... And Justice For All

A LEGAL NEWSLETTER FROM THE LAW OFFICES OF

Moore, O'Brien, Jacques & Yelenak

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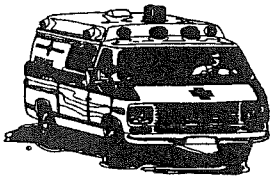
WHEN THE AMBULANCE DIDN'T COME...



Despite her long-standing Multiple Sclerosis, 42 year old Joyce P. enjoyed a full and active life with her husband, Paul, two teenage children and her teaching position with a local school district. That was until September 27, 1997 when she suffered an unexpected loss of consciousness while at home.

According to her husband, Joyce had been doing housework late that afternoon. When Paul entered their bedroom he found Joyce on the floor. Although unconscious, she was breathing normally. Paul immediately dialed 911 and reported the medical emergency. As a veteran police officer on the local force, Paul anticipated that an ambulance with a crew trained to handle the situation would arrive at their home within approximately 5 minutes and render appropriate care. So he tried to calm himself. However, the ambulance didn't come.

As time passed, Paul understandably became increasingly anxious. A patrol officer hearing the emergency call responded to the residence within a few minutes. After more time awaiting the arrival of the ambulance, Paul and the other officer contacted police headquarters and urgently requested the emergency unit to "please, step things up." Still, the ambulance did not arrive. Paul and the officer watched as Joyce's breathing became increasingly more shallow and then stopped. The men placed Joyce frantically on the bed to keep her airway open; however, because of her lack of breathing she began to turn blue. A full 16 minutes had passed from the time of the initial emergency call to when the emergency unit finally arrived at the house. By then, Joyce was experiencing a life-threatening hypoxic seizure. Although timely care was rendered once the crew arrived, because the ambulance dispatcher had failed to order a backup unit, and Joyce's condition required both attendants' attention, Paul himself was needed to drive the ambulance carrying his critically ill wife to the local hospital. As a result of the delayed response time by the ambulance crew, Joyce suffered permanent neurological deficits, including speech impairment, memory loss and difficulty walking. She underwent a lengthy course of physical and speech rehabilitation and was placed on indefinite leave from her teaching position where she was just 6 months short of vesting in a pension.

The family contacted Moore, O'Brien, Jacques & Yelenak to investigate the incident and take appropriate action. A lawsuit was immediately filed and the deposition testimony of the ambulance crew, company dispatchers and supervisors was taken. From the ambulance company internal report of the incident it was learned that at the time of the emergency the dispatch center was unable to contact the local ambulance substation to send an ambulance because the two crew members had tied up the incoming telephone lines with personal calls. In the lawsuit, the ambulance company disavowed these facts. However, based upon company documents generated by computer at the time of the emergency, the company could not deny the 16 minute response time.

It was subsequently learned that the reason for the delay was three-fold: First, due to the inexperience of the ambulance dispatcher who initially handled the call no attempt was even made to send an ambulance for more than three minutes; Second, once the ambulance crew was contacted - - and despite the requirement that the crew be familiar with the local streets' layout - - the crew, enroute to the scene, got lost; Finally, the street guide the crew consulted upon realizing they could not find the home was out-of-date and led them astray. In depositions, supervisors of the ambulance company and the police chief, who was a member of the town emergency services committee, testified that according to the Emergency Medical Services Contract between the company and the town a response time of more than eight minutes was unacceptable and would likely place victims in grave danger. The distance from the ambulance substation to Joyce and Paul's home was less than four miles and on that Saturday afternoon traffic was light.

"The emergency crew couldn't even find the house. They had to be found and guided there by the waiting officer who learned of their location on his portable police radio," explained partner Garrett Moore. "This whole episode is one of appalling negligence on the part of the company in whose hands the lives of local residents was entrusted."

In the lawsuit, the ambulance company has not contested liability but claims the injuries suffered by Joyce were caused by her pre-existing M.S. rather than the oxygen deprivation she suffered because of the delayed arrival of the ambulance.

"If the case can't be settled we are more than ready to place these facts before a jury and let the community render justice for Joyce," says Attorney Moore.

TEN SECRETS YOUR AUTO INSURER DOESN'T WANT YOU TO KNOW

Although auto insurers employ carefully-crafted slogans to convince consumers they are the customer's ally, the truth is the main goal of the insurance industry is to make a profit even at your expense. As a result, in most instances your interests and those of your insurer may frequently collide. The following are situations that arise which your insurer would prefer remain a secret.

1. You Are Paying Too Much For Insurance

If you have a good driving record, odds are that you can get a better deal on your auto insurance because in recent years most major companies are either leveling out prices or even reducing rates. Therefore, you should shop your policy to different companies each year, says a leading insurance expert. Also, if you buy insurance through an agent, consider one of the direct-response companies, such as GEICO or Amica, and cut out the middle man, which will mean cheaper rates for you.

2. Your Insurance Rates Are Probably Based Upon Your Credit Rating Not On Your Driving Record.

Many factors are used to determine your premiums, including your driving record, age, type of car you drive, marital status and, most importantly, your address. However, increasingly, companies are using your credit history as an indicator of how likely you are to file a claim.

There are a number of companies that provide insurers with a formula to determine your "credit score", which is your credit history boiled down to a single number. Your credit score, which is a major factor used by insurers to determine your rates, is private. You may have a spotless driving record, but perhaps your business failed or you have a serious medical condition or there is simply an error in your credit report. Such factors may make you unavailable for good driving rates. Although 12 states have laws that limit the use of credit scores in setting premiums, the remaining states (including Connecticut) allow the use of credit scores to determine rates. So check your credit history for inaccuracies and challenge your insurance company if it uses non-driving factors to set your premium.

3. Insurance Companies Pocket Your Deductible

If you are in an accident and it is the other driver's fault, his insurer is supposed to pay for the damage to you car. If the other driver's insurer stalls in paying, you can file a claim for the damage against your own company and then let the two companies fight it out later. It would follow that if your insurer wins the claim and doesn't have to pay, you should get your deductible back. Unfortunately, it does not always work that way.

Most states give insurance companies up to six months to go after the money owed by the other driver's insurer. After that, your company is required to either refund your deductible or let you go after the other company. In 1996, State Farm Insurance paid out a $22,000,000 settlement in Texas for failing to refund deductibles to customers. If you are in an accident, that is not your fault and have to pay your deductible, make sure you let your insurance company know that you may be entitled to reimbursement for your deductible.

4. Your Insurance Company Can Dump You On A Whim

The first 30 to 60 days after signing up for insurance is called the "binding period". During that time the insurance company can cancel your policy for practically any reason, even without an explanation. They may discover something they don't like in your driving record or credit history or, if you file a claim, they may consider you a bad risk. After the binding period, state laws vary on when you can be dropped. More common is "non-renewal", when you are simply cut off after your policy expires. If you are not renewed, you may find yourself banished to the dreaded "high risk" category of insurance along with drunk drivers and teenagers. As such, your premiums may go up at least 20% and you will probably not be able to get back to the good driver rate level for three years. Also, you may not be able to find out why your policy was not renewed because the formulas used by insurers to make such decisions are proprietary, meaning that the insurance companies are not required to divulge specific details.

5. Your Company May Short Change You If Your Car is Totaled

Even though your collision policy entitles you to the fair market value for your totaled car, the amount you actually get could leave you short changed. The valuing criteria used by many insurers for totaled cars is almost always lower than the traditional book values. In valuing your car, most insurers look at vehicles for sale in your area in similar condition. However, this figure usually represents a "take" price, which is the absolute *lowest* price that a used car dealer would accept for it. Further, there is absolutely no guarantee your insurer will pay even that figure.

To protect yourself, when your insurer gives you the written valuation report, make note of the vehicle identification numbers of the cars used to value yours so you can make sure the comparison vehicles actually exist and there are no mistakes. In one instance, a company comparison valued a wreck based on a model foreign car that never even existed!

6. The Secret Of Diminished Value Compensation

Most insurance companies are betting that you have never heard of diminished value. However, even if your car is repaired after an accident, there could be flaws in the repair process. Or even if properly repaired, the vehicle is probably worth less on the resale market. Your insurance company is obligated to pay you the difference. Simply by raising the issue of diminished value before your car is repaired may get a much better offer from your company.

7. You Do Need A Lawyer

Insurance companies don't like to deal with lawyers, so much so that starting in 1993, Allstate sent brochures to customers who had been in accidents advising them they did not need representation by an attorney. In Connecticut, because of consumer outcry and the efforts of the Connecticut Trial Lawyers Association, legislation was passed prohibiting insurers from advising customers and accident victims they did not need to consult an attorney before settling. *Never* settle your claim before obtaining competent legal advice.

8. The Body Shop That Repairs Your Vehicle Is Working For The Insurance Company

Most companies have a list of body shops they prefer to use.

You can take your car elsewhere, but your insurance company may not pay the full cost of repairs. Body shops preferred by insurers get business by keeping their costs low -- sometimes by spending less time on repairs, using cheaper parts and overlooking damages only a trained expert could spot. Because the insurance companies have such financial clout, many body shops cannot stay in business if they do not remain on the insurer's preferred list by keeping the companies happy. So check with the body shop repairing your car to make sure the job is done right.

9. Insurance Companies Make Money By Sitting On Your Claim

According to insurance experts, the average insurance claim takes 24 months to settle. Although this is not entirely the insurance industry's fault because you should not accept a final settlement until your doctor has cleared you of all possible injuries, insurance companies are nevertheless in no rush to write checks. Even in a clear-liability accident where the injuries are readily defined and treated, the insurance company may purposely drag its feet in settlement because it profits from investing the money it receives in premiums during the time it takes to satisfy your settlement. Consult your attorney about ways to make the insurance company get off the dime on your claim.

10. Your State Auto Insurance Commissioner Is Not Your Friend

Unlike banking and securities, the insurance industry is regulated at the state level. The result is a patchwork of often underbudgeted state agencies each trying to control its own small corner of a multi-billion-dollar industry. Further, in many states insurance commissioners are elected officials who are often willing recipients of campaign donations from the companies they are supposed to be regulating. In other states, the position is a political plum, appointed by government. And many former commissioners wind up working for insurers. State insurance departments have the duty of both financial regulation of companies and consumer protection, which is sometimes a fine line to walk. Therefore, if you file a complaint against your insurer, don't expect much. Only in extreme situations will the insurance commission think about taking aggressive action. You may need a lawyer to gain some clout.

WORKING FOR YOUR RIGHTS

Moore, O'Brien, Jacques and Yelenak is pleased to announce that partner Stephen Jacques has been appointed to the Board of Governors of the Connecticut Trial Lawyers Association. Steve joins partner Greg O'Brien on the board of the organization which lobbies for consumer rights. Partner Garrett Moore is a past president of CTLA.

CASEFRONT

Moore, O'Brien, Jacques and Yelenak is currently litigating or has recently resolved by settlement or verdict the following cases which may be of interest to our clients. Of course, the results here should not be applied to other cases.

• $1,000,000 Award for 54 Year Old Pedestrian

While crossing the street after visiting a hospitalized relative, our client was struck by a hit and run driver and thrown approximately 15 feet in the air over another car. She suffered significant head and hand injuries. However, her most significant injury was a severely broken leg which required the surgical implanting of pins and screws. Her medical bills were approximately $100,000 and she had shortening of the left leg by several inches. She was also out of work for six months and suffered from nightmares and flashbacks of the accident. Fortunately, because our client had uninsured motorist's coverage, she was able to make a claim against her own insurance company. The case was presented to a panel of experienced attorneys by Garrett Moore for binding arbitration. After hearing the evidence, our client was awarded $1,000,000.

• Slip And Fall On Ice Yields Jury verdict Of $615,000

In March 1993, our client fell on a two-inch thick piece of ice on the walkway leading to his apartment complex and injured his low back. The ice accumulation was a result of a snowstorm which blanketed the state the night before. As a result of the fall, our 31 year old client suffered two herniated discs in his low back which required surgery. He incurred approximately $87,000 in medical bills and his treating physician assigned him a 15% permanent partial disability of his back. As a school bus driver, the client incurred lost wages of approximately $33,000. At trial, partner Greg O'Brien introduced evidence showing that the apartment complex maintenance crew was understaffed and underequipped and, therefore, not capable of cleaning the ice after the storm. The defendant introduced the client's medical records which stated that the fall had occurred at a different location and at a different time than claimed. The defense also contended that only a portion of the client's post-accident medical treatment was due to his accident injuries. Just prior to trial, the client offered to settle the case for $150,000. The defendant offered only $15,000. At trial, the jury returned a verdict of $550,000. However, because an Offer of Judgment had been filed, the verdict was increased by a 10% annual interest rate resulting in a total award of $615,000.

• Failure Of Orthopedic Specialist To Treat Post-Operative Knee Infection Results In $385,000 Jury Verdict

In 1993, our 31 year old client, a computer specialist, underwent surgery for a degenerative knee condition. The operation, which was performed by a prominent orthopedic surgeon was a success. However, the client subsequently developed an infection in his knee joint. Despite numerous appointments over the next

year for the infection, because of the doctor's busy schedule, the client was usually seen by the doctor's less skilled assistant. The infection progressed to the point where another surgery was needed. The client's medical bills totaled $42,000 and he lost time from work. Partner Steve Jacques took the case to trial as the doctor claimed the client's residual disability was not the result of the infection but was due to the pre-existing degenerative knee condition. The jury awarded the client $320,000 for pain and suffering plus compensation for his medical bills and lost wages for a total verdict of $385,000.

• $805,000 Recovery for Husband And Wife Hit By Tractor Trailer

Our clients were traveling on Interstate I-84 when they were struck from behind by a tractor trailer. As a result of the impact, the husband lost control of the car and hit the guardrail. Initially, neither victim seemed to have suffered serious injury. However, within a few days, the husband began to experience shoulder, neck and low back symptoms. He ultimately underwent shoulder surgery and incurred medical bills of $30,000 with a 5% disability of his neck and a 10% disability of his shoulder. His wife, who hit the dashboard with her face, also had surgery and incurred $55,000 in medical bills. The case was brought in the Waterbury Superior Court by Garrett Moore and a jury was selected. However, the parties agreed to arbitration and at the hearing, the arbitrator found in favor of our clients and awarded the sum of $805,000.

• 61 Year Old School Teacher Awarded $225,000 for Shoulder Disability

In August 1994, our client was struck from behind by another vehicle. His car sustained less than $1,000 in damage; however, the impact caused him to be thrown about in his vehicle and he experienced immediate shoulder and neck pain. His doctor diagnosed a torn shoulder rotator cuff injury. For the next two years the client suffered from shoulder pain despite surgery and physical therapy. At age 61, he had looked forward to a retirement of golf, tennis, and swimming; however, his injuries spelled an end to those activities. At an arbitration, Garrett Moore won our client $225,000.

• Husband and Wife Accident $225,000 Settlement

While traveling on a busy street in Ansonia in December 1994, our husband and wife clients were taking their child to the doctor when without warning, the defendant made an illegal left turn in front of their car. The collision was severe. Our clients suffered back injuries. The wife also hit her knee against the dashboard. Several months later she entered St. Vincent's Hospital where her orthopedic surgeon performed knee surgery; however, she was left with a permanent knee injury that prevented her from working full time. Our clients also incurred $50,000 in medical bills. The insurance company hired a doctor who claimed the knee injury was not due to the accident and they therefore offered only $15,000 to settle the case. Bill Yelenak brought the case to mediation and obtained $225,000 for our clients.

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