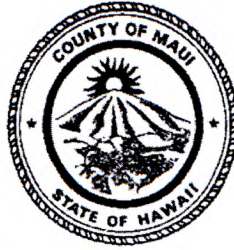


MICHAEL P. VICTORINO
Mayor

MOANA M. LUTEY
Corporation Counsel

RICHELLE M. THOMSON
First Deputy

LYDIA A. TODA
Risk Management Officer



DEPARTMENT OF THE CORPORATION COUNSEL
COUNTY OF MAUI
200 SOUTH HIGH STREET, 3RD FLOOR
WAILUKU, MAUI, HAWAII 96793
EMAIL: CORPCOUN@MAUICOUNTY.GOV

June 24, 2022

Via email only at county.clerk@mauicounty.us

Honorable Alice L. Lee, Chair
and Members of the Council
County of Maui
Wailuku, Hawaii 96793

RECEIVED
2022 JUN 24 AM 9:19
OFFICE OF THE
COUNTY CLERK

SUBJECT: Litigation Matters
Settlement of Workers Compensation Claim:
Claimant: Virginia Chapman
John Mullen Claim No.: 4062908
Resolution: Authorizing Settlement of Virginia Chapman vs.
County of Maui
Disability Compensation Division Case No.: 7-18-01109

Dear Chair Lee and Council Members:

Please find attached separately a proposed resolution entitled "AUTHORIZING SETTLEMENT OF VIRGINIA A. CHAPMAN V. COUNTY OF MAUI, DISABILITY COMPENSATION DIVISION CASE NO. 7-18-01109" The purpose of the proposed resolution is for settlement of this claim.

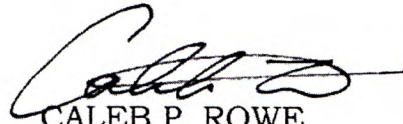
May I request that the proposed resolution be scheduled for discussion and action, or referral to the appropriate standing committee as soon as possible. A copy of the WC-1 filed with the Disability Compensation Division of the Department of Labor ("DCD") is attached. Please note that the County will continue to pay temporary total disability payments until this settlement is approved by the DCD.

It is anticipated that an executive session may be necessary to discuss questions and issues pertaining to the powers, duties, privileges, immunities, and liabilities of the County, the Council, and/or the Committee.

Honorable Alice L. Lee, Chair
and Members of the Council
County of Maui
June 24, 2022
Page | **2**

Should you have any questions or concerns, please do not hesitate to contact us. Thank you for your anticipated assistance in this matter

Sincerely,

A handwritten signature in black ink, appearing to read 'Caleb P. Rowe', with a long horizontal flourish extending to the right.

CALEB P. ROWE
Deputy Corporation Counsel

CPR:cs

cc: Lori Tsuhako, Director
Department of Housing & Human Services

Attachments

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a \$5,000 fine (Sec 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE

The law requires the employer to furnish the injured employee a copy of this report.

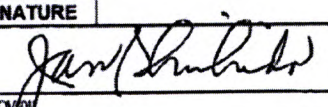
WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY										CASE NUMBER	
IDENTIFICATION SECTION											
NOTE: DO NOT WRITE IN SHADED BLOCKS											
EMPLOYEE NAME - LAST		FIRST	M.I.	SOC SEC NO	DATE OF BIRTH		SEX	MARITAL STATUS	DATE RECEIVED		
Chapman		Virginia	A		MM / DD / YY		MALE FEMALE ☒	MARRIED ☒ SINGLE	MM / DD / YY		
ADDRESS			ADDITIONAL ADDRESS INFORMATION (C/O)			CITY	STATE	ZIP CODE			
						Wailuku	HI	96793			
PHONE	OCCUPATION	DATE HIRED	YRS EMP'D CODE	DEPARTMENT		PAYROLL COMP CLASS CODE	OCC CODE				
	Ofc Ops Asst	MM / DD / YY		Hsg & Human Conc. - 14E		8810					
REGISTERED EMPLOYER						DRA					
County of Maui											
ADDRESS						CITY	STATE	ZIP CODE			
200 South High Street						Wailuku	HI	96793			
PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED		DATE OF INJURY/ILLNESS		PREFAB	DOL NUMBER		DBA		
270-7818	Government	07/06/18		07/06/18		WC-2 WC-6	M000002251				

DETAIL OF INJURY / ILLNESS									
TIME OF INJURY/ILLNESS	TIME OF DAY CODE	PLACE OF INJURY IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS			CITY	STATE	ON EMPLOYER'S PREMISES	INDUSTRIAL CODE	
11:45 AM		95 Mahalani Street, Room 20			Wailuku	HI	☒ YES ☐ NO		
HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)									
					TIME WORKSHIFT BEGAN	SOURCE OF INJURY		EVENT	
					7:45 AM				
EE lifted a box out of the corner of our upper storage unit on the property. The angle of the lift caused pain to the									
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)						TASK	ACTIVITY	ACCIDENT FACTOR	
The EE was out in the storage unit grabbing a box.									
OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him, the vapor or poison inhaled or swallowed the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)									
Lifted box above shoulder height, from a left facing angle.									
DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED						YES / NO	NATURE OF INJURY	PART OF BODY	
						DISFIGUREMENT			
						BURNS			

TIME LOST INFORMATION									
DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS OR LODGING	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR
07/09/18	YES ☒ NO		MM / DD / YY	YES ☒ NO	MM / DD / YY			40/00	

TREATMENT			OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE		GIVE NAME AND ADDRESS OF SURVIVORS ON BACK	
NAME OF PHYSICIAN			ADDRESS		PHYSICIAN'S CODE	
Maryann Hollman, MD						
NAME OF MEDICAL FACILITY			ADDRESS		INPATIENT OVERNIGHT? YES ☒ NO	
Minit Medical Clinic			270 Dairy Road Suite 239, Kahului, HI 96793		EMERGENCY ROOM ONLY? ☒	

INSURANCE				CARRIER I.D.	
1999					
NAME OF WC INSURANCE CARRIER		NAME OF ADJUSTING COMPANY		IF LIABILITY DENIED - WHY?	
Self Insured		Sedgwick			
POLICY NO.		POLICY PERIOD		ADJUSTER NAME	
Self Insured		Self Insured			
				CARRIER CASE NO.	
				ADJUSTER I.D.	
				MEDICAL DEDUCTIBLE	

SIGNATURE		TITLE		DATE	
		Deputy		Jul 11, 2018	
				MM / DD / YY	