

County of Los Angeles

December 17, 2024

Dawyn R. Harrison County Counsel

TO: EDWARD YEN

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

<u>Trinity Kennard v. County of Los Angeles, et al.</u>
Los Angeles Superior Court Case No. 22STCV18944

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



Hilda L. Solis

Supervisor, First District

Holly Mitchell

Supervisor, Second District

Lindsey P. Horvath Supervisor, Third District

Janice Hahn

Supervisor, Fourth District

Kathryn Barger

Supervisor, Fifth District



Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled <u>Trinity Kennard v. County of Los Angeles</u>, et al., Los Angeles Superior Court Case No. 22STCV18944, in the amount of \$600,000, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical malpractice lawsuit alleges that Olive View Medical Center staff negligently caused injury to Plaintiff in connection with a Cesarean section.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME Trinity Kennard vs. County of Los Angeles

CASE NUMBER 22STCV18944

COURT Los Angeles Superior Court

DATE FILED June 9, 2022

COUNTY DEPARTMENT Department of Health Services

PROPOSED SETTLEMENT AMOUNT \$ 600,000

ATTORNEY FOR PLAINTIFF Barry Novack

Law Offices of Barry Novack

COUNTY COUNSEL ATTORNEY Narbeh Bagdasarian

Principal Deputy County Counsel

NATURE OF CASE On September 8, 2021, Trinity Kennard, a 30-year-

old female, underwent a Cesarean section at Olive

View Medical Center ("OVMC"). Due to a

communication error, during the procedure, the staff erroneously transected Ms. Kennard's right fallopian tube. OVMC staff informed Ms. Kennard about the

error and offered an apology.

Ms. Kennard filed a civil action against the County alleging OVMC staff removed one of her fallopian tubes without her consent. The County agreed to

settle the case for the proposed amount.

PAID ATTORNEY FEES, TO DATE \$ 100,367

PAID COSTS, TO DATE \$ 35,067

|--|

Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary fo 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:	September 8, 2021
Briefly provide a description of the incident/event:	This case involves the care and treatment of a patient at Olive View Medical Center. The patient alleges that during a procedure on September 8, 2021, the staff improperly transected her right fallopian tube. Due to the uncertainties of litigation, a settlement was reached.

 Briefly describe the <u>root cause(s)</u> of the claim/lav 	νsι	U	J	L	L	L	L	L	l	Į	ı	,	,	ò	3	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	Ş	S	S	S	S	S	S	Ş	Ş	S	5	5	Ş	S	S	S	Ş	S	Ş	;	•	1	I	V	V	١	٨	V	١	ı١	1)	1	=	ć	ć	ĺ			,	1	r	1	ļ	ĺ	ĺ)	г	ć	l	ı)	C	(,)	3	ϵ	1	1	r	Ċ	t		Ì	t))	C	(1)	ì	S	(1	9	6	ò	S	ļ	J	ι	l	<u>a</u>	8	ć	3	C	C		t	t)	0	<u>C</u>	()(<u>)</u>	<u>C</u>	(r	Į		,	9	E	E	6	•	ľ	Ì	1
--	-----	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	----	---	---	---	---	---	---	---	--	--	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--	---	---	---	------------	---	---	---	---	---	--	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	----------	---	---	---	---	---	--	---	---	---	---	----------	---	----	----------	----------	---	---	---	--	---	---	---	---	---	---	---	---	---

Accidental transection of the right fallopian tube.	

- 2. Briefly describe recommended corrective actions:
 (Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)
 - All appropriate personnel corrective actions were taken.
 - Staff were trained regarding the State requirements related to consent for sterilization.
 - DHS created a guidance document for staff related to counseling patients about sterilization.
 - The DHS policy related to 'time-outs' before surgery was updated.
 - The standardized discharge instructions for tubal ligation were reviewed.
- 3. Are the corrective actions addressing department-wide system issues?

 - □ No The corrective actions are only applicable to the affected parties.

Document version: 4.0 (January 2013) Page 1 of 2

Name: (Risk Management Coordinator) Arun Patel, MD, JD	
Signature:	Date: 10/09/2024
Name: (Department Head)	
Christina Ghaly, MD	-
Signature:	Date:
Chily	10/16/24
Chief Executive Office Risk Management Inspector General USE O	NLY
Are the corrective actions applicable to other departments within the Co	unty?
☐ Yes, the corrective actions potentially have County-wide appli	cability.
No, the corrective actions are applicable only to this department	ent.
Name: (Risk Management Inspector General)	
Betty Karmirlian, Acting Risk Management Inspector General	
Signature:	Date:
Betty Karmirlian	10/17/2024