

FLORIDA DEPARTMENT OF INSURANCE
 FLORIDA MEDICAL PROFESSIONAL LIABILITY
 CLOSED CLAIM REPORTING FORM

11. NAME OF INSTITUTION: Holy Cross Hospital INSTITUTION CODE: 1100073
 (See Table D)

12. LOCATION OF INSTITUTIONAL INJURY: (Check one)

<input checked="" type="checkbox"/> (01) Patient's Room	<input type="checkbox"/> (05) Physical Therapy Dept.	<input type="checkbox"/> (09) Radiology
<input type="checkbox"/> (02) Operating Room	<input type="checkbox"/> (06) Nursery	<input type="checkbox"/> (10) Emergency Room
<input type="checkbox"/> (03) Recovery Room	<input type="checkbox"/> (07) Critical Care Unit	<input type="checkbox"/> (11) Other _____
<input type="checkbox"/> (04) Labor & Delivery Room	<input type="checkbox"/> (08) Special Procedure Room	_____

13. DATE OF OCCURRENCE: 2 / 18 / 87

DATE REPORTED TO INSURER: 5 / 25 / 89

14. INJURED PERSON'S AGE: 15 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: (M) F (Circle one)

14.1 INJURED PERSON'S NAME:

STREET ADDRESS:

CITY:

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED: (LEAVE BLANK)
Sickle-cell anemia, status post appendectomy, sepsis. 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.
Not applicable.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
Member admitted patient to hospital with complaints of severe abdominal pain. Patient subsequently underwent an appendectomy performed by Dr. Bloom. Post-operatively, patient experienced fever and was placed on antibiotics. Cultures grew versinia & entrocolitica. Patient experienced a cardiopulmonary arrest and expired. Patient had previously been treated by member for sickle cell anemia.

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: 18.
Exploratory laparotomy with appendectomy.

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: 19.
Death.

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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, missed 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.
- anent (07) Major - - - - - Paraplegia, blindness, loss of two limbs, brain damage.
- (08) Grave - - - - - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
- (09) Death

21. DATE OF SUIT, IF ANY: 8 / 25 / 89

21.1 CIRCUIT COURT CASE NUMBER: 89-23620

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 110 (SEE TABLE B)

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

DEFENDANT'S NAME (Last Name, First Name)	INSURER CODE NO.	INSURER FILE ID.
1) <u>Droller, David, M.D.</u>	<u>44050</u>	<u>89-12527-02-020</u>
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

23. WAS PLAINTIFF REPRESENTED BY AN ATTORNEY? (Check one)

- (01) Yes
- (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 05 / 02 / 91

25. FINAL METHOD OF CLAIM DISPOSITION:

- (01) Settled by parties.
- (02) Disposed of by a court.
- (03) Disposed of by arbitration.

26. STAGE OF THE LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD MADE: (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 filed and prior to or during the course of mandatory settlement conference.
- (05) During trial but before court verdict.
- (06) After court verdict and prior to filing of notice of appeal.
- (07) After notice of appeal is filed or post-judgement relief or action is required for recovery.
- (08) During appeal.
- (09) After appeal.
- (10) Claims or suit abandoned.

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27. COURT: (Check one)
- | | |
|---|--|
| <input checked="" type="checkbox"/> (01) No court proceedings.
<input type="checkbox"/> (02) Directed verdict for plaintiff.
<input type="checkbox"/> (03) Directed verdict for defendant.
<input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff.
<input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant.
<input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (07) Judgment for the defendant.
<input type="checkbox"/> (08) Judgment for the plaintiff after appeal.
<input type="checkbox"/> (09) Judgment for the defendant after appeal.
<input type="checkbox"/> (10) Other
<input type="checkbox"/> (11) Summary judgment for the plaintiff.
<input type="checkbox"/> (12) Summary judgment for the defendant. |
|---|--|
28. ARBITRATION: (Check one)
- | | |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.
<input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.
<input type="checkbox"/> (04) Award for defendant. |
|--|--|
29. Was there an itemized verdict? (Check one)
- (01) Yes (02) No (If yes, please attached copy of settlement verdict.)
30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 250.00
- 30.1 AMOUNT OF DEDUCTIBLE PAID BY THIS DEFENDANT: ----- \$ 0.00
31. INDEMNITY PAID BY EXCESS CARRIER ON BEHALF OF THIS DEFENDANT: ----- \$ 0.00
32. LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL:----- \$ 11,302.00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 14,776.00
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>6,300.00</u> | \$ <u>Unknown .00</u> | \$ <u>0.00</u> |
| B) ESTIMATED FUTURE ----- | \$ <u>0.00</u> | \$ <u>0.00</u> | \$ <u>0.00</u> |
38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 250,000.00
39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- | | |
|---|-------------------|
| A) PRESENT VALUE OF PERIODIC PAYMENTS ----- | \$ <u>N/A .00</u> |
| B) COST TO THE INSURER OF THE PAYMENTS ----- | \$ <u>N/A .00</u> |
| C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- | \$ <u>N/A .00</u> |
| D) DID YOU PURCHASE AN ANNUITY? <input type="checkbox"/> (01) Yes <input checked="" type="checkbox"/> (02) No | |

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: Not applicable.

41. TYPE OF NON-ECONOMIC DAMAGE LIMIT: (Check one)

- (01) No limit (neither party requests or agrees to voluntary binding arbitration).
 (02) No limit (defendant refuses claimant's offer of voluntary binding arbitration).
 (03) \$250,000 limit (both parties accept arbitration). (See Item 42 for exception.)
 (04) \$350,000 limit (plaintiff rejects arbitration).
 (05) Does not apply because occurrence happened before the 02-08-88 law.

42. IF (03) IS CHECKED IN ITEM 41 AND THE LIMIT ON NON-ECONOMIC DAMAGES IS DIFFERENT THAN \$250,000, THEN INDICATE THE MODIFIED LIMIT: ----- \$ N/A .00

43. COLLATERAL SOURCE INFORMATION:

ENTER TO THE NEAREST PERCENT (use no decimals) THE PERCENT RECOVERY FOR ECONOMIC LOSS FROM:

- | | |
|---|---|
| A. <input type="checkbox"/> % Health | D. <input type="checkbox"/> % Automobile |
| B. <input type="checkbox"/> % Disability | E. <input type="checkbox"/> % Medicare, Medicaid & Social Security |
| C. <input type="checkbox"/> % Workers' Compensation | F. <input checked="" type="checkbox"/> % Other sources, specify: <u>Not applicable.</u> |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY: Member has discussed case with medical experts and insurance company personnel.

CONTACT PERSON: David Fujian
TELEPHONE: 305/266-9804

MEDICAL RISK CONSULTANT GROUP
ADDRESS: 1350 S.W. 57th Ave., Suite 209
Miami, Florida 33144

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