STATEMENT OF PROCEEDINGS

FOR THE SPECIAL MEETING

OF THE LOS ANGELES COUNTY CLAIMS BOARD

HELD IN ROOM 648 OF THE KENNETH HAHN HALL OF ADMINISTRATION,

500 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

ON

MONDAY, NOVEMBER 9, 2009, AT 8:30 AM

Present: Rocky Armfield and John Naimo
Absent: John Krattli

The following items were presented to the Claims Board for consideration and the Claims Board took actions as indicated in bold.

1. Call to Order.

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

   No members of the public addressed the Claims Board.

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

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

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

   Action Taken:

   The Claims Board continued this matter.

   Absent: John Krattli

   Vote: Unanimously carried

   See Supporting Documents

4. Report of actions taken in Closed Session.

The Claims Board reconvened in open session and reported the actions taken in closed session as indicated under Agenda Item No. 3 above.

5. Adjournment.

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		On April 22, 2008, Claudia Chavez, who was pregnant with twins, was admitted to Olive View Medical Center. The staff began monitoring her closely. 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.

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	$	$124,310
PAID COSTS, TO DATE	$	24,512.74

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:

- Delay in performing a ceserean 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).

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

Signature: (Risk Management Coordinator)	Date: 10/1/09
Signature: (Interim Chief Medical Officer)	Date: 10/1/09
Signature: (Interim Director)	Date: 10/1/09