

FLORIDA DEPARTMENT OF INSURANCE
FLORIDA MEDICAL PROFESSIONAL LIABILITY
INSURANCE CLAIMS REPORT

1696

DEC 1 1986

DEPARTMENT FILE NO.
INSURER'S CLAIM NO. B82-5811-80

1. PRIMARY INSURER NAME: BUREAU OF DATA FLORIDA PHYSICIANS INSURANCE COMPANY INSURER CODE: 04160
(See Table A)

2. EXCESS INSURER NAME: None INSURER CODE: _____
(See Table A)

3. INSURED'S NAME: Watt, Edward Clements
(Last Name, First and Middle Name)

STREET ADDRESS: 819 Townsend Blvd. Suite 8

CITY, STATE: Jacksonville, Florida ZIP: 32211 COUNTY CODE: 02
(See Table B)

	<u>POLICY NUMBER</u>	<u>PER CLAIM POLICY LIMITS</u>	<u>AGGREGATE POLICY LIMITS</u>
4. PRIMARY INSURER:	<u>8201-28597</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)
 (01) Physicians & Surgeons ___ (04) Other Medical Professionals ___ (07) Other Health Care Facilities
___ (02) Hospitals ___ (05) Clinics
___ (03) Podiatrists ___ (06) Ambulatory Surgical Centers

7. SPECIALTY CODE: 8.0.153 (Applies to physicians, surgeons, and other health care professionals.
(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 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 ___ (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 (8) Other, then provide a description of the place where the injury occurred: _____

11. NAME OF INSTITUTION: Penoniel Hospital of Jacksonville INSTITUTION CODE: 100179
(See Table D)

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

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B82581-81

3. DATE OF OCCURRENCE: 80,07,05
 DATE REPORTED TO INSURER: 82,05,25
 4. INJURED PERSON'S AGE: 01 Years (If less than one year, then enter 01)
 INJURED PERSON'S SEX: M (Circle one) (Infant male)

4.1 INJURED PERSON'S NAME: _____
 Last Name

5. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:	(LEAVE BLANK)
<u>Term pregnancy</u>	15.
6. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION:	16.
<u>Alleged failure to diagnose preeclampsia</u>	
7. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:	17.
<u>Infant born severely depressed</u>	
8. 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.
<u>Emergency C-section done under general Anes.</u>	
9. 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.
<u>Multiple Neuro. Complications All Resolved except bilateral deafness.</u>	

10. 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. B581

21. DATE OF SUIT, IF ANY: 2, 9, 83


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>A. GARLAND JONES, JR. MD</u>	<u>04/60</u>	<u>A82-5811-80</u>
2) <u>James Hendrick MD</u>	<u>04/60</u>	<u>C82-5811-80</u>
3) <u>Gerald P. Atock MD</u>	<u>04/60</u>	<u>D82-5811-80</u>
4) _____	_____	_____
5) _____	_____	_____

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

24. DATE OF FINAL CLAIM DISPOSITION: 10/15/86

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

See Attached Memorandum


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.
- (02) Directed verdict for plaintiff.
- (03) Directed verdict for defendant.
- (04) Judgment notwithstanding the verdict for the plaintiff.
- (05) Judgment notwithstanding the verdict for the defendant.
- (06) Judgment for the plaintiff.
- (07) Judgment for the defendant.
- (08) Judgment for the plaintiff after appeal.
- (09) Judgment for the defendant after appeal.
- (10) Other.
- (11) Summary judgment for the plaintiff.
- (12) Summary judgment for the defendant.

28. ARBITRATION: (Check one)

- (01) Claim not subject to arbitration.
- (02) Claim subject to arbitration, but previously coded disposition reached in lieu of award.
- (03) Award for plaintiff.
- (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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DEPARTMENT FILE NO. B 5811
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30. INDEMNITY PAID BY YOU ON BEHALF OF 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: ----- \$ 0 .00
All lost adjustment expense paid under Jones file
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: ----- \$ 0 .00
(# 223, 235)
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 <i>N/A</i>
B) ESTIMATED FUTURE - - - - \$.00	.00	.00

38. AMOUNT PAID FOR INJURED PERSON'S NON-ECONOMIC LOSS: ----- \$ 0 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM:
- A) PRESENT VALUE OF PERIODIC PAYMENTS ----- \$ 0 .00 *N/A*
- B) COST TO THE INSURER OF THE PAYMENTS ----- \$ 0 .00
- C) TOTAL EXPECTED PAYMENT TO PLAINTIFF ----- \$ 0 .00
- D) DID YOU PURCHASE AN ANNUITY? ___ (01) Yes ___ (02) No ** N/A*

40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: Claim settled under Jones file. This insured dismissed

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



FLORIDA PHYSICIANS INSURANCE COMPANY

1000 RIVERSIDE AVENUE • P. O. BOX 44033 • JACKSONVILLE, FLORIDA 32231 - 4033
PHONE (904) 354-5910 • WATS 1-800-342-8349

November 12, 1986

To: Department of Insurance - Attn. Bill Bodiford/Jerome Vogel
FROM: Daniel J. Dupre
Claims Supervisor - Fla. Physicians Ins. Company
RE: Florida Department of Insurance, Florida Medical Professional
Liability Insurance Claims Report.
Austin Hills - A. Garland Jonas, Jr., M.D., Edward Watt, M.D.,
James Hendrick, M.D. and Gerald Platock, M.D.

EXPLANATION AND FINAL DISPOSITION CLAIM

Final disposition of these claims is as follows: a lawsuit was filed in the
Circuit Court of Duval County in February 1983. Prior to the date of trial,
Gerald Platock, M.D. received a voluntary dismissal from the plaintiff and
Dr. Platock's file was closed, no indemnity payment was made.

The case then proceeded to trial Drs. Jonas, Watt and Hendrick were
defendants at that trial.

When the jury returned, the forman advised the Court of a verdict for the
defendants. However, two of the members of the jury informed the judge that
a defense verdict was not their choice, they were carefully questioned by
the trial judge, he ruled that there was sufficient enough question in his
mind about the true verdict that the defense verdict was set aside and a
mistrial was declared.

The defense filed an appeal of the trial judge's decision. The trial judge
was sustained on appeal and the case was reset for trial a second time.

Two days prior to the second trial Edward Watt, M.D. received a voluntary
dismissal from the plaintiff. On the second day of trial, James Hendrick,
M.D. also received a voluntary dismissal from the plaintiff. Also on the
second day of trial, the case against Garland Jonas, M.D. was concluded by
a structured settlement. The final result therefore, is that all indemnity
payment on this lawsuit was charged against A. Garland Jonas, Jr., M.D./
Edward Watt, M.D., James Hendrick, M.D. and Gerald Platock, M.D. were all
closed by voluntary dismissal.

DD/ms
ms2-35