

County of Los Angeles

May 7, 2024

Dawyn R. Harrison
County Counsel



JEFF LEVINSON
INTERIM EXECUTIVE OFFICER

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TO: JEFF LEVINSON
Interim Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: ADRIENNE M. BYERS
Litigation Cost Manager 

RE: **Item for the Board of Supervisors' Agenda
County Claims Board Recommendation
Alfredo Hinojosa v. County of Los Angeles
Los Angeles Superior Court Case No. 22STCV07718**



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, Case Summary, and Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

AMB:lzs

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Alfredo Hinojosa v. County of Los Angeles, Los Angeles Superior Court Case No. 22STCV07718, in the amount of \$250,000, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical malpractice lawsuit against Harbor-UCLA Medical Center involves allegations that negligence resulted in injury to Plaintiff.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Alfredo Hinojosa v. County of Los Angeles
CASE NUMBER	22STCV07718
COURT	Los Angeles Superior Court
DATE FILED	March 3, 2022
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	\$ 250,000
ATTORNEY FOR PLAINTIFF	Steven D. Fondiler Law Offices of Steven D. Fondiler
COUNTY COUNSEL ATTORNEY	Narbeh Bagdasarian Principal Deputy County Counsel
NATURE OF CASE	<p>On June 20, 2021, Alfredo Hinojosa, a 26-year-old male, presented to Harbor-UCLA Medical Center's ("HUMC") emergency room after a fall from an off-road vehicle.</p> <p>To explore and rule out injury to his internal organs, staff ordered a computed tomography ("CT") scan with contrast. During the procedure, the contrast leaked out of the blood circulation and caused injury to Mr. Hinojosa's right hand.</p> <p>Mr. Hinojosa filed a lawsuit for medical malpractice alleging HUMC staff were negligent when performing the CT scan imaging study.</p>
PAID ATTORNEY FEES, TO DATE	\$ 38,621
PAID COSTS, TO DATE	\$ 9,284



Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for 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:	June 20, 2021
Briefly provide a description of the incident/event:	<p>On June 20, 2021, a 26-year-old male presented to Harbor-UCLA Medical Center's ("HUMC") emergency room after a fall from an off-road vehicle.</p> <p>To explore and rule out injury to his internal organs, staff ordered a computed tomography ("CT") scan with contrast. During the procedure, the contrast leaked out of the blood circulation and caused injury (compartment syndrome) to his right hand.</p>

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

- Incomplete documentation of contrast extravasation while completing the CT exam.
- Lack of standardized system for Fast Track NP on swing shift to sign out to on-duty Resident or Attending.
- Failure to document findings from final re-exam prior to Mr. Hinojosa's discharge from the ED.
- Lack of escalation by ED Attending and Resident when there were delays in reaching plastic surgery.
- Failure to recognize developing compartment syndrome by ED Attendings and Residents.
- Failure of the on-call Intern to respond to initial page to the Plastic Surgery Service.

2. Briefly describe recommended corrective actions:


(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

- Providers actions were examined using the Just Culture algorithm. Appropriate corrective actions were taken based on the Just Culture assessment.
- A standardized system for Fast Track NP on swing shift to sign out to on-duty Resident and Attending was established and communicated to ED Attendings, Residents, and NPs.
- All ED Attendings were reminded about the importance of escalating concerns through early contact with specialty service attending when there are delays in reaching on-call residents.
- The case was discussed in the Morbidity and Mortality Conference and the Emergency Department Quality Improvement meeting so that other providers are able to benefit from this learning opportunity.


3. Are the corrective actions addressing department-wide system issues?

- Yes – The corrective actions address department-wide system issues.
- No – The corrective actions are only applicable to the affected parties.

Name: (Risk Management Coordinator) Arun Patel, MD, JD	
Signature: 	Date: 1/25/24

Name: (Department Head) Christina Ghaly, MD	
Signature: 	Date: 1/29/2024

Chief Executive Office Risk Management Inspector General USE ONLY
Are the corrective actions applicable to other departments within the County?
<input type="checkbox"/> Yes, the corrective actions potentially have County-wide applicability.
<input checked="" type="checkbox"/> No, the corrective actions are applicable only to this department.

Name: (Risk Management Inspector General) Daniela Prowizor-Lacayo	
Signature: 	Date: 3/18/2024