COUNTY OF LOS ANGELES

CLAIMS BOARD

500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

MEMBERS OF THE BOARD

John Naimo
Auditor-Controller

Steven E. NyBlom
Chief Executive Office

John F. Krattli
Office of the County Counsel

NOTICE OF SPECIAL MEETING

The County of Los Angeles Claims Board will hold a special meeting on **Wednesday, June 9, 2010, at 3:00 p.m.**, in the Executive Conference Room, 648 Kenneth Hahn Hall of Administration, Los Angeles, California.

AGENDA

1. Call to Order.

2. Opportunity for members of the public to address the Claims Board on items of interest that are within the subject matter jurisdiction of the Claims Board.

3. Closed Session - Conference with Legal Counsel - Existing Litigation (Subdivision (a) of Government Code Section 54956.9).

   a. Leamon Scott v. County of Los Angeles
   Los Angeles Superior Court Case No. BC 406 340

   This lawsuit concerns allegations that an employee of the Department of Community and Senior Services was subjected to employment discrimination; settlement is recommended in the amount of $300,000.

   b. Tremayne Cole, Sr., and Shemeshia Page v. County of Los Angeles
   Los Angeles Superior Court Case No. VC 052 024

   This medical negligence/wrongful death lawsuit arises from treatment received by a patient at LAC+USC Medical Center, after being transferred from Los Padrinos Juvenile Hall; settlement is recommended in the amount of $400,000.
   (Continued from the meeting of May 17, 2010.)

See Supporting Documents

c. James Flores v. County of Los Angeles
Los Angeles Superior Court Case No. BC 398 286

This medical negligence lawsuit arises from treatment received by a patient while hospitalized at LAC+USC Medical Center; settlement is recommended in the amount of $1,999,000 plus assumption of a Medi-Cal lien in the amount of $747,204.

See Supporting Documents

4. Report of actions taken in Closed Session.

5. Adjournment.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Tremayne Cole, Sr., and Shemeshia Page v. County of Los Angeles, et al.
CASE NUMBER	VC 052024
COURT	Los Angeles Superior Court - South East District
DATE FILED	October 23, 2008
COUNTY DEPARTMENT	Department of Health Services and Probation Department
PROPOSED SETTLEMENT AMOUNT	$400,000
ATTORNEY FOR PLAINTIFF	Randy H. McMurray, Esq.
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian
NATURE OF CASE	On February 5, 2008, Tremayne Cole, was placed in the custody of one of the facilities of the County's Probation Department. Tremayne began having a fever and a headache. He received treatment for his condition. On February 19, 2008, Tremayne was transported to LAC+USC Medical Center where he was diagnosed with an infection. On March 4, 2008, Tremayne died as a result of complications arising out of his infection.

	Tremayne's parents filed a lawsuit against the County of Los Angeles alleging that the County staff delayed in providing the necessary care to Tremayne, and that such delay contributed to his death.
PAID ATTORNEY FEES, TO DATE	$153,095
PAID COSTS, TO DATE	$19,870.69

DHS

Case Name: COLE

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:	March 4, 2008
Briefly provide a description of the incident/event:	On February 5, 2008, Tremayne Cole was placed in the custody of one of the facilities of the County"s Probation Department. Tremayne began having fever and headache. He received treatment for his condition. On February 19, 2008, Tremayne was transported to LAC+USC Medical Center where he was diagnosed with an infection. On March 4, 2008, Tremayne died as a result of complications arising from his infection.

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

Delay in seeking physician involvement resulting in patient death.

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

- Appropriate personnel corrective actions were taken.
- Nursing procedures/policies/protocols were revised for documentation, patient care and follow up to more clearly delineate responsibilities and expectations.
- A procedure was implemented for hand-off communication to improve communication among caregivers regarding patient care responsibilities.
- A procedure was implemented for nursing clinical encounters to provide systematic review of clinical encounters.
- Nursing and Medical staff throughout JCHS were educated on newly developed and revised policies/procedures/protocols pertaining to their services.
- A nurse with quality improvement experience was permanently assigned to JCHS in November 2008.
- An acting clinical nursing director was assigned to JCHS in February 2010.
- A process was implemented to notify the Director of Probation at the respective facility of all missed dental appointments.

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

☐ Potentially has Countywide implications.

☐ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).

X Does not appear to have Countywide or other department(s) implications.

Name: (Risk Management Coordinator) Kimberly McKenzie	
Signature:	Date: 4/26/10

Name: (Department Head) John F. Schunhoff	
Signature:	Date: 4-26-10

Chief Executive Office Risk Management Branch

Name:	
Signature: Robert Chavez	Date: 04-16-10

Probation

Case Name: T. COLE V. COLA

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:	2008
Briefly provide a description of the incident/event:	On February 5, 2008 the plaintiff's 14 year-old African-American male son approximately 3'11" and 79 lbs., was detained at Los Padrinos Juvenile Hall (LPJH) for violation of conditions of the Community Detention Program (CDP). On February 5, 2008, Juvenile Court Health Services (JCHS) staff conducted a medical screening and intake, which reflected no medical problems now and no history of any medical problems. On or about February 9, 2008, the minor began having headaches/toothaches and was seen by JCHS staff several days in a row. JCHS nursing staff provided the minor with various types of medication, but did not send him to the doctor's clinic. On or about February 17, 2008, the minor was housed in the medical unit for JCHS observation and ultimately was sent to LAC/USC Medical Center. The plaintiff's allege beginning on or about February 18, 2008 their son received negligent and sub-standard treatment and care, which resulted in his death associated with meningitis on March 4, 2008. In October 2008 the plaintiff's filed a lawsuit alleging wrongful death related to a failure to provide or summon medical care, negligent hiring, general negligence and civil rights violations.

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

Root Cause Analysis:

The initial incident **stems from plaintiff son becoming ill while detained in a juvenile hall.** A root cause factor analysis was conducted including, but not limited to:

- **Exposure primarily relates to JCHS operations and is reflected in their Summary Corrective Action Plan (SCAP).**
- **Exposure compounded by:**
  - Death of plaintiff's son.
  - Witness unavailability and/or the substance of their recollection.
  - Limited charting in Juvenile Behavior Chart during important timeframes.
  - Minor continued to see JCHS staff during "Bed Rest", yet did not see the dentist.

Based upon the outcome of the above-referenced root cause analysis the Department has determined root cause factors include:

- **Limited application of charting guidelines.**
- **Reduced charting efforts.**

This matter is being settled to mitigate associated legal costs and to avoid a potentially adverse verdict associated with the root cause factors.

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

Recommended Root Cause Corrective Action:

Task #1 Name: **Probation Case Management System (PCMS) Development**

System Issue: ☒ Process/Procedure
☒ Personnel

Responsible Person: Fred Nazarbegian

Task Description:

1. The Department developed and implemented the Probation Case Management System (PCMS), which is a functional web-based application that contains various modules that handle numerous aspects of Probation's operations. PCMS enables staff to have easy access to and view information that includes, but is not limited to:
    a. One Juvenile system with the functionality from 11 systems
    b. Ability to see the complete record for each minor
    c. Ability to view and enter minor's behavioral documentation
    d. Availability of Detention information
    e. Ability view minor's history
    f. Ability to see and enter "Alert Types & Alerts" associated with the minor that specify:
        i. Special Handling Level 1-Close Observation
        ii. Medical Hold

This task was completed in April 2009 and is on-going based on the needs of the operation.

Task #2 Name:	**PCMS Training**
System Issue:	☒ Process/Procedure ☒ Personnel
Responsible Person:	Fred Nazarbegian
Task Description:	1. The Department developed and provided staff training on the use of PCMS. Upon completion of training and review of the training manual staff: a. Have an overview of PCMS b. Have a general knowledge of the web application c. Have general knowledge of the application features d. Have awareness of Probation processes and guidelines e. Have asked questions and retain the ability to receive support from the help desk **This task was completed in May 2009 and is on-going based on the needs of the operation.**
Task #3 Name:	Bureau Policy Modification associated with **PCMS**
System Issue:	☒ Process/Procedure/Personnel
Responsible Person:	Larry Rubin
Task Description:	1. The Department modified its existing Detention Services Bureau (DSB) policy in Section #5100 associated with Charting to include a renumbered Section #1800 related to the use of PCMS. Modifications relate to but are not limited to: a. Case Notes-Behavioral documentation shall no longer be handwritten manually in the Behavior Chart. All DSB staff shall enter supervision and behavioral information in the "Case Notes" section of PCMS . b. Each minor shall have a minimum of three charting entries per week. The number of recorded charting entries does not relieve staff's responsibility to record significant information on a minor at any time. c. Staff shall read and review each minor's chart weekly. Particular attention shall be given to minors requiring special handling. **This task was completed by the end of November 2009.**

Task #4 Name:	Juvenile Institutions Review of JCHS Bed Rest Policy
System Issue:	☒ Process/Procedure/Personnel
Responsible Person:	Jitahadi Imara
Task Description:	1. Probation Juvenile Institutions Division (responsible for oversight of Juvenile Halls and Camps) received the April 5, 2010 JCHS "Bed Rest" policy that is an addendum to the existing JCHS/Probation Memorandum of Understanding. Probation Juvenile Institutions Division managers will meet with staff to ensure their review and understanding of such JCHS "Bed Rest" policy, which includes, but is not limited to: a. **"Bed Rest" does not prohibit attendance at healthcare appointments.** b. If a youth has an appointment with health services in any of our (JCHS) departments, including physician, nurse, dentist, optometrist, x-ray, etc., the appointment should be kept and the patient should be transported to the clinic as scheduled even if on "Bed Rest". **This task will be completed by the end of September 2010.**

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management for assistance)

☒ Potentially has County-wide implications.

☒ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).

☒ Does not appear to have County-wide or other department implications.

Name: (Risk Management Coordinator) ERBIE PHILLIPS	
Signature: Erbie Phillips AO	Date: 6/2/10

Name: (Department Head) Donald H. Blevins	
Signature: Donald H. Blevins	Date: 6/2/10

Chief Executive Office Risk Management

Name: Robert Chavez	
Signature: Robert Chavez	Date: 5/28/10

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	James Flores v. County of Los Angeles
CASE NUMBER	BC 398286
COURT	Los Angeles Superior Court Central District
DATE FILED	September 16, 2008
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	$1,999,000 plus the assumption of the Medi-Cal lien in the amount of $747,204
ATTORNEY FOR PLAINTIFF	Steven Gamberdella, Esq.
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian
NATURE OF CASE	On August 6, 2006, James Flores presented to the emergency department at LAC+USC Medical Center ("LAC+USC") with complaints of chest and upper back pain. The LAC+USC staff evaluated the patient and conducted various diagnostic tests to identify the cause of his condition. The medical staff also arranged for various medical specialties to examine and evaluate the patient. In spite of the efforts undertaken by the staff at LAC+USC, including surgery, the patient developed a condition whereby his

	cervical spinal cords were compressed due to slow and minor bleeding. As a result, the patient became paralyzed. Mr. Flores brought a medical malpractice lawsuit against the County of Los Angeles, claiming that the LAC+USC staff delayed in providing the necessary medical care and treatment contributing to his paralysis. The County proposes to settle this case in the amount of $1,999,000 plus the assumption of the Medi-Cal lien in the amount of $747,204.
PAID ATTORNEY FEES, TO DATE	$509,956.54
PAID COSTS, TO DATE	$207,396.71

Case Name: FLORES

Summary Corrective Action Plan

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Date of incident/event:	August 6, 2006
Briefly provide a description of the incident/event:	On August 6, 2006, James Flores presented to the emergency department at LAC+USC with complaints of chest and upper back pain. The LAC+USC staff evaluated Mr. Flores and conducted various diagnostic tests to identify the cause of his condition. The medical staff also arranged for various medical specialties to examine and evaluate him. In spite of the efforts undertaken by the LAC+USC staff, including surgery, Mr. Flores developed a condition whereby his cervical spinal cord was compressed due to slow and minor bleeding. As a result, Mr. Flores became paralyzed.

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

Delayed work up of diagnostic tests resulting in incomplete quadriplegia.

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

- Availability of in-house CT/MRI at the new facility as well as other operational efficiencies has reduced the wait time for CT and MRI.
- The anticoagulation program policy was developed to provide guidelines to standardize pharmacy response to requests for assistance in managing anticoagulants.
- All DHS facilities have fully defined and implemented anticoagulation programs.
- All DHS facilities have procedures for obtaining CT scans on weekends.

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

☐ Potentially has Countywide implications.

☐ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).

X Does not appear to have Countywide or other department(s) implications.

Name: (Risk Management Coordinator) Kimberly McKenzie	
Signature: Kimberly McKenzie for	Date: 5-27-10

Name: (Department Head)	
Signature: John F. Schunhoff	Date: 5-27-10

Chief Executive Office Risk Management Branch

Name: Robert Chavez	
Signature:	Date: 5/19/10