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

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,

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

NOTE: DO NOT WRITE IN SHADED BLOCKS

CASE NUMBER

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST	FIRST	MI	SOC SEC NO	DATE OF BIRTH	SEX	MARITAL STATUS	DATE RECEIVED
CROWTON	GREGORY	L		[redacted]	[X] MALE ☐ FEMALE	MARRIED [X] ☐ SINGLE	01/23/16

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE
[redacted]		WAILUKU	HI	96793

PHONE	OCCUPATION	DATE HIRED	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC CODE
[redacted]	BUILDING MAINTENANCE REPAIRER I	05 / 01 / 14		PARKS AND RECREATION		

REGISTERED EMPLOYER	DBA
Unit/Location: 15B3 COUNTY OF MAUI RISK MANAGEMENT DIVISION	

ADDRESS	CITY	STATE	ZIP CODE
200 S. HIGH STREET 3RD FLOOR	WAILUKU	HI	96793

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	DOL NUMBER	DBA
	GOVERNMENT	01 / 11 / 16	01 / 11 / 16	☐ WC-2 ☐ WC-5		

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES	INDUSTRIAL CODE
10:00 AM ___ PM		NOT PROVIDED			☐ YES ☐ NO	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)

TIME WORKSHIFT BEGAN ___ AM ___ PM

SOURCE OF INJURY: STRAIN OR INJURY BY

EVENT:

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.

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific Identify tools, equipment or material the employee was using)

MOVING BOXES

REGULAR JOB DUTIES

TASK	ACTIVITY	ACCIDENT FACTOR

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)

	YES	NO
DISFIGUREMENT	☐	☐
BURNS	☐	☐

NATURE OF INJURY	PART OF BODY
[redacted]	[redacted]

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
01 / 14 / 16	☐ YES ☐ NO		/ /	[X] YES ☐ NO	/ /		[redacted]		

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIANS I.D CODE
DR. LENNY	MAHELANI ST WAILUKU HI 96793	

NAME OF MEDICAL FACILITY	ADDRESS		YES	NO
KAISER PERNANENTE	MAHELANI ST WAILUKU HI 96793	INPATIENT OVERNIGHT?	☐	[X]
		EMERGENCY ROOM ONLY?	☐	[X]

INSURANCE

CARRIER I D

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED – WHY?	IS LIABILITY DENIED?
	SEDGWICK		☐ YES ☐ NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO
	TO		

ADJUSTER I D	MEDICAL DEDUCTIBLE

SIGNATURE

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

(REV NOV/01)

Reported By Email