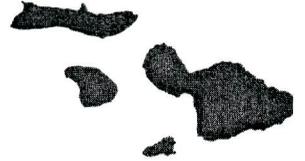
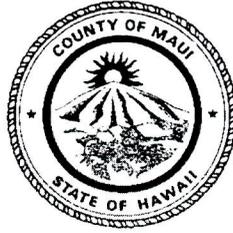


MICHAEL P. VICTORINO
Mayor

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

December 22, 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 DEC 29 AM 9:24
OFFICE OF THE
COUNTY CLERK

SUBJECT: AUTHORIZING SETTLEMENT OF GREGORY CROWTON V.
COUNTY OF MAUI, DISABILITY COMPENSATION DIVISION
CASE NO. 7-16-00279

Dear Chair Lee and Council Members:

Please find attached separately a proposed resolution entitled "AUTHORIZING SETTLEMENT OF GREGORY CROWTON V. COUNTY OF MAUI, DISABILITY COMPENSATION DIVISION CASE NO. 7-16-00279" The purpose of the proposed resolution is for settlement of a general liability 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.

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.

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 "B. Sova".

Bradley J. Sova
Deputy Corporation Counsel

cc: Director, Department of Parks & Recreation
Attachments

301652214990001

9674025

HAWAII

01/23/2016

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

PRINT		WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY				RESET		CASE NUMBER	
IDENTIFICATION SECTION		NOTE: DO NOT WRITE IN SHADED BLOCKS							
EMPLOYEE NAME - LAST CROWTON		FIRST GREGORY	MI L	SOC SEC NO	DATE OF BIRTH	SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	DATE RECEIVED 01/23/16	
ADDRESS			ADDITIONAL ADDRESS INFORMATION (C/O)			CITY WAILUKU	STATE HI	ZIP CODE 96793	
PHONE	OCCUPATION BUILDING MAINTENANCE REPAIRER I	DATE HIRED 05 / 01 / 14	YRS EMP'D CODE	DEPARTMENT PARKS AND RECREATION	PAYROLL COMP CLASS CODE	OCC CODE			
REGISTERED EMPLOYER Unit/Location: 15B3 COUNTY OF MAUI RISK MANAGEMENT DIVISION					DBA				
ADDRESS 200 S. HIGH STREET 3RD FLOOR						CITY WAILUKU	STATE HI	ZIP CODE 96793	
PHONE	NATURE OF BUSINESS GOVERNMENT	DATE INJURY/ILLNESS REPORTED 01 / 11 / 16	DATE OF INJURY/ILLNESS 01 / 11 / 16	PREFAB <input type="checkbox"/> WC-2 <input type="checkbox"/> WC-5	DOL NUMBER		DBA		

DETAIL OF INJURY / ILLNESS									
TIME OF INJURY/ILLNESS 10:00 AM	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS NOT PROVIDED	CITY	STATE	ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	INDUSTRIAL CODE 9111			
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.) THE EE WAS CLIMBING AMONG THE BOXES IN THE GARAGE AND AS HE PULLED OUT A BOX WITH HIS RIGHT ARM, HE FELT SOMETHING SNAP OR POP. THE EE FELT IMMEDIATE PAIN IN [REDACTED] BUT NOT ENOUGH TO WARRANT A VISIT TO THE DOCTOR. EACH DAY HE WORKED THE PAIN GOT WORSE AND BY 01/13/16 THE PAIN WAS UNBEARABLE. HE TOOK 01/14/16 AND 01/15/16 OFF. HE SOUGHT MEDICAL ATTENTION. NO VISIBLE INJURIES WERE REPORTED.					TIME WORKSHIFT BEGAN	SOURCE OF INJURY STRAIN OR INJURY BY	EVENT		
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.) MOVING BOXES					TASK	ACTIVITY	ACCIDENT FACTOR		
REGULAR JOB DUTIES					AOS				
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.)									
DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED STRAIN OR INJURY BY SHOULDER(S)					DISFIGUREMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	BURNS <input type="checkbox"/> YES <input type="checkbox"/> NO	NATURE OF INJURY		PART OF BODY

TIME LOST INFORMATION									
DATE DISABILITY BEGAN 01 / 14 / 16	WAS EMPLOYEE FURNISHED MEALS OR LODGING <input type="checkbox"/> YES <input type="checkbox"/> NO	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR
GIVE NAME AND ADDRESS OF SURVIVORS ON BACK									

TREATMENT			OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE				GIVE NAME AND ADDRESS OF SURVIVORS ON BACK		
NAME OF PHYSICIAN DR. LENNY		ADDRESS MAHELANI ST WAILUKU HI 96793			PHYSICIANS I.D. CODE				
NAME OF MEDICAL FACILITY KAISER PERMANENTE		ADDRESS MAHELANI ST WAILUKU HI 96793			INPATIENT OVERNIGHT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		EMERGENCY ROOM ONLY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		

INSURANCE									
NAME OF WC INSURANCE CARRIER		NAME OF ADJUSTING COMPANY SEDGWICK		IF LIABILITY DENIED - WHY?			IS LIABILITY DENIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
POLICY NO.	POLICY PERIOD TO	ADJUSTER NAME			CARRIER CASE NO				
				ADJUSTER I D		MEDICAL DEDUCTIBLE			

SIGNATURE			TITLE			DATE		
JARRAD KALUA			GENERAL CONSTRUCTION MAINT SUP II			01 / 23 / 16		