Summer 2022

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LEGAL UPDATE

Colorado • Utah • Wyoming • Texas

IN BRIEF

COLORADO

- Colorado Court of Appeals finds insurance company's regular use vehicle exclusion violated §10-4-609 and an insurance policy's UM/UIM coverage must apply to the person, not the vehicle.

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TEXAS

- The Supreme Court of Texas determines there is no special relationship between an insurer and insured that creates a duty for the insurer to ensure the insured's safety.

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COLORADO

COURT OF APPEALS FINDS CLASSIC CARS AUTO INSURANCE POLICY'S REGULAR USE VEHICLE EXCLUSION VIOLATES §10-4-609 AND EXTENDS *DEHERRERA* TO INCLUDE EVEN MORE COVERAGE THAN PLAINTIFF BARGAINED FOR.

Colorado Court of Appeals. Plaintiff Hughes alleged that she was seriously injured in an automobile accident caused by another driver while she was driving a Ford Edge which was her regular use vehicle. At the time of the accident, "Hughes was insured by two automobile insurance policies" including one policy with Defendant Essentia. Both policies provided UM/UIM coverage. The Essentia policy insured two classic cars and required "that the policy holder own a 'regular use vehicle,' that must be 'insured by a separate insurance policy.'" Hughes filed suit against both insurances for UM/UIM benefits and settled her claim against the other insurance company which insured her regular use vehicle.

Essentia moved for summary judgment claiming that Hughes was not "entitled to UM/UIM benefits under the Essentia policy because, at the time of the accident, she wasn't driving one of the covered" classic cars, but instead was driving her regular use vehicle.

The trial court agreed and granted Essentia's motion, finding "that the Essentia policy is specifically for classic cars and . . . states that the insured cars are not considered" regular use vehicles. The court further concluded "Hughes interest was protected through the Essentia policy's requirement that she maintain a

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separate and more substantial insurance policy for her" regular use vehicle.

The appeals court disagreed with the trial court based upon the Colorado Supreme Court decision, *DeHerrera* that provides "UM/UIM coverage, if not waived by the named insured, must protect persons insured" under the policy in accordance with §10-4-609(1), meaning that "UM/UIM benefits cover people and can't be tied to the occupancy of a certain vehicle."

Essentia argued Hughes was able to recover under the other car insurance policy required under Essentia's policy and therefore, Essentia's policy did not violate §10-4-609. The appeals court was not persuaded, stating the policy must cover the person and not the vehicle to comply with §10-4-609.

Essentia further argued the court should follow the Colorado Court of Appeal's decisions in *Jacox* and *Rivera* which both held plaintiffs were not "entitled to recover UM/UIM benefits under the driver's policy" finding the vehicle exclusions were "valid and enforceable." The appeals court declined to follow *Jacox* and *Rivera*, stating it was "bound by *DeHerrera*" a Colorado Supreme Court case. The court noted the plaintiffs in Jacox and Rivera, along with Hughes, were seeking to obtain coverage they didn't bargain for, but "plaintiffs in both *Jacox* and *Rivera* were seeking to recover UM/UIM benefits under the same policy that insured the vehicle in which they were injured" and Hughes was seeking to invoke the UM/UIM benefits of Essentia's policy "because the at-fault driver's coverage [was] inadequate, not because of any alleged shortcoming of the Essentia policy itself." Therefore, the appeals court reversed the summary judgment in favor of Essentia and remanded.

Hughes v. Essentia Ins. Co.,
2022 COA 49,
2022 Colo.App.LEXIS 666,
2022 WL 1417335
(Co. Ct. App.)
(May 5, 2022).

THE SUPREME COURT DECLINES TO FOLLOW *DiCARLO*, HOLDING THE TERM "ALL CHARGES" IN HOSPITAL SERVICES AGREEMENTS DOES NOT INCORPORATE A HOSPITAL'S CHARGEMASTER RATES

Supreme Court of Colorado. After being injured in an auto accident, French went to respondent's hospital for spinal fusion surgery, which would require two separate surgeries. French was informed that the total estimated cost of her surgeries "would cost $57,601.77" but "that she would personally be responsible for [only] $1,336.90" after her insurance covered the rest. Before the surgeries, French signed the hospital services agreements ("HSAs") acknowledging responsibility for any outstanding charges.

After the surgeries, the hospital realized they had misread French's insurance cards and that she was an out-of-network patient, meaning her surgeries were not covered by her insurance policy. The hospital subsequently sent French a bill for $229,112.13, "reflecting its full chargemaster rates" minus $73,597.35 that had been paid by her insurance. When French did not pay the hospital as billed, "it sued French for breach of contract, alleging that under the HSAs . . . she had agreed to pay [the hospital's] chargemaster rates and therefore owed the full balance of $229,112.13."

Prior to trial, the hospital "filed a Motion for Declaratory Judgment or for the Determination of Questions of Law" moving the court to declare:

> that (1) the HSAs that French had signed incorporated the chargemaster rates; (2) French's promise to pay 'all charges of the Hospital' was not an indefinite or open price term and unambiguously referred to [the hospital's] chargemaster; and (3) the HSAs and Patient Bill of Rights forms that French had signed required her to pay the outstanding charges.

The trial court denied the motion, concluding the HSAs did not "incorporate or refer to the chargemaster as a matter of law," finding the term "all charges" was "ambiguous" and that the HSAs themselves were "devoid of any reference to the Hospital's chargemaster." The trial court concluded the HSAs were "reasonably susceptible to more than one meaning."

At trial the hospital "conceded that they had provided French . . . with an estimate indicating that her surgeries would cost $57,601.77 and that French would owe $1,336.90." French testified that "no one told her she might owe more" than the quoted $1,336.90 and an expert "testified that he had estimated the actual cost of the medical services provided to French to be $70,500.00" opining that the hospital's "charges for the goods and services at issue greatly exceeded their reasonable value."

After denying the hospital's renewed motion "for a declaratory judgment regarding the language of the HSAs" the trail court "provided the jury with a special verdict form, requiring the jurors to decide . . . whether the term 'all charges of the Hospital' meant the chargemaster rates or the reasonable value of the goods and services provided to French." The jury found that "all charges of the Hospital" referred to the "reasonable value of the goods and services provided" and not to the chargemaster rates. The jury further determined that "the chargemaster rates billed to French were not reasonable" concluding that French owed the hospital a mere "$766.74 in damages."

The hospital appealed, claiming the trial court erred in determining that the term "'all charges' in the HSAs" was ambiguous. The appeals court agreed and reversed the trial court's

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judgment, opining that "most jurisdictions that had considered the question had interpreted hospital contracts requiring a patient to pay 'all charges' as unambiguously incorporating the hospital's chargemaster rates." French's petition to the Colorado Supreme Court for certiorari review was then granted.

The Supreme Court agreed with the trial court's judgment, concluding that the chargemaster rates were not incorporated by reference into the HSAs based on basic contract principles. The court found the record devoid of any evidence that French even "knew of the chargemaster's existence" or "clearly and knowingly assented" to the "chargemaster's terms." The court declined to follow the appellate court's decision in *DiCarlo* which concluded "that the term 'all charges' in a form signed by the plaintiff referred to the hospital's chargemaster" instead finding that, "principles of contract law can certainly be applied to hospital-patient contracts." The appellate court's judgment was thus reversed and remanded for further proceedings.

French v. Centura Health Corp.,
2022 CO 20,
509 P.3d 443,
2022 Colo.LEXIS 366
(May 16, 2022).

Utah

COURT OF APPEALS DECLARES HOSPITAL'S SECURITY GUARDS ASSUALT ON MAN SEEKING TREATMENT FOR MENTAL HEALTH ISSUES DID NOT INVOKE THE UTAH HEALTHCARE MALPRACTICE ACT.

Utah Court of Appeals. While suffering under a mental health crisis, Jason Shell sought medical care at LDS Hospital in Salt Lake City. Shell was escorted to an examination room and instructed to remove all his clothing, except his underwear, and change into a hospital gown. His clothing and other belongings were then placed by a staff member in a locker down the hall. A social worker arrived and requested Shell take "a sedative to get some rest." Shell refused the sedative and "asked whether he could receive an alternative treatment." The social worker told Shell he "could either take the sedative or leave" the hospital.

Shell decided to leave the hospital and "was taken to the lobby to use the phone" to call his girlfriend for a ride. Shell "was unable to reach his girlfriend, so the social worker escorted Shell back to the examination room." A hospital security guard then "walked over to the only public exit" accessible to Shell at the time "and locked the door" so that it could only be opened by a staff key card. Shell and the social worker continued to have a "peaceful conversation", but the social worker and other hospital staff "refused to provide treatment unless Shell took a sedative."

Shell again "informed the staff he wanted to leave" but needed a ride from his girlfriend and again requested to call her, but "the staff refused." Another security guard entered the area via a key card and "quickly approached Shell" coming "face-to-face" and "bumping him with his chest . . . blocking Shell from leaving." The first security guard and staff "surrounded" Shell who "took a few steps out of the exam room into the hallway" and continued backing up slowly due to the "increasing hostility coming from the staff."

The second security guard then "quickly grabbed Shell by his shoulders, dragged Shell across the lobby [and] slammed Shell against the wall." The second security guard "forced Shell to the ground with his hands around Shell's neck and with help" from the first security guard "kept Shell, who was mostly disrobed at this point, pinned down." During this ordeal, Shell called for help while other hospital "employees watched."

Shell was "slammed . . . into the ground" by the security guards, causing him "to start bleeding from his mouth and from the back of his head." One security guard "moved his forearm down to Shell's neck and forced his body weight on Shell's throat for 20 seconds" causing Shell to be "unable to call for help . . . because he couldn't breathe." Shell was then dragged down the hallway, "causing his hospital gown to come off completely." For "approximately 15 minutes" Shell was pinned to the floor before the hospital staff determined to call police. Before the police arrived, hospital staff "wiped blood away after discussing how it would appear to the police."

A year after the ordeal, Shell filed a complaint asserting seven causes of action against the hospital and staff involved. The hospital and staff moved the district court to dismiss, arguing that Shell did not comply with the pre-litigation requirements of the Utah Health Care Malpractice Act ("the Act"). Shell argued that "because he received no medical treatment" from the hospital or staff "the Act did not cover his claims." The district court agreed with the hospital concluding that "because Shell sought treatment" at the hospital "and because he was harmed by the [hospital's] security guards, his injuries arose from treatment" and dismissed his claims. Shell appealed.

The appellate court disagreed, finding that while "Shell sought treatment" he then "refused the treatment offered by the social worker, and the social worker refused to provide an alternative treatment" and thus "no medical care ensued" and Shell's complaint did not fall within the

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perimeters of the Act. The appellate court further determined "Shell's injuries could not have occurred during [Shell's] medical care, treatment, or confinement . . . because he did not undergo treatment at any point." The appellate court reversed the district court's dismissal and remanded for further proceedings.

Shell v. Intermountain Health Servs., 2022 UT App 70, 2022 Utah App. LEXIS 74, 2022 WL 2070324 (June 9, 2022).

COURT OF APPEALS AFFIRMS TRIAL COURT'S DECISION THAT NON-SLIP TILE FLOORING IN ELEVATOR THAT COULD BECOME WET FROM GUESTS USING HOTEL'S POOL IS NOT A DANGEROUS AND FORESEEABLE PERMANENT CONDITION

Utah Court of Appeals. While staying at a Hilton, Lee Stafford stepped into an elevator to go to the lobby from the fifth floor when "his foot slipped out from under him." While Stafford was able to regain his balance, and with a concerted effort "kept him[self] from actually falling to the ground" he allegedly incurred lower back pain. After the near slip-and-fall, Stafford "discovered a puddle of water that seemed to smell of chlorine and was only a couple of inches across" in the middle of the tile floor of the elevator. Once Stafford arrived at the hotel lobby "he found a trail of water leading toward Hilton's pool . . . separated from the elevator by about one hundred feet of carpeted hallway." Before his visit at Hilton ended, Stafford reported the incident to Hilton's staff. After his stay at the Hilton, Stafford alleged he "incurred substantial medical expenses" to relieve his lower back pain. Stafford then sued Hilton.

During discovery it was determined that Hilton had installed "nonslip" tile in their elevators and "had no knowledge of any other person ever slipping on the hotel's tile generally, and specifically the tile in the elevator." Testimony from Hilton's representative provided Hilton kept a "mat near the pool entry" as a "welcome touch point" and not for "slipping purposes."

Hilton filed a motion for summary judgment based on the assertion that "Stafford had failed to present evidence Hilton had either actual or constructive notice" of an unsafe condition and had failed to show that Hilton had a "reasonable opportunity to remedy the condition prior to the accident." After conceding "that Hilton did not have actual or constructive notice of the water" in the elevator, "Stafford argued that the hazard was not a temporary condition that Hilton was obligated to remedy upon notice, but rather, that it was an inherently dangerous and foreseeable permanent condition that required no proof of notice." The district court granted Hilton's motion for summary judgment based on Stafford's concession along with Hilton's temporary condition theory. The district court concluded Stafford had "failed to present evidence that Hilton could reasonably foresee that people would come from the pool, cause the tiles to become slippery when wet, and create a dangerous condition." Stafford appealed.

The appeals court noted "to prevail on a permanent unsafe condition theory, Stafford needs to demonstrate more than the mere existence of potentially slippery flooring." Stafford asserted the district court should have given "credence to the portion of the Hilton representative's testimony that the mats" might "help with people walking in and out if they are wet." The appeals court found this concession in the representative's testimony did not provide enough to demonstrate "that Hilton caused a permanent unsafe condition by its method of operation."

The appeals court further noted the water in the elevator was dripped onto the elevator floor by "an unknown third party" and that Hilton's measures did provide that it "took reasonable precautions to protect its customers" and therefore did not breach "any duty owed to Stafford." The appeals court affirmed the district court's decision, finding Hilton was "entitled to judgment as a matter of law" because there was no unsafe permanent condition and Hilton did not breach its duty to Stafford.

Stafford v. Sandy Paydirt LLC, 2022 UT App 76, 2022 Utah App. LEXIS 83, 2022 WL 2282841 (June 24, 2022).

Wyoming

SUPREME COURT HOLDS A PERSON WHO BORROWS ANOTHER PERSON'S VEHICLE DOES NOT OWE THE VEHICLE OWNER A DUTY TO PROTECT THE VEHICLE OWNER FROM INCREASED INSURANCE PREMIUMS, EVEN WHEN THE INCREASE IS BASED ON THE DRIVER'S NEGLIGENCE.

Supreme Court of Wyoming. Moses Inc. allowed Ms. Moses, a former employee and shareholder, to drive a vehicle insured by Moses Inc. While driving Moses Inc.'s vehicle, Ms. Moses "attempted to drive east on a service road, but instead entered an off ramp for the westbound lane of Interstate 80" and "collided head-on with a westbound vehicle." Both Ms. Moses and the other driver "were killed immediately."

After paying "millions" to settle the negligence claim resulting from the collision, Moses Inc.'s insurer "canceled Moses Inc.'s policy." Moses

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Inc. was able to obtain insurance through a different carrier that increased Moses Inc.'s "annual premium by approximately $200,000." The new policy also provided lower coverage and higher deductibles than Moses Inc.'s previous policy.

Moses Inc. filed a complaint against the Estate and Trust of Ms. Moses "seeking $15,000 for the loss of its vehicle as well as damages for its increased insurance costs." The district court granted The Trust's motion to dismiss concluding the increased premiums were not a reasonably foreseeable consequence for the tort of negligence and that "public policy would not be served by allowing recovery of Plaintiff's increased premiums." Moses Inc. appealed.

The Supreme Court of Wyoming provided that "one owes the duty to every person in our society to use reasonable care to avoid injury to the other person in any situation in which it could be reasonably anticipated or foreseen that a failure to use such care might result in such injury." The Court found that "when one party loans its vehicle to another, a bailment is created" and as such "Ms. Moses, as bailee, owed Moses Inc., as bailor, a duty of care to protect its vehicle from damage."

Despite caselaw providing this duty of care did not include premiums for insurance, Moses Inc. argued the duty of care should be extended to include increased insurance premiums in this matter because "Ms. Moses was clearly at fault in the accident . . . and she thus should have foreseen that her negligence would cause" Moses Inc. "to experience increased insurance costs." The Court declined to extend the duty to insurance premiums, noting that precedent "based their decisions less on who was at fault in the accidents and more on the remoteness of the injury." The Court found that "increased insurance costs are too remote from an act of negligence to be foreseeable" even in cases where the accident was caused by negligence, and further found "Moses Inc. had exclusive control over the decision to loan its vehicles and to whom it would loan them" and "it certainly could foresee that a person to whom it has loaned a vehicle might have an accident." Therefore, Moses Inc. "could have taken steps to minimize the risk . . . such as requiring the driver to carry separate insurance or requiring an indemnification agreement."

The Court held that "a person who borrows another's vehicle does not owe the vehicle owner a duty to protect it from increased insurance costs" and affirmed the district court's dismissal of Moses Inc.'s claims.

Moses Inc. V. Moses, 2022 WY 57, 2022 Wyo. LEXIS 57, 2022 WL 1420857 (May 5, 2022).

Texas

SUPREME COURT DETERMINES NO SPECIAL RELATIONSHIP BETWEEN AN INSURED AND INSURER EXISTS TO CREATE A DUTY FOR THE INSURER TO ENSURE AN INSURED'S SAFETY.

Supreme Court of Texas: On a rainy night, Lorraine Kenyon lost control of her vehicle on the slick roads, and collided with a guardrail. While the accident rendered the vehicle inoperable, Kenyon was "scared . . . but . . . uninjured." She "first called her husband, Theodore, and then her insurer Elephant Insurance Company, to report the accident." The phone call to Elephant was recorded and transcribed.

The "recording captured part of a brief exchange between Kenyon and an

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unknown person" and a conversation "between Kenyon and a firefighter, who stopped to inquire about her condition." Kenyon then "raised the subject of photographs" asking if Elephant wanted her to "take pictures." The representative answered in the affirmative and reminded Kenyon that they "always recommend that you get police involved but it's up to you whether you call them or not." Kenyon then told the representative that she had called Theodore first, "who was at their home, a short distance from the accident site." The representative then "recapped" stating "you said you're going to take pictures. And the vehicle is not drivable." The representative noted they did "have roadside assistance towing on the policy" so she could "transfer [Kenyon] over to them" and they could help her "with getting the vehicle towed."

Unknown to the representative, sometime during the phone call with Kenyon, Theodore had arrived and began taking pictures of the accident scene. While taking the pictures, "another driver lost control on the wet road; struck Theodore . . . and collided with Kenyon's vehicle." Kenyon requested the representative call 911 and ended the call. Unfortunately Theodore died on the way to the hospital and Kenyon was also injured, though not fatally.

Kenyon filed a wrongful death suit against Elephant and the other driver. Kenyon asserted that "Elephant failed to train its first-notice-of-loss representatives to instruct insureds at the scene of an auto accident in a safe and competent manner." She further claimed that based upon the "special relationship" held "between an insurer and insured, Elephant had a general duty to act as a reasonable prudent insurance company and breached that duty when it instructed the insureds to take photographs from the scene."

During discovery, the representative "testified she was trained to obtain information about the accident . . . as well as to encourage the insured to take photographs of the accident scene." She admitted she "was not trained to inquire about the insured's safety or to ask whether the insured was in a safe location." However, "Kenyon testified that she did not expect Elephant's employee to provide safety guidance" and "that she believed she and Theodore were safe." Kenyon further provided "they would have taken appropriate precautions" had they not felt safe.

Elephant filed a motion for summary judgment, arguing that (1) Kenyon's claimed "special relationship" between an insurer and insured did not give rise to duties outside the claim-processing context, (2) that "an insurer bears no duty to ensure an insured's safety," (3) that "Elephant owed no duty to ensure Theodore's safety," and (4) that "Kenyon could produce no evidence that Elephant breached any duty or standard of care imposed by Texas law."

The trial court rendered judgment in Elephant's favor, concluding that the insurer owed no duty to the Kenyons with respect to Kenyon's negligence and gross-negligence claims. Kenyon appealed and "in a split decision, the [appellate] panel affirmed the trial court's summary judgment." A rehearing was then held where the "court withdrew the panel opinion and reversed the trial court's order as to all of Kenyon's" negligence claims. Elephant then petitioned for review.

The Supreme Court found that while the "risk of harm was foreseeable to someone in Elephant's position, it was equally foreseeable – if not more so – to someone in Kenyon's or Theodore's position." Therefore Elephant had no duty to warn Kenyon or Theodore "about [the] open and obvious condition." The court further found "neither Elephant nor its [representative] engaged in an affirmative course of action necessary for the protection of the Kenyon's person or property" precluding Kenyon's claim for negligent undertaking.

The Supreme Court concluded "the trial court properly granted summary judgment" on all of Keyon's negligence claims and reversed the court of appeals' judgment.

Elephant Ins. Co., LLC, v. Kenyon,
2022 Tex.LEXIS 344,
644 S.W.3d 137, 65 Tex.Sup.J. 810,
2022 WL 1202307.

COURT OF APPEALS FINDS REPAIR OF GUARDRAIL COMPLIED WITH TxDOT CONTRACT AND THUS FELL UNDER THE AFFIRMATIVE DEFENSE OF §97.002.

Court of Appeals of Texas, Fourth District, San Antonio. While driving down Highway 281, eighteen-year-old Joslyn Markham, with her older sister Naomi as passenger, veered to the right shoulder and struck the guardrail. The pickup truck Joslyn was driving then "rode up the guardrail, over a parapet, and . . . fell approximately forty feet." Joslyn was killed in the accident, while Naomi was seriously injured.

The Markhams sued the Texas Department of Transportation (TxDOT), ISI Contracting, Inc., and Guerra Construction. The Markhams claimed "that months before the truck struck the guardrail, the guardrail had been damaged, and ISI and Guerra worked on that portion of the guardrail . . . replac[ing] the guardrail at a height that was too low – in violation of TxDOT's established standards" which "caused the pickup truck to ride up over the guardrail" and fall.

ISI and Guerra moved for summary judgment based on an affirmative defense under Tex. Civ. Prac. & Rem. Code Ann. §97.002 which provides "a contractor who constructs or repairs a highway, road, or street for" TxDOT

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"is not liable to a claimant for personal injury, property damage, or death arising from the performance of the construction or repair if . . . the contractor is in compliance with contract documents material to the condition or defect that was the proximate cause of the" claim. The trial court denied the motion, and ISI and Guerra appealed.

The Markhams argued that ISI and Guerra's work on the guardrail constituted "maintenance" and did "not qualify as repairs" and thus did not fall under §97.002. The appellate court disagreed finding that although the contract with ISI was entitled "IMPROVEMENTS OF 0.001 MILES of ROUTINE MAINTENANCE in BEXAR COUNTY" the contract "expressly" included that "ISI was to perform . . . all work for guardrail repair" with the term "repair" used throughout the contract in regards to work on guardrails. The appellate court found that the contract's plain language explicitly required ISI to perform "guardrail repairs."

The appellate court further found that the definition of repair "to restore by replacing a part or putting together what is torn or broken" further demonstrated that ISI and Guerra performed repair work on the guardrail and held "that ISI and Guerra's restorative work on the guardrail constitute[ed] repairs under section 97.002."

The appellate court further found that the contract between TxDOT and ISI and Guerra, provided that all work must be inspected, approved, and accepted by "The Engineer" and any decision by The Engineer was "final and binding." Thus the court found that because the TxDOT Engineer inspected and approved the work performed on the guardrail that "as a matter of law . . . ISI and Guerra were in compliance with" the contract. The court held that because ISI's and Guerra's repair of the guardrail complied with the terms of their contract, the Markhams' claims against ISI and Guerra fell under §97.002 and ISI and Guerra "were entitled to judgment as a matter of law against all the Markhams' claims." The trial court's order was reversed and the appellate court dismissed all claims against ISI and Guerra.

ISI Contr., Inc. v. Markham,
2022 Tex.App. LEXIS 2744,
2022 WL 1230106.

APPELLATE COURT FINDS APPRAISAL AWARD ACCOUNTS ONLY FOR DAMAGE CAUSED BY ONE SPECIFIC INCIDENT AND NOT FOR DAMAGE CAUSED BY PREVIOUS INCIDENTS.

Court of Appeals of Texas, Fifth District, Dallas. Richland Trace, a condominium community insured by Landmark American Insurance Company, Vericlaim, Inc. ("Landmark") sustained damage from a hailstorm on March 26, 2017. Richland Trace then made a claim with Landmark under their 2017 policy.

Because Richland Trace and Landmark disagreed on the amount of loss caused by the hailstorm, "Richland Trace invoked the 2017 Policy's appraisal provision" and both parties retained "impartial appraiser[s]" to "state separately the value of the property and amount of loss." When both appraisers agreed upon an amount and signed an Appraisal Award under the applicable deductible, "Landmark did not pay any benefits under the 2017 Policy" and "Richland Trace did not contest the Appraisal Award."

However, Richland Trace then filed a claim against Landmark, asserting that "Landmark failed to pay in accordance with its policy" because "the damage to its property predated the March 2017 storm" and Landmark's adjuster, Keen, who first inspected the damage, knew it predated the March 2017 storm. Richland Trace claimed the roofs were also damaged from a March 2016 storm and "that damage is subject to coverage under" Richland Trace's 2016 Policy, also issued by Landmark. Landmark moved for summary judgment "on the ground that the Appraisal Award foreclose[d] Richland Trace's claims under the 2016 and 2017 Policies" and because the award "fell below [Richland Trace's] deductible . . . the court must enforce the binding Appraisal Award." Landmark further argued that when the appraisal was conducted the appraisers assessed and valued "all existing hail damage, and loss for all hail damage" and included it in their Appraisal Award. Richland Trace countered that the "Appraisal Award only accounted for damage caused by the March 2017 storm and did not include damage resulting from the March 2016 storm." The trial court agreed with Landmark and summary judgment was granted. Richland Trace appealed.

The appellate court found that based on the language of the Appraisal Award, it only "reflect[ed] the loss caused by a singular hailstorm . . . subject to a singular policy, the listed 2017 Policy." The appellate court noted this was "consistent with the supreme court's pronouncements that the appraisal process resolves the issue of damage caused by a specific occurrence."

Landmark argued that even if the Appraisal Award did not cover loss as a result of the 2016 storm, Richland Trace was "barred from any recovery . . . because it failed to provide prompt notice that it was making a claim under the 2016 policy, and Landmark was prejudiced by that lack of notice." The appellate court found that "Richland Trace did not timely give notice" but there was "no evidence in the record that Landmark was prejudiced by any delay." Thus, based on the Appraisal Award not covering the loss from the 2016 storm and lack of prejudice to Landmark for the untimely claim, the appellate court reversed the trial court's summary judgment in favor of Landmark, and remanded for further proceedings.

Richland Trace Owners Ass'n v. Landmark Am. Ins. Co.,
2022 Tex.App.LEXIS 2330,
2022 WL 1076177.

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