier failure to answer, the trial court refused to open the judgment. The Superior Court reverses. Under PRCP 237.3, a defendant need only act within ten days of the judgment and attach to his motion a proposed Answer stating a meritorious defense. Prior to PRCP 237.3, the defaulted defendant also had to show a reasonable, excusable explanation for the failure to file a timely Answer. Providing such an explanation is no longer required. In addition, to meet the "meritorious defense" requirement, the proposed Answer need be no more specific than a typical broad Answer to a Complaint, for instance, denying negligence allegations and including New Matter references to comparative negligence.

Gaston v. Minhas, Pa. Super., 938 A.2d 453 (2007)

Following an appeal from arbitration, Gaston agreed on trial de novo to limit damages to $15,000 under PRCP 1311.1 (the statutory limit has since increased to $25,000) in return for admitting his medical evidence by report. As permitted under PRCP 1311.1, Minhas subpoenaed the physician who authored the medical records for the purpose of cross-examination at trial. The physician appeared but refused to testify on Fifth Amendment grounds, apparently because of a pending indictment for fraudulent billing practices. The medical records were accepted into evidence over Minhas' objection. On appeal, the Superior Court reverses and remands the case for a new trial on damages. When the witness refused to submit to cross-examination, Gaston lost the right to submit medical records in lieu of live testimony.

Ambrogi v. Reber, Pa.Super., 932 A.2d 969 (2007)

Plaintiffs (two fatalities and one burn injury) sought a preliminary injunction to prevent Defendants (property owners) from dissipating assets while tort litigation was pending. Defendants had $1,000,000 in liability coverage and also owned substantial real estate holdings. After Plaintiffs filed the tort suit, Defendants started liquidating their real estate holdings, prompting Plaintiffs to seek an injunction precluding Defendants from further dissipating assets. The trial court ordered Defendants to identify all real estate holdings, to deposit the net proceeds of any further real estate sales into a court-supervised account, to withdraw from the account only with court permission, and to post a $100,000 bond to cover Plaintiffs' potential lost interest. On appeal, the Superior Court affirms. Preliminary injunctions prevent irreparable injury or gross injustice by preserving the status quo. A preliminary injunction is extraordinary relief and should be issued only if the moving party's right to relief is clear and the wrong to be remedied is manifest. Pennsylvania law does not preclude grant of a preliminary injunction to prevent dissipation of assets. Plaintiffs were not required to prove that they would prevail in the underlying suit, only that there were substantial legal questions that had to be determined between the parties. Since appellate review of a grant of a preliminary injunction is on an "abuse of discretion" standard, the Superior Court need only find, and in this case did find, evidence of record to support the trial court ruling.

Vance v. 46 and 2 Inc., Pa. Super., 920 A.2d 202 (2007)

Vance suffered injuries during a fight with the defendants. At trial, a jury awarded Vance both compensatory and punitive damages, even though Vance presented no evidence as to the defendants' finances or wealth. On appeal, the defendants argued that punitive damages could not be imposed in the absence of evidence of finances or wealth. The Superior Court affirms the award of compensatory and punitive damages. Although wealth is a proper consideration in determining the amount of punitive damages, wealth is not relevant to whether or not punitive damages of some type ought to be awarded. In addition, although the evidence of wealth may be relevant, it is not a prerequisite to an award of punitive damages.

Salvadia v. Ashbrook, Pa. Super., 923 A.2d 436 (2007)

Tiffanie Salvadia, a minor, allegedly suffered harm due to medical malpractice in 1996. Her parents eventually filed a medical malpractice action on her behalf in 2001. Later that year, Tiffanie died. More than two years later, Tiffanie's lawyer filed a Notice of Death but did not take out Letters of Administration for an estate. Fifteen months after the Notice of Death, the malpractice defendant filed a Petition for Abatement for Failure to Take Out Letters of Administration. Under 20 P.S. §3375, a defendant may file for abatement if a personal representative of the deceased plaintiff is not appointed within one year after the filing of a Notice of Death. Dismissal of the pending suit is mandatory unless plaintiff provides a reasonable explanation for the delay in taking out Letters of Administration. Since no reasonable explanation was proffered in this case, dismissal was affirmed.

Burger v. Blair Medical Associates, Pa.Super., 928 A.2d 246 (2007)

After treatment for a work injury, Burger signed an authorization to allow Blair Medical to release medical records to her employer to review for payment of medical expenses related to the work injury. Blair Medical, however, also released other physician-patient records which detailed Burger's use of marijuana and prescription medication, even though those records had no relationship to Burger's work injury. When Burger's employer reviewed the marijuana and drug use records, Burger was fired. Burger sued Blair Medical for breach of physician-patient confidentiality. The Superior Court rules that Pennsylvania recognizes a breach of physician-patient confidentiality cause of action which is governed by a two-year statute of limitations. This tort is to be distinguished from the tort of invasion of privacy which has a one-year statute of limitations.

Jones v. Levin, Pa. Super., 940 A.2d 451 (2007)

Jones, a Levin Furniture Store employee, fell on ice after work when returning to her car in the store parking lot. She alleged a depression or irregularity in the parking lot allowed water run-off to freeze. Levin Estate owned the property but leased same to Levin Furniture Store. The lease listed a monthly rent but there was no evidence rent was actually paid. Levin Estate was granted summary judgment on a "landlord out of possession" defense. The Superior Court reverses. As a general rule, a landlord out of possession is not liable for injuries suffered by third parties on the leased premises. Where the landlord has reserved control over a defective portion of the leased premises or over a portion of the premises necessary to the safe use of the property, the "landlord out of possession" defense does not apply. Absent evidence that Levin Furniture Store actually paid rent to Levin Estate, factual issues remained as to whether a landlord-tenant relationship existed and thus whether Levin Estate could even qualify as a landlord, a prerequisite to any "landlord out of possession" defense. In addition, the lease prohibited the tenant from making structural repairs or alterations to the property without prior consent, creating a further fact issue whether Levin Estate, even if a landlord, retained control over the alleged defective portion of the parking lot. Finally, in yet another exception to the "landlord out of possession" defense, a landlord out of possession may be liable if it leases the premises for a purpose involving admission of the public and has failed to inspect for or repair dangerous conditions prior to transferring possession of the property. This "public use exception" applies not just to members of the general public (e.g., customers at the store) but to employees of the tenant as well.

Houdeshell v. Rice, Pa. Super., 939 A.2d 981 (2007)

While on Rice's property, Houdeshell walked into a sliding glass door, shattered the glass into large shards, and suffered disfiguring facial injuries. The sliding glass doors in the house were installed in 1958. Since 1971, use of plate glass in sliding doors has been illegal. Before Houdeshell's incident, Rice's son-in-law had shattered a different sliding glass door on the property. The trial court precluded evidence of the earlier incident, evidence of the 1971 plate glass law, and expert evidence that Rice should have replaced the plate glass with shatter-proof glass. On appeal, the Superior Court reverses the defense verdict. Houdeshell can prove the earlier incident, if only to establish notice to Rice of the dangerous properties of plate glass. The trial court, however, properly precluded evidence of the plate glass law and the expert opinion on Rice's duties under the law.

Holt v. Navarro, Pa. Super, 932 A.2d 915 (2007)

While at work, Holt experienced a schizophrenic episode. He heard voices threatening his life and, fearing the threats were true, he ran into a wooded area and hid for several hours. His co-workers eventually found him, called his parents, and Holt thereafter was voluntarily committed to a psychiatric hospital. After release, Holt asked for the key to his father's gun cabinet, saying he wanted to practice shooting because the voices were still threatening him. Holt was again admitted to a psychiatric institution. As he was being transferred, without physical restraints, from one such institution to another, Holt escaped from an ambulance, ran to a shopping center, had his nails done, left the nail salon with a phonebook to call a cab, noticed a car parked with its engine running, beat the car owner with the telephone book, jumped in the car, and tried to drive away. The owner, an off-duty police officer, slowed Holt down until other police arrived to subdue and arrest Holt. After the court rejected his insanity defense, Holt was convicted of robbery and assault.

Holt sued the ambulance company for negligence in transporting him unrestrained, thus facilitating his escape and ensuing criminal conduct and convictions. Holt claimed the convictions reduced his earning potential. A jury awarded $350,000, with the court adding almost $28,000 more in delay damages. On appeal, the Superior Court reverses and grants JNOV to the ambulance company. The defendant as a matter of law could not be liable for the collateral consequences of Holt's criminal convictions. Under common law, a person is not permitted to benefit by his own wrongdoing, particularly his own crimes. In addition, Holt failed to prove proximate or legal cause to support his negligence claim. While Holt's escape may have been a natural and foreseeable consequence of the ambulance company's failure to restrain him during transport, the loss of income due to Holt's criminal behavior following the escape was not a natural and probable outcome of that breach of duty.

C.C.H. v. Philadelphia Phillies, Inc., Pa., 940 A.2d 336 (2008)

C.C.H., an 11-year-old girl, sued three individual defendants (also minors) for sexual assault. At the civil trial, the defendants argued that C.C.H. consented to the sexual contact. By statute, such consent is not a defense in a criminal action where the victim is under age 13. The trial court and the Superior Court, however, allowed evidence and argument on consent in the civil case. The Pennsylvania Supreme Court reverses. The public policy considerations supporting the criminal statute similarly apply to bar the consent defense in any civil litigation.

Christian v. Yanoviak, Pa. Super., – A.2d – (2008)

After having a property survey performed, Yanoviak removed 13 mature trees from Christian's property, incorrectly identifying the trees as being on his own property. The trees ranged in size from 7 inches to 30 inches in diameter. Yanoviak sold the cut trees as timber. The trees were on Christian's residential property and served as a barrier against the nearby Pennsylvania Turnpike. The trial court refused to apply 42 Pa.C.S.A. §8311 **Damages and Actions for Conversion of Timber** which would have limited Christian's damages to fair market value of the timber (doubled for negligent removal or tripled for deliberate removal). The fair market value was only $2,200. The trial court instead awarded $20,000, the diminution in property value Christian suffered by the loss of the mature trees. Had the trees been easily replaced (e.g. saplings), replacement cost would have been the measure of damages. The statute cited above applies only to trees intended to be harvested for commercial use.

Everhart v. PMA Insurance Group, Pa., 938 A.2d 301 (2007)

Everhart, CEO of Russell Standard, was killed in an accident while driving a vehicle leased to his employer. Erie insured Russell Standard on a commercial fleet policy. Everhart was not a Named Insured or Additional Named Insured, but was listed by name in a Broadened First Party Medical Benefits Endorsement and a Drive Other Car Coverage Endorsement. Erie had a $1,000,000 liability limit and a properly reduced $35,000 UM/UIM limit. The Erie fleet policy covered 33 vehicles on a non-stacked basis. Erie did not offer Russell Standard (or any commercial fleet insured) the choice of purchasing or rejecting stacking on UM/UIM coverages. The trial court ruled that Everhart, a Class II insured, could not stack. The Superior Court affirmed that result, but by ruling instead that stacking was not required on commercial fleet policies, any language in the MVFRL notwithstanding. The Pennsylvania Supreme Court also affirms, ruling that the MVFRL did not replace or disturb existing law that UM/UIM stacking is not required on commercial fleet policies. Erie's failure to even offer a stacking option was proper.

Sackett v. Nationwide Mutual Insurance Company, Pa., 919 A.2d 194 (2007) and 940 A.2d 329 (2007)

These Supreme Court decisions (generally referred to as *Sackett I* and *Sackett II*) address the validity of waivers of UM/UIM stacking when an insured adds a vehicle to an existing multi-vehicle non-stacked policy. Sackett bought coverage in 1998 for two vehicles and signed a waiver of UM/UIM stacking. In 2000, Sackett added a third vehicle to the policy but did not sign any new waiver of stacking. After an accident, Sackett demanded stacked benefits. In *Sackett I*, the Supreme Court rules that a carrier must obtain a waiver of stacking whenever there is a "purchase" of coverage. Since Sackett "purchased" coverage for the third vehicle, a new obligation to obtain a waiver of stacking arose. Absent the new waiver of stacking, the prior non-stacking coverage converted to stacked coverage. In *Sackett II*, the Supreme Court, in apparent recognition of the widespread practical ramifications of *Sackett I*, reconsidered and amended its ruling. When a vehicle is added to a policy, there is no "purchase" of insurance triggering the need for a waiver of stacking **if** coverage is automatically provided on the policy for the newly acquired vehicle, assuming only timely reporting of the vehicle and payment of related premium. In such automatic coverage situations, any existing waiver of stacking remains unaffected. If, upon addition of a vehicle, the policy instead provides coverage only for a finite period, then a "purchase" of insurance occurs and the need for a new waiver of stacking, as announced in *Sackett I*, arises.

Burke v. Erie Insurance Exchange, Pa. Super., 940 A.2d 472 (2007)

Burke was injured while driving a company car in the course of employment. Erie, the WC carrier, paid approximately $237,000 in WC benefits. In the tort claim, Burke recovered the liability limits from the adverse driver. Burke thereafter settled his WC claim with Erie for $95,000 plus Erie's waiver of its WC lien and statutory subrogation rights. Burke next pursued a UIM claim against Erie as the employer's automobile carrier. Burke received a net UIM award of $800,000. The UIM arbitrators, upon Erie's objection, refused to award $237,000 of wage and medical damages previously covered by Erie's WC payments. On appeal, Burke contended that the MVFRL, as amended, no longer precludes recovery of medical and wage losses paid by WC. The Superior Court, while conceding that general proposition, nevertheless denies Burke's appeal. Erie agreed to forego its WC lien in the WC context with the intent that the lien would not be an item of special damages in the UIM case. Burke's attempt to include full wage and medical claims without the WC offset was essentially an attempt to avoid the prior WC settlement and to obtain a double recovery. The arbitrators properly refused to Award the extra $237,000 in damages.

Tannenbaum v. Nationwide Insurance Company, Pa. Super., 919 A.2d 267 (2007), allocatur granted, Pa., 934 A.2d 687 (2007)

Tannenbaum was injured in an automobile accident and recovered liability policy limits from the tortfeasor. Tannenbaum then demanded UIM benefits from Nationwide. Nationwide sought to offset any UIM exposure by amounts paid or payable to Tannenbaum under two personal disability income policies and one group income disability policy provided through Tannenbaum's employer. The UIM arbitrators awarded the credit or offset. The trial court reversed. On appeal, the Superior Court rules that the arbitrators should not have granted the credit or offset. Where personal policies are separate from UM/UIM coverage and are paid for exclusively by the claimant either directly or through payroll deductions which result in lower wages, benefits received from those personal policies do not duplicate benefits under the MVFRL as they are fundamentally different from MVFRL benefits. As a result, no credit or offset is permitted.

Brink v. Erie Insurance Group, Pa. Super., 940 A.2d 528 (2008)

Brink, a police officer, had personal auto coverage with Erie, including UIM coverage. He was injured in the course of employment while using a patrol car. Although using patrol cars was a regular part of his job, Brink was not assigned to any specific vehicle. Erie denied Brink's UIM claim, relying on an exclusion for bodily injury suffered while "using a non-owned motor vehicle which is regularly used by you." In Pennsylvania, "regular use" has long meant a principal use as distinguished from a casual or incidental use, so the Erie exclusionary language was not ambiguous. The question, then, was whether the unambiguous exclusionary language fit Brink's use of the patrol car involved in the accident. Citing Federal Court precedent, the Superior Court holds that an employee "regularly uses" a fleet vehicle if he regularly or habitually has access to vehicles in the fleet. "Regular use" of any particular vehicle is not required.

Erie Insurance Exchange v. E.L., Pa. Super., – A.2d – (2008)

E.L., a minor, was injured in an accident while a rear seat passenger in a vehicle owned by her mother and driven by her brother. E.L. collected the full liability limits on the mother's policy on the car. E.L.'s father had separate automobile coverage through Erie, although Erie did not insure the vehicle involved in the accident. E.L. sought UIM benefits from Erie. Erie denied the claim based on a "regularly used non-owned vehicle exclusion" which eliminated coverage when an insured is "using a non-owned motor vehicle" which is "regularly used by you or a resident, but not insured for UM or UIM under this policy." On appeal, the issue was whether E.L.'s status as a rear seat passenger constituted "using" the vehicle for purposes of the exclusion. The Superior Court finds the Erie exclusionary language ambiguous and subject to competing reasonable interpretations, and accordingly rules in favor of the insured. To have avoided coverage in this case, the Erie exclusion should have referenced "using or occupying" and "used or occupied by."

American States Insurance Company v. Estate of Braheem, Pa.Super., 918 A.2d 750 (2007)

Braheem, a passenger, was killed in a single-vehicle accident. Both Braheem and the driver had blood alcohol over the legal limit. Braheem recovered the liability policy limit for the driver and then his own UIM policy limit. More than two years after the accident, Braheem sought further UIM benefits from Braheem's step-father's policy. The trial court granted summary judgment to the carrier, noting that Braheem breached the notice, consent to settle, and subrogation clauses of the policy. The Superior Court reverses and remands for further evidence. Since American States was given credit for the full liability and primary UIM limits and since the driver was judgment-proof, American States could not prove prejudice from any lack of notice, consent to settle, or waiver of subrogation related to claims against the driver. American States was, however, potentially prejudiced by the passing of the statute of limitations on any Dram Shop action. Since American States produced affidavits to demonstrate that a Dram Shop action could have been pursued, the UIM case was remanded to the arbitrators to determine the recovery value of any such Dram Shop claim (had one been timely pursued), and thus the extent to which American States had been prejudiced. If, for instance, any Dram Shop verdict would have been uncollectible, American States could prove no prejudice. If a verdict would have been only partially collected, only that partial amount would serve as a credit against any American States UIM exposure. In addition, if Braheem's total damage claim exceeded all available coverage plus any Dram Shop potential recovery, then American States was entitled to no credit at all.

Blood v. Old Guard Insurance Company, Pa., 934 A.2d 1218 (2007)

Blood purchased automobile insurance from Old Guard in 1986 with a $500,000 liability limit and with UM/UIM reduced, by written request, to $35,000 stacked on three vehicles. In 2000, Blood reduced the liability coverage from $500,000 to $300,000 but did not change the UM/UIM coverage. Blood's son was thereafter injured in an accident after which Old Guard paid the $105,000 stacked UIM benefits. Blood, however, claimed $900,000 in UIM coverage ($300,000 stacked on three vehicles) on the theory that the 2000 change in liability limits from $500,000 to $300,000 triggered a new obligation on Old Guard to set UM/UIM limits at liability limits absent a new Blood request in writing for lower limits. The Pennsylvania Supreme Court rules that no new written request for lower limits was required. Once the first request for lower limits was properly made, the burden shifted to the insured to request any change in writing.

Nationwide Mutual Insurance Company v. Yungwirth, Pa. Super, 940 A.2d 523 (2008)

Yungwirth, an ATV passenger, was injured when ejected from the rear of the vehicle. At the time, the ATV was not on a public road, although it had been on public roads both before and after the accident. The ATV was not insured. Yungwirth sought UM benefits from Nationwide. Nationwide defined a UM vehicle to not include "any equipment or vehicle designed for use mainly off public roads, except while on public roads." Yungwirth contended that, since the MVFRL requires UM coverage "for persons who suffer injury arising out of the maintenance or use of a motor vehicle," the Nationwide narrow definition of a UM vehicle conflicted with the MVFRL and thus was void. The Superior Court notes that the MVFRL does not define "motor vehicle," although the Vehicle Code does contain a broad definition (i.e. "a vehicle which is self-propelled") which arguably includes an ATV. The Superior Court further notes, however, that the Vehicle Code has a specific definition for an ATV (i.e. "a motorized off-highway vehicle" and "a recreational vehicle not intended for highway use"). Since the specific statutory definition of an ATV prevails over the general definition of a motor vehicle, the Nationwide definition which excluded an ATV from the definition of a UM vehicle did not impermissibly narrow the MVFRL.

Schappel v. Motorists Mutual Insurance Company, Pa., 934 A.2d 1184 (2007)

Schappel, a chiropractor who regularly treated patients injured in automobile accidents, brought suit to collect 12% interest that insurance carriers had not paid on benefits paid late. The carriers contended that the MVFRL provided no private cause of action to medial providers to recover such interest. The Pennsylvania Supreme Court notes that, while Section 1716 admittedly does not explicitly set forth a private cause of action for interest, a broader interpretation of the statute, including legislative intent, establishes that a private cause of action was intended. Schappel was permitted to pursue a claim for interest on late payments.