Bottom Line

Case Number | 37-2011-00090124

Judge | Hon Jay Bloom

Plaintiff's Counsel | Otto Haselhoff (Santa Monica) and Guy Levy (San Diego)

Defendant's Counsel | Robert E. Gallagher, White, Oliver, Amundson & Gallagher

Type of Incident/Cause of Action | Pedestrian/commercial van. Defendants carpet cleaning van was heading to a location to do clean up work. After pulling onto the street where the plaintiff lived, the driver encountered a road block by police and fire personnel dispatched to a house file on the same street. After stopping the driver's van, and in response to verbal and physical gestures from police/firemen in the street, the driver began to slowly back up the van in order to complete a "K" turn, to turn the van around, and exit the scene. Plaintiff was on the opposite side of the street, and left the sidewalk as the van was moving slowly in reverse, and attempted to cross behind the van while it was moving.

Plaintiff alleged that the van driverwas negligent in not seeing the plaintiff in time to avoid the accident. Plaintiff also alleged that the employer/owner of the van was negligent as a matter of law as the rear windows of the van were covered with a company decal. Plaintiff also alleged that the employer/owner of the van was negligent as a matter of law, as the van was not equipped with a backup warning device. Defendant's motions in limine to exclude the last two causes of action were granted by the trial court. Further, plaintiff's motion to amend the complaint to assert punitive damages as the driver

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Insurance Law Update

By Jim Roth
The Roth Law Firm

In California, 2013 resulted in a variety of cases that extended and clarified the body of insurance law, including two decisions acknowledging questions of first impression.

INSURANCE BROKERS OWE A LIMITED DUTY TO THEIR CLIENTS, WHICH IS ONLY TO USE REASONABLE CARE, DILIGENCE AND JUDGMENT IN PROCURING THE INSURANCE REQUESTED BY AN INSURED

In *Travelers Property Casualty Company v. Superior Court (Michael M. Braum)* (2013) 215 Cal.App.4th 561, 155 Cal.Rptr.3d 459, the Court of Appeal, Second District, Division 3, held that absent evidence that a developer specifically asked its insurance broker to obtain the insurance required by the construction loan agreement and the developer's separate agreement to provide insurance to the construction lender, an insurance broker owed no duty to the construction lender as loss payee under a homeowners' association's condominium policy.

Developer, Joy Investment Group (Joy), obtained a construction loan from East West Bank (EWB), and began construction on a multi-unit condominium complex. EWB required Joy to maintain builder's risk insurance (i.e., a construction general liability policy) on the property and to identify EWB, and its successors and assigns, as the loss payee. Joy apparently did so. Eventually, when the condominium complex was near completion, Joy fell behind in its payments on the loan. After Joy's default, EWB sold the loan to an investor, Michael M. Braum, Trustee of the Braum Lalehzarzadeh Living Trust (Braum), who would ultimately foreclose on the property. After the assignment to Braum, but before the foreclosure sale, Joy's construction insurance policy lapsed and Joy sought a new policy. Joy represented to its insurance broker, Koram Insurance Center, Inc. (Koram) that a homeowner's association had been created, and that most of the condominium units had been sold. Given those facts, Koram discussed the possibility of replacing the builder's risk policy with a condominium policy issued to the homeowners association. Joy agreed and obtained a condominium policy for the homeowner's association from Travelers Property Casualty Company (Travelers) for which Koram was an authorized agent. However, it would subsequently be revealed that no certificate of occupancy was ever issued and no units were ever occupied — any sales which may have been pending failed to close.

Shortly after the new policy issued, the property was allegedly damaged by theft and vandalism. Joy thereafter filed for bankruptcy and Braum obtained the property through foreclosure. Braum then filed a claim against Travelers for the losses from the theft and vandalism. Travelers denied the claim because the condominium policy excluded coverage for such losses if incurred when the property was vacant. Braum filed suit against Travelers for breach of contract, and against Koram (and Travelers, as the broker's principal) for professional negligence.

Both Travelers and Koram moved for summary judgment, and their motions were denied. They then filed petitions for writs of mandate, challenging the trial court's rulings. The appellate court concluded that the trial court should have granted both motions for summary judgment.

The appellate court noted that under California law, insurance brokers owe duties to their clients to procure the insurance requested by the client.

Koram's client, Joy, was the developer. Braum did not contend that Koram breached a duty to Joy. The court acknowledged that the investor might have been able to recover as a third party beneficiary of the contract between Joy and Koram if Joy had instructed Koram to obtain insurance that complied with the insurance terms of the loan agreement. But the evidence suggested otherwise. The court refused to interpret Joy's forwarding of the request for insurance information from the original lender's representative as a request that Koram review the policy and loan contract's insurance provision to ensure compliance.

ATTORNEYS HIRED BY THE INSURERS TO DEFEND A DISSOLVED CORPORATION MAY OBTAIN PERMISSION FROM THE INSURER TO WAIVE THE CORPORATION'S ATTORNEY-CLIENT PRIVILEGE IN ORDER TO VERIFY DISCOVERY RESPONSES

In *Melendrez v. Superior Court of the State of California* (2013) 215 Cal.App.4th 1343, 156 Cal.Rptr.3d 335, the Court of Appeal, Second District, Division 3, held that California Evidence Code § 953, which provides that the attorney-client privilege of a corporation no longer in existence passes to its "successor, assign, trustee in dissolution, or any similar representative" is broad enough to encompass an insurer when the insurer's policy is the corporation's only remaining asset and the insurer is defending a claim asserted against the corporation that is covered under that policy.

Mary Melendrez, individually and as personal representative of the Estate of Lario David Melendrez; Mario Melendrez; Phillip Melendrez; David Melendrez; and Veronica Pueyo (collectively, Melendrez) prosecuted a wrongful death action against numerous entities, including Special Electric Company, Inc. (SECO), alleging that the decedent died of mesothelioma as the result of exposure to asbestos. Years prior to the action being filed, SECO filed a Chapter 11 bankruptcy petition, which the Bankruptcy Court approved, which reduced SECO to a shell for the sole purpose of defending asbestos lawsuits. Pursuant to the reorganization plan, a registered agent was appointed for the service of asbestos claims, who then forwarded those claims to SECO's insurers. The insurers, in turn, were required to defend and/or settle the claims "in accordance with and in a manner consistent with the language of the applicable [i]nsurance [p]olicies and applicable state law."

Pursuant to the reorganization plan, Melendrez's suit was defended on behalf of SECO by its insurers. Counsel was retained by the insurers to represent SECO for the purpose of providing such defense. During the litigation, Melendrez served SECO's counsel with requests for admission and special interrogatories, seeking the admission and identification of many facts which would result in a judgment in Melendrez's favor. Counsel for SECO prepared unverified responses signed by counsel. As case law provides, an unverified response is tantamount to no response at all. Melendrez moved for an order deeming the matters specified in the RFAs admitted and later for an order to find the unverified responses to the interrogatories deemed answered in Melendrez's favor.

Claiming its lack of officers, directors, employees, and agents to verify the discovery responses, SECO successfully opposed the motions. Melendrez then filed a petition for writ of mandate, challenging the trial court's rulings deeming verified the responses to the RFAs and the form interrogatory.

The appellate court framed the issue before it as follows: "Who can waive the privilege on behalf of a dissolved corporation with no officers, directors, or employees?" While the court agreed with SECO that its attorneys could not waive the privilege on its behalf, it disagreed with SECO's assertion that, as SECO has no officers or directors, it could never waive the privilege. The court noted that at the time of the discovery responses, SECO was operating pursuant to the reorganization plan approved by the bankruptcy court. Although SECO's earlier named director and president had since resigned, the court believed that a means may have existed for the election or appointment of a new director by determining if any shareholders still existed and then request them elect or appoint a new director. Therefore, explained the court, the proper course of action would have been to attempt to obtain a director for SECO, who could determine whether to waive the privilege. The Court distinguished between a dissolved corporation and one no longer in existence. If a means exists to appoint or to elect a director for a dissolved corporation, the corporation still exists. If not, then Evidence Code § 953(d) would apply.

The court rhetorically asked: what if SECO no longer existed in any real sense? Resorting to Evidence Code §

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was in a hurry to get to the next job for pecuniary reasons, was denied by the Court, based on defendants opposition to the motion for leave to amend.

Settlement Demand | Plaintiff made a statutory offer to compromise for the policy limits of $2,000,000 before trial. Defendant elected to allow the statutory offer to compromise to expire by operation of law.

Settlement Offer | $750,000

Trial Type | Jury

Trial Length | 2 days. The case settled following motions in limine, as a jury panel was called to the department in the sum of $850,000. ■

Bottom Line

Case Title | Rodolfo Alvarez, individually, and as Successor in Interest of Martha Avendivar De Alvarez, deceased, Marcela Alvarez, and Carlos Alvarez v. Trevor D. Nelson, M.D., LJR Medical Group, Scripps Health and Scripps Chula Vista

Case Number | 37-2011-00101108-CU-PO-CTL

Judge | Hon. Ronald L. Styn, Dept. 62

Type of Action | Medical Malpractice / Wrongful Death

Type of Trial | Court/Jury Trial

Trial Length | 9 Days

Verdict | Defense Verdict with a finding of no negligence.

Plaintiff's Counsel | R. Christian Hulburt, Esq. Hulburt & Bunn, LLP

Defendant's Counsel | Daniel S. Belsky, Esq. and Carolyn B. McCormick, Esq. for Trevor D. Nelson, M.D. and La Jolla Radiology Medical Group – Diagnosis, Inc.

Damages and/or Injuries | Wrongful Death

Settlement Demand | In July 2012, Plaintiffs served Defendants with a C.C.P. §998 Offer for $200,000. In November 2012, Plaintiffs raised their settlement demand to $250,000.

Settlement Offer | In December 2012, Defendants served Plaintiffs with C.C.P. §998 Offers for zero dollars and a waiver of costs.

Plaintiff's Attorney Asked the Jury for | $1,002,457 ■

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953(d), the court answered its question: the privilege would be held by SECO's "successor, assign, trustee in dissolution, or any similar representative." The next question posed by the court was who, under Evidence Code § 953(d) qualified as SECO's "successor" or "assignee" for purposes of asserting the privilege. Without specifically deciding the question, the court suggested that, depending on factual determinations on remand, the likely answer was SECO's liability insurers. Assuming that SECO's unsecured creditors' trust had been dissolved and the assets therein disposed, SECO's only remaining asset would be its insurance policies. While SECO existed in name only so that it could pass the claims on to the insurance companies for resolution of the claims pursuant to the policies, the result of that status was that SECO's insurance policy assets had been assigned to the insurance companies, as had been the claims against those assets. As SECO's de facto assignee, the insurers would hold SECO's attorney-client privilege, and have the authority to waive it, with respect to the asbestos actions against SECO's policies.

What was left unanswered was the breadth and scope of the privilege which a dissolved corporation's insurers may assert. Is there a foreseeable factual scenario in which the appointment of Cumis counsel becomes an issue?

INSURANCE CODE § 533.5 DID NOT BAR INSURER FROM DEFENDING AND INDEMNIFYING INSURED NAMED IN FEDERAL CRIMINAL INDICTMENT

In *Mt. Hawley Insurance Company v. Lopez* (2013) 215 Cal.App.4th 1385, 156 Cal.Rptr.3d 771, the Court of Appeal, Second District, Division 7, held that outside the special area of Unfair Competition Law and False Advertising Law actions brought by state or local prosecuting agencies, there is no public policy in California against insurance policies providing a defense to insureds facing criminal charges, as opposed to indemnification for those convicted of criminal charges.

The United States Attorney for the Central District of California filed a grand jury indictment charging Dr. Richard Lopez alleging criminal conspiracy, false statements, concealment and falsification of records. The indictment further alleged that Lopez, who was the medical director of the St. Vincent's Medical Center Comprehensive Liver Disease Center (St. Vincent's), conspired with another doctor and other hospital employees in the liver transplant program to transplant a liver into the wrong patient. The indictment claimed that Lopez engaged in a cover-up by directing his co-conspirators to restore the second patient's name to the transplant waiting list (even though the second patient had received the liver designated for the first patient), create a false pathology report for the first patient based on data in the second patient's pathology report, and alter medical reports to support a claim "that the transplant program had made an honest mistake confusing the names." The indictment included alleged violations of title 18 USC § 371 (conspiracy), § 1001 (making false statements), and § 1519 (destruction, alteration, or falsification of evidence in federal investigations).

Daughters of Charity Health Systems, Inc., which owned St. Vincent's, purchased a "Not For Profit Organization and Executive Liability Policy" pursuant to which Mt. Hawley Insurance Company (Mt. Hawley) agreed to "pay on behalf of the Insureds, Loss which the Insureds are legally obligated to pay as a result of Claims ... against the Insured for Wrongful Acts...." The policy defined "Loss" as "monetary damages, judgments, settlements, including but not limited to punitive, exemplary, multiple or non-contractual liquidated damages where insurable under applicable law, ... and Defense Expenses which the Insureds are legally obligated to pay as a result of

a covered Claim." The policy further provided that Mt. Hawley "shall have the right and duty to defend any Claim covered by this Policy, even if any of the allegations are groundless, false or fraudulent...." An endorsement defined "claim" to include "a criminal proceeding against any Insured commenced by the return of an indictment" or "a formal civil, criminal, administrative or regulatory investigation against any Insured...." The policy's definition of "insured" included employees of St. Vincent's such as Lopez.

Lopez tendered the defense to the charges to Mt. Hawley, which, through its attorneys, sent a letter to Lopez declining to defend or indemnify Lopez, and on the same date filed a coverage suit against Lopez. Mt. Hawley's coverage suit alleged that Lopez "engaged in an elaborate cover-up of the 'switch,' which included falsification of documents and encouragement of others to participate in the cover-up." Mt. Hawley further alleged that it had no duty to defend Lopez for reasons including the applicability of Insurance Code § 533.5 (which bars coverage for criminal actions and proceedings). Mt. Hawley sought a declaration from the trial court that it did not owe Lopez a duty to defend or indemnify in connection with the indictment. Lopez filed a cross-complaint against Mt. Hawley for breach of contract, breach of the implied covenant of good faith and fair dealing, and declaratory relief.

The trial court overruled Lopez's demurrer to the first amended complaint. Relying upon Insurance Code § 533.5, Mt. Hawley subsequently filed a motion for summary judgment or in the alternative for summary adjudication, which the trial court granted. The appellate court reversed the order granting summary judgment, and affirmed a trial court order overruling defendant's demurrer.

The appellete court determined that § 533.5 was unclear and ambiguous because it was susceptible to at least three reasonable interpretations: (a) that it addressed separately criminal actions generally, and actions pursuant to specific statutes; (b) that it applied to a criminal action for a fine or penalty sought by the listed state and local agencies, or to an unfair completion action; and (c) that it applied to any claim in which the recovery of a fine or restitution was sought specified state or local officials. Having determined the statute was ambiguous, the court examined the legislative history of Insurance Code § 533.5, which in the court's view, indicated that the goal of the statute was to preclude insurers from providing a defense in civil and criminal unfair competition law actions brought by the Attorney General, district attorneys, city attorneys or county counsel. The legislative history did not, in the court's view, establish an intent to address federal prosecutions.

The court then acknowledged that the maxims of statutory construction seemingly indicated that Insurance Code § 533.5 prevented an insurer from defending "any claim in any criminal action or proceeding." However, the court declined to allow technical rules of grammar and construction to defeat what it viewed as the clear legislative intent behind § 533.5, which was to address the problem that insurers were providing their insureds with an indemnity and defense in unfair competition law actions brought by state and local public entities. Extending the reach of § 533.5 beyond unfair competition lawsuits brought by state and local prosecutors would conflict with state laws such as Corporations Code § 317, authorizing a corporation to indemnify its agents against fines and settlements, and Government Code § 990, allowing a local public entity to insure against the expense of defending a claim brought against the entity or its employee where liability arose from an act or omission in the scope of the employee's employment. The court also noted that its interpretation of § 533.5, allowing insurers to provide a defense to certain kinds of criminal charges, such as federal charges, was consistent with the goal of encouraging individuals to serve on boards of directors and trustees of corporations and charities, and with the principle that insureds charged with crimes begin with a presumption of innocence.

LIABILITY INSURER'S RESERVATION OF RIGHTS IN PROVIDING A DEFENSE TO AN INSURED BUILDER, AND LIABILITY INSURER'S SEPARATE ACTION AGAINST ITS INSURED BUILDER FOR A DECLARATORY JUDGMENT THAT THE POLICY DID NOT COVER THE CLAIMS AGAINST INSURED BUILDER, REQUIRED THE APPOINTMENT OF INDEPENDENT CUMIS COUNSEL, SINCE THERE WAS AN ACTUAL CONFLICT OF INTEREST BETWEEN THE INSURER AND ITS INSURED AS TO WHETHER THE WORKERS THE INSURED HIRED WERE EMPLOYEES OR INDEPENDENT CONTRACTORS BECAUSE THE POLICY DID NOT COVER WORK PERFORMED BY INDEPENDENT CONTRACTORS

In *Schaefer v. Elder* (2013) 217 Cal.App.4th 1, 157 Cal.Rptr.3d 654, the Court of Appeal, Third District, Division 3, held that a liability insurer's reservation of rights issued to its builder insured and a concurrent separate action against the builder for a declaratory judgment that the policy did not cover the claims against the builder, required the appointment of independent Cumis counsel, since there was an actual conflict of interest between the insurer and its insured builder as to whether the workers the builder hired were employees or independent contractors because the policy did not cover work performed by independent contractors.

Plaintiff Steve Schaefer contracted with defendant Kelly Elder, doing business as Elder Construction, to design and build a residence for Schaefer. Later, Schaefer sued Elder for alleged construction defects in the construction of his residence, prosecuting causes of action for breach of contract, negligence, breach of implied warranty, strict liability, money

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lent, diversion of funds, failure to enter into a written contract, and excessive down payment.

Elder tendered the defense of the action to his insurer, CastlePoint National Insurance Company (CastlePoint), and CastlePoint appointed counsel of its choice to represent Elder, subject to a reservation of rights. CastlePoint also filed separately a declaratory relief action against Elder to determine whether the insurance policy provided coverage for the claims Schaefer made against Elder. The coverage dispute focused upon whether Elder breached his policy's "contractor's special condition," which excluded coverage for work performed by independent contractors unless the insured general contractor first obtained indemnity agreements and certificate of insurance from the subcontractors, which did not occur.

Elder hired his own attorneys to move to disqualify the law firm appointed by CastlePoint and to determine Elder's right to independent counsel. CastlePoint opposed the motion. The trial court granted Elder's motion, disqualifying the CastlePoint's appointed defense counsel and determined that under Cumis, Elder has a right to independent counsel at CastlePoints expense.

The appellate court noted that because the manner in which the Schaefer lawsuit was defended by counsel could influence the outcome of the coverage dispute, Elder was entitled to independent counsel. The applicability of the policy's "contractor's special condition" turned on whether the workers responsible for the alleged construction defects in Schaefer's home were Elder's employees or independent contractors. Because determination of the coverage issue would depend on whether Elder had sufficient control over the workers, the manner in which evidence was developed and presented be counsel representing Elder in the Schaefer litigation could affect the outcome of the coverage dispute. The fact that Elder was liable regardless of whether the workers were employees or independent contractors did not eliminate the conflict. If CastlePoint's appointed defense counsel was in a position to influence coverage, Elder was entitled to control the litigation through independent counsel selected by Elder and compensated by CastlePoint. As the court explained, CastlePoint's appointed counsel were caught in an intractable conflict of interest: "Put simply, the … [CastlePoint appointed counsel] had an ethical duty to Elder to try to establish that the workers were employees and, at the same time, had an ethical duty to CastlePoint to try to establish that the workers were independent contractors."

AFTER SETTLING HIS PERSONAL INJURY CLAIM AGAINST THE INSURED, THIRD PARTY PLAINTIFF MAY SUE INSURED'S LIABILITY INSURER FOR BREACH OF CONTRACT AND BAD FAITH WHEN THE INSURER FAILED TO SETTLE WITH PLAINTIFF UNDER THE MEDICAL PAYMENTS PROVISIONS OF THE INSURED'S POLICY

In *Barnes v. Western Heritage Insurance Company* (2013) 217 Cal.App.4th 249, 159 Cal.Rptr.3d 25, the Court of Appeal, Third District, held that a liability insurer's settlement of a personal injury lawsuit against its tortfeasor insured did not extinguish any rights the third party plaintiff had under the medical payments provisions of the insured's policy, permitting the plaintiff to sue the insurer for bad faith breach of the insured's policy's medical payment provisions after settling his personal injury claim against the insured.

Plaintiff Justin Barnes was injured when a table fell on his back during a recreational program co-sponsored by the Shingletown Activities Council (the Activities Council). Barnes made a claim against the Activities Council. But when Barnes subsequently requested payment from the Activities Council's insurer more than one year after the accident for consultation with a medical specialist, the insurer, Western Heritage Insurance Company (Western Heritage), denied the request. Western Heritage asserted that to qualify for medical payment coverage under the applicable policy, Barnes had to report a claimed medical expense to Western Heritage within one year of the accident.

Barnes settled a separate personal injury lawsuit against the Activities Council and other local entities regarding his medical expenses. Western Heritage was not a party to that lawsuit. Barnes later initiated suit against Western Heritage for breach of contract and breach of the implied covenant of good faith and fair dealing based on the denial of his request for medical payment coverage.

The trial court granted summary judgment in favor of Western Heritage. Among other things, the trial court ruled Barnes's lawsuit against Western Heritage was barred by collateral estoppel because he settled his claims in the underlying personal injury action, including any claim for medical expenses; allowing Barnes to recover under the medical payment provision of the policy would result in impermissible double recovery; and Western Heritage was not equitably estopped to assert the policy's one-year deadline as a defense because Western Heritage had no duty to disclose the deadline to Barnes and Barnes did not rely to his detriment on any failure to disclose.

Barnes's appeal contended that collateral estoppel did not bar his action because the issues raised, litigated and necessarily determined in the personal injury action were different from those raised, litigated and to be determined in his action against Western Heritage; permitting Barnes to recover under the medical payment provision would not result in double recovery because Western Heritage owed him a separate and direct duty under the medical payment provision; and Western

Heritage was equitably estopped from asserting the one-year deadline in the policy because it did not inform him of the deadline.

Liability policies often contain a medical payments provision obligating the insurer to pay medical bills of persons injured on the insured's premises without regard to the insured's fault. Medical payments provisions typically have a special sublimit much lower than the policy's liability limits and obligate the insurer for a finite period of time, usually one year after the claimant is injured. Medical payment provisions have the constructive purpose of engendering good will with the claimant and thereby avoiding lawsuits against the insured.

In revering the trial court, the appellate court first noted that Justin's claim against Western Heritage raised a question of first impression in the California appellate courts: "whether an injured plaintiff who receives some payment for medical expenses from a tortfeasor's insurer under the medical payment provision of an insurance policy, and who also settles a personal injury lawsuit against the tortfeasor and receives payment from the tortfeasor's insurer under the liability provision of the insurance policy, is thereafter precluded from separately suing the tortfeasor's insurer based on its alleged breach of direct duties owed to the plaintiff under the medical payment provision of the policy."

The appellate court disagreed with the trial court's position that allowing additional recovery under the medical payments provision would result in double recovery. The court observed that other courts, including the appellate division of a trial level court in California, have reached the same result as the trial court in this case by applying the collateral source rule. The collateral source rule provides that compensation an injured party receives from sources "wholly independent" of the tortfeasor should not be deducted from the damages the injured party collects from the tortfeasor. In *Jones v. California Casualty Indemnity Exchange* (1970) 13 Cal.App.3d Supp. 1, the Santa Clara Superior Court's appellate division denied recovery under a policy's medical payments after the injured party obtained a tort judgment against the insured on the ground that the medical payments provision in the tortfeasor's policy was "not wholly independent from, and collateral to" the tortfeasor. Here, however, the court rejected the Jones opinion's focus on the tortfeasor insured in determining whether medical payments provision was a collateral source. The court stressed that in a suit to recover under a medical payments provision, the insurer, not the insured, is the alleged wrongdoer. "The policy at issue," observed the court, "was not maintained by the insurer to provide coverage for its wrongdoing, and hence the insurance policy was collateral to the alleged wrongdoer in" that case.

The court concluded that Barnes still had rights to assert under the medical payments provision after settling with the Council unless the policy's one-year limitations period applied. Finding triable issues of fact regarding whether Western Heritage was equitably estopped from invoking the limitations period, the court ruled that the trial court improperly granted summary judgment for the insurer. In the unpublished portion of the opinion, the court explained that the insurer's failure to bring the one-year limit to the plaintiff's attention may preclude the insurer from relying on the limitations period, even though Justin was represented by counsel.

This case of first impression emphasizes the importance for liability insurers of being expressly included among the parties released in a settlement agreement and/or when the settlement is made on the record when a personal injury claim is settled. ■

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A Field Guide to Southern California Snakes

emotionally moved, and we always want jurors to 'feel' strongly that we should win. But the Reptile gets jurors to that point not on the basis of sentiment, but what is safe." (p. 39) Pointedly, in defending their theory, Keenan and Ball refer to a subjective "what is safe" standard rather than the law.

In order to separate the Reptile's theory from the law, jury instruction should include Ev. Code § 210 ("Relevant Evidence"), Ev. Code § 350 ("Only Relevant Evidence Admissible"), CACI 200 ("Evidence," regarding the burden of proof), CACI 400 ("Substantial Factor"), CACI 1602 and 1620 ("Intentional/Negligent Infliction of Emotional Distress," even if not claimed by the plaintiff), CACI 3924 ("No punitive Damages"), and CACI 5000 ("Duties of the Judge and Jury"). Where relevant, CACI 505 ("Success not Required") and CACI 506 ("Alternative Methods of Care") are appropriate.

Keenan and Ball are acutely aware the Reptile does not belong on the *terra firma* of the law. They admit, "We are often asked, 'How does this negligence stuff relate to causation and damages?' It relates in the most important way: It give jurors a personal reason to want to see causation and dollar amount come out justly, because a defense verdict will further imperil them. Only a verdict your way can make them safer." (p. 39) With this quote, the Reptile's own creators shed their skin and reveal the Reptile for what it is: a subversion of the law. The Reptile wants the juror to make a decision based on a "personal reason," (in violation of Ev. Code §§210, 350 and contrary to CACI 400 and 5000). Likewise, the Reptile wants to "imperil" the jury and "make them safer" (violating the Golden Rule).

Using these snake handling tools to better prepare yourself, our clients, and your case, and using the Reptile own words to educate the Courts, we can drive the Reptile back to the swamp. ■