



COUNTY OF LOS ANGELES
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Acting County Counsel

January 6, 2010

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: JOHN F. KRATTLI 
Senior Assistant County Counsel

RE: **Jaelyn Mancinas and Claudia Chavez v. County of
Los Angeles**
Los Angeles Superior Court Case No. PC 044 264

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 the 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.

JFK:rfm

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Jaelyn Mancinas and Claudia Chavez v. County of Los Angeles, Los Angeles Superior Court Case No. PC 044 264, in the amount of \$5,920,488, plus the assumption of the Medi-Cal lien in the amount of \$80,139.46, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical negligence lawsuit arises from treatment received by a patient and her mother at the Olive View Medical Center.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Jaelyn Mancinas and Claudia Chavez v. County of Los Angeles
CASE NUMBER	PC 044264
COURT	Los Angeles Superior Court Northeast District
DATE FILED	December 18, 2008
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	\$ 5,920,488 plus the assumption of the Medi-Cal lien in the amount of \$80,139.46
ATTORNEY FOR PLAINTIFF	Peter McNulty, Esq.
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian
NATURE OF CASE	<p>On April 22, 2008, Claudia Chavez, who was pregnant with twins, was admitted to Olive View Medical Center. The staff began monitoring her closely.</p> <p>On April 25, 2008, at around 4:00 p.m., Jaelyn Mancinas' (one of the twins) fetal monitor tracings showed a concerning pattern. The staff examined the patient and continued to monitor her. The concerning pattern on the monitor resolved at 4:30 p.m., but retained later. The staff continued to monitor the mother.</p>

Since the fetal monitoring strips continued showing concerning patterns, at about 2:17 a.m., on April 26, 2008, Ms. Chavez was taken to the operating room for an urgent Cesarean section. Jaelyn was delivered, but was diagnosed as having injuries caused by lack of oxygen to her brain.

Jaelyn Mancinas filed a lawsuit against the County of Los Angeles contending that the Olive View Medical Center staff failed to comply with the standard of care and delayed performing a Cesarean section.

Claudia Chavez, Jaelyn's mother, also brought an action against the County of Los Angeles for the emotional distress which she experienced during the birth of her daughter, Jaelyn.

The County proposes to settle this case in the amount of \$5,920,488 plus the assumption of the Medi-Cal lien in the amount of \$80,139.46.

PAID ATTORNEY FEES, TO DATE	\$	\$127,828.50
PAID COSTS, TO DATE	\$	36,996.93



Summary Corrective Action Plan

Date of incident/event:	April 26, 2008
Briefly provide a description of the incident/event:	On April 22, 2008, Claudia Chavez, who was pregnant with twins, was admitted to Olive View/UCLA Medical Center. The staff began monitoring her closely. On April 25, 2008, at approximately 4:00 PM, one twin's fetal monitor tracing showed a concerning pattern. Staff examined the patient and continued to monitor her. The pattern resolved at 4:30 PM, but returned later. Staff continued to monitor. Since the fetal monitoring strips continued to show a concerning pattern, at approximately 2:17 AM on April 26, 2008, Ms. Chavez was taken to the operating room for a cesarean delivery. One twin was diagnosed with brain injury due to lack of oxygen.

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

- Lack of resolution of the clinical significance of an unusual and rarely occurring heart rate pattern leading to a delay in performing a cesarean section

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 done
- A new policy was developed for consultation of the attending on call and the mandatory consultation policy was revised to include perinatology consultation.
- All other DHS hospitals were surveyed and determined to have satisfactory policies for physician consultation
- A policy was revised for the process of obtaining uncrossmatched blood.
- All other DHS hospitals were surveyed and determined to have satisfactory policies and procedures for obtaining uncrossmatched blood.
- System put in place for remote access to documents
- All applicable DHS hospitals have remote access to documents
- Fetal monitor competence testing was conducted at the facility
- Fetal monitor competence testing was conducted system wide for applicable DHS hospitals

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 County-wide implications.
- Potentially has implications 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.

Signature: (Risk Management Coordinator) <i>Kim McKenye (et)</i>	Date: 12-21-09
Signature: (Interim Chief Medical Officer) <i>Robert Splawn</i>	Date: 12/21/09
Signature: (Interim Director) <i>W. Johnson</i>	Date: 12-21-09