

**STATEMENT OF PROCEEDINGS  
FOR THE REGULAR 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, MAY 7, 2012, AT 9:30 AM**

Present: Chair John Naimo, Laurie Milhiser and Patrick Wu

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. **Lianna Avetisyan, et al. v. County of Los Angeles, et al.  
Los Angeles Superior Court Case No. BC 396 962**

This alleged dangerous condition, wrongful death lawsuit arises from an automobile accident on a County road.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of \$190,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

**[See Supporting Documents](#)**

**b. Saint Francis Medical Center v. County of Los Angeles  
Los Angeles Superior Court Case No. BC 451 808**

This lawsuit concerns claims of reimbursement for medical care costs provided by Saint Francis Medical Center.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of \$275,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

[See Supporting Documents](#)

**c. Arthur Lerille, Jr., et al. v. County of Los Angeles, et al.  
Los Angeles Superior Court Case No. KC 059 580**

This lawsuit arises from injuries sustained in a vehicle accident involving an employee of the Sheriff's Department.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of \$525,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

[See Supporting Documents](#)

**d. Monique Lynch, et al. v. County of Los Angeles, et al.  
United States District Court Case No. CV 10-01441**

This lawsuit arises out of the alleged wrongful detention of a minor by the Department of Children and Family Services.

Action Taken:

The Claims Board approved settlement of this matter in the amount of \$100,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

[See Supporting Documents](#)

e. **Laura Moreno v. County of Los Angeles, et al.**  
**United States District Court Case No. CV 10-9706**

This lawsuit concerns allegations of sexual assault by a Los Angeles County Office of Public Safety Officer.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of \$250,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

**[See Supporting Documents](#)**

f. **Alyssia Frenzel v. County of Los Angeles, et al.**  
**Los Angeles Superior Court Case No. BC 432 895**

This lawsuit concerns allegations of State and federal civil rights violations, negligence, and failure to furnish medical care to a minor under the supervision of the Probation Department.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of \$161,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

**[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. Approval of the minutes of the April 16, 2012, meeting of the Claims Board.**

Action Taken:

The Claims Board approved the minutes.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

**[See Supporting Document](#)**

6. **Items not on the posted agenda, to be referred to staff or placed on the agenda for action at a further meeting of the Board, or matters requiring immediate action because of emergency situation or where the need to take immediate action came to the attention of the Board subsequent to the posting of the agenda.**

No such matters were discussed.

7. **Adjournment.**

## **CASE SUMMARY**

### **INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION**

CASE NAME	Lianna Avetisyan, et al. v. County of Los Angeles, et al.
CASE NUMBER	BC396962
COURT	Los Angeles Superior Court
DATE FILED	August 8, 2008
COUNTY DEPARTMENT	Department of Public Works – Road Maintenance
PROPOSED SETTLEMENT AMOUNT	\$ 190,000
ATTORNEY FOR PLAINTIFF	Arash Homampour, Esq. Margarit Mardirosian, Esq.
COUNTY COUNSEL ATTORNEY	Samuel Muir, Esq. Brian T. Chu, Principal Deputy County Counsel
NATURE OF CASE	This is an alleged dangerous condition lawsuit concerning an automobile accident which occurred on October 24, 2007, at approximately 10:50 p.m. Migran Gevoglanyan, age 27, was driving a 2002 Ford Crown Victoria sedan, southbound on La Cienega Boulevard, approaching the Slauson Avenue exit. For unknown reasons, Mr. Gevoglanyan lost control of his vehicle, causing it to slide sideways onto the raised median of the exit ramp, and into the end of the guardrail on the raised

median. The impact caused the guardrail to impact the driver's door, which then caused fatal injuries to Mr. Gevoglanyan. Mr. Gevoglanyan's spouse and minor son allege a dangerous condition of public roadway. The County denies that there was a dangerous roadway condition and contends that none of the roadway features contributed to this accident.

Due to the risks and uncertainties of litigation, a full and final settlement of the case in the amount of \$190,000 is recommended.

PAID ATTORNEY FEES, TO DATE	\$	310,053
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PAID COSTS, TO DATE	\$	51,671
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## Summary Corrective Action Plan

### County of Los Angeles Department of Public Works



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.

Plaintiffs:	Lianna Avetisyan, et al.
Date of incident/event:	October 24, 2007
Briefly provide a description of the incident/event:	<p>On October 24, 2007, a vehicle driven by 27-year-old Migran Gevorglyan was traveling southbound on La Cienega Boulevard near Slauson Avenue in the unincorporated County of Los Angeles area, when he broadsided the existing guardrail end-treatment at a high rate of speed, which resulted in fatal injuries. The plaintiffs allege: (1) The guardrail was on a concrete base/raised median when it should not have been; 2) the end-treatment was not curved properly; and 3) the rectangular washers that were present on the guardrail should have been omitted based on the approved standards at the time of installation.</p> <p>La Cienega Boulevard is a north/south major roadway with three lanes in each direction. The posted speed limit for southbound La Cienega Boulevard is 55 miles per hour. The subject metal guardrail and end-treatment was installed on a raised curb between La Cienega Boulevard and the southbound ramp from La Cienega Boulevard to Slauson Avenue. According to our records, the guardrail was replaced and upgraded in 1987. The contractor that performed this work was Modern Alloys, and they were successfully brought into the litigation for equitable indemnity of the County. Subsequent to their involvement, Modern Alloys set forth strong arguments that the subject end-treatment had been altered or repaired some time after their contract work in 1987.</p> <p>An investigation revealed that the repaired end-treatment struck by Mr. Gevorglyan was not installed in accordance with existing Caltrans standards because it included washers that were called to be omitted. The washers were shown to be used in a 1981 version of the Caltrans guidelines and were eliminated in the 1984 version. The minimum offset for the taper of the end-treatment was modified from the standard due to the existing space restrictions at the location.</p>

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

An out-of-control vehicle struck a guardrail that is not designed for side impacts.

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

1. Following the incident date, between late July 2008 and early August 2008, Public Works repaired the damaged end-treatment.
2. By May 1, 2012, Public Works will prepare a memo outlining the internal processes that will be followed to ensure that the design, placement, and repair of new guardrail end-treatments are based on good engineering judgment and in accordance with the applicable standards. It is expected that these processes will provide a basis for asserting a design immunity defense for any future and similar claims.
3. By May 1, 2012, Public Works will submit a proposal to develop a database using the Maintenance Management System and/or Document Management System to document and retain records and design plans related to the repair, upgrade, and replacement of guardrail end treatments. The proposal will identify the schedule and resources needed to develop the database.

4. 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 Countywide 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 Countywide or other department implications.



County of Los Angeles Department of Public Works  
Summary Corrective Action Plan

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Signature: (Risk Management Coordinator) <i>Steve M. Hennessee</i> Steven G. Steinhoff	Date: 3-26-2012
Signature: (Director) Gail Farber <i>Gail Farber</i>	Date: 4-11-12.

Chief Executive Office Risk Management Branch

Name: LEO COSTANTINO	Date:
Signature: <i>Leo Costantino</i>	Date: 3/26/2012

ML:psr  
PA:AVETISYAN SCAP2

**DEPARTMENT OF PUBLIC WORKS  
CORRECTIVE ACTION PLAN**

**LAWSUIT OF:** Lianna Avetisyan, et al.

**INCIDENT DATE:** October 24, 2007

**INCIDENT LOCATION:** Southbound La Cienega Boulevard, 424 feet south of Slauson Avenue, unincorporated County of Los Angeles area.

**RISK ISSUE:**

Public Works could be held liable for the design, repair, or reinstallation of guardrail end-treatments that are not in compliance with the standards as they existed at the time of design.

**INVESTIGATIVE REVIEW:**

On October 24, 2007, a vehicle driven by 27-year-old Migran Gevorglanyan was traveling southbound on La Cienega Boulevard near Slauson Avenue in the unincorporated County of Los Angeles area, when he broadsided the existing guardrail end-treatment at a high rate of speed, which resulted in fatal injuries. The plaintiffs allege: (1) The guardrail was on a concrete base/raised median when it should not have been; 2) the end-treatment was not curved properly; and 3) the rectangular washers that were present on the guardrail should have been omitted based on the approved standards at the time of installation.

La Cienega Boulevard is a north/south major roadway with three lanes in each direction. The posted speed limit for southbound La Cienega Boulevard is 55 miles per hour. The subject metal guardrail and end-treatment was installed on a raised curb between La Cienega Boulevard and the southbound ramp from La Cienega Boulevard to Slauson Avenue. According to our records, the guardrail was replaced and upgraded in 1987. The contractor that performed this work was Modern Alloys, and they were successfully brought into the litigation for equitable indemnity of the County. Subsequent to their involvement, Modern Alloys set forth strong arguments that the subject end-treatment had been altered or repaired some time after their contract work in 1987.

An investigation revealed that the repaired end-treatment struck by Mr. Gevorglanyan was not installed in accordance with existing Caltrans standards because it included washers that were called to be omitted. The washers were shown to be used in a 1981 version of the Caltrans guidelines and were eliminated in the 1984 version. The minimum offset for the taper of the end-treatment was modified from the standard due to the existing space restrictions at the location.

## **POLICY ISSUES:**

Under current practices, guardrail end-treatments can be evaluated for conformance with the latest standards when:

- Damage occurs requiring repairs or replacement to guardrail end-treatments;
- New roadway resurfacing or reconstruction projects, excluding preventive maintenance projects, are initiated;

In these instances, engineers involved in the review of existing conditions should ensure the end-treatments are installed based on good engineering judgment, and in accordance with the applicable standards.

## **CORRECTIVE ACTION:**

1. Following the incident date, Public Works repaired the damaged end-treatment between late July 2008 and early August 2008.
2. By May 1, 2012, Public Works will prepare a memo outlining the internal processes that will be followed to ensure that the design, placement, and repair of new guardrail end-treatments are based on good engineering judgment and in accordance with the applicable standards. It is expected that these processes will provide a basis for asserting a design immunity defense for any future and similar claims.
3. By May 1, 2012, Public Works will submit a proposal to develop a database using the Maintenance Management System and/or Document Management System to document and retain records and design plans related to the repair, upgrade, and replacement of guardrail end treatments. The proposal will identify the schedule and resources needed to develop the database.

Reviewed & Recommended:

  
Sree Kumar, Asst. Deputy Director

  
David MacGregor Asst. Deputy Director

Approved:

  
Patrick V. DeChellis, Deputy Director

  
ML:psr  
P4:AVETISYAN CAP2

## **CASE SUMMARY**

### **INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION**

<b>CASE NAME</b>	Saint Francis Medical Center v. County of Los Angeles
<b>CASE NUMBER</b>	BC 451808
<b>COURT</b>	Los Angeles Superior Court - Central District
<b>DATE FILED</b>	December 22, 2010
<b>COUNTY DEPARTMENT</b>	Los Angeles County Sheriff's Department and Department of Health Services
<b>PROPOSED SETTLEMENT AMOUNT</b>	\$275,000 (To resolve all 302 claims.)
<b>ATTORNEY FOR PLAINTIFF</b>	Aleksandra Sarosiek, Esq. Stephenson, Acquistio & Colman
<b>COUNTY COUNSEL ATTORNEY</b>	Robert E. Ragland Principal Deputy County Counsel
<b>NATURE OF CASE</b>	This is a case related to 302 claims for reimbursement for the expenses of medical care provided for prisoners in county jail. Saint Francis is a trauma hospital with an emergency room. The hospital provides emergency and other medical treatment to persons who have been arrested by local law enforcement officers, require medical treatment, and are brought to its emergency room. Some of these arrestees are medically treated by St. Francis prior to being committed into county jail.

PAID ATTORNEY FEES, TO DATE	\$83,024
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PAID COSTS, TO DATE	\$653
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Case Name: St. Francis Medical Center v City of Los Angeles and County of Los Angeles



## 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:	Various dates of medical services.
Briefly provide a description of the incident/event:	Prisoners/inmates who were under custodial arrest were brought to St. Francis Medical Center and provided with medically necessary services, supplies, and equipment. The total charges billed for the medically necessary services were either denied or underpaid.

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

St. Francis alleges that they were not fully reimbursed for inmate medical treatment.

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

In January 2012, Medical Services Bureau, Medical Billing Unit revised the "Medical Bills Denial Letter" form to include information regarding the prebook status of arrestees, including the date and time they were committed to County jail (see attached).

Medical Services Bureau will review all incoming billing to determine appropriateness of treatment and verify that patients are committed to the Los Angeles County Sheriff's Department.

Medical Services Bureau will monitor all paramedic transports on a regular basis, including mode of transportation, destination, and appropriateness of transfer. This allows tracking all emergent transport via paramedics to the nearest available hospital versus non-emergent transport to a County Hospital. When it appears that there is a questionable paramedic transport to a private facility, cases which might have been more appropriately transported to a County hospital, Medical Services Bureau-Quality Management Unit will notify the Chief Physician or designee and Facility Clinical Nursing Director in writing for their review and corrective action.

The Emergency Response class will be updated and training for nursing personnel, including staff from the Century Regional Detention Facility will be provided.

A presentation on emergent versus non-emergent transport will be provided to all physicians during the Professional Staff Association meeting.

County of Los Angeles  
Summary Corrective Action Plan

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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 for assistance)

- ☐ Potentially has County-wide implications.
- ☐ Potentially has an implication 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.

Name: (Risk Management Coordinator)	
ALEXANDER R. Yin	
Signature:	Date:
Alexander R. Yin	4/27/12

Name: (Department Head)	
Paul Tanaka	
Signature:	Date:
Paul Tanaka	4-27-12

**Chief Executive Office Risk Management**

Name:	
Signature:	Date:



## Corrective Action Plan

**Department:** Los Angeles Sheriff's Department

**Case Name:** Saint Francis Medical Center v. City of Los Angeles and County of Los Angeles

**Case No.:** BC 451808

### 1. General Information

Date CAP document prepared:	April 5, 2012
Department:	Los Angeles Sheriff's Department – Medical Services Bureau
Name of departmental contact person:	Rita Dineros
• title:	Director, Medical Services Bureau
• phone number:	(213) 893-5510
• e-mail:	rcdinero@lasd.org

### 2. Incident/Event Specific Information

Date of incident/event:	Various dates of medical services.
Location of incident/event:	St. Francis Medical Center.
Event contact person:	Rita Dineros
• phone:	(213) 893-5510
• e-mail:	rcdinero@lasd.org
Claim adjuster: (Third Party Administrator or County Counsel)	N/A
• phone number:	N/A
If claim is in litigation, please complete the following:	
County Counsel Attorney:	Robert E. Ragland
• phone number:	(213) 974-1928



### 3. Incident/Event Description:

Nature of incident/event:	Payment for emergency medical treatment provided to arrestees.
Provide a brief description of the incident/event:	Plaintiff is alleging that the County of Los Angeles is responsible for paying the emergency medical treatment received by prisoners/inmates at St. Francis Medical Center.

### 4. Corrective Action Plan Problem Statement

St. Francis Medical Center alleges that they were not fully reimbursed for inmate medical treatment.

### 5. Root Cause Analysis

Root Cause Analysis tool:	N/A
Incident/event root causes:	The Los Angeles Sheriff's Department at various times brought patients to St. Francis Medical Center to obtain medical treatment. St. Francis Medical Center alleges that the claims for these patients were either denied or underpaid.

### 6. Corrective Action Plan Steps

Task number:	N/A
Task name:	N/A
System issue:	<input type="checkbox"/> Process/procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Personnel
Schedule start date:	January 2012
Schedule completion date:	January 2012
Responsible person:	Medical Services Bureau – Medical Billing Unit
Task description:	In January 2012, Medical Services Bureau, Medical Billing Unit revised the "Medical Bills Denial Letter" form to include information regarding the prebook status of arrestees, including the date and time they were committed to County jail (see attached).

County of Los Angeles  
Corrective Action Plan

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Task number:	N/A
Task name:	N/A
System issue:	<input type="checkbox"/> Process/procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Personnel
Schedule start date:	May 2012
Schedule completion date:	N/A
Responsible person:	Medical Services Bureau
Task description:	<p>Medical Services Bureau will review all incoming billing to determine appropriateness of treatment and verify that patients are committed to the Los Angeles County Sheriff's Department.</p> <p>Medical Services Bureau will monitor all paramedic transports on a regular basis, including mode of transportation, destination, and appropriateness of transfer. This allows tracking all emergent transport via paramedics to the nearest available hospital versus non-emergent transport to a County Hospital. When it appears that there is a questionable paramedic transport to a private facility, cases which might have been more appropriately transported to a County hospital, Medical Services Bureau-Quality Management Unit will notify the Chief Physician or designee and Facility Clinical Nursing Director in writing for their review and corrective action.</p> <p>The Emergency Response class will be updated and training for nursing personnel, including staff from the Century Regional Detention Facility will be provided.</p> <p>A presentation on emergent versus non-emergent transport will be provided to all physicians during the Professional Staff Association meeting.</p>

### 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:	<i>Alexander R. Gini</i>	<i>4/27/12</i>
Document reviewed by department head or designee.	<i>Paul J. Fomala</i>	<i>4-27-12</i>

Case Name: St Francis Medical Center v. City of Los Angeles and County of Los Angeles



## 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:	Various dates of medical services
Briefly provide a description of the incident/event:	The Los Angeles County Sheriff's Department maintains a jail facility in Lynwood, California. The closest hospital to the jail facility is St. Francis Medical Center. When an inmate in the Lynwood Jail requires emergency medical treatment, the ambulance transports the inmate to the nearest emergency room. Over the previous two years, 148 County inmates from the Lynwood Jail facility have been treated by St. Francis Medical Center. St Francis Medical Center refused to accept the rate of payment for these inmates, and has also claimed that the County was legally responsible for payment of treatment costs for individuals that had not yet been committed into a County jail.

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

The County of Los Angeles is responsible for the cost of medical care provided by private hospitals to prisoners who have been committed into the County jail. The involved hospital was under the impression that the HS-40 In-Custody Medical Treatment (ICMT) Form authorized reimbursement from the County for medical services provided to arrestees who had not yet been committed into the County jail.

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

SYSTEMS

- On February 29, 2012, the County of Los Angeles Department of Health Services issued a letter to the Patient Finance Office of the involved private hospital which notified them of the discontinuation of the HS-40 ICMT Form for In-Custody billings.

SYSTEMWIDE

- On February 29, 2012, the County of Los Angeles Department of Health Services notified 28 participating private hospitals of the discontinuation of the HS-40 ICMT Form for In-Custody billings.

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 have Countywide implications.
- ☐ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).
- ☐ Does not appear to have Countywide or other department(s) implications.

Name: (Risk Management Coordinator) <i>Kimberly McKenzie</i>	
Signature: <i>[Signature]</i>	Date: <i>4/25/12</i>

Name: (Department Head)	
Signature: <i>[Signature]</i>	Date: <i>4/25/12</i>

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## Corrective Action Plan

Department of HEALTH SERVICES

Case Name: St. Francis Medical Center v. City of Los Angeles and County of Los Angeles

Case No.: BC 451808 RMIS No.: 10-1082530\*001-173

### 1. General Information

Date CAP document prepared:	April 24, 2012
Department:	Department of Health Services
Name of departmental contact person:	Eva Mora-Guillen
• title:	Interim Chief, Fiscal Services
• phone number:	(213) 240-7875
• e-mail:	<a href="mailto:eguillen@dhs.lacounty.gov">eguillen@dhs.lacounty.gov</a>

### 2. Incident/Event Specific Information

Date of incident/event:	Various dates of medical services
Location of incident/event:	St. Francis Medical Center
Event contact person:	Eva Mora-Guillen
• phone:	(213) 240-7875
• e-mail:	<a href="mailto:eguillen@dhs.lacounty.gov">eguillen@dhs.lacounty.gov</a>
Claim adjuster: <small>(Third Party Administrator or County Counsel)</small>	N/A
• phone number:	N/A
If claim is in litigation, please complete the following:	
County Counsel Attorney:	Robert E. Ragland
• phone number:	(213) 974-1928

### 3. Incident/Event Description:

Nature of incident/event:	Payment for emergency medical treatment provided to arrestees.
Provide a brief description of the incident/event:	The Los Angeles County Sheriff's Department maintains a jail in Lynwood, CA. The closest hospital to the Lynwood jail is St. Francis Medical Center. When an inmate in the Lynwood jail requires emergency medical treatment, the ambulance transports the inmate to the nearest emergency room. Over the previous 2 years, 148 County inmates from the Lynwood jail facility have been treated by St. Francis Medical Center. St. Francis Medical Center refused to accept the rate of payment for these inmates, and also claimed that the County was legally responsible for the payment of the medical treatment costs of arrestees that had not yet been committed into a County jail.

### 4. Corrective Action Plan Problem Statement

St. Francis Medical Center stated that a signed HS-40 In-Custody Medical Treatment (ICMT) Form was the authorization for reimbursement for the medical services provided to arrestees not yet committed into County jail.

### 5. Root Cause Analysis

Root Cause Analysis tool used:	N/A
Incident/event root causes:	The County of Los Angeles is responsible for the cost of medical care provided by private hospitals to prisoners who have been committed into the County jail. The involved hospital was under the impression that the HS-40 ICMT Form authorized reimbursement from the County for medical services provided to arrestees who had not yet been committed into the County jail.

### 6. Corrective Action Plan Steps

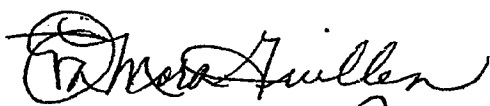
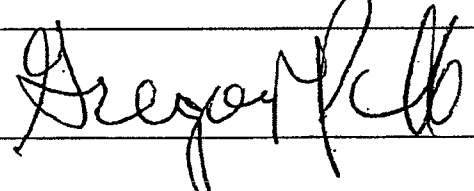
Task number:	N/A
Task name:	N/A
System issue:	<input checked="" type="checkbox"/> Process/procedure <input type="checkbox"/> Equipment <input type="checkbox"/> Personnel

County of Los Angeles  
Corrective Action Plan

Schedule start date:	2/29/12
Schedule completion date:	2/29/12
Responsible person:	Eva Mora-Guillen
Task description:	Effective 2/29/12, notification was sent to the private hospitals, including the involved hospital, that the HS-40 ICMT Form had been discontinued.

**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 completed by: Eva Mora-Guillen Interim Chief, Fiscal Services		4/25/12
Document reviewed by department head or designee: Gregory C. Polk		4/25/12



## CASE SUMMARY

### INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Arthur Lerille Jr., et al v. County of Los Angeles, et al.
CASE NUMBER	KC059580
COURT	Los Angeles County Superior Court East District
DATE FILED	September 13, 2010
COUNTY DEPARTMENT	Sheriff
PROPOSED SETTLEMENT AMOUNT	\$ 525,000
ATTORNEY FOR PLAINTIFF	Pitre & Teunisse, Inc.
COUNTY COUNSEL ATTORNEY	Vicki Kozikoujekian Principal Deputy County Counsel
NATURE OF CASE	<p>On November 8, 2008, a Deputy Sheriff, while in the course and scope of his employment, entered the intersection and collided with Mr. Lerille's vehicle.</p> <p>Plaintiff claims that the Sheriff Deputy negligently broad-sided his vehicle, by entering the intersection on a red light. The County claims that the plaintiff failed to wear a seatbelt which was the direct cause of his injuries.</p> <p>Due to the risks and uncertainties of litigation, the Sheriff's Department proposes a full and final settlement of the case in the amount of \$525,000.</p>
PAID ATTORNEY FEES, TO DATE	\$ 65,968
PAID COSTS, TO DATE	\$ 17,458

Case Name: Arthur J. Lerille, Jr. v. County of Los Angeles



## 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	Saturday, November 8, 2008; approximately 5:25 a.m.
Briefly provide a description of the incident/event	<p><b><u>Arthur J. Lerille, Jr. v. County of Los Angeles</u></b> Summary Corrective Action Plan No. 2012-011</p> <p>On Saturday, November 8, 2008, at approximately 5:25 a.m., a Los Angeles County deputy sheriff was driving a standard, black and white, County-owned patrol vehicle west on Arrow Highway, east of Sunflower Avenue, Glendora (unincorporated Los Angeles County). After he entered the intersection, the vehicle he was driving collided with the plaintiff's vehicle.</p>

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

This incident was thoroughly investigated by representatives of the Los Angeles County Sheriff's Department and the California Highway Patrol. Their investigations concluded that the deputy sheriff caused the traffic collision by violating California Vehicle Code section 21453(a), Circular Red or Red Arrow.

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

The Los Angeles County Sheriff's Department had relevant policies and procedures/protocols in effect at the time of this incident.

The Los Angeles County Sheriff's Department's training curriculum addresses the circumstances which occurred in this incident.

The Los Angeles County Sheriff's Department's administrative review revealed employee misconduct. Appropriate administrative action was taken.

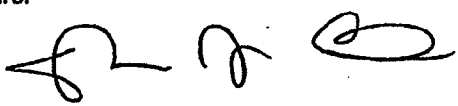
County of Los Angeles  
Summary Corrective Action Plan

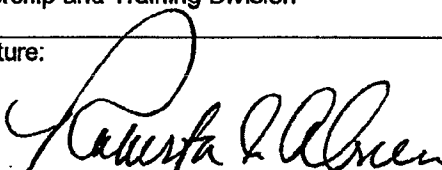
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3. State if the corrective actions are applicable to only your department or other County departments:  
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance).

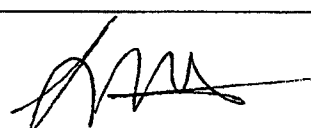
- ☐ Potentially has Countywide implications.
- ☐ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).
- ☒ Does not appear to have Countywide or other department(s) implications.

**Los Angeles County Sheriff's Department**

Name: (Risk Management Coordinator)  Shaun J. Mathers, Captain Risk Management Bureau	
Signature: 	Date: 3/22/12

Name: (Department Head)  Roberta A. Abner, Chief Leadership and Training Division	
Signature: 	Date: 03/27/12

**Chief Executive Office Risk Management Branch**

Name:  LEO COSTANTINO	
Signature: 	Date: 4/17/12

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## **CASE SUMMARY**

### **INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION**

CASE NAME	Monique Lynch, et al. v. County of Los Angeles, et al.
CASE NUMBER	CV 10-01441 JHN (FFMx)
COURT	United States District Court
DATE FILED	03/03/2010
COUNTY DEPARTMENT	Department of Children and Family Services
PROPOSED SETTLEMENT AMOUNT	\$ 100,000
ATTORNEY FOR PLAINTIFF	Mark A. Massey Joyce A. Komanapalli Komanapalli Massey LLP
COUNTY COUNSEL ATTORNEY	Lauren M. Black Principal Deputy County Counsel  Jennifer Gysler Clayton Averbuck Monroy, Averbuck & Gysler
NATURE OF CASE	Plaintiff alleges that the Department of Children and Family Services violated their rights.
PAID ATTORNEY FEES, TO DATE	\$ 54,836
PAID COSTS, TO DATE	\$ 749

Case Name: Lynch v. County of Los Angeles



**Summary Corrective Action Plan  
Department of Children and  
Family Services**



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:	March 2008
Briefly provide a description of the incident/event:	The plaintiffs allege that DCFS violated their rights.

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

The minor was detained from his legal guardian.

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

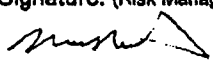

The Department has reviewed relevant policy and training. The appropriate modifications have been made.

County of Los Angeles  
Summary Corrective Action Plan

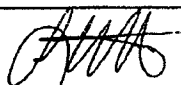
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3. State if the corrective actions are applicable to only your department or other County departments:  
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

- ☐ 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)  Michelle R. Victor	Date: 2-21-12
Signature: (Department Head)  PHILIP L. BROWNING, Interim Director	Date: 2/12/12

Chief Executive Office Risk Management Branch

Name: LEO COSTANTINO	
Signature: 	Date: 2/10/12

## CASE SUMMARY

### INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME		<u>LAURA MORENO vs. COLA, et al.</u>
CASE NUMBER		CV 10-9706 DSF(Ex)
COURT		United States District Court
DATE FILED		December 17, 2010
COUNTY DEPARTMENT		Office of Public Safety
PROPOSED SETTLEMENT AMOUNT	\$	250,000
ATTORNEY FOR PLAINTIFF		Moreno, Becerra & Casillas
COUNTY COUNSEL ATTORNEY		Millicent L. Rolon
NATURE OF CASE		<p>Plaintiff Laura Moreno alleges that her civil rights were violated when she was sexually assaulted by a Los Angeles County Office of Public Safety Officer.</p> <p>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 \$250,000 is recommended.</p>
PAID ATTORNEY FEES, TO DATE	\$	40,709
PAID COSTS, TO DATE	\$	5,126

Case Name: Moreno, Laura v. County of Los Angeles



## 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:	March 30, 2010
Briefly provide a description of the incident/event:	Plaintiff alleges on 3/30/10 she was driving at or near the I 405 and I 105 when she was stopped by a County Safety Police Officer for alleged traffic violations. Said stop was made without reasonable suspicion, probable cause or any other lawful or valid reason as claimant had not violated any traffic laws. The officer sexually molested claimant by fondling her breasts and groin area and kissing her. The police officer did not cite claimant for any violations.

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

Sexual assault committed by an on duty officer employed by the Office of Public Safety (OPS).

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

When the incident was reported to OPS on April 17, 2010, immediate action was taken including the initiation of an investigation by California Highway Patrol and placing the officer on administrative leave. The officer was terminated on September 30, 2010.

The former officer was arrested by Los Angeles S.W.A.T. on April 17, 2010 for Assault by a Peace Officer and released. No known criminal charges have been filed at this time.

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 for assistance)

☒ Potentially has County-wide implications.

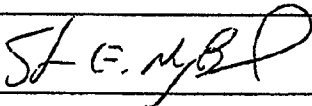
☐ Potentially has an implication to other departments (i.e., all human services, all safety departments, or one or more other departments).

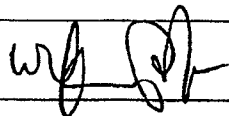
☐ Does not appear to have County-wide or other department implications.



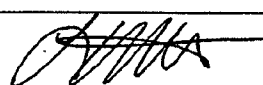
County of Los Angeles  
Summary Corrective Action Plan

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Name: (Risk Management Coordinator) Steven NyBlom	
Signature: 	Date: 2-29-12

Name: (Department Head) William T Fujioka	
Signature: 	Date: 3/7/12

**Chief Executive Office Risk Management**

Name: Leo Costantino	
Signature: 	Date: 2/29/2012

## CASE SUMMARY

### INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	<u>Alyssia Frenzel v. County of Los Angeles, et. al.</u>
CASE NUMBER	BC 432895
COURT	Los Angeles Superior Court
DATE FILED	March 3, 2010
COUNTY DEPARTMENT	Probation Department
PROPOSED SETTLEMENT AMOUNT	\$ 161,000
ATTORNEY FOR PLAINTIFF	Daniel G. Sheldon, Esq.
COUNTY COUNSEL ATTORNEY	Millicent L. Rolon
NATURE OF CASE	<p>Plaintiff, Alyssia Frenzel alleges that her federal civil rights were violated when she was seriously injured while in custody at Probation's Central Juvenile Hall due to improper supervision by Probation staff.</p> <p>Due to the risks and uncertainties of litigation, a full and final settlement of the case in the amount of \$161,000 is recommended.</p>
PAID ATTORNEY FEES, TO DATE	\$ 32,737
PAID COSTS, TO DATE	\$ 2,541

Case Name: FRENZEL V. COLA



## 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:	May 23, 2008 at approximately 4:30pm
Briefly provide a description of the incident/event:	Plaintiff was a 17 year old White Female that was approximately 5'3" 192 lbs., when she was detained at Central Juvenile Hall (CJH) on March 10, 2008 related to an Assault with a Deadly Weapon offense. The plaintiff continuously experienced hallucinations while being detained at CJH. Department of Mental Health (DMH) staff noted the plaintiff's behavior concern as self-injury and recommended an intervention plan that included keeping the plaintiffs hands/wrists/arms in sight; and actively intervene before the situation escalates if minor engages in any self harming activities. As a result, the plaintiff was placed on Level 3 and Level 4 Supervision Status throughout the timeframe she was housed at CJH, which generally requires a designated staff remain in close proximity. On May 23, 2008 at approximately 4:30p.m., the plaintiff was in the Coed Gymnasium when she ran out of the door for a ball. Staff pursued the plaintiff. However, she ran across a grass field and went up the Unit C/D steps and jumped from the 2 <sup>nd</sup> level. The plaintiff sustained injuries to both arms, her left elbow and she burst the orbital capillaries in both eyes. In March 2010, plaintiff filed a lawsuit alleging a violation of constitutional rights, negligent hiring, failure to train and supervise and general negligence.

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

### Root Cause Analysis:

The initial incident stems from plaintiff's departure from the recreational activity area while on Level 3 Enhanced Supervision. A root-cause factor analysis was conducted including, but not limited to:

- Exposure area relates to minor not following direct orders given by staff to stop.
- Compounding factors include:

- Enhanced Supervision Policy vague as to what is considered close proximity.
- Staff was not in close enough proximity to intervene and/or prevent the jump incident.
- Staff lack of attentiveness to the minor during all aspects of the recreational activity.
- Staff limited experience supervising minors during daytime activities as a DSO.
  - Staff was a Group Supervisor Nights (nighttime sleeping hour supervision) prior to the incident.
- Administrative investigation findings.
- The substance of witness recollection.

Based upon the outcome of the above-referenced root cause analysis the Department has determined root cause factors include:

- **Probation staff member deviation from Department Policies**, which included:
  - Staff failed to keep the minor in close proximity and in direct line of sight.
  - Staff failed to maintain direct and continuous visual and audio supervision of the minor.
  - Staff failure to remain alert.
- **Enhanced Supervision Policy** lack of clarity related to:
  - Description of "close proximity to minor".
  - Description of "Experienced Staff" and its relation to staff with experience as a Group Supervisor Nights (GSN), etc.
- **Minor's lack of compliance with policy** about following all rules and orders given by staff.

This matter has been settled to mitigate associated legal costs and to avoid a potentially adverse verdict associated with the root cause factors.

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

**Recommended Root Cause Corrective Action:**

**Task #1 Name:** Detention Services Bureau (DSB) Appropriate Disciplinary Action for Staff

**System Issue:** ☒ Process/Procedure/Personnel

**Responsible Person:** Larry Rubin

**Task Description:**

1. The Department will take appropriate disciplinary action against the employee with clear documented policy violations associated with this matter. Action taken will be consistent with current Performance Management/Discipline Guidelines, which include, but

is not limited to:

- a. Disciplinary Action-Notice of Suspension

This task will be completed by the end of April 2012 and may be subject to the Civil Service Commission Appeal Process.

Task #2 Name: Enhanced Supervision Policy Modification & Reinforcement

System Issue: ☒ Process/Procedure/Personnel

Responsible Person: Larry Rubin

Task Description:

1. The Department DSB reinforced modified policy in Directive #1188 that was previously in Directive #1132 and DSB Manual Section 1400 related to Enhanced Supervision. Reinforcement was done by using at least one of the following: (1) Discussion in staff meetings, (2) Individual staff review with supervisors, (3) Posted in an area frequented by staff, or (4) Electronic distribution. The policy includes, but is not limited to the following information:
  - a. Designated staff member shall:
    - i. Remain in close proximity to the minor (approx. 8-12 feet).
    - ii. Remain directly in the line of sight.
    - iii. Staff shall ensure that no minor leaves their immediate room, dormitory, or other immediate areas of supervision for any reason, without the direct authorization of the staff supervising the minor, the Shift Leader or the Duty Supervisor.
    - iv. Provide continuous visual and audio supervision of the minor.
    - v. The assigned staff shall initiate and maintain an Enhanced Supervision Observation Form (ESO) on each eight (8) hour shift during the minor's assignment to Level 4 Supervision status.
      1. The form shall be reviewed, approved and signed by the shift leader at the facility at the conclusion of each eight (8) hour shift and retained in the minor's behavior file.
  - b. Duty Supervisor Responsibilities include, but are not limited to:
    - i. Assigning appropriate staff for supervision of minors placed on Level 2, Level 3, or Level 4 status.
  - c. Shift Leader Responsibilities include, but are not limited to:

- i. Ensuring that staff assigned to supervise minors on Level 2, Level 3, or Level 4 Enhanced Supervision status are appropriately instructed as to their specific duties, including the proper positioning and supervision responsibilities, so they can provide safe and effective supervision.
- ii. Ensure that the ESO is completed by each staff member responsible for supervising a minor and that the off-going staff member's form is signed by the on-coming shift staff member, prior to the shift exchange being concluded.
- d. Supervisory staff shall only assign experienced staff to provide supervision of Level 3 Enhanced Supervision status minors (Level 4 status shall be supervised in accordance with Level 3 status).
  - i. Experienced staff is defined as one that is CORE and POST qualified, and has a minimum of six (6) months experience as a peace officer in the Probation Department (includes GSN, DSO, DPO, SDSO or SDPO series staff).

**This task was completed by the end of January 2011 and is on-going based on operational needs.**

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 for assistance)

- ☒ Potentially has County-wide implications.
- ☒ Potentially has an implication 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.

Name: (Risk Management Coordinator)	
DANIEL ACER	
Signature: D. L. Acer	Date: 4/16/12

Name: (Department Head)	
JERRY E. BOWERS	
Signature: Jerry Bowers	Date: 4/16/12

County of Los Angeles  
Summary Corrective Action Plan

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Chief Executive Office Risk Management

Name: <i>LED COSTANTINO</i>	
Signature: <i>[Signature]</i>	Date: <i>3/28/2012</i>

# **COUNTY OF LOS ANGELES CLAIMS BOARD**

## **MINUTES OF REGULAR MEETING**

**April 16, 2012**

### **1. Call to Order.**

This meeting of the County of Los Angeles Claims Board was called to order at 9:30 a.m. The meeting was held in the Executive Conference Room, 648 Kenneth Hahn Hall of Administration, Los Angeles, California.

Claims Board Members present at the meeting were: John Naimo, Laurie Milhiser, and Patrick Wu.

Other persons in attendance at the meeting were: Office of the County Counsel: Rosemarie Belda, Edwardo Montelongo, Albert Kelly, Richard Bloom and Joyce Aiello; Department of Health Services: David Cochran and Edgar Soto; Department of Community and Senior Services: Cynthia Banks, Lorenza Sanchez and Rafael Carbajal; Outside Counsel: Calvin R. House, Elizabeth M. Kessel and Lauren Thibodeaux.

### **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).**

At 9:30 a.m., the Chairperson adjourned the meeting into Closed Session to discuss the items listed as 4(a) through 4(h) below.

### **4. Report of actions taken in Closed Session.**

At 10:40 a.m., the Claims Board reconvened in open session and reported the actions taken in Closed Session as follows:

#### **a. Rahul Sheth v. County of Los Angeles, et al. Los Angeles Superior Court Case No. BC 464 946**

This lawsuit concerns allegations that an employee of the Department of Health Services was wrongfully discharged based on discrimination, harassment, and retaliation.

#### **Action Taken:**

The Claims Board approved settlement of this matter in the amount of \$97,000.

Vote: Ayes: 2 - Laurie Milhiser and Patrick Wu  
Noes: 1 - John Naimo



b. **Michael Rogne v. County of Los Angeles**  
**Los Angeles Superior Court Case No. BC 412 936**

This lawsuit concerns allegations of age discrimination against a former employee of the Department of Health Services, which allegedly led to his early retirement.

**Action Taken:**

The Claims Board approved settlement of this matter in the amount of \$55,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

c. **Lela Bohannon v. County of Los Angeles**  
**United States District Court Case No. CV 11-05251**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

**Action Taken:**

The Claims Board approved settlement of this matter in the amount of \$25,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

d. **Rlynn Smith-Thomas v. County of Los Angeles**  
**United States District Court Case No. CV 11-05249**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

**Action Taken:**

The Claims Board approved settlement of this matter in the amount of \$32,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

e. **Jesse Rivas v. County of Los Angeles**  
**United States District Court Case No. CV 11-08538**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

Action Taken:

The Claims Board approved settlement of this matter in the amount of \$32,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

f. **Jose Troconis v. County of Los Angeles**  
**United States District Court Case No. CV 08-04289**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

Action Taken:

The Claims Board approved settlement of this matter in the amount of \$60,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

g. **Khosrov Tavitian v. County of Los Angeles**  
**United States District Court Case No. CV 11-09777**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

Action Taken:

The Claims Board approved settlement of this matter in the amount of \$68,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

h. **Jorge Salcedo v. County of Los Angeles**  
**United States District Court Case No. CV 11-09775**

This lawsuit concerns allegations that the Department of Community and Senior Services failed to properly compensate employees for overtime under the Federal Fair Labor Standards Act.

Action Taken:

The Claims Board approved settlement of this matter in the amount of \$68,000.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

5. **Approval of the minutes of the April 5, 2012, special meeting of the Claims Board.**

Action Taken:

The Claims Board approved the minutes.

Vote: Ayes: 3 - John Naimo, Laurie Milhiser, and Patrick Wu

6. **Items not on the posted agenda, to be referred to staff or placed on the agenda for action at a further meeting of the Board, or matters requiring immediate action because of emergency situation or where the need to take immediate action came to the attention of the Board subsequent to the posting of the agenda.**

No such matters were discussed.

7. **Adjournment.**

The meeting was adjourned at 10:55 a.m.

COUNTY OF LOS ANGELES CLAIMS BOARD

By Carol J. Slosson  
Carol J. Slosson