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Sleeping Giants: Defamation Claims and "Personal Injury" Coverage

By Russell B. Pierce, Jr., Esq.

On occasion, a complaint triggering defense coverage under standard commercial general liability or homeowners policies may also include a claim for "defamation." Unless the defamation claim is the main feature of the lawsuit, it is also not uncommon to see defamation claims pleaded as "tag-along" claims, usually appearing near the end of the complaint. Just as often, defamation claims appear in this fashion in cases primarily focused on generally uncovered events like business disputes, breaches of contract, or other kinds of "interference" torts. The defamation claim may also be pled with a series of related torts, such as "invasion of privacy," the tort of "false light," the tort of "highly offensive" publicity, the free-standing "infliction of emotional distress" claims, or even a claim for tortious interference with advantageous economic relations. What all of these defamation and companion tort claims have in common, is that the conduct the plaintiff claims caused an injury, is *speech* – written or spoken words.

Since each of these torts involve speech, each of them forklift into the case a heavy and complex cargo load of First Amendment law and related statutory law, all to be applied or analyzed in the context of these unique speech-based torts. The First Amendment of the U.S. Constitution protects against laws "abridging the freedom of speech." Because defamation cases, and any related speech-based claims, potentially impose liability on a person by virtue of the person's speech, logically this network of First Amendment principles will be brought into play. The network of principles has been expounded upon and developed since the founding of the nation, and continues to undergo reaffirmation and further evaluation with nearly every term of the Court. State courts are bound by the Constitution to apply these federal constitutional principles to state tort claims, like defamation.

Hence, what often begins as a "tag-along" claim to other more central covered or uncovered occurrences in a complaint, turns into a force of its own: we have seen the seemingly innocuous defamation claim open up the case to a unique and potentially complex mix of law involving federal constitutional case law and Maine statutes. Some statutes, like Maine's so-called "anti-SLAPP" statute, even have the potential to "take over" a case by delaying all discovery and thrusting an interlocutory appeal into the matter, at the expense of the parties turning to the main crux of the lawsuit. Cases potentially triggering the "anti-SLAPP" statute are those where the complained-of "speech" is speech directed to governmental agents or agencies (e.g., police officers, local municipal officials, planning board members, city councilors, etc.). A recent example here in State court, in a matter still pending, involved a business dispute focused

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primarily on breach of joint venture arrangements and "promissory estoppel" claims – business disputes not likely to trigger any insurance coverage. But there was a makeweight "defamation" claim thrown in. The defamation claim was based on somewhat tangential statements the defendant had made to State investigators, during an investigation that happened to follow an alleged unraveling of the parties' business dealings. Ultimately, the defamation claim was dropped voluntarily by the plaintiff, mid-way through the case, because an anti-SLAPP interlocutory appeal to the Maine Law Court had threatened to postpone resolution of the entire rest of the case for at least another year.

On the defense side of the issues, a defamation claim raises other concerns, not the least of which is a set of unique insurance coverage considerations. In many standard homeowners insurance policies, "personal injury" coverage will be provided as an additional coverage, often by separate endorsement such as that provided by ISO form HO 24 82 04 02. In turn, in typical commercial general liability policies, the coverage is provided under the "personal and advertising injury" coverage forms. In both cases (CGL and homeowners) it is important to note that the "personal injury" coverage is treated separately from "bodily injury" coverage, and the two are not the same. This type of injury – "personal injury" – is defined separately from bodily injury, and in both CGL and homeowners policies consists of injury arising out of "oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." Personal injury can also arise out of claims such as false arrest or malicious prosecution, among the list of other specific offenses in this part of the insurance policy, including "oral or written publication of material that violates a person's right of privacy."

In this definition, "slander" means spoken defamation; and "libel" means written or printed defamation. It is not necessary that the person suffer bodily injury as a result of the speech-based offense, in order to trigger coverage. Although consequential bodily injury claims can be subsumed in or part of defamation injury (usually at least in the form of emotional distress) there does not need to be any bodily injury pled or claimed in order for the "personal injury" coverage to be otherwise triggered. Further, the idea of "publication" under the definition of the offense in issue, is the idea that the defendant merely have spoken or written the defamatory words to at least one other person (someone other than the plaintiff) to communicate the slander or libel. No defamation claim requires "publication" in the sense of printed publication, or in the sense of open broadcast on television or broad circulation in the newspaper. (There are related speech-based torts – like the tort of "highly offensive" publicity – which do, however, require widespread publicity as an essential element.) In most lawsuits the defamation claim indeed takes the form of much more limited types of "publication," like e-mail correspondence, letters, social media publication to limited groups, or just oral conversations – even private conversations.

Often one of the most difficult aspects of a defamation claim to the defense, whether it is based on spoken "slander" or written "libel," is how damages exposure is evaluated. "Personal injury" in this form is not bodily injury, so there are rarely if ever any medicals associated with the damages to reputation and/or "mental anguish and suffering" that a plaintiff seeks to recover. Sometimes there is an identifiable loss of money, especially in cases where the defamation claim is based on publication to a third person who might have conferred an economic benefit of some kind on the plaintiff. But just as often, the defamation claim rests on damage to reputation, which, in general, is the kind of damage that the law recognizes and provides for in defamation recovery. Damage to reputation arising out of a defamation claim is, by definition, "personal injury" covered under insurance policies, because it is injury "arising out of" the particular offenses involving "oral or written publication of material that slanders or libels a person or organization" under the policy definitions.

Jury verdicts in defamation cases are as wide-ranging and to large degree unpredictable as the variety of cases themselves. What makes them more unpredictable than the usual assessment of "general damages" in a tort case, is that there are often no guidelines for the particular jury hearing a case in the form of any special damages; and even when there are some form of special damages, they could be extremely low or logically bear absolutely no relation to the damage to "reputation" that is the main driver of the plaintiff's claim.

In practice, this jury verdict valuation problem is addressed overall by the more subjective assessments of the plaintiff himself or herself. To evaluate the case exposure, the defense will ask questions like whether the plaintiff is simply "likable" to a jury; whether the plaintiff had a "good reputation" to begin with; and if the plaintiff's reputation was strong in the beginning, whether in theory it has really endured any harm by being subject to disparaging speech. Inevitably, the subjective questions veer to the nature of the speech, too, so that damages start to become "guesstimated" naturally in rela-

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tion to the precise conduct in issue: Was the defamation prolonged, repeated, or relentless? Or was it a brief, one-time mention? What did the listener or the receiver of the message think? Was the speech laced with rhetoric or figurative language that no one really takes seriously, or was the speech conveying a provably false fact about the plaintiff in a way in which that falsity might be believed? The difficulty in valuing the exposure in defamation claims is that there is no objective rule of thumb, no objective measures, and only subjective impressions to guess at an outcome. It seems that every defamation case is "one-of-a-kind," and very rarely can the facts of one case inform the outcome of another.

But if it is any consolation to the defense, because a defamation claim imports "freedom of speech" principles, a defamation claim can often be significantly narrowed before trial, and quite often successfully defeated without a trial (through summary judgment or other dispositive motion). In the end, however, what most often appears at the beginning of the case as a quiet claim "tossed into the mix" of a much more fundamental or paramount dispute between parties, becomes a claim that is more than either party bargained for in the handling of the case through discovery and trial.

For the defense, sometimes the only way to defeat a legitimate defamation claim, if at all, is on summary judgment, relying on all the important principles of the First Amendment. On the other hand, plaintiffs have experienced how a defamation claim will throw the doors of discovery "wide open," intrinsically folding into the case aspects of a plaintiff's personal and public life, and what other people really think about that, in a fashion not always truly intended by the plaintiff when the case began. In either case, "personal injury" insurance coverage is likely triggered if there are CGL or deluxe homeowners policies in place, making defamation and related speech-based claims the potential "sleeping giants" of complex litigation. □

Emergency in the ED: Complying with EMTALA When Patients Refuse Care

By Jonathan W. Brogan, Esq. and Kristina M. Balbo, Esq.

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Jonathan Brogan, assisted by Kristina M. Balbo, recently conducted a seminar at a local hospital regarding the federal Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C.A. § 1395dd. This presentation raised a number of questions regarding some of the thornier issues with respect to hospital responsibility under the statute, particularly in instances in which a patient refuses examination or treatment against medical advice.

EMTALA was enacted by Congress in 1986 as a response to a practice known as "patient dumping," in which hospitals would refuse to provide emergency medical treatment to individuals who were unable to pay for their care, or would transfer patients in unstable medical conditions to public hospitals in an attempt to avoid financial burden. The goal of EMTALA is to ensure that all patients, regardless of their perceived ability or inability to pay, be given consistent emergency medical attention and that emergency medical screenings be administered even-handedly. Under EMTALA, a hospital is obligated to provide these services regardless of an individual's ability to pay and without delaying to inquire about an individual's method of payment or insurance status.

EMTALA applies to all hospitals with emergency departments that participate in the Medicare Program, and it is enforced by the Centers for Medicare and Medicaid Services ("CMS") and the Office of the Inspector General ("OIG") for the U.S. Department of Health and Human Services. Hospitals and individual physicians found in violation of the statute could be subject to civil monetary penalties up to $50,000 (or, in the case of hospitals with fewer than 100 beds, $25,000). In instances of flagrant or repeated conduct, they could also face exclusion from participation in Medicare and state healthcare programs. Individuals may also bring private rights of actions against hospitals, and the nature of recoverable damages will be governed by applicable state law.

EMTALA provides that all individuals who request assistance for a

possible emergency medical condition must, at a minimum, receive an appropriate medical screening by a qualified medical professional ("QMP") and, if needed, receive medical stabilization and an appropriate transfer to a different medical facility.

An emergency medical condition ("EMC") means "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in" placing the health of an individual or, in the case of a pregnant woman, an unborn child in serious jeopardy or serious impairment to bodily functions or serious dysfunction of any bodily organ or part. In the case of a pregnant woman having contractions, an EMC encompasses instances in which there is "inadequate time to effect a safe transfer to another hospital before delivery" or that such a transfer "may pose a threat to the health or safety of the woman or the unborn child." 42 U.S.C. § 1395dd(e)(1).

When a patient requests emergency medical treatment, EMTALA requires that a medical screening procedure beyond initial triage be performed by a QMP. This procedure must be reasonably calculated to identify critical medical conditions that may be afflicting symptomatic patients. The screening does not need to be perfect, and it does not necessarily need to be accurate or successful at identifying medical issues; it simply needs to be administered uniformly among patients, and be comparable to exams offered to other patients presenting similar symptoms. It is important to remember that EMTALA is not intended to be used as a federal malpractice statute, and those plaintiffs whose EMTALA claims are based solely on allegations of professional negligence are unlikely to prevail. Moreover, the inquiry is exclusively related to care in the ED; once a patient is admitted as an inpatient, a hospital's duties and obligations under EMTALA generally cease.

For example, in *Reynolds v MaineGeneral Health*, 218 F.3d 78 (1st Cir. 2000), the estate of deceased patient, William Reynolds, sued MaineGeneral after it allegedly failed to diagnose and treat Mr. Reynolds for a deep vein thrombosis ("DVT") following a motor vehicle accident. Mr. Reynolds arrived at the emergency room with fractures to his leg and toes, and was given a screening for these lower extremity injuries. No inquiry was made into Mr. Reynolds's family history of hypercoagulability, and he was not screened for DVT or given any prophylactic treatment to prevent the formation of blood clots in the ED or at any time during his stay at the hospital. Five days after his discharge from the hospital, Mr. Reynolds died as a result of a massive pulmonary embolism that emanated from a DVT. The court ruled in favor of the hospital, finding that it had no duty to screen for DVT because there were no symptoms of the condition manifest in the ED, and, in fact, the plaintiff acknowledged that it was unlikely that Mr. Reynolds could have developed DVT so soon after the motor vehicle accident.

Why did the court rule in favor of the hospital when this death arguably could have been avoided? EMTALA is not concerned with potential medical negligence; its goal is simply to ensure equal dealings for ED patients, not to ensure that their care meets any professional standards of care. Plaintiff's argument that Mr. Reynolds received disparate treatment because he was not asked about his family history for blood clots was unavailing because the hospital had no general policy that would require medical screening of leg injuries to include such an inquiry. The court considered the fact that Mr. Reynolds was admitted as an inpatient for the EMC of his lower extremity injuries as *prima facie* evidence that the screening requirements were in fact satisfied.

If the goal of EMTALA is to make sure that patients seeking emergency medical treatment are not turned away, what happens where it is the patient, and not the hospital, that wishes to leave before an adequate medical screening can be performed? EMTALA provides that a hospital meets the statutory requirements if it (i) offers an individual further medical examination, treatment, or transfer under EMTALA; (ii) informs him of the risks and benefits of examination, treatment, or transfer; and (iii) the individual nonetheless refuses to consent to such offered care. A hospital must also take all reasonable steps to secure written informed consent of such a refusal from either the individual or a person acting on his behalf.

Patients who leave against medical advice, particularly under circumstances where they leave before they are seen by a QMP or where written informed consent cannot be obtained, pose particular challenges to hospitals trying to meet EMTALA requirements. In these tricky situations, it is vital that hospitals keep detailed and accurate records of the steps they took to comply with EMTALA. In the case where an individual leaves without being seen by anyone, for example, a hospital should:

- Document the fact that the individual was in the ED;
- Retain triage notes or any other records; and
- Document the time it was discovered that the patient left, and any other relevant circumstances surrounding his departure.

These issues become even more complicated when a patient leaving against medical advice may not have the capacity to make such a decision. If a patient is incompetent, then he is incapable of giving his consent to refuse care against medical advice. A failure to screen and treat incompetent patients who attempt to leave the ED could, then, potentially give rise to a violation of EMTALA. It is all too common for hospitals to encounter individuals who cannot give informed consent due to incapacitating physical conditions, mental illness, or drug or alcohol intoxication. Nonetheless, the statute is silent on the issue of competence, and

CMS has not provided any guidance on this point. Few courts have addressed this issue, and the case law that does exist provides little insight into a hospital's obligations under these circumstances.

A California court managed to avoid this prickly situation altogether in *Cavender v. Sutter Lakeside Hosp., Inc.*. 2005 WL 2171714 (N.D. Cal). This case arose from an elderly inpatient's self-discharge from a hospital and the hospital's unsuccessful attempts to convince her to come back. Shortly after Mary Lou Cavender snuck out of the hospital, staff discovered her in a ditch across the street, with a fresh cut to her head. Although a nurse was able to coax Ms. Cavender into the ER to treat her fresh wound, the woman refused further evaluation or treatment. Over the objections of her family, the hospital allowed Ms. Cavender to leave. Plaintiff argued that the hospital violated EMTALA by failing to admit her because she did not have the capacity to refuse medical care. The court ruled in favor of the hospital, noting that Plaintiff was in a Catch-22. It reasoned that if Ms. Cavender was incompetent at the time she returned to the ED, then she was also incompetent at the time of her elopement. This would mean that EMTALA would therefore not apply because she still had inpatient status. Likewise, if she was competent to discharge herself, then she was also competent to refuse examination and treatment against medical advice in the ED. Either way, the hospital could not be found liable for allowing Ms. Cavender to leave.

So what is a hospital to do when EMTALA requirements and a patient's rights to refuse care come to a head? As with everything, the best measure a hospital can take is to ensure that it has developed sound procedures, and that these procedures are being carried out in a consistent and even-handed manner. During medical screenings, it will be important to conduct a mental orientation evaluation if there are any concerns about a patient's capacity. Medical personnel should have a good understanding in advance of what options may be available to them when these issues arise. For example, a hospital should have guidelines as to how to address concerns about a patient that may be a harm to himself or others when a provider is unable to talk the patient into staying, such as notifying an administrator for further guidance or requesting police assistance. ED staff should remain abreast of both involuntary commitment laws and EMTALA, and should be provided with the tools they need to navigate through these challenging situations. Standard forms to help document events in a uniform manner are imperative.

Whatever protocols a hospital puts into place, there are no guarantees that a patient will not come back later and allege an EMTALA violation. A hospital cannot prevent an individual from bringing suit; it must instead protect itself from liability by avoiding violations in the first place. □

RECAP OF 2013 WORKERS' COMPENSATION LEGISLATION

By Kevin M. Gillis

The first session of the 126th Maine Legislature produced a number of proposals in the area of workers' compensation, which was not surprising in the first session after the Democrats regained control of the legislature after two years of being in the minority. However, very few bills in this area were actually enacted. The following is a summary of legislation enacted as well as legislation proposed but not enacted in 2013.

Enacted Legislation

LD 1

This bill, which becomes effective on October 9, 2013, primarily amends various provisions of the Workers' Compensation Act so that those provisions are consistent with the amendments to the statute enacted in 2012, particularly relating to the creation of the Appellate Division of the Workers' Compensation Board in 2012. However, the bill also made some substantive changes to the Act. The legislation restores the eligibility of chiropractors, podiatrists, and psychologists to serve as independent examiners under Section 312, which had inadvertently been removed by prior legislation. Section 218 was also amended, so that the time period for the obligation of employers with 200 or fewer employees to reinstate the injured employee to available and suitable work is extended from 1 year to 2 years from the date of injury.

LD 444-Protection for Employees of Employers without Insurance Coverage

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This legislation, enacted as a Resolve, calls for the Workers' Compensation Board to study possible means of protecting workers who are injured while working for employers which have failed to obtain workers' compensation

coverage. The Board will be studying this issue in 2013, and reporting back to the legislature in 2014. The Board will be considering the possibility of a fund of some type to pay these claims and possible mechanisms to administer the claims.

LD 696 and 761-Agricultural Exemption

These bills revised the exemption for small agricultural businesses from application of the Workers' Compensation Act, by including horse farms in the definition of agriculture, and by updating the size of the agricultural concern, with respect to the maximum number of employees, for eligibility for the agricultural exemption.

LD 949-Offset For Retirement Benefits

The bill amends Section 221 of the Workers' Compensation Act to clarify that the offset for private retirement benefits received is based upon the proportionate contribution made to the retirement plan by the employer at the time of injury relative to all contributions made on behalf of the employee to the same plan. The legislation becomes effective October 9, 2013. Under current law, if retirement benefits are being received from a retirement fund into which more than one of the injured employee's employers has contributed, arguably the entire retirement benefit would be subject to offset. Under this legislation, in this situation, the offset would be limited to the percentage of the retirement benefit reflected by the proportionate contribution to the plan made on behalf of the employee by the employer at the time of injury relative to all contributions on behalf of the employee. This legislation will not have widespread application.

LD 1376-Prescription Drugs

As originally proposed, this legislation would amend Section 206 of the Workers' Compensation Act to provide that employees have the right to select the provider of prescription medication, and then proposed a fee schedule for prescription medication based upon average wholesale price plus a factor. As amended and enacted, the legislation simply provides that employees have the right to select the provider, but does not propose a specific fee schedule. This legislation does not alter present law, because under the statute currently, employees are not required to obtain prescription medication from the provider to which they are directed by the employer, but often do so, and presumably will continue to do so. It should be noted that, after the enactment of this legislation, employers will retain the right to challenge the reasonableness of the costs of medication prescribed to injured employees.

Legislation Proposed but not Enacted

LD 443-Partial Incapacity

This bill would have significantly amended Section 213 of the Act, which applies to partial incapacity benefits, and would have to a great extent reversed changes to Section 213 enacted in 2012. Originally drafted as a concept bill, without specific provisions, the bill was eventually amended to include two key provisions. First, under the bill, for injuries beginning January 1, 2013, the 520 week durational limit on partial incapacity benefits would not apply if the employee after 520 weeks was working and earning 70% or less of the original average weekly wage, regardless of permanent impairment resulting from the injury. Under current law, for these injuries, partial incapacity benefits would terminate after 520 weeks, unless the employee is working and earning 65% or less than the average weekly wage, and unless the permanent impairment from the injury exceeds 18%. Second, the bill proposed an unprecedented standard for entitlement to 100% partial incapacity benefits for unemployed workers, proposing a presumed entitlement to 100% benefits if the employee conducts a work search sufficient for unemployment benefit purposes. Industry analysis concluded that this bill, if enacted, would have significantly increased system costs.

LD 443 was passed by both chambers of the Legislature, but was vetoed by the Governor, and the veto was sustained by the Legislature.

LD 235-Injuries to On-Call Firefighters and Emergency Medical Personnel

As originally proposed, this bill would have provided that injuries to volunteer firefighters or volunteer emergency medical personnel are considered compensable as long as they occur after the call for the emergency is received, regardless of the nature or cause of the injury. As amended, the bill provided a presumption that such injuries are compensable, and expanded the application to include professional firefighters and professional emergency medical personnel. Because of the potential cost increases to municipalities resulting from the legislation, a mandate was attached to the bill, which meant that a two-thirds majority in each chamber was necessary for enactment. Neither chamber passed the bill with the necessary two-thirds majority, so that enactment failed.

LD 1149-Corrections Workers

This bill would have created a presumption that hypertension or cardiovascular disease of corrections workers is compensable. The bill was rejected by the Labor, Commerce, Research and Economic Development ("LCRED") Committee.

LD 1201-Remedy for Abusive Work Environment

As originally drafted, this bill provided a right of action for employees against employers based upon an "abusive work environment." This right of action would have been available even if the employee had developed a mental injury as a result of mental stress from this environment, compensable under the Workers' Compensation Act. As amended, the bill called for the Workers' Compensation Board to study the issue of possible remedies for an abusive work environment, and report back to the Legislature. The bill was passed by both chambers of the Legislature, but was vetoed by the Governor, and the veto was sustained. □

Designation of Retirement Account Beneficiaries: An Integral Part of An Estate Plan

By Kathryn M. Longley-Leahy

While millions of Americans take advantage of tax-deferred savings each year by setting aside a portion of their earned income into various forms of retirement accounts in anticipation of being able to save sufficient funds for retirement, it is important for each retirement account owner to be aware of how those growing retirement account values will be distributed should the account owner die leaving a retirement account balance.

A fundamental component in the preparation or review of a client's estate plan is the coordination of the client's probate assets (i.e. those assets owned individually by the client that will be distributed to named beneficiaries in accordance with the terms of the client's Last Will and Testament) with those non-probate assets (i.e. jointly-owned assets, assets with a transfer on death (TOD) designation) and, most particularly, those assets on which the client has made a specific, contractual beneficiary designation identifying an individual, trust or charity as the "designated beneficiary" to whom some or all of the retirement accounts will be distributed upon the death of the retirement account owner.

Of the non-probate assets, it is those carrying a beneficiary designation that clients frequently overlook or forget to review following life changing events such as death or divorce of a spouse, birth or death of a current or potential retirement account beneficiary, a new job, etc. While certain statutory protections may void reference to an ex-spouse in a Last Will and Testament, in most states, designating a spouse as a retirement account or life insurance beneficiary remains valid notwithstanding a subsequent divorce unless the beneficiary designation is pro-actively changed by the account owner following the divorce. Failing to review the status of beneficiary designations can not only result in unintended consequences upon the death of a retirement account owner, but more importantly, such neglect can totally derail a carefully crafted estate plan.

Since much of a client's wealth is often invested in retirement plans, failure to coordinate the flow of probate and non-probate assets as part of the estate plan can completely derail a client's estate planning objectives. The object of this article is to create awareness of the importance of beneficiary designations in particular, as well as highlighting the importance of a periodic review with professional advisors of the overall estate plan to confirm that all assets flow in the intended direction upon the client's death regardless of any key changes in circumstances that may have occurred since the initial designation was made.

While life insurance and retirement accounts are the two primary non-probate assets that often account for the vast majority of a client's net worth, the retirement account is unique in that its origin is based on Congressional enactment of tax code provisions permitting the deferral of income tax on certain amounts of earned income in order to encourage savings for retirement. As a result, the designation of a beneficiary to receive the retirement account upon the death of the account owner can result in both income and estate tax consequences. Because of the potential for both estate tax consequences for the deceased account owner and income tax consequences for the estate and the named retirement account beneficiary,

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this article is intended to highlight the importance of reviewing and understanding of the provisions set forth in a retirement plan contract, knowing what distribution options are made available in the retirement plan, and carefully incorporating the distribution of the retirement plan account with the overall estate plan to minimize estate tax consequences, maximize the income tax deferral and, most importantly, achieve coordination with the overall estate plan to meet estate planning objectives.

While a detailed review of the many different retirement accounts, including but not limited to, defined benefit plans, 401(k) plan, Individual Retirement Accounts (IRAs), Roth IRAs, profit sharing plans, etc., and the tax rules and regulations governing each plan is beyond the scope of this article, there are several common planning issues applicable to all retirement accounts. First, every retirement account owner needs to know and understand the terms and conditions included in their particular retirement plan. While the tax laws set forth rules governing the amount, timing and tax consequences of retirement account distributions to the account owner during retirement and when distributed to a 'designated' or 'non-designated'

1 Generally speaking, a "designated beneficiary " is either an individual or a qualifying trust that is entitled to take retirement account distributions over the individual or trust beneficiary's lifetime, while a beneficiary that does not qualify as a 'designated beneficiary' must take the distributions within a five-year period.

beneficiary[1] following the death of the account owner, not all plans offer every distribution option statutorily available. Retirement account owners should also look closely at the distribution options offered by the retirement plan. Once aware of the options, each account owner should confirm that a primary and secondary beneficiary is designated on each retirement account, review how well your primary and secondary beneficiary designations are incorporated into the overall estate plan, understand the flow of assets underlying the estate plan, and make a point of reviewing the designations on a regular basis.

While assisting a client in an estate's administration, is not unusual to find that the now deceased retirement account owner failed to designate a beneficiary on one or more retirement accounts. It may be that a new retirement account was opened, and that the owner never "got around" to making the beneficiary designations, or more likely, never revised the beneficiary designation once a retirement account was opened. When there is no designated beneficiary named, the terms of the particular retirement plan control. Some plans may include a "default" beneficiary, which could be the spouse, children or even the Estate, with each possibility having significantly different distribution rules and income tax consequences. If the decedent's estate is the retirement plan's 'default' beneficiary, all retirement account distributions are typically required to be made to the estate within a five-year period, thereby losing the income tax deferral advantages available to a properly designated beneficiary.

There are significant income tax advantages in naming a surviving spouse as the primary beneficiary of a retirement plan as current tax laws permit the surviving spouse to "rollover" a deceased spouse's retirement account into his or her own, thereby further deferring the income tax on retirement account distributions over a longer period of time; however, while helpful to defer the income tax over the lifetime of the surviving spouse, a "roll-over" of the first deceased spouse's retirement account into the surviving spouse's retirement account could cause unwanted state or federal estate tax exposure upon the death of the surviving spouse. This is an especially significant issue when the value of the spouses' combined retirement account value represents a high percentage of the couple's overall net worth, and the combined value of the couple's assets exceeds the threshold above which an estate tax will be imposed.

To minimize potential estate tax exposure upon the death of the surviving spouse, and in lieu of naming the surviving spouse as the outright beneficiary of the retirement account, the owner of a large retirement account might consider designating a trust for the lifetime benefit of the surviving spouse as the designated beneficiary of the retirement account. While naming a trust as the designated beneficiary may provide estate tax planning benefits, a host of other problems can arise when a trust is named as beneficiary of a retirement plan, including the limited flexibility afforded by current IRS rulings in identifying the "measuring life" used for calculating the required minimum distributions payable to the surviving spouse.

For example, leaving retirement benefits to a trust that qualifies as an estate tax-free transfer between two spouses (i.e. a QTIP trust) does not have any income tax benefits as it often results in a forced distribution of the benefits sooner than would be the case if the surviving spouse, individually, were named as the beneficiary. Similarly, naming the credit shelter trust as the beneficiary of a retirement account unnecessarily creates a situation where the credit shelter trust is receiving, and distributing some or all of the income to or for the benefit of the surviving spouse thereby reducing the value of the credit shelter trust while potentially increasing the estate tax exposure of the surviving spouse. Further, any undistributed retirement account income from the trust would be subject to income taxation at the higher income tax rates imposed on trust income.

Another intended result could occur when a retirement account owner names a surviving spouse who has not yet attained the age of age 59 ½ as his or her designated beneficiary as doing so could create a planning challenge for the surviving spouse. While a surviving spouse can choose to between leaving the inherited benefits in the deceased spouse's plan (where s/he may be forced to take minimum requirement distributions as the beneficiary) or "rollover" the retirement account into his or her own retirement account, if the surviving spouse is under the age of 59 ½, the rollover option may restrict withdraws from her own plan (which would then include the deceased spouse's retirement account) until attaining age 59 ½ unless the survivor incurs a 10% early withdrawal penalty that would not apply if the surviving spouse elected to take beneficiary distributions from the deceased spouse's retirement account directly. On the other hand, if the surviving spouse dies while the benefits are still in the deceased spouse's retirement account, the distribution options after the surviving spouse's death are typically less favorable than the options would have been had the surviving spouse rolled the benefits into his or her own retirement account.

Unintended results can also occur where a retirement account owner names the surviving spouse as the primary beneficiary with the couples' minor children named as the secondary beneficiaries of both the Will and the retirement accounts, or simply names the children as the primary beneficiary of life insurance and/or retirement accounts. While the typical retirement account owner does want his or her children to benefit from his or her retirement account proceeds, especially if there is no surviving spouse, in all likelihood, the client may not have intended that young children, or their legal guardian, or worse, an ex-spouse, be given an option to withdraw, in a

lump sum, all of the retirement funds and insurance proceeds at one time, nor is the client likely to have considered the enormous income tax consequence if the children elected to take the retirement distributions in such manner. More typically, a parent of young children would prefer to direct a child's beneficial interest in his or her estate or retirement accounts to a trustee of a trust who would manage and distribute the funds to or for the benefit of the child or children in a tax efficient manner while making account funds available for the child's care and support over a longer period of time.

In summary, naming and monitoring the existence of retirement account beneficiary designations is no simple matter and involves the balancing of multiple tax and non-tax considerations, and the unintended consequences of making a beneficiary designation without fully understanding how the distribution options can best be incorporated into an overall estate plan can lead to a largely ineffective estate plan. To avoid falling into the planning trap for the unwary, consider the following planning recommendations:

- Periodically review the language in your retirement account with specific attention toward the retirement account distribution options provided in a particular plan;
- Upon the occurrence of significant life events, such as the birth or death of a family members, divorce, separation, marriage or remarriage, etc., consider the impact of current beneficiary designations, and make the necessary changes.
- Confirm how existing beneficiary designations impact income and estate tax exposure by reviewing the pros and cons of beneficiary designations from an income and estate tax planning perspective; and
- Confirm that all existing primary and secondary beneficiary designations are consistent with the overall estate plan designed to meet overall estate planning objectives. □

Feeling Your Pain: Law Court holds that emotional distress is not a covered "bodily injury" in personal liability insurance policy.

By Lance E. Walker

In *Langevin v. Allstate Insurance Co.*, 2013 ME 55, the Law Court held that personal liability policies defining "bodily injury" as "physical or bodily harm, sickness or disease or death that results," do not cover emotional distress damages. This leaves a substantial and common category of tort damages potentially uncovered, which ineluctably will lead to legislative, regulatory and market responses.

Background

In August 2010, the Langevins filed a complaint against Charles Johnson ("underlying complaint") arising out of their purchase from Johnson of property located in Hollis, Maine. The underlying complaint included ten counts, although the Langevins pursued only the counts of negligence, negligent misrepresentation, negligent infliction of emotional distress and intentional infliction of emotional distress based on the following allegations.

During the pendency of the sale of the property, Johnson allegedly misrepresented the condition of the property and failed to disclose its prior use as a junkyard. As a result of Johnson's misrepresentations, the Langevins purchased the property for $315,000 and suffered damages, including loss of the investment value of the property, undisclosed physical problems with the property, and emotional distress.

While he owned the property in Hollis, Johnson maintained a homeowners insurance policy with Allstate. The Allstate policy provided the following definition of bodily injury: "physical harm to the body, including sickness or disease, and resulting death."

LANCE E. WALKER

Johnson tendered the underlying complaint to Allstate. Allstate refused to defend or indemnify Johnson. The Langevins and Johnson eventually reached an agreement resolving the underlying complaint and the court entered a judgment against Johnson in the amount of $330,000. The judg-

ment did not specify the basis for liability or damages.

Armed with the judgment, the Lagevins initiated a reach and apply action against Allstate. On cross motions for summary judgment, the court concluded, in relevant part, that the damages for injury to the property did not result from an "occurrence" and did not constitute "property damage." Accordingly, the court granted Allstate's motion for summary judgment, denied the Langevins' motion for summary judgment and entered judgment for Allstate. The court's order entering judgment did not discuss the Langevins' claim that the policy covers any damages resulting from their emotional distress. The Langevins appealed the decision of the Superior Court.

The Langevins argued that the judgment awarded damages for loss of investment and physical problems with the property on their negligent misrepresentation claim as well as damages for emotional distress on their claims for infliction of emotional distress and negligent infliction of emotional distress. The Langevins argued that 1) the damages for loss of investment and physical problems with the property constitute covered "property damage" and 2) the emotional distress damages constituted a covered "bodily injury."

As part of the court's analysis, it provided affirmations of a couple of important principles to insurers. First, the court reiterated its holding in *Jacobi v. MMG Insurance Co.*, 2011 ME 56, ¶ 14, 17 A.3d 1229, that "the party seeking to recover pursuant to the reach and apply statute. . . has the burden to demonstrate that [his] awarded damages fall within the scope of the insurance contract."

The court, in addressing the damages for negligent misrepresentation, reaffirmed the central principle that loss of investment expectation in a misrepresentation of the sale of property does not constitute "property damage" as that term commonly is defined in liability policies. *See Vigna v. Allstate Insurance Co.*, 686 A.2d 598, 600 (Me. 1996)("Economic injury does not constitute 'property damage' for purposes of insurance coverage.")

The Lagevins argued that because they also sought to recover for physical problems with the property, their damages for negligent misrepresentation fall within the definition of "property damage." The Law Court rejected that argument because the physical problems with the property did not result from an "occurrence" as defined by the policy. The only factual allegation in the complaint that arguably constituted an "occurrence" was Johnson's act of misrepresenting the condition of the property. The fortuity that the misrepresentation pertained to the physical condition of the property, necessarily resulted from his misrepresentation but did not constitute "property damage".

The most significant portion of the court's holding was addressed in the section dealing with the Langevins' alleged damages for emotional distress.

Emotional Distress Does Not Constitute Bodily Injury

The Langevins argued that the Law Court's decision in *Vigna* conclusively established that emotional distress constitutes indemnifiable "bodily injury" regardless of how that term is defined in an insurance policy. In *Vigna*, the Court held that Allstate had a duty to defend a couple against a complaint alleging emotional distress resulting from their failure to pay a contractor for home renovations. Allstate had issued two policies to the couple, a homeowners policy and an umbrella policy. Based on the possibility, observed in *Maine Bonding & Casualty Co. v. Douglas Dynamics, Inc.*, 594 A.2d 1079, 1081 (Me. 1991), that "bodily injury, sickness or disease" could result from emotional distress, the Court concluded that "unless excluded, a claim for emotional distress triggers an insurer's duty to ***defend*** under bodily injury coverage if the emotional distress is caused by "an accident or occurrence" within the meaning of the policy." *Vigna*, 686 A.2d at 600. The Court held that *Vigna* did not establish that emotional distress always constitutes "bodily injury" when determining whether an insurer has a duty to ***indemnify.*** As the Law Court explained, the *Vigna* case determined that given the allegations made in that complaint and the language of the applicable policy, emotional distress could constitute "bodily injury" and, therefore, the insurer was obligated to defend the claim. Presumably what the court intended to say is that physical manifestations, if any, of emotional distress would constitute "bodily injury."

The court then revisited its decision in *Ryder v. USAA General Indemnity Co.*, a discussion of which was included in a previous edition of the Norman, Hanson & DeTroy Newsletter. In that case, a couple sought a declaratory judgment to determine whether their bystander claims for negligent infliction of emotional distress constituted claims for bodily injury pursuant to a policy defining "bodily injury" as "bodily harm, sickness, disease or death." 2007 ME 146, ¶ 1, ¶ 6, 938 A.2d 4. In that case, Justice Hjelm, sitting as the trial court judge,

concluded that the definition of "bodily injury" only covers claims for physical harm to the body and not emotional distress. The Law Court, rather than holding that emotional distress always constitutes "bodily injury" regardless of the policy definition, evaluated USAA's definition of that term and concluded that the term was ambiguous as a result of its grammatical structure. The Court came to this conclusion, relying on the standard grammatical rule that when an adjective modifies the first of a series of nouns, a reader will expect the adjective to modify the rest of the series as well. When applied to USAA's definition of "bodily injury," this grammatical rule led to the term "bodily death." Although relevant in the spiritual realm, such a definition carries little meaning in the secular world of insurance contracts. Given the grammatical structure employed in the USAA definition, it was unclear to the Law Court whether "bodily" was intended to modify all of the nouns that followed it. Therefore the entire definition was held to be ambiguous, resulting in a finding of coverage.

By contrast, the Allstate policy at issue in *Langevin* defined "bodily injury" as "physical harm to the body, including sickness or disease, and resulting death." Unlike the definition of "bodily injury" at issue in *Ryder*, this definition was held to be unambiguous. The Law Court held that the definition in the Allstate policy quite clearly restricted "bodily injury" to physical ailments and/or resulting death such that an ordinary person would understand that it does not encompass emotional pain and suffering.

The Impact of Langevin

Although the Law Court has visited this issue twice in the last six years, this most recent proclamation provides much greater clarity as to whether emotional distress constitutes "bodily injury" as that term is commonly defined in ISO-member policies. For example, in the standard homeowners policy form HO 00 03 10, "bodily injury" is defined as "bodily harm, sickness or disease, including required care, loss of services and death that results." This definition presumably does not suffer from the same faulty grammatical structure that led the court to deem it ambiguous in *Ryder v. USAA*.

Perhaps the most striking aspect of the *Langevin* case was that the Law Court, in applying a mechanically appropriate interpretation of a simple insurance provision, leaves a substantial gap between bodily injuries which are indemnifiable under common homeowners and auto policies, and commonly sought tort damages, such as emotional distress, which now are the burden of the insured alone. One potential response may be market-based. That is, personal lines underwriters may identify a business opportunity to provide enhanced coverage for emotional distress damages, which as a practical matter under Maine law constitute a minimal economic driver to most tort cases.

For the time being, however, the Law Court has, with unusual clarity, unburdened Maine insurers from the prospect of emotional distress damages being covered under personal liability policies. □

Norman, Hanson & DeTroy Sponsors 75th Anniversary of Maine Credit Union League

Norman, Hanson & DeTroy was a proud Diamond Sponsor of the Maine Credit Union League's 75th Annual Meeting and Convention, which began on Thursday, June 13 at Belgrade Lakes Golf Club in Belgrade. The convention tournament raised over $47,000 for the Maine Credit Union's Campaign for Ending Hunger. Firm members participating in the fun at Belgrade included Jim Poliquin, Dan Cummings, Rod Rovzar, Bob Bower, Lance Walker and Diane LaCourse.

The 75th Annual Meeting events commenced on Friday, June 14th in earnest! The convention venue was the Holiday Inn by the Bay in Portland, ironically, just a few blocks away from the League's first annual meeting at the old Columbia Hotel near Longfellow Square. While 75 individuals attended that first meeting of the state's new trade association organized to form and support credit unions, nearly 800 credit union representatives and guests attended this year's two-day event.

The firm was represented during the course of the 75th Annual Meeting by Rod Rovzar, Dan Cummings, Adrian Kendall, Jim Poliquin, Bob Bower, Lance Walker, Diane LaCourse, Darya Haag, and Kelly Hoffman.

Rod Rovzar introduced the Keynote Speaker for the opening session, Lee Wetherington,

Director for Strategic Insight for ProfitStars, who provided a statistical overview of the future in the financial services industry. The delegates meeting featured a keynote address by Bill Cheney, President/CEO of the Credit Union National Association, who delivered an address on national credit union affairs and key legislative events in Washington. The Saturday closing session was highlighted by a special address by Jim Morris, the real-life inspiration for *The Rookie*, a movie sensation. The Friday night banquet included entertainment by comedian Bob Marley and Let's Hang On, a popular Frankie Valli tribute show.

Norman, Hanson & DeTroy values its partnership with the Maine Credit Union League, its subsidiary Synergent, as well as each of the firm's many Maine credit union clients. The firm has been working with the League and Maine credit unions for over 33 years, with as many as ten attorneys working on League and credit union projects at one time or another! □

WORKERS' COMPENSATION – LAW COURT DECISION

By Stephen W. Moriarty

STEPHEN W. MORIARTY

Offset for specific loss injury.

Specific loss benefits are payable pursuant to §212(3) for injuries which result in amputation of designated portions of the body. A specific number of weeks is assigned by statute to each portion of the body, and actual amputation, as opposed to loss of use, is required before such benefits are payable. *Gibbs v. Fraser Paper, Ltd.*, 1997 ME 225 703 A.2d 1256. In addition, it has been recognized that specific loss benefit entitlement may be offset against weekly incapacity benefits for the same injury. *Boehm v. American Falcon Corp.*, 1999 ME 16, 726 A.2d 692. A recent decision of the Law Court clarified the circumstances under which the offset may be claimed.

In *Scott v. Fraser Papers, Inc.,* 2013 ME 32 (March 21, 2013), the employee sustained a crush injury to his left hand in May 2003 and was voluntarily paid benefits for total incapacity until early December of that same year, when he returned to work. However, the condition of his index finger deteriorated and ultimately the finger was surgically amputated in April 2004. He lost one week from work as a result and then returned without any ongoing wage loss.

The employee filed a petition seeking specific loss benefits for the loss of the index finger, for which 38 weeks of compensation may be awarded under the Act. The employer argued that it was entitled to offset incapacity benefits paid *prior* to the amputation against the specific loss entitlement, and the presiding hearing officer agreed. Following denial of a Motion for Findings of Fact, the Court agreed to hear the employee's appeal.

In its opinion a unanimous Court recited the legislative history underlying §212(3) and reiterated that when an injury and an amputation occur simultaneously an employer is entitled to offset incapacity benefits against the specific loss entitlement. However, as noted in this case, the amputation occurred eleven months after the injury itself. The Court observed that the voluntary incapacity benefits had been paid *before* the claim for specific loss benefits came into existence. Therefore, because the employee was not legally entitled to receive specific loss benefits until after the amputation had taken place, the Court ruled that the employer was not entitled to reduce the specific loss payment by the amount of voluntary incapacity benefits paid prior to the surgery. The Court found that the Board had erroneously allowed an offset for pre-amputation benefits, and the decision of the presiding hearing officer was vacated. □

Recent Decisions From The Law Court

By Matthew T. Mehalic

MATTHEW T. MEHALIC

Actions for professional negligence

In *D.S. v. Spurwink Services, Inc.*, 2013 ME 31 (March 21, 2013) an incapacitated woman who attended Spurwink Services, Inc.'s education facility alleged that Spurwink breached its duty of care to her. The alleged breach arose when the woman, then sixteen years old, arrived at the facility in the morning and declared that she was not going to school, and subsequently left the property on foot. School personnel pursued the woman along with assistance from the police, but she was not located. The woman approached a vehicle and spoke to a man, who invited her into the vehicle. Ultimately she had nonconsensual sexual intercourse and sexual contact with him and another man.

The claims against Spurwink alleged negligence, negligent infliction of emotional distress, breach of fiduciary duty, and punitive damages. Spurwink moved for summary judgment while the matter was pending in the Superior Court on the grounds that the Superior Court lacked jurisdiction pursuant to the Maine Health Security Act, (MHSA), which requires that claims for professional negligence are subject to a prelitigation screening panel. Claims for professional negligence under the MHSA include (1) any action for damages for injury or death, (2) against any health care provider, its agents or employees, or health care practitioner, his or her agents or employees, (3) whether based upon tort or breach of contract or otherwise, (4) arising out of the provision or failure to provide health care services. The Superior Court agreed with Spurwink and granted summary judgment in favor of Spurwink. The matter was appealed to the Law Court, which reversed the Superior Court finding that the claims against Spurwink were not an action for professional negligence as defined by the MHSA, and therefore, the claims were not subject to the mandatory prelitigation procedural requirements, or to the MHSA statute of limitations.

At all relevant times Spurwink held a mental health license from the Maine Department of Health and Human Services (DHHS). The education facility the woman attended focuses on providing necessary emotional, psychological and other therapeutic services and education in a therapeutic environment for children and adolescents with behavioral and developmental challenges. All individuals attending the facility have a primary diagnosis of mental illness, developmental disability, major personality disorder, or a combination of disorders.

Upon admission, the woman received an individualized treatment plan (ISP) based on her individual physical, psychological, education, and social needs. The ISP was in part formulated through consultation with a psychiatrist. However, the psychiatrist's evaluation did not tell Spurwink staff what to do, but made only some recommendations for approaches to her treatment. The ISP also included input from individuals employed by Spurwink, including licensed clinical social workers, therapists, educators, and case managers. The ISP set the goals and objectives, procedures relating to care and safety, and behavior plans.

In finding that the claims against Spurwink were not an action for professional negligence subject to the MHSA, the Law Court focused on the requirement that in order to be a "health care provider" the entity must be one in which skilled nursing care or medical services are prescribed by or performed under the general direction of persons licensed to practice medicine, dentistry, podiatry or surgery in the State. Despite the psychiatrist's evaluation of the woman and participation in a planning meeting, he did not generally direct the performance of the educational facility's medical services on a day-to-day level, he was not an employee of Spurwink, and he had no supervisory authority over those who may have performed any medical services. In addition, he never prescribed any particular medical services. The Court also declined to extend health care practitioner status to licensed clinical social workers. Accordingly, the Court determined that Spurwink's educational facility at issue did not provide medical services prescribed

by or performed under the general direction of a physician necessary to subject the claims to the requirements of the MHSA.

Retaliation for discharge following employee participation in deposition

In *Trott v. H.D. Goodall Hospital*, 2013 ME 33 (March 21, 2013), the Law Court addressed on appeal whether summary judgment in favor of an employer, H.D. Goodall Hospital, should be affirmed in a matter that alleged violation of the Maine Whistleblowers' Protection Act (WPA). The specific allegation was that the employee was discharged following her participation in a deposition in a wrongful death action against the hospital.

The employee spoke with the deceased patient's daughter and speculated as to possible causes of death, including a morphine overdose, after the patient's death. Subsequently, the patient's estate commenced a wrongful death lawsuit.

During the employee's deposition preparation, the hospital's attorney told her that she was to blame for the lawsuit because she had indicated to the patient's daughter that the hospital might be liable due to a morphine overdose. At the deposition, the employee was questioned about the condition she observed the patient in during the employee's rounds in the hours leading up to the patient's death. The employee testified that the employee was sound asleep and that she entered that information in the patient's medical records. Thereafter, the employee was presented with the patient's medical record, which included her entry on the date at issue and read that the patient was "alert, oriented times three" and had an "unsteady gait."

The day after the employee signed her deposition she was terminated on the ground that the medical record entry the employee made constituted a falsification of a patient medical record – a terminable offense under the Hospital's Conduct and Discipline policy.

The hospital successfully moved for summary judgment in the Superior Court. The Law Court reversed the Superior Court finding that a genuine issue of material fact existed as to whether there was a causal link between the employee's participation in the deposition and her discharge. Despite reversing the grant of summary judgment to the hospital, the Law Court held that although the WPA protects the employee from discrimination based on the employee's requested participation in a deposition, it does not prevent an employer from taking an adverse employment action against an employee based on the content of the employee's deposition testimony.

The Court utilized a three-step burden-shifting analysis to examine the question of causation. The Court found a genuine issue of material fact existed on the causation element due to three different potential interpretations of the evidence, all of which could have led a reasonable juror to conclude that the Hospital discharged the employee unlawfully. Key to the Court's holding was its commentary upon credibility determinations in the employment discrimination context. Specifically, the Court stated that due to the unique nature of employment discrimination matters, circumstantial evidence is usually the only type of evidence available to an employee to prove her case. The Court implied that the Superior Court allowed credibility and weight of the evidence to dictate the result on the hospital's motion for summary judgment. The Law Court emphasized that although a pretext case may be weak, it is not the same as no case. The Court's holding once again reaffirmed the benefit ascribed to the non-moving party in summary judgment practice.

Disagreement is not bad faith in context of claims against condominium association

In *America v. Sunspray Condo. Assoc.*, 2013 ME 19 (Feb. 12, 2013), a condominium owner's claims against the condominium association and its board of directors arising from alleged failure to enforce a smoking ban were dismissed for failure to state a claim upon which relief could be granted. The Law Court affirmed the dismissal.

The owner alleged that the association and board engaged in bad faith in failing to enforce the smoking ban. The allegations included that the board failed to investigate or otherwise take effective action upon receipt of reported violations. The Court held that an absolute refusal to enforce a condominium rule might be actionable as a decision made in bad faith unprotected by the business judgment rule. However, an inadequate or insufficient response did not equate to bad faith. The Court stated, "Disagreement is not bad faith," the reason being that there is no dishonest purpose, wrongdoing, or motive of self interest.

Also included in the Court's affirmation of the owner's complaint's dismissal was rejection of asserting a derivative action on behalf of a nonprofit corporation or condominium association and rejection of the idea that exposure to second hand smoke without more is a cognizable injury. □

New Associate: Sadie Jones

We are pleased to announce that Sadie Jones joined the firm in March, 2013, as an associate attorney. Sadie was born in New Orleans and raised in Washington D.C., although spent her summers in Maine on Damariscotta Lake. She attended Georgetown Day School and was a twelve-season varsity athlete who was voted captain of the soccer, basketball, and lacrosse teams. Sadie graduated from Middlebury College in 2005 with a B.A. in English and a minor in Political Science. Prior to law school, Sadie worked for former Senator John Kerry and his presidential campaign, and later moved to Vail, Colorado to pursue another passion—skiing.

Sadie graduated from the University of Maine School of Law *cum laude* in 2011. While in law school, she served as Case Note and Comment Editor of the *Maine Law Review* and generally focused her studies on tax and business related matters. Sadie also spent a summer clerking for the Honorable Jon D. Levy of the Maine Supreme Judicial Court and later worked in the Office of the Attorney General. Following graduation from law school, Sadie pursued her tax-related interests at one of Maine's largest accounting firms.

Sadie married a lifelong Mainer and has been proud to officially call

SADIE JONES

Maine home for the past five years. She and her husband recently moved from Portland's East End to Freeport with their dog, Fischer. In her free time, Sadie enjoys skiing, biking, cooking, and attempting (pathetically) to golf. □

KUDOS

The July 2013 edition of "Maine" magazine included **PETER DeTROY** in a feature article titled "50 People Who Have Made a Difference in Maine". Noting his extensive statewide trial experience, the article also featured Peter's leading role in the tobacco settlement of the late 1990's together with his service to the bar on the Task Force on Gender Bias in the Courts and the Maine State Bar Association silent partners programs.

MARK DUNLAP has been elected to the American Board of Trial Advocates, a nation-wide organization of experienced civil trial attorneys devoted to the integrity and preservation of our civil justice system.

JOHN VEILLEUX has served for eight years on the Board of the Casco Bay Hockey Association, and was recently elected to a third term as president. Casco Bay is Maine's largest youth hockey association with nearly 900 skaters and 150 coaches. In June John attended the USAHockey Annual Congress in Colorado Springs at the invitation of the Maine Amateur Hockey Association. USAHockey is the governing body for all amateur hockey nationally, including the U.S. Olympic team.

At the annual summer meeting of the Maine State Bar Association, **PETER DeTROY** participated in a panel summarizing the Maine Bar Disciplinary Enforcement Rules, which will be considered for adoption shortly by the Maine Supreme Judicial Court. In May Peter also spoke at the Osher Lifelong Learning Institute on the subject of "The Heart and Soul of Lawyering."

KEVIN GILLIS spoke at the SEAK National Workers' Compensation Seminar in Hyannis, Massachusetts, on July 15, 2013.

In May **LANCE WALKER** spoke as a faculty lecturer at the Litigation Institute, a two-day conference sponsored by the Maine State Bar Association in Augusta. Over three separate sessions, Lance lectured to a diverse group of attorneys from all over the state about strategic considerations at the intersection of litigation and insurance coverage issues. □

NHD attorneys honored by Benchmark Litigation.

Benchmark Litigation has listed NHD as one of five “highly recommended” firms within the State of Maine, and has honored Jonathan Brogan, Peter DeTroy and Mark Lavoie as “local litigation stars”. Lance Walker is recognized as an “emerging insurance talent”, Jim Poliquin as a “leading insurance attorney” and both Dave Herzer and Tom Marjerison have been recognized as “future stars”.

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