

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

100223

11. NAME OF INSTITUTION: Ft. Walton Beach Medical Center INSTITUTION CODE: Unknown (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: 08 / 19 / 94

DATE REPORTED TO INSURER: 12 / 19 / 94

14. INJURED PERSON'S AGE: 38 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: Major Depression with psychotic features, Dysthymic Disorder, Post Traumatic Stress Disorder (Incest Trauma), Borderline Personality Disorder and Alcohol Abuse (LEAVE BLANK) 15.

16. DESCRIBE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION: N/A 16.

17. DESCRIBE ACTION WHICH CAUSED CLAIM TO BE MADE: The patient was placed on suicide watch which entailed observation by the nursing staff every 15 minutes. Despite same, she hanged herself with a bathrobe belt and expired. Her Estate alleged a failure to implement appropriate suicide precaution and failure to appropriately monitor and treat patient's ** 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: Please refer to Response No. 17. 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: Asphyxia with extended hypoxia resulting in brain death. The family elected to take the patient off of the ventilator resulting in death. 19.

**17. psychiatric needs.

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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) N/A
- | | |
|---|--|
| <input 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) N/A
- (01) Yes (02) No (If yes, please attach copy of settlement or verdict.)

30. INDEMNITY PAID BY YOU ON BEHALF OF THIS DEFENDANT: - - - - - \$ 100,000 .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: - - - - - \$ 26,402 .00
33. ALL OTHER LOSS ADJUSTMENT EXPENSE PAID: - - - - - \$ 7,556 .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: - - - - - \$ 100,000 .00

39. IF A STRUCTURED SETTLEMENT OR PERIODIC PAYMENTS USED IN THIS CLAIM: N/A
- | | |
|--|--------------|
| 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? <input type="checkbox"/> (01) Yes <input type="checkbox"/> (02) No | |

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40. BRIEFLY DESCRIBE THE STRUCTURED SETTLEMENT INCLUDING HOW IT IS FINANCED: N/A

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

- A. % Health
B. % Disability
C. % Workers' Compensation
D. % Automobile
E. % Medicare, Medicaid & Social Security
F. % Other sources, specify: _____

44. SAFETY MANAGEMENT STEPS TAKEN BY INSURED TO MAKE SIMILAR OCCURRENCES LESS LIKELY:
Insured discussed case with defense counsel and insurance personnel.

CONTACT PERSON: Carol Ann Labrag ADDRESS _____
TELEPHONE: (407) 648-9028 ext 109

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