

MAR 28 1997

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

9700681

DEPT. FILE NO.

BUREAU OF PROPERTY
CASUALTY FORMS & RATES

INSURER'S CLAIM NUMBER: 96M06512

1. PRIMARY INSURER NAME: Frontier Insurance Co. of New York INSURER CODE: 0,9,5,7,4
(See Table A)

2. EXCESS INSURER NAME: N/A INSURER CODE:
(See Table A)

3a. HEALTH CARE PROVIDER: Stinson, Daniel Terrill
(Last Name, First and Middle Name or Hospital Name from Table D)

3b. IF HEALTH CARE PROVIDER (above) IS A PHYSICIAN, DENTIST OR
PODIATRIST ENTER DEPARTMENT OF PROFESSIONAL REGULATION LICENSE NUMBER: 0,0,1,9,3,8,8

3c. INSURED'S NAME: Daniel Terrill Stinson, M.D.

STREET ADDRESS: 4319 Salisbury Road

CITY: Jacksonville STATE: FL ZIP: 3,2,2,2,3 COUNTY CODE: 0,2
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
PRIMARY INSURER:	<u>R-ML-0300862-5</u>	<u>\$ 1,000,000 .00</u>	<u>\$ 3,000,000 .00</u>
EXCESS INSURER:	<u>N/A</u>	<u>\$ N/A .00</u>	<u>\$ N/A .00</u>

5. IS THE INSURED PHYSICIAN A FOREIGN MEDICAL GRADUATE? (01) Yes (02) No (If yes, enter the country
in which primary medical education was received: Switzerland **52**)

6. PROFESSION OR BUSINESS: (Check one)
 (01) Physicians & Surgeons (04) Dentist (07) Crisis Stabilization Unit
 (02) Hospitals (05) Abortion Clinics (08) Health Maintenance
 (03) Podiatrists (06) Ambulatory Surgical Centers Organization

7. SPECIALTY CODE: 8,0,2,4,9 (Applies to physicians, surgeons, and dentists.
(See Table C) Use ISO Common Statistical Base Classification Codes.)

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. Enter the additional specialty code here: _____
 (04) Insured is not board certified. (See Table C)

9. PLACE WHERE INJURY OCCURRED: (Check one)
 (01) Hospital Inpatient Facility (04) Nursing Home (07) Other Outpatient Facility
 (02) Emergency Room (05) Physician's Office (08) Other Location
 (03) Hospital Outpatient Facility (06) Patient's Home (09) Other Hospital/Institution

10. IF PLACE OF INJURY (above) IS CHECKED AS ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY
OCCURRED: N/A

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11. NAME OF INSTITUTION: St. Vincent's Medical Center INSTITUTION CODE: 1,0,0,0,4,0
 (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 Suite	<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: 01 / 18 / 96
 DATE REPORTED TO INSURER: 09 / 12 / 96

14. INJURED PERSON'S AGE: 53 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)
AXIS I 1. Dysthymia 2. Multiple drug abuse and dependency. 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: 16.
None

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: 17.
In the course of treatment which included methadone for detoxification, the claimant developed respiratory distress. He became comatose and remains in a vegetative state.

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.
The claimant was administered 80-120 mgs of methadone per day and was not monitored according to orders. This presumably resulted in respiratory failure. The high dose of methadone was used due to the excessive amount of opioids claimed by the claimant on admission.

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.
Post ischemic encephalopathy

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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, 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

21. DATE OF SUIT, IF ANY: N/A / /

21.1 CIRCUIT COURT CASE NUMBER: N/A

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: N/A (SEE TABLE B)

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>St. Vincent's Medical Center</u>	<u>UNKNOWN</u>	<u>UNKNOWN</u>
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 02/26 / 97

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) Claim 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 attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: ----- \$ 950,000 .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: ----- \$ 340 .00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 463 .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>-0-</u> .00	\$ <u>-0-</u> .00	\$ <u>-0-</u> .00
B) ESTIMATED FUTURE -----	\$ <u>-0-</u> .00	\$ <u>-0-</u> .00	\$ <u>-0-</u> .00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 950,000 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:

A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ 360,000 .00

B) COST TO THE INSURER OF THE PAYMENTS ----- \$ 251,066 .00

C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- \$ 558,000 .00

D) DID YOU PURCHASE AN ANNUITY? (01) Yes (02) No

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: \$1500 per month guaranteed for 20 years on joint life expectancy of the plaintiff and his wife.

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 type="checkbox"/> % Other sources, specify: <u>N/A</u> |

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:

Insured discussed case with defense counsel and insurance personnel.

CONTACT PERSON:
TELEPHONE:

Jill Cannon
407648-4028

ADDRESS

Frontier Insurance Company of N.Y.
20 North Orange Avenue
Suite 702
Orlando, FL 32801