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### Recent Case Developments

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# RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel\**

## WORKERS COMPENSATION APPLIES TO EMOTIONAL INJURY CAUSED BY SUPERVISOR CRITICISM

*Appeal of New Hampshire Department of Health and Human Services, 2000 N.H. LEXIS 44 (New Hampshire Supreme Court, August 23, 2000)*

In a decision much criticized by some in the insurance industry, the New Hampshire Supreme Court has affirmed a state Compensation Appeals Board decision finding a worker's "major depression" to be "compensable under the workers' compensation statutes because it was caused by employment-related stress arising from her supervisor's legitimate criticism of her work performance." 2000 N.H. LEXIS 44 at \*2.

Gail Sirvis-Allen began working as a "Clerk I" with the State of New Hampshire in February 1978. She left state employment because of the depression and stress in August 1995 as a Case Technician II, a position she had held for nine years. The job duties included "taking applications for food stamps, Medicare, and disability, as well as verifying information and entering it into a computer" as well as contacting "clients and following up by letter." *Id.* at \*2. Her job performance was checkered.

During her tenure. . . [she] often failed to adequately fulfill her assigned work responsibilities. In 1989, due to job performance problems including inaccuracy and a poor attitude, she was transferred to a slower-paced environment. In 1992, she was given a series of performance warnings and

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transferred to an even less demanding position. Her tenure was also marked by frequent medical and psychological problems. . . . In March 1994, she was diagnosed with clinical depression and problems related to attention deficit disorder (ADD) and excused from work [for a short time].

In September 1995, Sirvis-Allen filed her workers' compensation claims, "claiming that she suffered a work-related stress injury resulting from disciplinary action taken against her on or about August 5, 1995." *Id.* at \*4.

The Department of Labor hearing officer denied the claim. After a de novo hearing, the Board reversed, finding that her "ADD constituted a pre-existing weakness which caused her work performance to suffer. It also found that her supervisor's criticism, although justified, caused her major depression. Finally, the board concluded that the respondent's work-related stress, which triggered depression, headaches, and chest pain, was greater than normal, non-employment related stress." *Id.* at \*4.

The employer challenged the Board's ruling, arguing that compensation benefits should not have been available because (1) Sirvis-Allen was not injured in an "accident;" (2) her depression and disability did not "arise out of" employment; (3) there was an insufficient showing that her problems were caused by the work-related criticism rather than other factors; (4) an award of compensation benefits was inconsistent with desirable public policy because "workers' compensation should not be awarded for injuries resulting from good faith criticism of an employee's job performance." *Id.* at \*5. The Court rejected all of these arguments and upheld the Board's award of benefits to Sirvis-Allen.

The Court backed the Board in part because under the applicable law of workers' compensation, like most administrative law schemes, courts are required to defer to the fact-finding of the regulatory board unless it is clearly erroneous or decisions are arbitrary and capricious. The Court affirmed the award in part because of this deference to the Board's fact-finding that Sirvis-Allen was indeed disabled and that her depression was in fact sufficiently causally related to her work (thus "arising out" of employment) even though the supervisors' criticisms were apparently necessary and not excessively harsh. *See id.* at \*8-9 (quoting *New Hampshire Supply Co. v. Steinberg*, 121 N.H. 506, 509, 433 A.2d 1247, 1249 (1981)).

Under the law, the Court found legally sufficient causation because the claimant had demonstrated to the Board's satisfaction that her employment-related stress was greater than what she encountered in ordinary life outside the workplace. *See id.* at \*8-\*9. In addition, the Court emphasized that it was

operating under the presumption that all reasonable doubts as to construction of the statutes should be resolved in favor of the injured employee, a central principle of workers' compensation in most states.

On the issue of whether the inability to work was sufficiently "accidental," the Court read the New Hampshire workers' compensation statute as requiring only that the injury be accidental, not that the events leading to injury be accidental or unintended. *See id.* at \*6 (N.H. Rev. Stat. Ann. §281-A:2 speaks of "accidental injury" rather than injury caused by accident). The criticisms and work assignments of Sirvis-Allen were of course no accident—they were part of the job—but her supervisors never expected her to go into dysfunctional depression in response. Consequently, the Court found the injury sufficiently accidental. This is consistent with the purpose of workers' compensation law, which is to provide compensation for work-related injuries that stem from the regular operations of the employer. Coverage is not limited to only the improperly operating aspects of the workplace.

Regarding public policy, the Court acknowledged that affirming the award tended to be a "troubling" extension of liability greater than normally found in a common law system because of the unusual nature of the claimant's injuries and the claimant's "thin skull" susceptibility to depression coupled with her receipt of more criticism because of her pre-existing ADD and difficulty performing her work tasks. The Court also noted that cases in other states had diverged on the issue of whether proper criticism of employee work performance could be the cause of compensable workers' compensation injury. *Compare Calovechhil v. State*, 233 Mich. App. 349, 566 N.W.2d 40 (Mich. Ct. App. 1997) (injury from stress of investigation compensable) with *Duncan v. Employers Cas. Co.*, 823 S.W.2d 722 (Tex. Ct. App. 1992) (injury from stress of reprimand and job transfer not compensable). So long as a worker's depression is real rather than feigned and results from work stress, compensation would appear to be consistent with this area of the law, just as it would be for back injuries and other more physical and typical mishaps in the workplace. Because of the division of courts and observers on this issue, additional litigation and legislation on the issue is likely. Courts and legislatures may need to expressly decide whether they would rather see workers' compensation costs increase by some amount to cover mental/emotional injuries from workplace stress or whether they believe the better social policy is to leave workers on their own for these types of injuries.

SIX-YEAR DELAY IN CLAIMING DISABILITY  
BENEFITS DOES NOT BAR CLAIM AS A MATTER OF  
LAW

*Brown v. Life Insurance Co. of North America*, 8 P.3d 333  
(Wyoming Supreme Court, July 5, 2000)

Kent Brown, a dentist, was injured in a fireworks accident on July 4, 1987 and as a result had “virtually no vision in his left eye, except for light perception.” 8 P.3d at 335. His physician told him that the maximum medical recovery would take place in six months. After that time, Brown’s vision was no better. He continued to practice dentistry but with difficulty and concluded that he could not continue, taking steps to sell his practice. However, the practice was not finally sold until May 1, 1993. During Summer 1993, Brown finally submitted a claim for total disability to his insurer.

The policy provided that notice should be given to the company “within 30 days after the occurrence of any loss” or “as soon thereafter as is reasonably possible.” Proof of loss under the policy was required within 90 days after the date of loss but late proof of loss would not diminish benefits so long as the proof was “furnished as soon as reasonably possible and in no even . . . later than one year” (absent capacity of the claimant to make a claim during the relevant time period). *See* 8 P.3d at 336.

Despite the six-year delay in notice, the Wyoming Supreme Court rejected the insurer’s defense, ruling that the notice was not late as a matter of law and might under the unusual facts of the case be notice as soon as was “reasonably possible.”

Dr. Brown took the position that notice was not reasonably possible to give until he was aware of the full extent of his disability and completely unable to practice. The insurer took the view that the disability policy was triggered at the time of the accident itself (July 4, 1987) or six months later when the policyholder’s vision showed no improvement (or at least insufficient improvement to overcome the disability). The policy in question defined total disability as inability to “practice your own occupation (your special area of dental practice).” 8 P.3d at 337. Based on these facts, the Court found that

[u]nder the terms of the policy, so long as he was practicing his profession as a dentist, he was not disabled and would not have been eligible for disability benefits. Moreover, the

question as to what constitutes a reasonable time for filing of the claim in the context of disability insurance is ordinarily for the jury. Perhaps of greater importance, the disability from which Brown suffered was a continuous disability, and under the terms of the policy, there was nothing to prevent submission of the claim within the duration of the disability covered by the policy.

8 P.3d at 337 (citations omitted).

Clearly influenced by the equities of the situation favoring the policyholder, the Court also observed that

based on the record before us, [the insurer] does not have a viable defense based on prejudice because of an inability to investigate the claim. The record extant demonstrates that an accident occurred, that Brown was eventually totally disabled by it, and that the policy provided for benefits once Brown was deemed disabled from practicing as a dentist.

8 P.3d at 337. In other words, even though the notice was late, this if anything advantaged the insurer, making the late notice defense stand appear excessively bellicose.

ARIZONA SUPREME COURT INVALIDATES AUTO  
EXCLUSION AS INCONSISTENT WITH  
UNDERINSURED MOTORIST LAW; UIM BENEFITS  
APPLY TO EXTENT INJURED POLICYHOLDER NOT  
MADE WHOLE BY ANY APPLICABLE LIABILITY  
PAYMENTS

*Taylor v. Travelers Indemnity Company of America*, 9 P.3d  
1049 (Sept. 15, 2000)

Nellie Taylor was a passenger in a family car being driven by her husband when his negligent driving caused an accident that killed him and injured her as well as four people in the other vehicle.

The Taylors had a \$300,000 single-limit liability policy issued by Travelers, with UIM [underinsured motorist] coverage in the same amount. Mr. Taylor was the named insured and Plaintiff [Ms. Taylor] was insured as a family member. Plaintiff and the four occupants of the other

vehicle presented claims on the liability coverage, which Travelers settled by apportioning the \$300,000 liability limit among the five claimants. Plaintiff received \$183,500, far less than her medical bills, let alone her total damages. Having no coverage from any other source, Plaintiff made a UIM claim on her Travelers policy.

9 P.3d at 1051.

Travelers denied coverage based on a policy exclusion that barred coverage to *any* person who had received *any* payment for bodily injury under the liability provisions of the policy. *See* 9 P.3d at 1050-51 (emphasis added). The trial judge agreed and entered judgment as a matter of law for the insurer. The Court of Appeals reversed, “finding the policy provision that prohibited paying UIM to a person who received payment under the liability coverage was void because it was not permitted” by Arizona’s UIM statute. *See* 9 P.3d at 1052. The Arizona Supreme Court agreed, also finding the provision too inconsistent with the statute to be effective.

Arizona law requires that UIM coverage be made available to policyholders in an amount equal to the liability limits of the auto policy and that the UIM coverage provide coverage to a person who is injured but unable to obtain full compensation for the injury from available sources of liability insurance.

#### PRINCIPALS IN CORPORATION ARE NOT “INSUREDS” FOR PURPOSES OF MAKING CLAIMS UNDER POLICY OR PURSUING BAD FAITH ACTION

*Jadco Management Corp. v. Federal Ins. Co.*, 9 P.3d 92  
(Oklahoma Court of Civil Appeals; decided Feb. 4, 2000;  
rehearing denied, March 3, 2000; certiorari denied, May 16,  
2000)

Jadco Management Corp. purchased insurance from Federal. Later, it made a claim against Federal asserting that large quantities of crude petroleum were stolen from its facility in Tussey, Oklahoma. Federal denied the claim. Jadco was predictably upset. So was its sole shareholder, director and officer, John R. Armstrong. He joined Jadco’s suit against Federal alleging breach of contract and bad faith handling of the claim and alleged that he suffered damages of emotional distress. The trial court dismissed

Armstrong from the lawsuit and the court of appeals affirmed, holding that the principals of a corporate policyholder have no standing to bring a lawsuit against the insurance company. According to the Court, the duty of good faith and fair dealing in insurance runs between the policyholder and the insurer, not between the insurer and those who own the insured company or are interested in its fate.

“The option of becoming an insured under an insurance policy is presumably available if the individual owner has an adequate insurable interest matching that of the company. For corporations and shareholders, however, satisfaction of this criterion will vary. For example, if Jadco Corporation is liable in tort, Armstrong’s personal wealth is presumably beyond the reach of the claim because tort liability extends only to the corporation. For first-party claims (such as the crude oil theft alleged in the instant case), however, Armstrong and other company owners would appear to have an insurable interest. If Jadco goes bankrupt because of lost crude oil and no insurance payment, Armstrong as sole shareholder would certainly suffer a real loss as well when his shares are lowered in value. Presumably, he and others can find insurance carriers who will make them part of first-party coverage if that is what they desire, provided that the pool of owners is small. It is unlikely that an insurer would agree to consider shareholders insureds in the case of the typical publicly traded corporation, which has thousands of shareholders.

SEAFOOD HAULER BEREFT OF COVERAGE UNDER  
BOTH MARINE CARGO AND WAR RISK POLICIES  
FOR LOSSES STEMMING FROM RUSSIAN SEIZURE  
AND CONFISCATION OF CARGO

*Kimta v. Royal Insurance Company*, 9 P.3d 239 (Washington  
Court of Appeals, Sept. 18, 2000)

In December 1996, the motor vessel ship BIKIN was transporting cargo of fish and crab from the Russian Far East to Korea when Russian authorities arrested the vessel and its cargo, citing failure of the ship’s captain to comply with orders to return to port and failure to obtain a required transshipment permit. “Following judicial proceedings in Russia, the Russian authorities confiscated the cargo [valued at \$3 million] and sold it at auction.” See 9 P.3d at 240. The owners of the cargo sought coverage under their marine



cargo insurance or war risk policies, whichever might be applicable. The trial court denied war risk coverage but also declined to rule for the insurer as a matter of law on the marine cargo coverage issue. The Washington Court of Appeals affirmed that there was no war risk coverage under these circumstances and also found for the insurer that, as a matter of law, the marine cargo policy offered no coverage.

A marine cargo policy, as its name implies, provides first-party coverage to the owners of ocean-going cargo that is lost. The policy generally covers losses of all types and this policy also included a so-called "Inchmaree" clause providing coverage for losses caused by the negligence of captain or crew in the navigation or management of the vessel. *See* 9 P.3d at 240. However, the policy also contained a standard "paramount warranty" provision commonly called a "Free of Capture and Seizure Clause," which excludes coverage when the cargo is confiscated by the "capture, seizure, arrest, restraint, detainment, confiscation, preemption, requisition or nationalization, and the consequences thereof or any attempt thereat, whether in time of peace or war and whether lawful or otherwise." *See* 9 P.3d at 241.

At the outset, the Court devoted considerable discussion to the applicable law to be applied, concluding that the coverage issue was governed by federal admiralty law in view of the history of maritime insurance. *See* 9 P.3d at 241-43. The Court's determination was also buttressed by the obvious need for maximum consistency in this line of insurance, where losses frequently occur in a variety of jurisdictions, with the insured cargo's itinerary varying to considerable degree. *See* P.3d at 242-43.

The use of federal admiralty law made the decision straightforward. Established precedent in the area establishes that the negligence of the captain leading up to a government seizure of goods is not the efficient proximate cause of the loss (rather, the excluded seizure is the proximate cause of the loss) unless the negligence of captain or crew endangers the cargo in a manner "independent" of the seizure. *See* 9 P.3d at 243-44. Because the captain's negligence in not returning to port and not obtaining proper permits did not threaten the cargo as such but merely led to the seizure, the loss was excluded as one resulting from seizure, notwithstanding the captain's negligence. *See* 9 P.3d at 244.

EMPLOYEE ON LEAVE REMAINS A "FULL-TIME"  
EMPLOYEE FOR PURPOSES OF BENEFIT PLAN AND  
WAS ENTITLED TO DEATH BENEFIT COVERAGE

*Tester v. Reliance Standard Life Insurance Company*, 228  
F.3d 372 (4th Cir. Sept. 25, 2000)(applying federal common  
law)

Annie Ruth Tester began working for Bibb Company as a full-time employee on June 1, 1993. In August 1993, Bibb obtained group accident coverage for its employees, with death benefit coverage of \$50,000 provided through a group policy with Reliance. The policy provided that it covered full-time and part-time employees, with part-time defined as working at least 20 hours per week; temporary or seasonal workers were excluded. On January 8, 1995, Tester took an approved medical leave because of health problems. On February 15, 1995, she died from injuries sustained in an automobile accident (she was a passenger and the accident was not related to her health problems).

Reliance refused to pay the accidental death benefit to her husband, arguing that she was no longer covered under the policy because she was not actively working at the time of the accident. The U.S. Court of Appeals for the Fourth Circuit rejected the insurer's defense and found coverage for the Testers. Applying the federal common law of contract interpretation applicable to employee benefit plans under ERISA (the Employee Retirement Income Security Act), the court found that the policy was ambiguous as to whether the taking of a leave made the employee "inactive" and therefore ineligible for coverage. 228 F.3d at 376.

The Fourth Circuit's decision makes sense not only in terms of the language of the policy and the likely expectations of the Bibb Company employees but also in terms of the purpose of the eligibility requirements of the policy. To avoid adverse selection, group insurers issuing policies to employers seek to define eligibility so that persons likely to need insurance will not be signing on with the company for the insurance coverage. Rather, the insurer seeks to cover a group of persons who just happen to be working at the company in order to work, with insurance a mere fringe benefit. Requiring that employees be full-time or of significant connection to the company helps to accomplish this underwriting goal. The "engaged in continuous employment" requirement also makes it easier for the insurer to assess its risk because the number of employees covered is ascertainable and

stable in a way it is not if temporary or sporadic workers are covered. Seen in this light, coverage of Annie Ruth Tester hardly undermines the insurer's legitimate need to define the covered group. Her death did not result from any health problems that could have animated adverse selection on her part; she was simply the tragic victim of a car accident. Under these circumstances, the case for coverage was overwhelmingly persuasive and the insurer's resistance to payment difficult to understand.

FEDERAL APPEALS COURT FINDS THAT  
POLICYHOLDER'S REFUSAL TO UNDERGO  
EXAMINATION UNDER OATH DOES NOT VOID  
COVERAGE UNLESS INSURER IS PREJUDICED

*Talley v. State Farm Fire & Casualty Company*, 223 F.3d  
323 (United States Court of Appeals for the Sixth Circuit,  
August 10, 2000) (applying Tennessee law).

George Talley had a homeowner's insurance policy with State Farm. After a fire damaged his house, he submitted a claim. In response, State Farm asked him to submit to an examination under oath, as required by the policy. It is not routinely imposed but is used where the insurer regards the claim as subject to question in either source or amount of loss. Talley refused to submit to an examination "because of an ongoing criminal investigation of the fire and its cause." *See* 223 F.3d at 325.

On the basis of Talley's refusal, State Farm denied his claim, arguing that the refusal to undergo an examination under oath was a breach of the policy. The federal district court in Tennessee granted judgment as a matter of law to State Farm when Talley sued over the claim. The U.S. Court of Appeals for the Sixth Circuit (which includes Tennessee, Kentucky, Michigan, and Ohio) vacated the judgment and remanded the case for further trial proceedings. The Appeals Court ruled that the failure to participate in the examination under oath would void coverage only if the insurer could demonstrate that it suffered prejudice because of the refusal of the policyholder to be examined.

The Sixth Circuit analogized the examination under oath provision of the policy to the "cooperation" clause and related clauses in the policy (such as notice and proof of loss requirements). *See* 223 F.3d at 325-27. The overwhelming majority rule regarding cooperation holds that an insured's

failure to cooperate with the insurer (or to give timely notice or provide a sufficiently detailed proof of loss) will vitiate coverage only if the insurer is prejudiced by the policyholder's failures of cooperation.

Tennessee state courts have long followed the majority rule regarding cooperation, late notice, and proof of loss. Although the Sixth Circuit found no on-point Tennessee case addressing examination under oath, it reasoned that the Tennessee Supreme Court, if faced with the case, would require a showing of prejudice for examination under oath deficiencies as well as for other cooperation deficiencies by the policyholder. *See* 223 F.3d at 327.

One can certainly question the Sixth Circuit's analysis. Other jurisdictions have tended to construe the examination under oath strictly in view of its origins and importance. It is by no means clear that Tennessee would take as relaxed a view of the provision as did the Sixth Circuit. The examination under oath provision is included in property policies because of the traditional difficulty insurers have faced regarding arson and other fraudulent claims. In *Talley*, there was a fire of sufficiently suspicious origin that criminal proceedings were in progress and the policyholder was sufficiently concerned about these proceedings to cite this as a reason for refusing to be examined under oath. The case was thus practically tailor-made for such an examination so that State Farm could better determine whether Talley's claim was too suspicious to be paid. Instead, the Court essentially told State Farm to start digging elsewhere for evidence of arson or fraud.

#### MURDER OF TENANT IS "ACCIDENT" UNDER LANDLORD'S LIABILITY POLICY

*Agoado Realty Corporation v. United International  
Insurance Company*, 95 N.Y.2d 141, 733 N.E.2d 213, 711  
N.Y.S.2d 141 (New York Court of Appeals, June 20, 2000)

Agoado Realty owns apartment buildings. In 1996, a tenant in one of them was murdered by an unknown assailant. The decedent's estate sued Agoado as landlord, alleging that the tenant's wrongful death occurred because of the landlord's negligence in maintaining premises security. The landlord's liability insurer raised a number of defenses to coverage, including an argument that the death was not an "accident" within the meaning of the policy because of the murder. The Court of Appeals (the highest state court

in New York) rejected this defense as inconsistent with basic principles of insurance and a common sense reading of the policy.

The Court of Appeals reversed the trial court's determination in favor of the insurer on the "accident" issue. The trial court had also ruled in favor of the insurer's late notice defense. The Court of Appeals remanded this issue to the trial court for further fact finding on whether the policyholder had given notice to the insurer "as soon as practicable" as required under the policy. The murder took place on May 19, 1996. The wrongful death action was commenced on February 10, 1997 but Agoado Realty did not receive a copy of the summons and complaint until June 20, 1997. On June 20, 1997, the insurer received the summons and complaint and notice of the occurrence. Although this was a whopping 397 days after the murder, the Court of Appeals determined that notice may be considered timely in view of the fact that the insurer received notice two weeks after receipt of the complaint against the policyholder, although there remained issues as to whether the policyholder had sufficient information so that it should have informed the insurer prior to June 1997.

WORKERS COMPENSATION STATUTE  
UNCONSTITUTIONAL TO THE EXTENT IT REQUIRES  
LIVE TESTIMONY IN CLAIMS OF MENTAL  
IMPAIRMENT BUT ACCEPTS DOCUMENTARY  
EVIDENCE ALONE IN CASES OF PHYSICAL  
IMPAIRMENT

*Esser v. Industrial Claim Appeals Office of the State of Colorado*, 8 P.3d 1218 (Colorado Court of Appeals, Jan. 20, 2000, Modified on Denial of Rehearing, March 23, 2000, Certiorari Granted, August 21, 2000).

Colorado's workers' compensation statute provides that where a worker claims injury and mental impairment, this must be "proven by evidence supported by the *testimony* of a licensed physician or psychologist." Mental impairment is defined as existing where there is no evidence of physical injury to the claimant. However, for claims of physical injury, a worker may prove up the claim without use of live expert testimony through use of medical records and other documentary evidence. A claimant asserting mental impairment challenged the statute's treatment as unfairly uneven

regarding mental and physical injury claims. The Colorado Court of Appeals agreed, holding that differential evidentiary treatment of the two sorts of claims was a violation of the equal protection of laws guaranteed in both the state constitutions. The Appeals Court found that there was no rational reason to require live testimony for mental impairment claims but to deem documentary proof sufficient for physical injury claims. *See* 8 P.3d at 1221-23. The Appeals Court did, however, stress that the legislature was within its prerogatives in requiring sufficient evidence of mental impairment; the legislature erred in resolutely requiring different minimum forms of evidence for different injury claims.

The very real purpose of requiring proper verification of the claim is met once an appropriate expert report is received.

And, in all cases in which the employer chooses to examine that expert, an opportunity for such examination must be provided, even if that expert is not initially called as a witness in the claimant's case.

Given these considerations, therefore, we conclude that the further requirement that a mental impairment claimant produce a live witness in the first instance achieves no legitimate purpose . . . .

8 P.3d at 1222-23.

