INSURER: **ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY**
PHOENIX MEDICAL OFFICE - 02A
8900 N 22nd Avenue
Apt/ste 300
Phoenix, AZ 850216018

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
P.O. Box 7238
Reno, NV 89510

Claim No.: DM06628927-02A001/YY00152 **Date:** January 31, 2002

Date of Loss: November 8, 1996 **Date of Claim:** November 3, 1998
Date Suit Filed: September 30, 1998 **Date Closed:** January 17, 2002

MLSP Complaint No: L98-10-1574
Findings: Reasonable probability of malpractice.
Other Dispositions: Case settled prior to trial.

Settlement of $450,000.00

INSURED: Frank P. Silver, M.D.
Address: 341 N Buffalo, Apt/ste B
Las Vegas, NV 89128

Loss Description Complaint alleges insured was negligent during ablation surgery and burned two holes in patient's bladder resulting in urine leak and sepsis in then 47 year old woman.

Loss Location: Lake Mead Hospital, Las Vegas, NV

CLAIMANT: Pauline Lam
Patient: Same as Claimant DOB/Age: [redacted] 53 years old
Address: c/o Daniel Marks, Esq., 302 E. Carson, Suite 702, Las Vegas, NV 89101

Person Making Report: Connie Heinsohn, Claim Specialist
Address: 8900 N 22nd Ave, Ste 300, Phoenix, AZ 85021
Phone: (602) 678-3424

Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: A414074

INSURER: ST. PAUL FIRE & MARINE INSURANCE COMPANY
P.O. BOX 39600
PHOENIX, AZ 85069-9600
(602) 678-3400

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Reno, NV 89510

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Claim No.: DM08900582-02A001 Date: DECEMBER 17, 1997

Date of Loss: 04/04/91 Date of Claim: 06/14/91
Date Suit Filed: Date Closed: 10/29/97

MLSP Complaint No.:
Findings:
Other Dispositions: $65,000

INSURED: FRANK SILVER, MD
Address: 2031 McDaniel St., Suite 210, North Las Vegas, NV 89030

Loss Description: Suit alleges insured negligently injured bowel of 44-year old woman during hysterectomy procedure.
Loss Location: Las Vegas, NV

CLAIMANT: BRENDA FAYE YOUNG
Patient: {*Same as Claimant*} DOB/Age: 44
Address: c/o Atty. Rick Petrone, 3900 Paradise Ln., #181, Las Vegas, NV 89109

Person Making Report: Connie Heinsohn - Claim Representative
Address: P.O. Box 39600, Phoenix, AZ 85069-9600
Phone: (602) 678-3400

☐ Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: N/A

CH/tlj

Nevada State Board of Medical Examiners
P. O. Box 7238
Reno, NV 89510

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INSURER: St. Paul Fire & Marine Insurance Company
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064
Telephone: (602) 553-3400 **Claim ID No.:** DM06610233-02A003
Date Of Alleged Injury: 08/29/94 **Date Of Claim:** 08/21/95
MLSP Complaint Number: Unknown
Findings: Claim settled prior to being reviewed by the Medical Legal Screening Panel. Medical Legal Screening Panel case has been dismissed.
Date Suit Filed: N/A $106,000 **Date Closed:** 11/05/96
Other Dispositions: Lump sum payment paid in exchange for full release of any and all claims against insured and dismissal of the Medical Legal Screening Panel complaint. Settlement includes release agreement with a confidentiality and non-disclosure.

INSURED'S NAME: Frank P. Silver, M.D.
Address: 2031 McDaniel Street, Suite 210, North Las Vegas, NV **Zip Code:** 89030
Place Of Occurrence: Lake Mead Hospital Medical Center
Address: 1409 E. Lake Mead Blvd., North Las Vegas, NV **Zip Code:** 89030

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:
Insured physician failed to diagnose tubal pregnancy in 31 year old woman, with subsequent rupture. Patient had to undergo removal of one tube. Patient now pregnant.

CLAIMANT'S NAME: Gwendolyn Chaney-Braimoh
PATIENT'S NAME: Gwendolyn Chaney-Braimoh **Birth Date:** [redacted]
Address: c/o Anita A. Webster, Esq., 325 S. Maryland Parkway, Las Vegas, NV 89101

PERSON MAKING THIS REPORT: Connie Heinsohn
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064
Telephone: (602) 553-3400

☐ **Summons and Complaint Attached**

If Summons And Complaint not attached, Case No.: N/A
Rev. 5/89

CH:mkl

Nevada State Board
of Medical Examiners
P.O. Box 7238
Reno, Nevada 89510

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REPORT OF MEDICAL MALPRACTICE CLAIM PURSUANT TO NEVADA REVISED STATUTES - §690b.045

NOT FOR PUBLICATION

INSURER: St. Paul Fire and Marine Insurance Company
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064-0291
Telephone: (602) 553-3400 **Claim ID No.:** DM08900183-02A001
Date Of Alleged Injury: 12/9/86 **Date Of Claim:** 3/11/88
Date Suit Filed: 1/31/89
Settlement: $ **Award:** $99,090.93 **Date:** 5/17/93
Other Dispositions:

INSURED'S NAME: [redacted]
Address: **Zip Code:**
Place Of Occurrence: Women's Hospital
Address: 2025 E. Sahara Ave., Las Vegas, NV **Zip Code:** 89106

OTHER DEFENDANTS NAMED IN SAME CLAIM OR SUIT:
1. Ranjit Jain, M.D.
2. John Dudek, M.D.
3.
4.

DESCRIPTION OF ACTION OR INJURY PRECIPITATING CLAIM OR SUIT:
Failure to diagnose and properly treat the plaintiff's vesicovaginal fistula resulting in urinary incontinence. Plaintiff originally underwent hysterectomy which resulted in the fistula that Insured tried to repair.

CLAIMANT'S NAME: Jerlean McFarland
PATIENT'S NAME: Jerlean McFarland **Birth Date:** [redacted]
Address: c/o Atty. Gerald Gillock, 43053 3rd St., Las Vegas, NV
Zip Code: 89101

PERSON MAKING THIS REPORT: Cindy R. Robertson
Address: P.O. Box 10291, Phoenix, AZ **Zip Code:** 85064-0291
Telephone: (602) 553-3400

[ ] **Summons and Complaint Attached**

If Summons And Complaint not attached, Case No.: 22646

Rev. 5/89 ik

INSURER: ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY
PHOENIX MEDICAL OFFICE - 02A
8900 N. 22nd Avenue, #300
Phoenix, AZ 85021-6018

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P.O. Box 7238
Reno, NV 89510

Claim No.: DM06628927-02A002 / HT00145

Date: June 19, 2003

Date of Loss: October 20, 1997
Date Suit Filed: August 16, 2000

Date of Claim: July 1, 1999
Date Closed: April 30, 2003

MLSP Complaint No: L99-06-1706
Findings: Probable malpractice
Other Dispositions: Case settled -- amount confidential

INSURED: FRANK P. SILVER, M.D.
Address: 341 N. Buffalo, Suite B
Las Vegas, NV 89128

Loss Description: THE CLAIMANT, A 62 YEAR OLD FEMALE, ALLEGES SHE DEVELOPED A RECTOVAGINAL FISTULA FOLLOWING A HYSTERECTOMY PERFORMED BY INSURED. SHE ALSO ALLEGES LACK OF POST-OP CARE AND OTHER SIGNIFICANT POST-OP COMPLICATIONS AS WELL.

Loss Location: Las Vegas, Nevada

CLAIMANT: MARLENE LEWIN
Patient: Same as Claimant DOB/Age: [redacted]
Address: c/o Burris & Thomas
844 E. Sahara Avenue
Las Vegas, NV 89104-3017

Person Making Report: Connie Heinsohn, Medical Claim Specialist
Address: 8900 N. 22nd Avenue, #300
Phoenix, AZ 85021-6018
Phone: (602) 678-3424

Summons & Complaint Attached. If Summons & Complaint not attached, Case No.: A423093

Nevada Medical Professional Liability Closed Claim Report

I. Background

1. Name of Insurer **ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY**		2. Insurer Claim No. **DM06628927-02A002 / HT00145**
3. Injury Date (Date of Loss) **10/20/1997**	4. Report Date **06/30/1999**	5. Closure Date **04/30/2003**
6. Policy Type (choose a, b, or c) a) ☐ Occurrence b) ☒ **Claims made** c) ☐ Tail/Reporting Endorsement		
7. Policy Limits (Per Claim/Aggregate) **$ 1 MIL. / $ 3 MIL.**		8. Date This Closed Claim Report Submitted **06/20/2003**
9. Type of Report (choose a or b) a) ☒ **Initial Report** b) ☐ Updated Report		

II. Defendant & Co-Defendants

1. Defendant's Name	Last **SILVER**	First **FRANK**	M.I. **P**	Credentials (e.g. MD, DO, DMD, DDS) **M.D.**
2. License Number **2641**	3. Specialty Description **OB/GYN** ISO Code _____			4. Co-Defendant(s)? ☐ Yes ☒ **No** ☐ Unknown
5. Number of Co-Defendant(s): _____ or _____ Unknown				
6. Name, License Number and Insurer of Each Co-Defendant, if known: **N/A**				

III. Injured & Injury

1. Injured Party's Name	Last **LEWIN**	First **MARLENE**	M.I.	2. Sex: ☐ Male ☒ **Female**
3. Age **62**	4. Date of Birth (MM/DD/YY) [redacted]	5. Malpractice code (per Appendix 1): **PO**		6. Injury Code (per appendix 2): **ORG**
7. Description of Alleged Malpractice and Injuries (Attach Additional Sheet(s) if Necessary.) **Claimant alleges she developed a rectovaginal fistula following a hysterectomy performed by insured. She also alleges lack of post-op care and other significant post-op complications as well.**				
8. City Where Injury Occurred **Las Vegas**		9. Name of Institution (If Injury Occurred in Institution)		

IV. Medical/Dental Screening Panel (Hereafter, Panel)

1. Case Filed with Panel? ☒**Yes,** ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 AND 3)
2. Panel Case Number **L99-06-1706**
3. Panel Decision: Is there Reasonable Probability of Malpractice? a) ☒**Yes** b) ☐No c) ☐Unable to Decide d) ☐Case Dismissed e) ☐Other [case settled/withdrawn before panel met]
4. Court Case Filed After Panel Decision ☒**Yes** ☐No ☐Unknown

V. Court Case

1. Court Case Filed? ☒**Yes,** ☐No, ☐Unknown (IF YES, ANSWER QUESTIONS 2 - 7)		
2. Court Case Number **A423093**	3. Court Name **Dist. Court, Clark County, Nevada**	4. Court Department Number **21**
5. Date Court Case Was Filed **08/16/2000**	6. Date Verdict Was Filed, if Applicable **N/A**	7. Date Settlement Offer Accepted, if Applicable **04/23/2003**

VI. Reserves (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Reserves	Initial **$150,000**	Highest **$350,000**	Last **$350,000**

VII. Claim Disposition (Attributed to this Defendant Only)

1. Claim Disposition (check one)	a) ☐ Decided By Trial in Favor of Plaintiff	a) ☐ Decided By Trial in Favor of Defendant	b) ☐ Decided by Arbitrator in Favor of Plaintiff	c) ☐ Decided by Arbitrator in Favor of Defendant
d) ☒ **Settled w/o Court or Prior to Trial**	e) ☐ Claim Denied	f) ☐ Claim Inactive	g) ☐ Claim Withdrawn	h) ☐ Other
2. If Claim Disposition is e, f, g or j, Please Explain				

Name of Insurer ST. PAUL MEDICAL LIABILITY INSURANCE COMPANY	Insurer Claim No. DM06628927-02A002 / HT00145
Defendant's Name (Last, First, M.I.) SILVER, FRANK M.D.	Date This Closed Claim Report Submitted 06/20/2003

VIII. Verdict Information (Attributed to All Defendants in Case)

1. Verdict Awarded $ or ☒ N/A

IX. Claim Information (Amounts Attributed to this Defendant Only, If Multiple Defendants)

1. Verdict or Settlement Awarded $550,000 or ☐ N/A		2. Verdict or Settlement Paid $550,000 or ☐ N/A	
3. Reasons for Amount Awarded (1) Not Being Equal to Amount Paid (2), if Applicable (Check More than One, if Applicable) a) ______ Post Verdict Settlement b) ______ Award Reduced to Present Value c) ______ Interest Awarded d) ______ Court Costs Awarded e) ______ Non-economic damages limited by Judge to $350,000 f) ______ Award Capped by Judge at Policy Limit g) ______ Other (Explain)			
4. How Will/Did Plaintiff Receive Payments?	a) ☒ Lump Sum	b) ☐ Periodic Payments	c) ☐ N/A
5. If Periodic Payments, What is the Present Value (as of Date of Award) of the Payments? $ N/A			
6. Sources of Award Payments	a) Company $550,000	b) Defendant $	c) Other (describe) $
7. Allocated Loss Adjustment Expenses	Total $53,113.23	Attorney's Fees $40,655.00	Other $12,458.23

X. Claim Information (Amounts Attributed to Other Defendants)

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ______	ISO Code ______	4. Verdict Awarded a) ☐ Yes b) ☐ No c) ☐ Unknown	
5. Settlement Made a) ☐ Yes b) ☐ No c) ☐ Unknown		6. Verdict or Settlement Awarded $ or ☐ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ______	ISO Code ______	4. Verdict Awarded a) ☐ Yes b) ☐ No c) ☐ Unknown	
5. Settlement Made a) ☐ Yes b) ☐ No c) ☐ Unknown		6. Verdict or Settlement Awarded $ or ☐ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ______	ISO Code ______	4. Verdict Awarded a) ☐ Yes b) ☐ No c) ☐ Unknown	
5. Settlement Made a) ☐ Yes b) ☐ No c) ☐ Unknown		6. Verdict or Settlement Awarded $ or ☐ N/A		

1. Co-Defendant's Name	Last	First	M.I.	Credentials (e.g. M.D., D.O)
2. License Number	3. Specialty Description ______	ISO Code ______	4. Verdict Awarded a) ☐ Yes b) ☐ No c) ☐ Unknown	
5. Settlement Made a) ☐ Yes b) ☐ No c) ☐ Unknown		6. Verdict or Settlement Awarded $ or ☐ N/A		

(Attach Additional Sheet(s) if Necessary.)

XI. Closed Claim Report Information

1. Contact Person's Name (Last, First) **Heinsohn, Connie**
2. Contact Person's Phone Number {(999) 999-9999} **(602) 678-3424**
3. Contact Person's Address **8900 N. 22nd Avenue, #300** **Phoenix, AZ 85021-6018**

Name of Person Responsible for Report (Last, First) **Todd, Theodore**
Signature of Person Responsible for Report Ted Todd/ew

ST. PAUL DOES NOT UTILIZE ISO CODES