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

9300182

DEPT. FILE NO.

BUREAU OF RATES P/C
FLA. DEPARTMENT OF INSURANCE

INSURER'S CLAIM NUMBER: 89-13156-020

1. PRIMARY INSURER NAME: PHYSICIANS PROTECTIVE TRUST FUND INSURER CODE: 440501
(See Table A)

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

3a. HEALTH CARE PROVIDER: Kelly, Thomas Jervey
(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: 001160911

3c. INSURED'S NAME: Same
STREET ADDRESS: 4020 S. Ocean Blvd.
CITY: Manalapan STATE: FL ZIP: 33462 COUNTY CODE: 06
(See Table B)

Table with 3 columns: POLICY NUMBER, PER CLAIM POLICY LIMITS, AGGREGATE POLICY LIMITS. Rows for PRIMARY INSURER and EXCESS INSURER.

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

6. PROFESSION OR BUSINESS: (Check One)

- (01) Physicians & Surgeons (02) Hospitals (03) Podiatrists (04) Dentist (05) Abortion Clinics (06) Ambulatory Surgical Centers (07) Crisis Stabilization Unit (08) Health Maintenance Organization

7. SPECIALTY CODE: 80249 (Applies to physicians, surgeons, and dentists. Use ISO Common Statistical Base Classification Codes.)

8. BOARD CERTIFICATION: (Check One)

- (01) In specialty code in Item 7, above. (02) In a different specialty. (03) In the specialty in Item 7 and another. (04) Insured is not Board Certified. Enter the additional specialty code here: (see 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 ((08) OTHER), THEN PROVIDE A DESCRIPTION OF THE PLACE WHERE THE INJURY OCCURRED: N/A

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11. NAME OF INSTITUTION: Lake Hospital of the Palm Beaches INSTITUTION CODE: 11040111  
 (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: 5 / 28 / 86

DATE REPORTED TO INSURER: 11 / 6 / 89

14. INJURED PERSON'S AGE: 21 Years (If less than one year, enter 00; if unknown, enter UNK.)

INJURED PERSON'S SEX: M (E) (Circle One)

14.1 INJURED PERSON'S NAME: \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_

\_\_\_\_\_ first and Middle Initial

15. FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED:  
Paranoid Schizophrenia.

(LEAVE BLANK)  
 15.

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

16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE:  
Plaintiff's attorney alleged failure to comply with the Florida Mental Health Act respective to the confinement of the plaintiff. They alleged wrongful detention and/or false imprisonment. Medical records showed the patient's mother gave informed consent to the patient's admission and signed the "Authorization for Treatment" which is considered proof of expressed and informed consent. Medical records did not establish the patient's mother ever revoked her consent to her daughter's care and treatment.

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:  
The patient was at risk for suicide and as such she was not permitted contact with her family members as it was felt any such communication would be harmful to her.

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:  
Patient claims she suffered injury to her reputation and health, shame, humiliation, mental anguish and hurt feelings.

19.

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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.
- nent  (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: 9 / 12 / 89

21.1 CIRCUIT COURT CASE NUMBER: 89-9260-AI

21.2 COUNTY CODE OF COUNTY SUIT FILED IN: 1016 (SEE TABLE B)

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

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

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

- (01) Yes
- (02) No

24. DATE OF FINAL CLAIM DISPOSITION: 01 / 21 / 93

25. FINAL METHOD OF CLAIM DISPOSITION: N/A

- (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 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.

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27. COURT: (Check One)

- |   |  |
|---|--|
| <input type="checkbox"/> (01) No court proceedings.<br><input checked="" type="checkbox"/> (02) Directed verdict for plaintiff.<br><input type="checkbox"/> (03) Directed verdict for defendant.<br><input type="checkbox"/> (04) Judgment notwithstanding the verdict for plaintiff.<br><input type="checkbox"/> (05) Judgment notwithstanding the verdict for defendant.<br><input type="checkbox"/> (06) Judgment for the plaintiff. | <input type="checkbox"/> (07) Judgment for the defendant.<br><input type="checkbox"/> (08) Judgment for the plaintiff after appeal.<br><input type="checkbox"/> (09) Judgment for the defendant after appeal.<br><input type="checkbox"/> (10) Other<br><input type="checkbox"/> (11) Summary Judgment for the plaintiff.<br><input type="checkbox"/> (12) Summary Judgment for the defendant. |
|---|--|

28. ARBITRATION: (Check One)

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> (01) Claim not subject to arbitration.<br><input type="checkbox"/> (02) Claim subject to arbitration, but settlement reached in lieu of award. | <input type="checkbox"/> (03) Award for plaintiff.<br><input type="checkbox"/> (04) Award for defendant. |
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29. Was there an itemized verdict? (Check One)

- (01) Yes     (02) No

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: . . . . . \$ 0.00

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: . . . . . \$ 160,612.00

33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: . . . . . \$ 65,381.00

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:	MEDICAL	WAGE LOSS	OTHER EXPENSES
A) INCURRED TO DATE . . .	\$ <u>0.00</u>	\$ <u>0.00</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: . . . . . \$ 0.00

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: N/A

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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-ECONOMICAL 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. <u>0%</u> Health                | D. <u>0%</u> Automobile                           |
| B. <u>0%</u> Disability            | E. <u>0%</u> Medicare, Medicaid & Social Security |
| C. <u>0%</u> Worker's Compensation | F. <u>0%</u> Other sources, specify: _____        |


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

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*cr/lof*  


CONTACT PERSON: Cliff Rapp, Miami Claims Regional Manager ADDRESS:  
TELEPHONE: (305) 442-4001

Physicians Protective Trust Fund  
2121 Ponce De Leon Boulevard, Suite 350  
Coral Gables, Florida 33134

DF/yt:#A:TIKE-1.47:PPTF:D/1-18