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County Counsel

February 16, 2010

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: JOHN F. KRATTLI
Senior Assistant County Counsel

RE: **Raymundo Soto v. County of Los Angeles, et al.**
Los Angeles Superior Court Case No. TC 021 289

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, the Summary Corrective Action Plan, and the Corrective Action Plan to be made available to the public.

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

JFK:rfm

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Raymundo Soto v. County of Los Angeles, et al., Los Angeles Superior Court Case No. TC 021 289, in the amount of $200,000, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the budget of the Los Angeles County Police.

This lawsuit concerns allegations that Los Angeles County Police Officers used excessive force in removing an individual from a hospital lobby.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME		Raymundo Soto V. County Of Los Angeles, et. al.
CASE NUMBER		TC 021289
COURT		Los Angeles Superior Court South Central District
DATE FILED		September 19, 2007
COUNTY DEPARTMENT		Los Angeles County Police
PROPOSED SETTLEMENT AMOUNT	$	200,000
ATTORNEY FOR PLAINTIFF		Nicholas Nassif and David Lumb
COUNTY COUNSEL ATTORNEY		Millicent L. Rolon
NATURE OF CASE		Plaintiff alleges that he was improperly escorted out of a County hospital and subjected to the use of excessive force by Los Angeles County Police Officers. The Officers contend that the plaintiff was improperly filming patients inside the hospital and that the force they used was reasonable and in response to resistance from the Plaintiff. Due to the risks and uncertainties of litigation, and in light of the fact that a prevailing plaintiff in a federal civil rights lawsuit is

		entitled to an award of reasonable attorneys' fees, a full and final settlement of the case in the amount of $200,000 is recommended.
PAID ATTORNEY FEES, TO DATE	$	69,897.25
PAID COSTS, TO DATE	$	14,777.56

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:	**Soto vs. Los Angeles County Police, Claim number 07-0150785*001 August 23,2006**
Briefly provide a description of the incident/event:	**On August 23, 2006, Harbor Station dispatch personnel received a call from hospital triage staff that a suspicious person was using a video camera to film the inside triage/patient areas of the hospital.** **Officers arrived in the triage area and observed a male Hispanic sitting in a wheel chair holding a video camera. As officers confronted the plaintiff to question him regarding the use of the camera, the plaintiff attempted to conceal the camera and became belligerent, yelling at the officers causing a disturbance inside the triage area interfering with the care being provided to other patients. Officers asked the plaintiff to follow them outside of the hospital so they could continue to talk with him and finish their investigation, but the plaintiff refused.** **Officers then pushed the plaintiff in his wheelchair out of the hospital and continued with their investigation. The plaintiff allegedly continued to yell at them and used his cell phone. The officer advised the plaintiff that he was being detained and then attempted to search the plaintiff by removing the keys and video camera from his lap.** **As the handling officer attempted to pickup the video camera, the plaintiff grabbed the officers forearm and started squeezing it tightly. As the officer pulled his arm away from the plaintiff's grasp, the plaintiff stood up from his wheelchair and struck the officer in the face with his fist.** **The plaintiff attempted to strike the officer several more times, but missed. The officer placed the plaintiff in a rear wrist lock and took him to the ground. With the help of other officers, the plaintiff was handcuffed and placed back into his wheelchair.** **The plaintiff was cited out and the case was filed with District Attorney's Office. During the court proceedings it was stated by the officers that they thought they were enforcing the privacy rights of patients under the Health Insurance Portability and Accountability Act (HIPPA), and that person's taking pictures within the hospital could not violate patient's rights (Court Proceedings, pp 17, 136).**

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

The plaintiff was initially video taping within the hospital. Upon contact the plaintiff was uncooperative with uniformed law enforcement officers, and the handling officer detained the plaintiff for what he thought was a violation of law. The officer then pushed the wheelchair with the plaintiff outside the hospital where further investigation took place. During a subsequent physical altercation with police officers, the plaintiff allegedly struck the handling officer in the face. Officers took the plaintiff to the ground where he was taken into custody.

Officers need to understand that photographing the inside of a hospital is not a violation of law, and should not detain citizens absent any other criminal behavior

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

<u>Correction Action One</u>: Develop training to enforce when officers can legally detain citizens, and the difference between policies and laws.

Due Date: February 28, 2010.

Responsibility: Sergeant Noble, Training Unit.

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 have 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)	Date: 01-12-10
Signature: (Department Head)	Date: 01-12-10

Corrective Action Plan

1. General Information

Date CAP document prepared:	**November 13, 2009**
Department:	**Los Angeles County Police**
Name of departmental contact person:	**Michael O'Shea**
• title:	**Captain**
• phone number:	**310- 222-3308**
• e-mail:	**moshea@police.lacounty.gov**

2. Incident/Event Specific Information

Date of incident/event:	**August 23, 2006**
Location of incident/event:	**Harbor-UCLA Hospital. 1000 West Carson St. Torrance, CA 90509**
Event contact person:	**Michael O'Shea**
• phone:	**310-222-3308**
• e-mail:	**moshea@police.lacounty.gov**
Claim adjuster: (Third Party Administrator or County Counsel)	**Millicent L. Rolon, Principal Deputy County Counsel**
• phone number:	**(213) 974- 1880**
If claim is in litigation, please complete the following:	
County Counsel Attorney:	**Millicent L. Rolon, Principal Deputy County Counsel**
• phone number:	**(213) 974- 1880**

3. Incident/Event Description:

Nature of incident/event:	**Photographing the inside of Harbor UCLA Medical Center.**
Provide a brief description of the incident/event:	**On August 23, 2006, OPS personnel responded to a call from triage staff that a suspicious person was using a video camera to film inside of the hospital.** **Officers confronted the plaintiff to question him regarding the use of the camera. The plaintiff attempted to conceal the camera and became belligerent yelling at the officers and causing a disturbance inside the triage area interfering with the care being provided to other patients. Officers asked the plaintiff to follow them outside of the hospital so they could continue to talk with him and finish their investigation, but the plaintiff refused.** **Officers then pushed the plaintiff in his wheelchair out of the hospital. The plaintiff continued to yell at the officers. An officer advised the plaintiff that he was being detained and then attempted to search the plaintiff by removing the keys and video camera from the palintiff's lap.** **As the handling officer attempted to pickup the video camera the plaintiff grabbed the officers forearm and started squeezing it tightly. As the officer pulled his arm away from the plaintiff's grasp, the plaintiff stood up from his wheelchair and struck the officer in the face with a closed fist.** **The paintiff then attempted to strike the officer several more times but was unsuccessful. The officer placed the plaintiff in a rear wrist lock and while the plaintiff was still resisting, the officer took him to the ground. With the help of the back up Officer and other officers, now at the scene, the plaintiff was handcuffed and placed back into his wheelchair.**

☐ Include a copy of the supervisor's first report of incident (or related accident, event or incident investigation documentation).

4. Corrective Action Plan Problem Statement

Provide a written narrative of the incident/event problem statement:
Lacking legal authority the officer detained the plaintiff after he discovered that the plaintiff was only violating a hospital policy, and not statutory law.

5. Root Cause Analysis

Root Cause Analysis tool used:	**The "5 Why" analysis approach was followed to get the root cause**
Incident/event root causes:	**List incident/event root causes.** **1. Officers failed to recognize that the nature of the call was a violation of a (hospital) rule or policy, not a law, statue or ordinance. Hospital workers, who are sensitive to patient confidentiality issues, believed they were allowing a HIPPA (Health Insurance Portability Act) violation to occur when the photography occurred in the lobby area.** **2. It has been a long standing and unchallenged practice within Health Services to preclude the unauthorized filming of patients within the hospital. Because of the close working relationship between the hospital staff and the County Police, what was once a way of doing business and commonplace, is now recognized as possibly being unlawful.** **3. The officer moves the subject from the lobby to a different area to complete his investigation.**

☐ Include a copy of the Root Cause Analysis tool utilized (or related Root Cause Analysis documentation).

6. Corrective Action Plan Steps

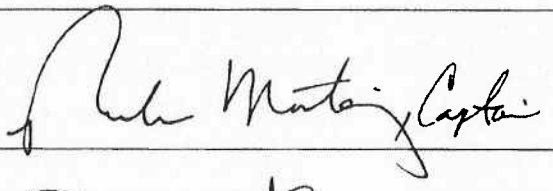
Task number:	**ONE**
Task name:	**Develop a training bulletin outlining hospital policies (i.e. HIPPA,) that are not enforceable by law enforcement officers. However, reiterate in the same bulletin that if hospital personnel exercise their right to have a policy violator removed from the hospital, that staff member would need to complete a private person's arrest on the violator. This would only be accomplished after the violator is advised of the policy violation and refuses to leave the County facility (Penal Code Section 602, Trespass). This bulletin would also address the criteria for detentions, reasonable suspicion stops and probable cause arrests.**

System issue:	❑ Process/procedure ❑ Equipment ❑ Personnel
Schedule start date:	**December 1, 2009**
Schedule completion date:	**February 28, 2010**
Responsible person:	**Sergeant Noble, Training Unit.**
Task description:	**1) Create a training bulletin.** **2) Create an alpha roster and send to station training coordinators for dissemination.**

* If additional task sheets are needed; cut and paste the above table, as needed. If necessary, delete unused Corrective Action Plan Step tables.

7. Review and Authorization

The department has reviewed the incident/event investigation, Root Cause Analysis documentation and Corrective Action Plan and has taken all appropriate corrective actions required.

Review and authorization steps:	Signature:	Date:
Document reviewed by department Risk Management Coordinator:		01/12/10
Document reviewed by department head or designee.		1/12/10

Ten Point CAP Development Model Worksheet

Please complete the worksheet with necessary information to complete the CAP form.

Model element	Description
Describe incident/event and overview of the plan	Harbor Station dispatch personnel received a call from hospital triage staff that a suspicious person was using a video camera to film the inside of the hospital. Officers arrived in the triage area and observed a male in a wheel chair holding a video camera. Officers asked the suspect to follow them outside of the hospital so they could continue to talk with him and finish their investigation, but the suspect refused. Officers detained and moved the subject out of the hospital for a violation of what they thought was law. Subsequently a use of force and an arrest of the plaintiff occurred which resulted in litigation.
Describe personnel required for implementation	Training Unit Barry Noble, Sergeant – research, development and approval of training material ALL HSB supervisors – [Sergeants & Lieutenants assigned] brief and provide in-service training
Describe time required to implement	Four Months
Describe training required	In-Service training with personnel using training bulletins
Describe equipment needed	None
Describe document that will need to be revised	No documentation will need to be revised
Describe impact on business process or project plans	Implement training for officers
Describe customer, staff, or departmental input or approval needed	Meet with DHS management and advise them that person's taking photographs within the hospital is not against the law. However, each incident would still require a review from both law enforcement and hospital administration personnel to ensure that the facility remains safe.
Describe who is needed to authorize the actions/CAP	Assistant Chief Steve Lieberman
Describe when the plan will be fully implemented and how the plan implementation effectiveness will be measured	April 30, 2010, for full implementation. The plan effectiveness will be measured by unit commanders auditing reports of citizen contacts with police personnel.