

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

870323E

DEPARTMENT FILE NO.
INSURER'S CLAIM NO. 492-5907-80

1. PRIMARY INSURER NAME: FLORIDA PHYSICIANS INSURANCE COMPANY INSURER CODE: 04160
(See Table A)
2. EXCESS INSURER NAME: NONE INSURER CODE: _____
(See Table A)
3. INSURED'S NAME: Leeds, Paul ~~Leeds, Paul~~
(Last Name, First and Middle Name)

STREET ADDRESS: 1395 N. Courtenay Parkway
CITY, STATE: Merritt Island, FL ZIP: 32952 COUNTY CODE: 19
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
4. PRIMARY INSURER:	<u>8201-06333</u>	<u>\$ 1,000,000.00</u>	<u>\$ _____ .00</u>
EXCESS INSURER :	_____	<u>\$ _____</u>	<u>\$ _____</u>

5. Is the insured physician a Foreign Medical Graduate? If yes, enter the country in which primary medical education was received:
 (01) Yes
 (02) No

6. PROFESSION OR BUSINESS: (Check one)
- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> (01) Physicians & Surgeons | <input type="checkbox"/> (04) Other Medical Professionals | <input type="checkbox"/> (07) Other Health Care Facilities |
| <input type="checkbox"/> (02) Hospitals | <input type="checkbox"/> (05) Clinics | |
| <input type="checkbox"/> (03) Podiatrists | <input type="checkbox"/> (06) Ambulatory Surgical Centers | |

7. SPECIALTY CODE: 80261 (Applies to physicians, surgeons, and other health care professionals.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check one)
- | | |
|---|-----------|
| <input type="checkbox"/> (01) In specialty coded in Item 7, above. | |
| <input type="checkbox"/> (02) In a different specialty. | |
| <input type="checkbox"/> (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: _____ | |
| <input checked="" type="checkbox"/> (04) Insured is not board certified. | (Table C) |

9. PLACE WHERE INJURY OCCURRED: (Check one)
- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> (01) Hospital Inpatient Facility | <input type="checkbox"/> (04) Nursing Home | <input type="checkbox"/> (07) Other Outpatient Facility |
| <input type="checkbox"/> (02) Emergency Room | <input type="checkbox"/> (05) Physician's Office | <input type="checkbox"/> (08) Other Location |
| <input type="checkbox"/> (03) Hospital Outpatient Facility | <input type="checkbox"/> (06) Patient's Home | <input type="checkbox"/> (09) Other Hospital/Institution |

10. If Place of Injury (above) is checked as (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: Westhoff Hospital INSTITUTION CODE: 100092
(See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)
- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> (01) Patient's Room | <input type="checkbox"/> (04) Labor & Delivery Room | <input type="checkbox"/> (07) Critical Care Unit |
| <input type="checkbox"/> (02) Operating Suite | <input type="checkbox"/> (05) Physical Therapy Dept. | <input type="checkbox"/> (08) Special Procedure Room |
| <input type="checkbox"/> (03) Recovery Room | <input type="checkbox"/> (06) Nursery | <input type="checkbox"/> (09) Radiology |
| | | <input type="checkbox"/> (10) Emergency Room |

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 INSURER'S CLAIM NO. A82-590-82

13. DATE OF OCCURRENCE: 2/16/82
 DATE REPORTED TO INSURER: 6/22/82
 14. INJURED PERSON'S AGE: 30 Years (If less than one year, then enter 01)
 INJURED PERSON'S SEX: M (Circle one)

14.1 INJURED PERSON'S NAME: _____
 Last Name First and Middle Initial

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>Total Occlusion Rt internal CAROTID Artery</u>	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>Alleged failure to make the diagnosis soon enough.</u>	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>Pt died survived by newborn child + husband, husband brought claim</u>	17.
18. DESCRIBE THE OPERATION, DIAGNOSTIC OR TREATMENT PROCEDURE CAUSING THE INJURY. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE PROCEDURES USED. INCLUDE METHOD OF ANESTHESIA, OR NAME OF DRUG USED FOR TREATMENT, WITH DETAIL OF ADMINISTRATION: <u>Multiple diagnostic scans, BARDITURATE induced COMA, vascular + Angiographic studies</u>	18.
19. DESCRIBE THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM. USE NOMENCLATURE AND/OR DESCRIPTIONS OF THE INJURY. INCLUDE TYPE OF ADVERSE EFFECT FROM DRUGS WHERE APPLICABLE: <u>DEATH</u>	19.

20. SEVERITY OF INJURY: (check only one -- rate most serious injury if several are involved.)
- (01) Emotional only - Fright, no physical damage.
 - (02) Insignificant - Lacerations, contusions, minor scars, rash. No delay.
 - Temp- (03) Minor - - - - - Infections, misset fracture, fall in hospital. Recovery delayed.
 - orary (04) Major - - - - - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
 - (05) Minor - - - - - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.
 - Perma- (06) Significant - - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
 - nent (07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
 - (08) Grave - - - - - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
 - (09) Death

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21. DATE OF SUIT, IF ANY: 3,15,84

22. LIST OTHER DEFENDANTS INVOLVED IN THIS CLAIM, THE INSURER'S NUMBER AND THE COMPANION CLAIM FILE ID NUMBER:

	DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1)	<u>Hood, Ainslee RD</u>	<u>St. Paul</u>	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)
 (01) Yes (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 2,6,87

25. FINAL METHOD OF CLAIM DISPOSITION:
 (01) Settled by parties.
 (02) Disposed of by a court.
 (03) Disposed of by arbitration.

26. SETTLEMENT: (Check one)
 (01) Within the presuit period as set forth in Section 768.57, Florida Statute (usually within 90 days).
 (02) After arbitration is initiated or prior to suit being filed.
 (03) Within 90 days of suit being filed.
 (04) More than 90 days after suit is filed and prior to or during the course of mandatory settlement conference.
 (05) Prior to completion of the swearing of the jury.
 (06) Prior to filing of the notice of appeal.
 (07) After notice of appeal is filed or post-judgment relief or action is required for recovery.
 (08) During appeal.
 (09) After appeal.
 (10) Claim or suit abandoned.

27. COURT: (Check one)
 (01) No court proceedings. (06) Judgment for the plaintiff.
 (02) Directed verdict for plaintiff. (07) Judgment for the defendant.
 (03) Directed verdict for defendant. (08) Judgment for the plaintiff after appeal.
 (04) Judgment notwithstanding the verdict for the plaintiff. (09) Judgment for the defendant after appeal.
 (05) Judgment notwithstanding the verdict for the defendant. (10) Other.
 (11) Summary judgment for the plaintiff.
 (12) Summary judgment for the defendant.

28. ARBITRATION: (Check one)
 (01) Claim not subject to arbitration. (03) Award for plaintiff.
 (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award. (04) Award for defendant.

29. WAS THERE AN ITEMIZED VERDICT UNDER FLORIDA STATUTE 768.48? (Check one)
 (01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

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 INSURER'S CLAIM NO. AK2-5901-82

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 160,000 .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 0 .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL: ----- \$ 23,390 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 12,198 .00
34. NUMBER OF DAYS OF INJURED PERSON'S WAGE LOSS PAID TO DATE: ----- 0 days
35. ESTIMATED NUMBER OF FUTURE DAYS OF INJURED PERSON'S WAGE LOSS: ----- 0 days
36. INJURED PERSON'S GROSS WEEKLY INCOME: ----- \$ 0 .00

37. INJURED PERSON'S TOTAL ECONOMIC LOSS:

	<u>MEDICAL</u>	<u>WAGE LOSS</u>	<u>OTHER EXPENSES</u>
A) INCURRED TO DATE -----	\$ <u>wk</u> .00	\$ <u>wk</u> .00	\$ <u>wk</u> .00
B) ESTIMATED FUTURE -----	\$ <u>wk</u> .00	\$ <u>wk</u> .00	\$ <u>wk</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 100,000 .00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM: 55,000
- A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ ~~75,000~~ .00
- B) COST TO THE INSURER OF THE PAYMENTS ----- \$ 55,000 .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- \$ 440,000 .00
- D) DID YOU PURCHASE AN ANNUITY? (01) Yes (02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: Single premium
Annuity purchased to provide periodic lump
sum payments to minor child & survivor.

41. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: None known

CONTACT PERSON: DAN DUPRE ADDRESS 1000 Riverside Avenue, P.O. Box 44033
 TELEPHONE: (904) 354-5910 Jacksonville, Florida 32231-4033