COUNTY OF LOS ANGELES
OFFICE OF THE COUNTY COUNSEL

648 KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

MARY C. WICKHAM
County Counsel

TELEPHONE
(213) 974-1609
FACSIMILE
(213) 626-2105
TDD
(213) 633-0901
E-MAIL
rgranbo@counsel.lacounty.gov

October 4, 2017

TO: LORI GLASGOW
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: ROGER H. GRANBO
Senior Assistant County Counsel
Executive Office

RE: **Item for the Board of Supervisors' Agenda**
County Claims Board Recommendation
Maria Loberg, et al. v. County of Los Angeles, et al.
United States District Court Case No. 16CV-06190

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

RHG:ds

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Maria Loberg, et al. v. County of Los Angeles, et al., United States District Court Case No. 16CV-06190 in the amount of $1,700,000 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Sheriff Department's budget and the Department of Mental Health's budget.

This lawsuit concerns allegations that Mr. Loberg committed suicide while in the custody of the Sheriff's Department at the Twin Towers Correctional Facility and while receiving care provided by the Department of Mental Health.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME		Maria Loberg, et. al. v. County of Los Angeles, et al.
CASE NUMBER		16CV-06190
COURT		United States District Court
DATE FILED		August 17, 2016
COUNTY DEPARTMENT		Department of Mental Health Sheriff-Custody Services Division-Specialized Programs-Twin Towers Correctional Facility
PROPOSED SETTLEMENT AMOUNT	$	$1,700,000
ATTORNEY FOR PLAINTIFF		Ronald Kaye Kaye, McLane, Bednarski & Litt
COUNTY COUNSEL ATTORNEY		Narbeh Bagdasarian Principal Deputy County Counsel
NATURE OF CASE		On November 17, 2014, Eric Loberg was arrested by Pomona Police Department and transferred to Los Angeles County Sheriff Department's custody on November 18, 2014. Mr. Loberg was evaluated and housed in general population, mental health service area. On November 26, 2014, Mr. Loberg jumped down from the upper tier of the public area where he was being housed. He was immediately transported to LAC+USC Medical Center. On December 4, 2014, Mr. Loberg died as a direct result of his head injuries. Mr. Loberg's daughters, Maria Loberg and Erica Loberg, filed a complaint against the County of Los Angeles alleging that the Los Angeles Sheriff's Department and Department of Mental Health failed to recognize Mr. Loberg's suicide risk and prevent it.
PAID ATTORNEY FEES, TO DATE	$	95,839
PAID COSTS, TO DATE	$	20,264

Case Name: Eric Loberg

Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	November 26, 2014
Briefly provide a description of the incident/event:	Eric Loberg, a 47 year old male, was first seen on September 10, 2013 in the Los Angeles Sheriff Department (LASD) Inmate Reception Center (IRC). His medical history included a diagnosis of paranoid schizophrenia and abuse of crack cocaine. On September 18, 2013, Mr. Loberg was examined by a Jail Mental Health (JMH) psychiatrist, Phoung Troung who noted that he had a disorganized thinking pattern and had difficulty answering questions. His assessment indicated that Mr. Loberg was at low risk for suicide. Mr. Loberg was approved for single inmate housing. On September 27, 2013, Mr. Loberg was taken to Olive View Medical Center to receive psychiatric treatment. On September 30, 2013, Mr. Loberg was transferred to Kedren Community Health Center (Kedren), a non-County psychiatric facility, where he stayed until his release on November 21, 2013. In the course of the following twelve months, Mr. Loberg was admitted to Kedren and also Olive Vista, another non-County mental health facility. While at Olive Vista, Mr. Loberg eloped twice but was later found and brought back. On November 17, 2014, Mr. Loberg again eloped from Olive Vista but was later found and arrested by the Pomona Police Department. On November 18, 2014, Mr. Loberg, who was on a Lanterman-Pertris Short (LPS) conservatorship, was brought back to the LASD. He was again evaluatied in the IRC and denied any history of mental illness and suicidal ideation. Mental Health (MH) staff William Bowers, R.N., evaluated the client, assessing him for suicide risk using the Suicide Risk Assessment Checklist (SRAC). Although, he determined that he was at a low risk for suicide, he recommended placement in MH High Observation Housing (HOH). MH psychiatrist, Phuong Truong, who had seen Mr. Loberg 14 months earlier as noted above, assessed Mr. Loberg the next day. Dr. Troung noted that, although Mr. Loberg was in a suicide gown, he had no signs or symptoms of a mental illness. He also completed a suicide risk assessment using the Suicide Risk Assessment Checklist (SRAC) and found him to be at low risk for suicide. He ordered the patient a moderate dose of risperidone, the antipsychotic medication he had ordered for him previously. He concluded that Mr. Loberg was alert and oriented, had a normal mood and was not depressed, anxious or delusional, that he was calm, answered questions appropriately, had no abnormal voluntary movements and was noted to be disheveled. The client told Dr. Troung that he wanted to be transferred to a dorm setting. Dr. Troung deemed Mr. Loberg was "ok for single man housing" and did not need risk precautions. During the week he spent in Moderate Observation Housing (MOH) prior to his death, Mr. Loberg had 20%

	compliance in taking the prescribed medication. He did not have any incidents. At this time, there were no JMH systems in place to notify a conservator of medication refusal or to expedite a conserved client to psych line for a revaluation and subsequent discussion by the psychiatrist and conservator regarding the risk and benefits of forcing medication. Given that there were no incidents or other concerns about the client during this time, it is the opinion of JMH Chief Psychiatrist, Joseph Neil Ortego, M.D., that it is unlikely that the client would have been forced to take the medication. During the one week period on MOH, Mr. Loberg climbed on the upper tier railing of the two-tiered housing module and leaned over the rail falling to the tier below and landing on his head, resulting in his death due to a head injury. It should also be noted that at the time of this event, all of pods in the towers had two tiers, with showers located on the second tier. All clients had free access to the stairs. If Mr. Loberg had been assessed to be at risk for jumping, he would have been sent to the Correctional Treatment Center (CTC) inpatient unit, or, if housed in High Observation Housing (HOH), he would have required cuffing for any out of cell activity or transport, with no free access to the tiers at any time. Subsequent to this event, steel mesh barriers were installed to prevent jumping in these pods persuant to the settlement agreement with the Department of Justice (DOJ).

1. Briefly describe the **root cause(s)** of the claim/lawsuit:

1. At this time, notification by Medical Services Bureau (MSB) staff to Mental Health (MH) staff regarding psychotropic medication refusal was done by emailing an excel spreadsheet containing approximately 150 to 200 patient names per day who refused psychotropic medication to the MH Program Head, Supervising Clinicians, Supervising MH psychiatrist and clerical support staff. Due to unfilled budgeted psychiatrist items, initial medication evaluations were prioritized in lieu of scheduling routine referrals, including those for patients who refused medication. Consequently the psychiatrist stated he was unaware of the client's refusal of the psychotropic medication he had ordered. It should be noted that if Dr. Troung would have been made aware of the 20% compliance, the client would have been re-scheduled for an evaluation to determine and discuss with the conservator, the risk and benefits of forcing medication.
2. At the time of the event, there was no policy for MH staff to alert a conservator of a patient who was refusing psychotropic medications.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

1. A Cerner Electronic Medical Record function in Power Chart will be utilized for referrals for healthcare requests which will include patient referrals for medication refusal.
2. A Mental Health Alert tab was added to the Power chart set of available alerts at the last Cerner upgrade, which went live in March of 2016. There is now an LPS- Conserved Alert tab.
3. The process whereby patients who refuse medication will be reviewed by a nurse and triaged according to urgency of need was added to the Correctional Health Services Draft Policy, Mental Health Referrals, stating that for patients who refuse medications, the mental health clinical staff will expedite for referral to the psych line, any patient who is LPS conserved and that Mental Health Staff will notify the Conservator as soon as possible.
4. On February 7, 2017, an administrative memo was sent to all clinical staff directing the above.
5. The policy statement: "For Patients on LPS conservatorship who are non-compliant with prescribed

medications, the Conservator will be notified as soon as possible of medication refusal," was added as a revision to the Mental Health Medication Consent Policy 70.3.1.

Are the corrective actions addressing department-wide system issues?

☐ Yes – The corrective actions address department-wide system issues.

X No – The corrective actions are only applicable to the affected parties.

Name: (Risk Management Coordinator)
Margo Morales, Administrative Deputy

Signature: Margo Morales | Date: 08/22/17

Name: (Department Head)
Jonathan E. Sherin, M.D.,Ph.D., Director

Signature: JES | Date: 8/23/17

Chief Executive Office Risk Management Inspector General USE ONLY

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☒ No, the corrective actions are applicable only to this department.

Name: (Risk Management Inspector General)
Destiny Castro

Signature: Destiny Castro | Date: 8/28/2017