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FLORIDA DEPARTMENT OF INSURANCE  
FLORIDA MEDICAL PROFESSIONAL LIABILITY  
INSURANCE CLAIMS REPORT

**BUREAU OF RATES**

DEPARTMENT FILE NO. **8801307**  
INSURER'S CLAIM NO. **509JL6769 CAL300**

1. PRIMARY INSURER NAME: The St. Paul Fire and Marine Ins Co INSURER CODE: 01470  
(See Table A)

2. EXCESS INSURER NAME: NONE INSURER CODE: \_\_\_\_\_  
(See Table A)

3. INSURED'S NAME: MARKHAM Richard D.  
(Last Name, First and Middle Name)

STREET ADDRESS: 3421 - F. S. CARTER ST

CITY, STATE: TAMPA, FL ZIP: 33629 COUNTY CODE: 03  
(See Table B)

4.	POLICY NUMBER	PER CLAIM POLICY LIMITS	AGGREGATE POLICY LIMITS
PRIMARY INSURER:	<u>509JL6769</u>	\$ <u>250,000</u> .00	\$ <u>750,000</u> .00
EXCESS INSURER:	<u>NONE</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)  
 (01) Physicians & Surgeons  
 (02) Hospitals  
 (03) Podiatrists  
 (04) Other Medical Professionals  
 (05) Clinics  
 (06) Ambulatory Surgical Centers  
 (07) Other Health Care Facilities

7. **SPECIALTY CODE:** 80102 (Applies to physicians, surgeons, and other health care professionals. Use ISO Common Statistical Base Classification Codes.)  
(See Table C)

8. **BOARD CERTIFICATION:** (Check one)  
 (01) In specialty coded in Item 7, above.  
 (02) In a different specialty.  
 (03) In the specialty in Item 7 and another specialty. Enter the additional specialty code here: \_\_\_\_\_  
 (04) Insured is not board certified. (Table C)

9. **PLACE WHERE INJURY OCCURRED:** (Check one)  
 (01) Hospital Inpatient Facility  
 (02) Emergency Room  
 (03) Hospital Outpatient Facility  
 (04) Nursing Home  
 (05) Physician's Office  
 (06) Patient's Home  
 (07) Other Outpatient Facility  
 (08) Other Location  
 (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: Centro Asturiano Hospital INSTITUTION CODE: 100149  
(See Table D)

12. **LOCATION OF INSTITUTIONAL INJURY:** (Check one)  
 (01) Patient's Room  
 (02) Operating Suite  
 (03) Recovery Room  
 (04) Labor & Delivery Room  
 (05) Physical Therapy Dept.  
 (06) Nursery  
 (07) Critical Care Unit  
 (08) Special Procedure Room  
 (09) Radiology  
 (10) Emergency Room

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13. DATE OF OCCURRENCE: 02/18/85

DATE REPORTED TO INSURER: 12/16/86

14. INJURED PERSON'S AGE: 20 Years (If less than one year, then enter 01)

INJURED PERSON'S SEX:

14.1 INJURED PERSON'S NAME:

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: <u>Acute Asthma Attack</u>	(LEAVE BLANK) 15.
16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: <u>Failure to timely diagnose and treat acute asthma attack with aggressive intervention (ie, intubation). Failure to obtain timely consultation to treat client.</u>	16.
17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: <u>Client's death, following acute asthma attack.</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>Emergency Room treatment of client's acute asthma attack.</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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DEPARTMENT FILE NO. \_\_\_\_\_  
 INSURER'S CLAIM NO. SC97L 6769

21. DATE OF SUIT, IF ANY: 04/08/87

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

<u>DEFENDANT'S NAME (Last Name, First Name)</u>	<u>INSURER CODE NO.</u>	<u>INSURER FILE ID.</u>
1) <u>NONE</u>		
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 12/01/87

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)

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> (01) No court proceedings.</li> <li><input type="checkbox"/> (02) Directed verdict for plaintiff.</li> <li><input type="checkbox"/> (03) Directed verdict for defendant.</li> <li><input type="checkbox"/> (04) Judgment notwithstanding the verdict for the plaintiff.</li> <li><input type="checkbox"/> (05) Judgment notwithstanding the verdict for the defendant.</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> (06) Judgment for the plaintiff.</li> <li><input type="checkbox"/> (07) Judgment for the defendant.</li> <li><input type="checkbox"/> (08) Judgment for the plaintiff after appeal.</li> <li><input type="checkbox"/> (09) Judgment for the defendant after appeal.</li> <li><input type="checkbox"/> (10) Other</li> <li><input type="checkbox"/> (11) Summary judgment for the plaintiff.</li> <li><input type="checkbox"/> (12) Summary judgment for the defendant.</li> </ul> |
|--|---|

28. ARBITRATION: (Check one)

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> (01) Claim not subject to arbitration.</li> <li><input type="checkbox"/> (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> (03) Award for plaintiff.</li> <li><input type="checkbox"/> (04) Award for defendant.</li> </ul> |
|--|--|

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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DEPARTMENT FILE NO. \_\_\_\_\_  
 INSURER'S CLAIM NO. 5097L 6769 09250

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT:-----\$ 225,000 .00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT:-----\$ 0 .00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL:-----\$ 5815 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID:-----\$ 3609 .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-----\$	_____ .00	\$ _____ .00	\$ _____ .00
B) ESTIMATED FUTURE-----\$	_____ .00	\$ _____ .00	\$ _____ .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS:-----\$ 225,000 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS:-----\$ \_\_\_\_\_ .00
- B) COST TO THE INSURER OF THE PAYMENTS:-----\$ \_\_\_\_\_ .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF:-----\$ \_\_\_\_\_ .00
- D) DID YOU PURCHASE AN ANNUITY? \_\_\_(01) Yes  (02) No

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: NONE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONTACT PERSON: Andrew C Lynch ADDRESS: The St. Paul Ins Co  
 TELEPHONE: (813) 286 1154 PO Box 31826 Tampa, FL  
33631-7826