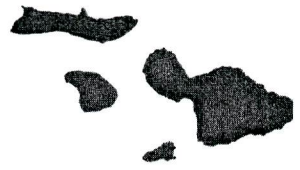
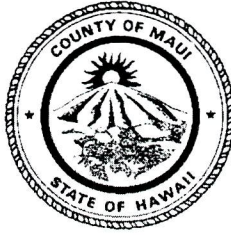


MICHAEL P. VICTORINO  
Mayor

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, 3<sup>RD</sup> FLOOR  
WAILUKU, MAUI, HAWAII 96793  
EMAIL: CORPCOUN@MAUICOUNTY.GOV

December 22, 2022

Via email only at [county.clerk@mauicounty.us](mailto: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

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

<b>DETAIL OF INJURY / ILLNESS</b>									
TIME OF INJURY/ILLNESS <b>10:00</b> AM	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS <b>NOT PROVIDED</b>	CITY	STATE	ON EMPLOYER'S PREMISES <input type="checkbox"/> YES <input type="checkbox"/> NO	INDUSTRIAL CODE <b>9111</b>			
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.) <b>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.</b>					TIME WORKSHIFT BEGAN ____ AM ____ PM		SOURCE OF INJURY <b>STRAIN OR INJURY BY</b>		EVENT
WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using) <b>MOVING BOXES</b>					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					YES	NO	NATURE OF INJURY		PART OF BODY
STRAIN OR INJURY BY <b>SHOULDER(S)</b>					DISFIGUREMENT	<input type="checkbox"/>	<input type="checkbox"/>		
					BURNS	<input type="checkbox"/>	<input type="checkbox"/>		

<b>TIME LOST INFORMATION</b>									
DATE DISABILITY BEGAN <b>01 / 14 / 16</b>	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 WKD / WK	WEIGHING FACTOR

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

<b>INSURANCE</b>		CARRIER I.D.			
NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY <b>SEDGWICK</b>	IF LIABILITY DENIED - WHY?		IS LIABILITY DENIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
POLICY NO.	POLICY PERIOD <b>TO</b>	ADJUSTER NAME		CARRIER CASE NO	
		ADJUSTER I.D.		MEDICAL DEDUCTIBLE	
<b>SIGNATURE</b>					
<b>JARRAD KALUA</b>		TITLE <b>GENERAL CONSTRUCTION MAINT SUP II</b>		DATE <b>01 / 23 / 16</b>	