



AGENDA

LEGEND: A - Action may be taken
I - Information
1 - Included
2 - Handout
3 - Separate
4 - Verbal

JPA: ACCEL CLAIMS COMMITTEE MEETING

DATE/TIME: Thursday, February 29, 2024 at 2:30 PM

LOCATION: Teleconference

Link: <https://alliantins.ance.zoom.us/j/97274876742?pwd=VG1hV0hlaGhPY3FIaWxDSHNjSGs5UT09>

Meeting ID: 972 7487 6742

Passcode: 459145

Dial: (669) 900-6833

In accordance with the requirements of the Brown Act, notice of this meeting must be posted in publicly accessible places, 72 hours in advance of the meeting, at the office of ACCEL's Secretary.

Per Government Code section 54954.2, persons requesting disability-related modifications or accommodations, including auxiliary aids or services in order to participate in the meeting, are requested to contact Alliant Insurance Services at (415) 403-1400, 24 hours in advance of the meeting. Access to some buildings may require routine provision of identification to building security. However, ACCEL does not require any member of the public to register his or her name, or to provide other information, as a condition to attendance at any public meeting and will not inquire of building security concerning information so provided. See Government Code section 54953.3.

- MEMBER** • **City of Anaheim**, 201 South Anaheim Blvd., Suite 503, Anaheim, CA 92805
LOCATIONS • **City of Bakersfield**, 1600 Truxtun Ave., 4th Floor, Bakersfield, CA 93301
VIA TELE - • **City of Ontario**, 200 North Cherry Ave., Ontario, CA 91764
CONFERENCE • **City of Santa Cruz**, 1200 Pacific Ave., Suite 290, Santa Cruz, CA 95060
• **City of Santa Monica**, 1685 Main Street, Room 131, Santa Monica, CA 90401

PAGE

A. CALL TO ORDER

B. CONSENT CALENDAR

(A)

3-5

- 1 1. Approval of Minutes for the January 8, 2024 Claims Committee Meeting
The Committee will review these minutes and will take action to approve or give direction.

C. REPORTS

1. CLAIMS COMMITTEE'S REPORT

6-24

- 1 a) Proposed Changes: ACCEL Claims Reporting and Handling Policy and Procedure (A)
The Committee will discuss proposed changes. Action may be taken to provide a recommendation to the Board or direction given.

25-30

- 1 b) Litigation Update (I)
George Hills will provide the Committee a litigation update.

- 3 c) **CLOSED SESSION – Pursuant to Gov't Code 54956.95** (A)

Members will review the following Closed Session items and may take action or give direction.

- i. Committee Review – ACCEL Open Loss Run
- ii. George Hills Estimated Loss Payments

RECONVENE - DISPOSITION OF CLOSED SESSION ITEMS

ACCEL

Authority for California Cities Excess Liability
c/o Alliant Insurance Services, Inc.
Corporation Insurance License No. 0C36861
560 Mission Street, 6th Floor, San Francisco, CA 94105



D. PUBLIC COMMENTS

(1)

4 *The public is invited at this point to address the Committee on issues of interest to them.*

ADJOURNMENT

**MINUTES OF THE
ACCEL CLAIMS COMMITTEE MEETING**

**Item No. B.1
Claims Committee
February 29, 2024**

Monday, January 8, 2024 at 11 AM

**LOCATION:
Teleconference**

Link: <https://alliantinsurance.zoom.us/j/92199587298?pwd=RmhDaEZlSn11bURqOEJEUzJOWWc2UT09>

Meeting ID: 921 9958 7298

Passcode: 891085

Dial: (669) 900-6833

MEMBERS PRESENT:

Jena Covey, City of Bakersfield *(left at 12:10 PM)*

Numeya Williams, City of Ontario *(left at 12:15 PM)*

Ross Brandon, City of Santa Cruz

Oles Gordeev, City of Santa Monica

MEMBERS ABSENT:

Tracey Matthews, City of Anaheim

GUESTS AND CONSULTANTS:

Alvaro Valdez, City of Burbank Alternate *(left at 11:06 AM)*

Ben Oram, George Hills Company

Conor Boughey, Alliant Insurance Services

Lorissa Huey, Alliant Insurance Services

A. CALL TO ORDER

Jena Covey called the meeting to order at 11:01 AM.

B. CONSENT CALENDAR

B1. Approval of Minutes for the December 12, 2023, Claims Committee Meeting

A motion was made to approve the consent calendar.

MOTION: Ross Brandon **SECOND:** Oles Gordeev **MOTION CARRIED**



	Tracey Matthews	Jena Covey	Numeya Williams	Ross Brandon	Oles Gordeev
Aye		X	X	X	X
Nay					
Abstain					

C. REPORTS

C1. CLAIMS COMMITTEE’S REPORT

C1a. Closed Session Confidentiality Policy and Procedure Review

Lorissa Huey reported that every even numbered year prior to the January Board Meeting, the Claims Committee reviews the Closed Session Confidentiality Policy and Procedure.

The Committee reviewed and did not want to propose any changes. Direction was given to change the reviewed date to the date of the Committee Meeting.

C1b. CLOSED SESSION – Pursuant to Gov’t Code 54956.95

A motion was made to enter into Closed Session at 11:07 AM.

MOTION: Jena Covey **SECOND:** Ross Brandon **MOTION CARRIED**

	Tracey Matthews	Jena Covey	Numeya Williams	Ross Brandon	Oles Gordeev
Aye		X	X	X	X
Nay					
Abstain					



A motion was made to come out of Closed Session at 12:15 PM.

MOTION: Oles Gordeev **SECOND:** Ross Brandon **MOTION CARRIED**

	Tracey Matthews	Jena Covey	Numeya Williams	Ross Brandon	Oles Gordeev
Aye			X	X	X
Nay					
Abstain					

RECONVENE - DISPOSITION OF CLOSED SESSION ITEMS

Conor Boughey reported out of closed session that no reportable action took place.

D. PUBLIC COMMENTS – There were no public comments.

ADJOURNMENT

The meeting was adjourned at 12:16 PM.



Item No. C.1.a
Claims Committee
February 29, 2024

PROPOSED CHANGES: **CLAIMS REPORTING AND HANDLING POLICY AND PROCEDURE**

ISSUE: There are two proposed changes to the Claims Handling Policy and Procedure.

First:

ACCEL reimburses Members when a claim is fully resolved. With ACCEL's \$1,000,000 retention, typically this occurred when all aspects of the claim were resolved, and final payments are needed. In today's litigation environment, Members may have claims which are one occurrence, but have multiple claimants, and a single claimant closed claim may exceed the members retention and the member may seek reimbursement. The question is whether ACCEL reimburse its Member as individual claims close or wait until all claims related to the occurrence are final?

ACCEL's General and Coverage Counsel, Byrne Conley reviewed ACCEL's Memorandum of Coverage and the Claims Reporting and Handling Policy and Procedure (P&P) and the comments are in the background section.

Under Section VIII. Claims Reimbursement Requests, a new bullet point #4 with three options is proposed language in red-lined for the Committee to discuss:

- 4) If reimbursement has been approved for an occurrence that remains open, any additional reimbursements for defense costs and fees will be processed
- Option 1: in batches (max 2 annual).
- Option 2: as further matters related to the occurrence are resolved.
- Option 3: when bills exceed \$500,000.

Second:

The Program Administrators and the Claims Chair reviewed the P&P and found within Section V. Coverage Determinations, it discussed RORs, partial disclaimer of uncovered damages, but does not get into when and how to solicit a coverage opinion. To address this, we propose adding additional language such as below:

Upon review of claim details, if coverage is not clear and the Claims Administrator cannot make a coverage determination, the Claims Administrator will present the claim to the Claims Committee for review and potential approval of a coverage opinion. Further, if a Member disputes ACCEL's coverage, the Claims Committee or Claims Committee Chair may authorize a coverage opinion. When a coverage opinion is solicited by ACCEL, ACCEL's Claims Committee will review the opinion and may authorize sharing with the affected Member. Coverage opinions will not be shared with the Member without the prior approval from the Claims Committee or Claims Committee Chair.



RECOMMENDATION: The Committee will discuss, review, and make a recommendation to the Board to adopt the proposed changes or give direction.

Additional Consideration

In favor: The proposed changes to the P&P aim to provide guidance to the Claims Administrator regarding reimbursements and when to obtain coverage opinions. The proposed edits clarify member reimbursement expectations for closed claims related to an open occurrence. The current P&P does not say anywhere whether if the occurrence is resolved and with the proposed language of the various options presented, these limitations help make it easier for the administrators to process reimbursements administratively.

Against: If ACCEL does not want to adopt the proposed changes to the P&P, as the current language's intent is that ACCEL can already reimburse its Members because of an excess case or judgement put into the excess layer, as it does not say the occurrence is resolved anywhere in the P&P. It was implied at the time. A vote against may indicate that the Committee believes the current language does not need to be amended.

FISCAL IMPACT: No financial impact is expected from the recommended action.

BACKGROUND: Byrne Conley, ACCEL's General and Coverage Counsel comments are below regarding member reimbursement for closed claims but open occurrence:

First, I looked at MOC section I.A which says we will reimburse. The No Action clause at Section VI.D does talk about no action shall lie until final determination of the covered party's obligation to pay but I think that applies to each claim.

Then the Policy and Procedure document at Section VII of course provides some standing authority in excess of the reserve. And Section VIII permits the member to seek reimbursement but does not require that the member wait until final resolution of the claim, at least in the P and P language.

With other excess pools, in my experience the member keeps paying defense costs and submits periodic requests for reimbursement, or sometimes the excess pool simply begins paying the defense attorney bills once excess is reached, particularly if the excess pool is taking over active control.

In the [Member 1] case, I don't even think of it as prefunding, I think of it as final settlement of some claims, even though there are other claims arising from the same Occurrence. I do not see any reason for the City to wait to be reimbursed after the last claim is settled, in fact I don't see anything in the



language that would permit us to do that. Under the MOC they have a right to reimbursement once they incur costs in the excess layer with our consent. You could argue that the No Action clause implies not ongoing reimbursement of defense costs until the end of a particular claim, but I am not sure that was the intent of that language. But here, some claims are settled and there should be no reason not to reimburse for those claims now.

In the [Member 2] case, I think the City has the right to immediate reimbursement as well. But, it may be administratively convenient for the City to pay bills as they go and ask for reimbursement in periodic batches.

If the Board agrees, you might want to add to the P and P that members will continue to pay ongoing defense costs in these situations, but with billing for reimbursement at set periods.

In workers comp as you know this happens regularly. The primary TPA continues to adjust and bills periodically on excess claims.

ATTACHMENT: Claims Reporting and Handling Policy and Procedure – Redlined

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: CLAIM REPORTING AND HANDLING

DATE: May 1, 1987

AMENDED DATE: March 21, 2024

REVIEWED DATE: February 29, 2024

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- VII. Settlement Authority Process**
- VIII. Claims Reimbursement Requests**
- IX. Claims Audits**
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I. Statement

It is the policy of the Authority for California Cities Excess Liability Joint Powers Authority (hereinafter referred to as “Authority”) that:

1. Each Member Agency will report all occurrences, claims, and lawsuits (hereinafter referred to as “claims”) meeting the Authority’s reporting criteria to its Claims Administrator as soon as possible and in accordance with the Authority’s Memorandum of Coverage (“MOC”).
2. Each Member Agency will assume primary responsibility for managing all reported claims filed against the Member Agency. However, the Authority reserves right to associate in or participate with a Member Agency in the negotiation, investigation, defense, appeal, or settlement of a claim subject to the terms and conditions of the Authority’s MOC.
3. The Authority’s Claims Administrator is responsible for notifying the Authority’s excess insurance carriers of all Member Agency claims with the potential to exceed the Authority’s retained limit in accordance with excess carriers’ claims reporting and handling policies. However, each Member Agency is responsible for notifying and complying with all insurance policies unaffiliated with the Authority, and purchased individually by the Member Agency (i.e., Non-Authority purchased coverage).
4. Should a discrepancy arise between this document and the Authority’s MOC, the MOC will govern.

II. Role of Claims Committee

The Claims Committee is composed of Board Members appointed by the Executive Committee and approved by the Authority; the Committee Chair is selected by Committee members. Committee membership shall not meet or exceed a quorum of the Board. The Claims Committee, with support from the Authority's claims management firm, is responsible for the following activities:

1. Monitoring all claims reported by Member Agencies to the Authority to ensure reserves are adequate, defense strategies are sound, coverage issues are promptly identified and communicated to Member Agencies, and excess carriers are promptly notified of claims with potential to exceed the Authority's retained limit;
2. Reporting key developments and/or concerns regarding active claims to the Authority's Board of Directors;
3. Providing recommendations to the Board of Directors on claims and claims matters requiring Authority action, including, but not limited to, coverage determinations, reserve levels, defense strategies, settlement offers, and decisions to try or appeal lawsuits;
4. When appropriate, soliciting and reviewing coverage opinions and other related coverage matters (e.g. reservation of rights letters). The Claims Committee Chair may approve releasing the coverage statement to the Member, to be ratified at the following Claims Committee Meeting;
5. Overseeing the activities of the Authority's claims management firm; and
6. Assisting with the selection of the Authority's claims management firm and claims auditor.

The Claims Committee will meet at least quarterly to fulfill its designated responsibilities.

III. Role of Claims Administrator

The Authority will retain the services of a claims management firm to oversee all claims reported by its Member Agencies. The claims management firm, in turn, will assign a claims administrator to the Authority. The Claims Administrator will serve as the Authority's point of contact for all reported claims and be responsible for fulfilling the scope of work contained in the service contract between the Authority and the claims management firm. The Claims Administrator will notify the excess carriers of claims in accordance with excess carriers' claims reporting and handling policies.

It is the duty of the Claims Administrator to report any claim or occurrence to each excess carrier, without regard to liability, that meets the reporting requirements in each of the excess policies, (e.g. death, traumatic brain injury, paralysis, burns, and other severe injuries, or a reserve of half or more of the retention) or which meet ACCEL's reporting requirements in Section IV below.

IV. Reporting Requirements for Member Agencies

1. Member Agencies will report to the Authority's Claims Administrator as soon as possible all events meeting any of the criteria identified below, without regard to liability:
 - a. Claims¹ in which the ultimate net loss is estimated to exceed 25% of the Member Agency's retained limit.
 - b. Claims¹ falling within any of the following classifications,:
 - i. Class action suits.
 - ii. Law enforcement actions alleging excess use of force or wrongful conviction.
 - iii. Claims involving allegations of harassment, including but not limited to sexual, employment-based or third-party.
 - iv. Sexual misconduct or molestation – including allegations of assault, misconduct, rape and related offenses.
 - v. Fatalities.
 - vi. Spinal cord injuries resulting in any degree of paraplegia or quadriplegia.
 - vii. Nerve damage injuries resulting in paralysis or loss of sensation.
 - viii. Brain damage claims including; but not limited to, closed head injuries, permanent disorientation, behavior disorder, personality change, seizure, motor deficit or other cognitive disorders.
 - ix. Burns – Third degree burns involving 10% of the body, or second degree burns involving 30% of the body.
 - x. Amputation – complete or partial.
 - xi. Impairment of vision or hearing – 50% or greater.
 - xii. Multiple injuries arising out of one occurrence, including but not limited to; massive internal injuries or multiple fractures involving more than one claimant.
 - xiii. Severe disfigurement.
 - xiv. Long term hospitalization (30 days or more).
 - xv. Multiple claims arising out of the same occurrence in which the aggregate ultimate net loss is estimated to exceed 25% of the Member Agency's retained limit.
 - xvi. Any claim with an assigned trial date in the next 60 days that has not been otherwise reported.
 - c. Lawsuits or writs involving employment practices liability.
 - d. Demands in excess of \$250,000 arising out of any of the following settings:
 - i. Statutory demand;
 - ii. Post closed discovery (not expert) demand;
 - iii. Mandatory Settlement Conference demand;
 - iv. Mediation demand; or
 - v. Arbitration demand.
2. Member Agencies will ensure that the initial report provided to the Claims Administrator contains a brief description of what occurred, along with all available/relevant documents (e.g., claim, investigative reports, photos, medical reports, etc.) and a reserve recommendation.

Member Agencies will provide the initial report and all future reports to the Authority's Claims Administrator:

George Hills Company
P.O. Box 278
Rancho Cordova, CA 95741
Phone: (855) 442-2357
Attention: Ben Oram / David Trautz
Ben.Oram@georgehills.com / David.Trautz@georgehills.com
(916) 269-4108 / (747) 282-2810

¹ See page 1 of this policy – the definition of “claim” includes occurrences, claims, and lawsuits.

Once a reported claim is litigated, Member Agencies will promptly advise the Claims Administrator of legal counsel selection and forward a copy of the lawsuit along with any additional relevant documents available that were not provided with the initial report.

3. Member Agencies will ensure that assigned legal counsel provides the Claims Administrator with a case analysis report (“CAR” – sample attached) or equivalent as soon as reasonably possible after receipt of the lawsuit and status reports every ninety days thereafter or when an action occurs that could change the value of a lawsuit, whichever occurs first. Further, Member Agencies will ensure that status reports are complete and contain sufficient information for the Claims Administrator to properly evaluate the lawsuit and keep the Claims Committee informed of key developments that may require its action. If Member Agencies fail to comply with these requirements, the Claims Administrator will promptly alert the Claims Committee and may request intervention.

V. Coverage Determinations

The Claims Administrator will promptly evaluate all reported claims to determine whether coverage is available under the Authority's MOC.

If this review reveals a potential coverage issue(s), the Claims Administrator will send the affected Member Agency a partial disclaimer of uncovered damages and provide a copy to the Program Administrator. Upon further review of claim details, the Claims Administrator will request Claims Committee approval to issue a reservation of rights letter that clearly states the basis and justification for the finding; a copy of the letter will be provided to the Program Administrator and each Claims Committee Member. The Claims Chair has Authority to approve the issuance of a Reservation of Rights if circumstances dictate that the Claims Committee may not be able to approve. Any Reservations of Rights approved by the Claims Chair will be presented to the Claims Committee for ratification at the next Claims Committee meeting. The Claims Committee, in turn, will apprise the Board of Directors of all reservation of rights letters issued to Member Agencies and will provide regular status updates until matters resolve. All denials of coverage must be approved by the Authority.

Member Agencies can dispute a reservation of rights letter by contacting the Authority's Board President and requesting that an item be placed on the next available Board of Directors meeting agenda to discuss the matter. In the event of a conflict (i.e., the Board President's Member Agency

is disputing a reservation of rights letter), the Vice President will assume the Board President's responsibilities.

Upon review of claim details, if coverage is not clear and the Claims Administrator cannot make a coverage determination, the Claims Administrator will present the claim to the Claims Committee for review and potential approval of a coverage opinion. Further, if a Member disputes ACCEL's coverage, the Claims Committee or Claims Committee Chair may authorize a coverage opinion. When a coverage opinion is solicited by ACCEL, ACCEL's Claims Committee will review the opinion and may authorize sharing with the affected Member. Coverage opinions will not be shared with the Member without the prior approval from the Claims Committee or Claims Committee Chair.

VI. Duty to Disclose a Potential Conflict of Interest

Members have a duty to disclose a conflict of interest if a conflict of interest or potential conflict exists.

VII. Settlement Authority Process

As stated in the ACCEL Bylaws Article XI Settlement of Claims:

All claims settlement recommendations shall be presented by the Claims Committee to the Board of Directors for its approval prior to final settlement.

ACCEL's Board will review claims covered by ACCEL's Memorandum of Coverage and take the following steps to review and grant authority to resolve claims:

1. The TPA will review claims for exposure to ACCEL's shared risk layer.
2. Claims which are likely to exceed the member retention and require ACCEL funds to resolve will be brought to the Claims Committee for review.
3. For claims in which an ACCEL reserve is being requested, the claim shall be brought to ACCEL's Board for review and action. If a reserve is approved, the reserve will be posted on ACCEL's loss run and indicates ACCEL's level of approval to resolve the claim.
4. If an opportunity to resolve a claim arises, and the amount is less than the approved reserve, ACCEL authorizes the following levels of authority. If the claim involves the Chair's own city, the President will have authority to approve.
 - a. \$1,000,000 to \$2,000,000 - Claims Committee Chair or the Claims Committee in an event there is a conflict situation.
 - b. \$2,000,000 to \$5,000,000 - Claims Committee
 - c. \$5,000,000 to Authority's Retained Limit - ACCEL Board
5. If a claim resolution exceeds the Board approved reserve, the claim must be brought back to the Board for further discussion and potential action.
6. Any claim involving ACCEL's funds requires a final report to the Board, informing the Board of the claim resolution and financial impact to ACCEL.
7. Claims payments will be processed in accordance with ACCEL's Accounting Guide.

Confirmation of Authority: Prior to attending a settlement conference, the Claims Administrator should provide written notification to the Member Agency and to the Claims Committee of the settlement plan including the details of the mediation or settlement conference, if applicable, the reserves set by ACCEL, confirmation on the potential target settlement value, and where applicable, confirmation that the remainder of the Member Agency SIR may be tendered in the course of finding a resolution.

VIII. Claims Reimbursement Requests

For claims that fall under the Policy Year 2015-16 and after, the Authority's MOC allows for a Member Agency to seek reimbursement from the Authority.

When seeking reimbursement Member Agencies are required to provide the Authority's Claims Administrator a summary as well as all invoices and documentation to substantiate the exhaustion of the Member SIR and the amount requested in the claim reimbursement.

The statement above does not change any agreement between the Authority and a Member Agency which allows the Member Agency (such as a flat fee agreement) to provide a summary report of the amount requested as part of the claim reimbursement along with a signed affidavit that all bills have been reviewed for accuracy, appropriateness, and reasonableness.

The Authority will reimburse Members or credit their Self-Insured Retentions (SIRs) for reasonable attorney fees and necessary litigation expenses incurred while managing, investigating, defending or litigating covered claims.

ACCEL Members are required to notify the Claims and Program Administrators regarding any claim in which attorney rates are in excess of \$400/hour. The Program Administrators will agendaize the claim for the Claims Committee to review rates for reasonableness. The Committee may take action or provide direction.

To process claims reimbursement requests the following will occur:

- 1) Once prior written authorization is given to settle an excess case, or a judgment puts it into the Authority or other excess layers, the Member or its administrator must submit:
 - a) Copies of all settlement documents, including releases, annuity forms (if structured), and properly filed dismissals.
 - b) Copies of all itemized bills from defense attorneys, claims administrators, expert witnesses and any other cost bills. (*see attached sample billing procedures*)
 - c) Copies of valid evidence of payment properly matched to the bills and settlement documents. Valid evidence of payment can take the form of check copies, data processing runs, Member warrant registers, department payment records, TPA claim payment screen printout, identifying the following:
 - a. Check or warrant number
 - b. Issue date
 - c. Payee
 - d. Paid amount
- 2) A cover letter requesting reimbursement of the net amount after deducting the SIR, must be submitted with the above documentation.
- 3) Once the figures are reconciled, a check request will be made to reimburse the Member in the appropriate amount. When issued this check will be mailed to the Member contact person, with a copy to the claims administrator (if applicable).

- 4) If reimbursement has been approved for an occurrence that remains open, any additional reimbursements for defense costs and fees will be processed
Option 1: in batches (max 2 annual).
Option 2: as further matters related to the occurrence are resolved.
Option 3: when bills exceed \$500,000.
- 5) If a Member requests an advancement on a reimbursement to prefund a large payment, the Claims Committee Chair has the authority to approve the prefunding request. If the claim involves the Chair's own city, the President will have authority to approve.
- 6) If special circumstances arise, which require exceptions or interpretation, the Program Administrators will agendaize for Committee or Board consideration.

IX. Claims Audits

All Member Agencies are required to complete an annual claims audit. Such audits will be conducted by a qualified outside audit firm recommended by the Claims Committee and approved by the Authority. The cost of the audits will be shared equally by Member Agencies.

The Claims Auditor will issue a written report summarizing the findings and recommendations for each Member Agency. This report will be presented and approved by the Authority's Board of Directors at a regular Board meeting. The Authority may require a Member Agency to formally respond to an audit finding contained in the report. A Member Agency shall submit its response to the Authority within sixty days of the request.

X. Attachments

- 1) Sample CAR and Budget Form
- 2) Sample Billing Procedures

**APPENDIX 1
CASE ANALYSIS REPORT**

Caption of Lawsuit: _____

Court: _____

Court Case Number: _____

Date Suit Filed: _____

Date of Service: _____

Fast Track? ____ Yes ____ No

Excess TPA Claim Number: _____

Date of Loss: _____

Primary TPA Claim Number: _____

I. PARTIES

A. Plaintiffs:

B. City and City-Related Defendants:

C. Third-Party and Other Defendants:

II. TRIAL DATE AND OTHER IMPORTANT DATES

III. JURISDICTION AND EVALUATION

IV. TRIAL JUDGE AND EVALUATION

V. EVALUATION OF COUNSEL

A. Plaintiff's Attorney's Name and Evaluation:

B. City's Defense Attorney's Name:

C. Co-Defendants' Attorneys' Names and Evaluations:

VI. STATEMENT OF FACTS

VII. INJURIES

VIII. SPECIAL DAMAGES

A. Medical Expenses:

1. Past:

2. Future:

B. Loss of Earnings:

1. Past:

2. Future:

C. Other (specify);

IX. LIABILITY ALLEGATIONS

- A. Plaintiff's Contentions:**
- B. Defenses:**
 - 1. Legal Defenses:**
 - 2. Factual Defenses:**
- C. Plaintiff's Expert Witnesses and Opinions:**
- D. Defense Expert Witnesses and Opinions:**

X. VERDICT EXPOSURE

- A. Chances of Defense Verdict:**
[Note: a percentage number shall be provided.]
- B. Gross Verdict Range as to all Defendants:**
- C. Potential Offsets and Credits:**
- D. Net Verdict Range to City after Offsets, Credits and Allocation of Fault:**
- E. Plaintiff's Attorney's Fees (if applicable):**
- F. Punitive Damages (if applicable):**

XI. SETTLEMENT HISTORY

- A. Last Demand:**
- B. Last Offer:**
- C. History of Settlement Negotiations:**

XII. RECOMMENDATIONS OF COUNSEL

- A. Reasonable Settlement Value:**
- B. Proposed Litigation Strategy:**
- C. Other Recommendations:**

XII. BUDGET

- A. Fees and Costs Invoiced to Client as of the Date of this Report:**
- B. Fees and Costs from this Date to Trial:**
- C. Fees and Costs of Trial:**
- D. Initial Case Budget:**
- E. Experts' Fees and Costs to Date:**

F. Experts' Fees and Costs through Trial:

G. Litigation Budget Summary Form (see Attachment 1):

XIII. MISCELLANEOUS

A. Does Complaint Conform to the Tort Claim Filed?

(If not, specify differences)

B. Is Indemnification, Subrogation, or Contribution Available?

(If so, specify by whom, and in what amounts)

Attachment

1 – Litigation Budget Summary Form

ATTACHMENT 1 -- LITIGATION BUDGET SUMMARY FORM

Name of Attorney: _____ Case Name: _____

Est Hrs / Cost

1. **Preliminary Activity**
(Review File, Interview Witnesses, Case Analysis, Litigation Plan, Budget)
2. **Initial Pleadings**
(Answer, Cross-Complaint, Demurrer)
3. **Fact Finding – Information Gathering**
(Document Review, Research, Strategy Development, Sub Rosa, Travel)
4. **Discovery**
(Interrogatories, Depositions [by individual], Other Requests)
5. **Law & Motion and Pre-Trial Activity**
(Motions [specify], Arbitrations, Settlement Conferences, Mediations, Court Hearings, Pre-Trial Reports)
6. **Experts**
(Identify Each Expert [if known] and Area of Expertise)
7. **Documentation – Administrative Support**
(Correspondence, Copies, Faxes, Other Costs)
8. **Trial Activity**
(Trial Preparation, Trial Attendance, Briefings, Exhibits, Post-Trial Report)

TOTAL _____

BUDGET SUMMARY:

1. Preliminary Activity	\$
2. Initial Pleadings	\$
3. Fact Finding-Information Gathering	\$
4. Discovery	\$
5. Law & Motion and Pre-Trial Activity	\$
6. Experts	\$
7. Documentation – Administrative Support	\$
8. Trial Activity	\$

TOTAL

\$ _____

SUBMITTED BY:

Defense Counsel:

_____ Date: _____

Signature

Printed Name

SAMPLE DEFENSE COUNSEL GUIDELINES – Billing Procedures

BILLING PROCEDURES

All invoices are to be submitted on a [monthly/quarterly] basis and directed to [name of person or position to whom invoices should be sent]. Billings that do not comply with the billing guidelines will not be paid. Payment of any bill by the [entity name and/or the TPA] does not constitute a waiver of the [entity name's] right to question, dispute, obtain reimbursement, compromise, or request repayment or future credit, for any bill or invoice previously paid.

Invoices for counsel fees and expenses should be submitted [monthly/quarterly], within thirty (30) days of the end of the billing period. Final invoices should be submitted within thirty (30) days from receipt of a filed Dismissal. Defense Counsel is responsible for obtaining all outstanding invoices from outside vendors, including experts, before submitting the final bill. Receipts must be submitted for all travel and other expenses.

Firm staffing on all cases should be as limited as possible. Absent prior approval, the [entity name] will not pay for more than one (1) attorney performing the same task. For example, the [entity name] will not pay for two (2) or more attorneys to attend the same deposition. Work should be assigned to those individuals who are most appropriate for the task in terms of their competency and experience.

There should be no more than two (2) attorneys and one (1) paralegal performing work on a case at any given time. Other firm personnel may occasionally have to work on a case due to job departures, vacations, illnesses, schedule conflicts, etc., but this is the exception, not the rule. [Entity name] will not pay for “training” time for new attorneys or “learning” time or “orientation” time as new billers become involved in a matter and are learning the facts and issues. If a firm has summer associates, their time should not be billed to a case without first being approved by the [entity name and/or TPA]

A. Invoices

Invoices should accurately itemize, in detail, all work performed on a matter. Each invoice must include the following:

- Law firm name and address
- Date of the bill
- Law firm tax identification number
- The TPA and/or entity claim number
- Plaintiff(s) name(s)
- Each billing entry must state the name or initials of the timekeeper who performed the work, the date the work was performed, the hours billed, a detailed description of the services performed, and the total amount billed for that entry
- Attorneys and paralegals should bill actual time spent in increments, no greater than 1/10th of an hour for each entry
- Summarize at the end of the bill, the number of hours for each specific biller

- Summarize at the end of the bill the totals for fees, costs, and experts
- Narrative or block/bundled billing is not permitted
- Final bills should be clearly marked
- Invoices must reflect activity for only one (1) case
- Billing entries should be listed chronologically in order of occurrence and not sub-divided by individual or task
- If a number of different tasks are undertaken in one day, each task must be separately identified with a specified time for performing that task, e.g., “telephone conference with John Doe (.30); Attend conference with Jane Doe (1.20), etc.”
- Entries regarding telephone conferences must specify the participants and the subject matter discussed

Vague descriptions such as “work on file,” “telephone call,” “conference,” and “research,” without further explanation, are not acceptable.

Vendor invoices (e.g. experts, mediators, photocopy services, court reporters, and others) in an amount up to [insert amount here] dollars (\$XXXX) per case should be paid by the law firm and included with the monthly attorney billing. Defense Counsel must review and approve all vendor invoices.

B. Maximum Allowable Charges and Travel

The following guidelines are provided regarding maximum allowable charges:

- The [entity name] will only pay the actual cost incurred for reasonable expenses without any markups.
- A firm may conduct necessary and appropriate research up to five (5) hours per case without prior approval by the [entity name and/or its TPA].
- Photocopy costs should not exceed ten cents (\$0.10) per page. Firms are expected to limit the making of photocopies and, wherever cost effective, to use the resources of designated copy services. Billing entries for photocopies must provide the number of copies made, the per page rate, and the total amount billed.
- Mileage should be billed at the applicable Federal rate at the time of travel. The invoice should state the number of miles actually driven.
- Telephone and Fax: Actual long distance charges only. No charges for an incoming fax and no per-page fax charge.
- Air travel is limited to coach or economy rate. Receipts for airfare should allow a reviewer to identify the fare as economy/coach class.
- Rental cars are acceptable only if such vehicles are the most economical means of accomplishing necessary business. Reimbursement is limited to the mid-size class.
- Incidentals, such as movies, alcohol, and entertainment are not allowed.
- Travel time shall be pro-rated if the travel includes time spent on non-[entity name] business.

C. Disallowed Charges

In addition to items listed above in sections A and B, the [entity name] will not reimburse for the following:

- Local telephone calls and all cellular phone charges.
- Routine postage, such as the U.S. Postal Service rates for letters. Any necessary extraordinary postage charges (such as certified mail, overnight service, or oversized packages) must be delineated on the bill with an explanation of the nature and purpose of the charge. Any postage charges that are not explained will not be reimbursed.
- File opening, file organization, or other administrative charges.
- Interoffice conferences between members of the firm, including assigning files or tasks to members of the firm.
- Case administration (e.g. reviewing status of assignments given to associates and paralegals; directing associates, paralegals, or secretaries; preparing or reviewing bills).
- Clerical tasks (e.g. transcription, pulling files, photocopying documents, arranging for copying, labeling documents for production, communication with court clerks, updating master case caption, preparing proofs of service, indexing pleadings, faxing).
- Meals, except in conjunction with out-of-town travel (alcohol will not be reimbursed in conjunction with any travel).
- Routine legal research, including issues considered to be common knowledge among reasonably experienced counsel in the local jurisdiction.
- All work customarily performed by secretaries and other administrative personnel including but not limited to, photocopying, date stamping documents, scanning documents, transcription, retrieving files, indexing pleadings, updating case captions, making travel arrangements, calendaring, and preparing bills/invoices.
- Subscription services (e.g. Westlaw, Lexis-Nexis, or other legal database charge).
- Responding to requests from [entity name and/or TPA] and/or their auditors relating to case file management and/or billing issues.



Item No. C.1.b
Claims Committee
February 29, 2024

LITIGATION UPDATE

ISSUE: At today's meeting, Ben Oram, ACCEL Litigation Manager will provide another update because the Committee requested these to be provided quarterly.

RECOMMENDATION: This is an information item, no action is necessary.

FISCAL IMPACT: No financial impact is expected.

BACKGROUND: The Program Administrators discussed services with ACCEL's Claims Chair, Tracey Matthews. As a result of that discussion, ACCEL requested that George Hills provide a quarterly update.

ACCEL has not previously received litigation updates as part of our litigation management services, but has received updates at strategic planning meetings.

The Litigation Update documents are posted on the ACCEL Website in the Members' Only section.

ATTACHMENT: Litigation Update from George Hills.

DANGEROUS CONDITION

Maria Ruiz Perez et al. v. Oakdale Irrigation District

Docket: F084621 (Fifth Appellate District)

Opinion Date: January 8, 2024

Applicable Law

This case implicates **Gov. Code section 831.8 (b)**, known as “canal immunity,” which provides immunity to government entities for injuries caused by the condition of canals, conduits, or drains when the injured person was using the property for any purpose other than that intended by the government entity. Specifically, section 831.8 (b) provides that canal immunity applies “*if at the time of the injury the person injured was using the property for any purpose other than that for which the district of state intended it to be used.*”

Facts

Plaintiff and her minor children sued the Oakdale Irrigation District (OID) following the deaths of Hector and Giselle Evangelista (Plaintiff’s husband and daughter), who drowned after their vehicle overturned and landed in a drain on August 7, 2018. The complaint alleged that the vehicle, driven by 16-year-old Giselle who did not possess a driver’s license, crashed and submerged in irrigation water within the Crane Drain on Patterson Road north of Oakdale, a structure alleged to be in a dangerous condition due to OID’s ownership and maintenance practices. OID argued it was immune from liability under section 831.8, as the drain and adjacent roadway where the accident occurred were neither designed nor maintained by it, and the victims were not ‘using’ the property as intended.

Analysis & Holding

The court affirmed the summary judgment in favor of OID, rejecting plaintiffs’ argument that canal immunity should only apply if the injured party *volitionally* used the property. The court interpreted the statute to provide immunity for all injuries not occurring during the use of the property as intended by the government, regardless of whether the interaction with the property was volitional. The court emphasized the legislature’s intent to limit government liability to *foreseeable uses* of the property, noting that both intentional and unintentional interactions with the property, if outside the intended use, are subject to immunity. The decision highlights the broad protection provided by section 831.8(b) against liability for injuries related to the condition of water distribution infrastructure, so long as the injured party was *not* using the property for its *intended* governmental purpose at the time of the injury.

Key points include:

1. **Statutory Provision:** Gov. Code § 831.8, subdivision (b) provides immunity to government entities for injuries caused by the condition of canals, conduits, or drains, except when the injured person was using the property for its intended purpose. This is known as “canal immunity.”

2. **Interpretation of Immunity:** The appellate court clarified that the statute's immunity applies broadly to all injuries not arising while the property was used as intended by the government. This interpretation encompasses both intentional and unintentional interactions with the property, focusing on whether the interaction was anticipated or intended by the government entity.
3. **Legislative Intent - Foreseeability vs. Assumption of Risk:** The court determined that the legislative intent behind including the clause at the end of subdivision (b) was concerned with the foreseeability of the injury to the government, rather than the injured person's assumption of responsibility. This suggests that section 831.8(b)'s immunity applies based on how foreseeable the use of the property was to the government, regardless of whether the interaction was intentional.
4. **California Law Revision Commission (CLRC) Recommendations:** The CLRC's recommendations highlight that a "dangerous condition" of public property should be defined based on the foreseeability of the property's use by persons exercising due care. This supports the interpretation that immunity should apply to uses of the property that are not intended or foreseen by the government, which could include both intentional and unintentional uses.

VICARIOUS LIABILITY / SCOPE OF EMPLOYMENT

Adams v. California Dept. of Corrections and Rehabilitation

Docket: G062782 (Fourth Appellate District, Third Div.)

Opinion Date: January 9, 2024

Applicable Law

- Government Code section **815.2 (a)** provides for public entity liability “for injury proximately caused by an act or omission or an employee of the public entity within the scope of his employment...”

Facts

In the early hours of August 1, 2018, Gwendolyn Adams was pursued in a high-speed chase by Michael William Becker, a peace officer employed by the California Department of Corrections and Rehabilitation (CDCR). Becker suspected Adams of wrongdoing, although his suspicions were unfounded. The pursuit resulted in a catastrophic accident that caused severe injuries, and ultimately the death of Adams's son. Plaintiff filed a lawsuit against the CDCR, alleging negligence causing wrongful death, assault, and battery, and violation of the Tom Bane Civil Rights Act.

Central to the parties' dispute was whether—at the time of Becker's early morning pursuit of Plaintiff—he was engaged in law enforcement functions as an “outgrowth” of his employment or whether, as CDCR argues, he engaged for purely personal reasons in a “road rage” incident. The CDCR cited evidence that Becker's employment did *not* include typical law enforcement functions inside the prison “let alone outside its walls,” because he was assigned to “culinary duty.” The CDCR relied on the workplace “coming and going” exclusion rule of *respondeat superior* liability and argued that Becker was acting as a private citizen.

The CDCR sought summary judgment, arguing that Becker was not acting within the scope of his employment during the pursuit. The trial court agreed and entered judgment in favor of the CDCR, followed by Plaintiff's appeal.

Analysis & Holding

On appeal, the court reversed and remanded the case. It found that whether Becker was acting within the scope of his employment when he pursued Plaintiff was a question of fact that should be decided by a jury. The court scrutinized the factual circumstances around Becker's actions, including his decision to pursue plaintiffs based on his role as a peace officer and the implications of his uniform and presence of a firearm. The court also noted that Becker's actions may have been influenced by his role as a peace officer, and it was not clear whether he was acting as a private citizen or a law enforcement officer during the pursuit. The court emphasized that determining whether an employee's actions fall within the scope of employment usually fall to a jury given the potential for various reasonable interpretations of the events. The court also highlighted that the "coming and going" rule and associated statutes defining a peace officer's scope did not conclusively remove Becker's actions from his scope of employment. Therefore, the trial court erred in granting summary judgment to the CDCR.

WORKERS' COMP. EXCLUSIVITY RULE • SUITS BETWEEN PUBLIC EMPLOYEES IN DIFFERENT DEPTS.

Matthew Vann v. City and County of San Francisco et al.

Docket: A165231 (First Appellate District, Second Div.)

Opinion Date: December 12, 2023

Applicable Law

This case centers on the exclusivity provisions of the Workers' Compensation Act (**Labor Code, § 3200 et seq.**), which stipulates that workers' compensation is often the sole remedy for employees injured in the course of their employment. The exclusivity rule also extends to injuries caused by co-employees acting within the scope of their employment.

Facts

Plaintiff Matthew Vann, a San Francisco Fire Department firefighter, was injured during an emergency response when a bus, driven by SFMTA driver Louis Yu, ran over a firehose, causing it to detach and strike Plaintiff. Plaintiff sustained severe injuries, including a traumatic brain injury. He was receiving workers' compensation benefits for his injuries but also sought to pursue additional claims against the City and Yu. Plaintiff argued that SFMTA and SFFD are separate entities, suggesting that Yu was not a co-employee.

Analysis & Holding

The trial court sustained a demurrer by the City and Yu, dismissing Plaintiff's lawsuit on the basis of the exclusivity provisions of the Workers' Compensation Act. The appellate court affirmed this decision, ruling that both the City and Yu (as a co-employee) were protected under the exclusivity rule, which bars additional civil claims for work-related injuries when workers' compensation applies. The court rejected Plaintiff's argument that different departments within the City could be considered separate legal entities for the purposes of circumventing the exclusivity rule. In its opinion, the court discussed *Walker v. City and County of San Francisco* in which a firefighter's death resulted from a collision between a fire truck and a streetcar, both operated by city employees. Similarly, in *Colombo v. State of California*, an officer's injury led to a claim against the State and its Department of Transportation. In both cases, the courts affirmed workers' compensation's exclusivity, underscoring that different departments are part of the same government entity.

**EXCESS LIABILITY COVERAGE:
'WILFULL ACTS' UNDER INSURANCE CODE § 533 & LABOR CODE 1102.5**

City of Whittier v. Everest National Insurance Company

Docket: B321450 (Second Appellate District, First Division)

Filed: December 26, 2023(certified for publication)

Facts

On March 3, 2015, six police officers sued the City of Whittier under Labor Code section 1102.5 alleging they were retaliated against for refusing to participate in an unlawful arrest and citation quota.

The City notified its excess liability insurers, Everest National Insurance Company (Everest) and Starr Indemnity & Liability Company (Starr), about the possibility of a multi-million-dollar judgment implicating their policies, which provided coverage of employment practices liability (EPL) of \$10 million per “wrongful act” in excess of a retained limit of \$1 million. The underlying lawsuit filed by the City’s officers was settled for \$3 million on 12/24/19. The City tendered the settlement to Everest and Starr, who then denied coverage based on CA Insurance Code 533. Everest and Starr moved for summary judgment, arguing that because the officers had alleged that the City had engaged in intentional conduct, indemnification was barred by Insurance Code section 533, which disallows coverage for “willful act[s].” The trial court ruled in favor of the insurers, whereupon the City appealed. In addition, Starr contended that the settlement did not constitute liability for damages as required by the insuring agreement in its policies.

Analysis & Holding

The court of appeal overturned the trial court’s ruling, finding that Insurance Code section 533, under which “[a]n insurer is not liable for a loss caused by the willful act of the insured,” does not *always* bar indemnification for whistleblower claims made under Labor Code section 1102.5 because “not all Labor Code section 1102.5 claims involve necessarily willful conduct.” Instead, the court explained, “some involve conduct more akin to negligence.” The court’s decision rested on two primary justifications:

- *Insurance Code § 533* - First, the court explained that Insurance Code section 533 bars indemnification in two contexts. The most common is where the insured engages in a “willful act,” meaning, “an act deliberately done for the express purpose of causing damage or intentionally performed with knowledge that damage is highly probable or substantially certain to result.” The other, less common, context arises when the insured seeks coverage for “an intentional, wrongful act that is inherently and necessarily harmful,” regardless of “whether or not the insured subjectively intended the harm.”
- *Labor Code § 1102.5* – Second, the court determined that not every violation of Labor Code section 1102.5 necessarily involves a “willful act.” In fact, an employer could be found liable under Labor Code section 1102.5 “despite making concerted and reasonable efforts to avoid violating the law.” For example, an employer could terminate an employee for refusing to participate in a company policy that the employer reasonably believes is legal. If this terminated employee later brought a whistleblower lawsuit and a reviewing court then found the policy illegal, the employer would still be liable under Labor Code section 1102.5, regardless of its subjective good intent.

Applying these principles, the Court of Appeal held that the City's conduct was "closer to negligence than intentional misconduct" because the City "intended the act—the adverse employment action—but not the consequence—a violation of the employee's rights under Labor Code section 1102.5." This is possible because these "rights do not become clear until a court has decided the legality of the conduct in which the employee refused to participate." Therefore, because the policy complained of by the officers was not so obviously illegal that the City's belief it was following the law was unreasonable, the city could not be said to have "willfully acted to violate the law. Insurance Code section 533 would not bar indemnification because the police officers' complaint alleged a theory of recovery that did not require proof of the City's "willful conduct."

Notwithstanding the Court of Appeal's reversal of the trial court's decision based on Insurance Code section 533, in the unpublished portion of its decision, the court found that the settlement of the officers' lawsuit did not constitute "damages" as required by the insuring agreement in the Starr policies.