# COUNTY OF LOS ANGELES

## CLAIMS BOARD

500 WEST TEMPLE STREET

LOS ANGELES, CALIFORNIA 90012-2713

MEMBERS OF THE BOARD

John Naimo
Auditor-Controller

Steve Robles
Chief Executive Office

Patrick A. Wu
Office of the County Counsel

## NOTICE OF MEETING

The County of Los Angeles Claims Board will hold its regular meeting on **Monday, January 4, 2016, at 9:30 a.m.**, in the Executive Conference Room, 648 Kenneth Hahn Hall of Administration, Los Angeles, California.

## AGENDA

1. Call to Order.

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

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

   a. Carol Mabee v. County of Los Angeles
   Los Angeles Superior Court Case No. BC 546 568

   This lawsuit concerns allegations that an employee of the Department of Health Services was subjected to disability harassment and that the Department failed to provide a reasonable accommodation; settlement is recommended in the amount of $95,000.

   b. Beau M. v. County of Los Angeles, et al.
   Los Angeles Superior Court Case No. NC 057 214

   This medical malpractice lawsuit concerns allegations of injuries sustained by Plaintiff when receiving care and treatment at Harbor-UCLA Medical Center; settlement is recommended in the amount of $1,000,000, plus assumption of the medical liens in the approximate amount of $450,000.

   See Supporting Document

c. Alice Stockton v. County of Los Angeles, et al.
United States District Court Case No. CV 14-5764

This wrongful death lawsuit concerns allegations of excessive force arising from a shooting by a Sheriff Deputy; settlement is recommended in the amount of $375,000.

See Supporting Documents

d. Heather Kowalczyk v. County of Los Angeles, et al.
Los Angeles Superior Court Case No. BC 531 503

This lawsuit arises from injuries sustained in a vehicle accident involving an on-duty Sheriff's Deputy; settlement is recommended in the amount of $2,200,000.

See Supporting Documents

4. Report of actions taken in Closed Session.

5. Approval of the minutes of the December 21, 2015, regular meeting of the Claims Board.

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.

7. Adjournment.

## CASE SUMMARY

## INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

| | | |
|---|---|---|
| CASE NAME | | Beau M. v. County of Los Angeles, et al. |
| CASE NUMBER | | NC 057214 |
| COURT | | Los Angeles County Superior Court |
| DATE FILED | | February 22, 2012 |
| COUNTY DEPARTMENT | | Department of Health Services |
| PROPOSED SETTLEMENT AMOUNT | $ | 1,000,000, plus the County's assumption to the medical liens |
| ATTORNEY FOR PLAINTIFF | | Roger Hawkins, Esq.<br>Taubman, Simpson, Young & Sulentor |
| COUNTY COUNSEL ATTORNEY | | Narbeh Bagdasarian<br>Senior Deputy County Counsel |
| NATURE OF CASE | | On January 18, 2011, Beau M., a 6 months old female, was brought to Harbor-UCLA Medical Center to receive treatment for her infection.<br><br>In the course of the treatment, Beau M. suffered a cardiopulmonary arrest. She was resuscitated and received necessary treatment.<br><br>Beau M., through her Guardian ad Litem, filed a medical malpractice action against the County of Los Angeles and her non-County physician alleging that the defendants' care and treatment was negligent causing her to suffer injuries. |
| PAID ATTORNEY FEES, TO DATE | $ | 111,680.00 |
| PAID COSTS, TO DATE | $ | 45,730.00 |

# CASE SUMMARY

## INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

| | | |
|---|---|---|
| CASE NAME | | Alice Stockton v. County of Los Angeles, et al. |
| CASE NUMBER | | CV 14-5764 |
| COURT | | United States District Court |
| DATE FILED | | Claim filed April 2, 2014<br>Complaint filed July 24, 2014 |
| COUNTY DEPARTMENT | | Los Angeles County Sheriff's Department |
| PROPOSED SETTLEMENT AMOUNT | $ | 375,000 |
| ATTORNEY FOR PLAINTIFF | | Brian T. Dunn, Esq.<br>The Cochran Firm |
| COUNTY COUNSEL ATTORNEY | | Jonathan McCaverty |
| NATURE OF CASE | | This is a recommendation to settle for $375,000, the lawsuit filed by Alice Stockton against the County of Los Angeles alleging federal civil rights violations for excessive force and related State-law claims for wrongful death stemming from the shooting of her son Darrell Atkinson.<br><br>Due to the risks and uncertainties of litigation, a reasonable settlement at this time will avoid further litigation costs. Therefore, a full and final settlement of the case in the amount of $375,000 is recommended. |

| | | |
|---|---|---|
| PAID ATTORNEY FEES, TO DATE | $ | 28,874 |
| PAID COSTS, TO DATE | $ | 8,194 |

Case Name: Alice Stockton 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: | Sunday, October 6, 2013, approximately 3:45 p.m. |
| Briefly provide a description of the incident/event: | **Alice Stockton, et al. v. County of Los Angeles, et al.**<br>Summary Corrective Action Plan No. 2015-032<br><br>On Sunday, October 6, 2013, at approximately 3:45 p.m., two uniformed Los Angeles County deputy sheriffs, assigned to the Los Angeles County Sheriff's Department's Transit Services Bureau (currently known as Transit Policing Division), were parked in their standard, black and white patrol vehicle when they saw the decedent acting suspiciously as he crawled on the ground behind a line of several shopping carts.<br><br>One deputy sheriff exited the patrol vehicle and contacted the decedent. The deputy sheriff could not see the decedent's hands, as his view was blocked by the shopping carts. The deputy sheriff asked the decedent to show him his hands several times, but the decedent refused.<br><br>The decedent armed himself with a wooden club and angrily yelled at the deputy sheriff. The deputy sheriff pointed his firearm at the decedent and ordered him to drop the club. The decedent raised the club and quickly advanced in the direction of the deputy sheriff. The deputy sheriff retreated while ordering the decedent to drop the weapon. The decedent continued to advance and closed the distance between the two of them.<br><br>The deputy sheriff continued to retreat until he felt that he was about to fall backwards off the curb and into traffic. Fearing for his safety, the deputy sheriff discharged three rounds from his Department-issued duty weapon at the decedent. This appeared to have no effect on the decedent as he continued to advance on the deputy. The deputy sheriff disharged three additional rounds, striking the decedent (Exhibit A - Los Angeles County Sheriff's Department Manual of Policy and Procedures section 3-10/200.00 Use Of Firearms And Deadly Force).<br><br>The decedent was transported to a local hospital where he was pronounced dead. |

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

The **primary** root cause in this incident was the decedent's failure to follow the orders of a Los Angeles County deputy sheriff to drop his weapon and discontinue his aggressive advance toward the deputy sheriff. The decedent's actions caused a member of the Los Angeles County Sheriff's Department to deploy deadly force.

An associated **primary** root cause in this incident was the decedent's mental health issues. The decedent was a combat veteran diagnosed with post-traumatic stress disorder. The decedent reportedly walked away from his family and his mental health treatment in Texas and came to live as a transient in the Los Angeles area.

A **secondary** root cause in this incident was that a Taser, or other less-lethal option, was not utilized. When the decedent armed himself with a weapon capable of great bodily injury, the first deputy drew his firearm, foreclosing on the opportunity to deploy (or even consider) a less-lethal option. As a result, when posed with a perceived potentially life-threatening attack, the first deputy shot the decedent with his firearm to stop the attack.

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

Initiation and Completion of a Criminal Investigation

The Department had relevant policies and procedures/protocols in effect at the time of the incident.

The Department's training curriculum addresses the circumstances which occurred in the incident.

This incident was thoroughly investigated by representatives from the Los Angeles County Sheriff's Department's Homicide Bureau to determine the extent to which one or more members of the Los Angeles County Sheriff's Department engaged in *criminal* misconduct.

The results of their investigation were presented to representatives from the Los Angeles County District Attorney's Office. On September 24, 2014, the Los Angeles County District Attorney's Office concluded "that (the deputy sheriff) was placed in reasonable fear of imminent danger of death or great bodily injury by (decedent's) actions and acted lawfully in self-defense when he used deadly force."

Initiation and Completion of an Administration Investigation

Following the criminal investigation by the Los Angeles County Sheriff's Department's Homicide Bureau, the incident was then investigated by the Los Angeles County Sheriff's Department's Internal Affairs Bureau to determine the extent to which one or more members of the Los Angele County Sheriff's Department engaged in *administrative* misconduct.

On August 20, 2015, the results of the administrative investigation were presented to the members of the Los Angeles County Sheriff's Department's Executive Force Review Committee. The Committee concluded the use of force was objectively reasonable and consistent with Department policy and tactics.

Re-Training

Although the members of the Executive Force Review Committee concluded the use of force was objectively reasonable and consistent with the Department's policy and tactics, they recommended that both deputy sheriffs participate in eight hours of tactics and survival training and eight hours of training handling individuals with issues related to mental health.

The deputy sheriffs attended a tactics and survival training class on September 16 and 17, 2015. They attended a Dealing with Mentally Ill for Law Enforcement training class on July 22 and September 21, 2015.

Counseling and De-Briefing

The members of the Executive Force Review Committee also recommended that the deputy sheriffs' unit commander conduct a thorough tactical debriefing with the deputy sheriffs to fully examine the important components of the incident.

The de-briefing occurred on September 21, 2015. Vital components of the debriefing included (but were not limited to) general officer-safety issues, placing oneself in precarious situations while on or off duty, and utilizing relevant training and experiences.

No other employee misconduct is suspected, and no systemic issues were identified. Consequently, no further personnel-related administrative action was taken, and no other corrective action measures are recommended nor contemplated.

Mental Health Awareness and Development

In November of 2014, the Department began participation in a mental health task force entitled, "Investment in Mental Health." This working group meets approximately once per month and consists of representatives from the Department, the Los Angeles County District Attorney's Office, the Los Angeles County Department of Mental Health, the Department's Employee Support Services, and the Office of the Inspector General.

The group was empaneled to (among other objectives) (1) explore the mental health industry's best practices; (2) develop strategies for providing responsive, compassionate service(s) to those with some level of confirmed or suspected mental illness; (3) develop, refine, and implement relevant training for members of the Los Angeles County Sheriff's Department; and (4) explore funding sources to expand crisis intervention training to 40 hours, and strengthen the Department's crisis intervention business model to include the creation of a Mental Health Bureau (commanded by a captain and supported by appropriate staff) and the expansion of mental evaluation teams available in the field.

Mental Health Training

The "Investment in Mental Health" Task Force is collaborating with the Department of Mental Health to improve patrol response to mental illness related contacts and incidents. As a result, the Department has implemented several programs to educate personnel. Several layers of training have been implemented with further expansion within this fiscal budget year.

A mandated Peace Officer Standards and Training Mental Illness update training video has been distributed and, as of this report, 2,454 patrol personnel (49.9%) have completed the training. The Department expects all patrol personnel to have completed this training by July, 2016.

A non-mandated, eight-hour "Law Enforcement and Effective Interaction with Mentally Ill" training course is available, and attendance is highly encouraged by division chiefs. As of this report, 263 personnel have attended this training, and new classes continue to be scheduled.

A 40-hour "Mental Health Crisis Intervention for Patrol" training class has been funded, is in the development, and is expected to commence in January, 2016.

Mental Health Evaluation Team Expansion

As of July 2015, the Department increased the staffing and deployment of their field mental health crisis intervention Mental Health Evaluation Teams from five to eight (the most the Department has ever had deployed).

Based on the "Investment in Mental Health" Task Force's assessment, evaluations, and recommendations, the Los Angeles County Board of Supervisors approved funds that will allow the

Department to further increase the number of mental health crisis intervention Mental Health Evaluation Teams from eight to 23 by the end of Fiscal Year 2015-2016.

Mental Health Resource Material

There were several mental health information resources throughout the Department that gave guidance on how to deal with different scenarios involving mentally ill persons. Based on the "Investment in Mental Health" Task Force's recommendations, the Department has re-evaluated and consolidated the information into a single source material for personnel.

The Department's Field Operations Support Services (FOSS) is in the final approval process of a new FOSS Newsletter entitled "*Engaging the Mentally Ill.*" This resource material is being designed to help Department personnel:

- Better recognize symptoms and behaviors associated with mental illness
- Develop communication and engagement skills that make handling situations with the mentally ill more effective

Additionally, the Department has created a new mental health informational pocket pamphlet entitled "*LASD Cares.*" This pamphlet is designed for family members of mentally ill persons. It describes the 5150 WIC (72-hour hold) process and provides information regarding other mental health resources (see *LASD Cares* Pamphlet in **Exhibit B**).

Less-Lethal Options

During the incident, the first deputy did not have a TASER device on his person, but he did have other less-lethal options. The second deputy sheriff did have a TASER on his person in addition to other available less-lethal options. The deputy sheriffs also had a less-lethal stunbag shotgun in the trunk of their vehicle.

Even if the first deputy sheriff had a TASER or other less-lethal options, the necessity to re-holster his firearm in order to retrieve a less-lethal option makes it a non-practical option.

Based on the rapid progression of the situation, the suspect's distance from the first deputy, the likelihood of the decedent's attack having the ability to cause severe injury or death to the first deputy, a less-lethal option was not practical in this situation.

It is practical that the second deputy sheriff could have assessed the decedent's threat and either applied deadly force or utilized an available less-lethal option. By the time the second deputy sheriff exited his vehicle and began to get involved in the incident, the shooting had already occurred.

Department policy regarding the possession and deployment of less-lethal options is regulated by existing Department policy (Exhibit C – Los Angeles County Sheriff's Department's Manual of Policy and Procedures section 5-06/040.05 Use of Less Lethal Weapons, and section 5-06/040.95 Electronic Immobilization Device [Taser] Procedures).

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.

Los Angeles County Sheriff's Department

| Name: (Risk Management Coordinator) | |
|---|---|
| Scott E. Johnson, Captain<br>Risk Management Bureau | |
| Signature: 155628 | Date: 11-6-15 |

| Name: (Department Head) | |
|---|---|
| Karyn Mannis, Chief<br>Professional Standards Division | |
| Signature: Karyn Mannis | Date: 12-18-15 |

**Chief Executive Office Risk Management Inspector General USE ONLY**

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☒ No, the corrective actions are applicable only to this department.

| Name: (Risk Management Inspector General) | |
|---|---|
| Steven E. Nobles for Destiny Castro | |
| Signature: SE. NB | Date: 12-22-15 |

# EXHIBITS

# EXHIBIT A

## 3-10/200.00 USE OF FIREARMS AND DEADLY FORCE

The Department's policy on use of firearms and deadly force is:

- discharging a firearm at another human being is an application of deadly force and must, therefore, be objectively reasonable. Each Department member discharging a firearm must establish independent reasoning for using deadly force. The fact that other law enforcement personnel discharge firearms is not by itself sufficient to justify the decision by a Department member to shoot;
- Department members may use deadly force in self-defense or in the defense of others, only when they reasonably believe that death or serious physical injury is about to be inflicted upon themselves or others;
- Department members may use deadly force to effect the arrest or prevent the escape of a fleeing felon only when they have probable cause to believe that the suspect represents a significant threat of death or serious physical injury to the member or other person(s). If feasible, members shall identify themselves and state their intention to shoot before firing at a fleeing felon;
- the firing of warning shots is inherently dangerous. They should not be fired except under the most compelling circumstances. Warning shots may be fired in an effort to stop a person only when the Department member is authorized to use deadly force, and if the member reasonably believes a warning shot can be fired safely in light of all the circumstances of the encounter; and
- cover fire is defined as target specific controlled fire which is directed at an adversary who poses an immediate and on-going lethal threat. This tactic shall only be utilized when the use of deadly force is legally justified. Target acquisition and communication are key elements in the successful use of this tactic. Department members employing cover fire must establish their reason(s) for utilizing this tactic.

**Revised 07/12/13**
**Revised 12/19/12** (Implementation January 1, 2013)
**Revised 06/13/05**
**Revised 05/16/05**
**04/01/96 MPP**

# EXHIBIT B

Law enforcement agencies around the nation, including LASD, have developed training on ways to deal with individuals with mental illness. Tips from that training include:

- *Speak calmly and quietly.*
- *Keep a reasonable distance. Remember your personal safety.*
- *Do not take the individual's strong language personally.*
- *Respond to rage with quiet reassurance. Slow down the pace.*
- *Be willing to repeat yourself.*
- *Listen carefully and do not interrupt. Be respectful.*
- *Do not challenge the individual. Make no sudden moves.*
- *Do not try to hurry the resolution.*
- *Be patient and take your time.*

**Have Time, Go Online-Visit**

**www.HealthyCity.org**

**Hours: Online, anytime**
**Referrals specific to your zip code**

*Los Angeles County*

**Sheriff's Department**

211 West Temple Street
Los Angeles, CA 90012

**www.lasd.org**

# LASD Cares

## Need Help with Mental Illness?

Pocket Planner

*Dealing With Mental Illness*

## 1. Life Threatening Emergency - Dial 9-1-1

Call 24 hours a day in case of an extreme emergency if you, your loved one and/or the public are facing an imminent threat.

## 2. Urgent Questions - call the DMH ACCESS Center (800) 854-7771

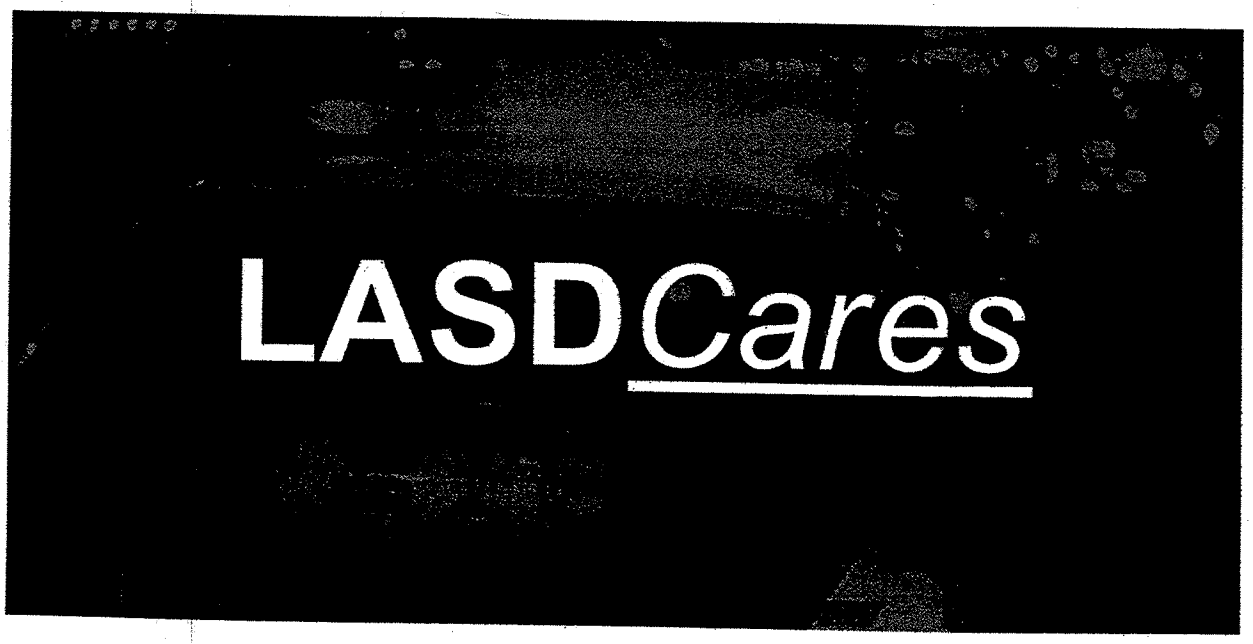
**Call: 24 hours a day**

If you need help with a situation that seems to be getting worse, but hasn't turned into an emergency, call the DMH Access Center. They will discuss resources and if necessary, may send a Psychiatric Mobile Response team to your location to help evaluate the situation. However, the Response Team won't come out right away, it may take a few hours, so if the situation changes to an emergency, dial 911 immediately.

## 3. Start a Caregiver Plan - Dial 2-1-1

**Call: 24 hours a day**

211 LA County provides access to comprehensive social services and disaster support for Los Angeles County residents. They work closely with the DMH ACCESS Center on mental health resources. They can help you with questions about your loved one's behavior such as suicidal thoughts, hallucinations, or what to do when your loved one becomes gravely disabled. After a series of telephone prompts, you will speak to a live person.




## 4. Who Qualifies for a '5150' Hold?

Under certain circumstances, officers can place your loved one on a 5150 Hold. This means a mentally ill person is held for at least 72-hours at a hospital while being evaluated. This can only be done when (1) the individual presents a danger to himself or others, or (2) a person is so disabled that he or she cannot take care of daily life activities (for example, has stopped eating for days and won't come out of the bedroom). However, this is a very difficult standard to meet. In most cases, the LASD cannot take your loved one to a hospital against his or her will.

## 5. Crisis Lines:

**Suicide Prevention and Survivor Hotline: (24 hours/7 days)**

Calling from Los Angeles, Orange, Ventura, San Bernardino, Riverside and Imperial Counties:

- English: 877-727-4747
- Spanish: 888-628-9454

Calling from outside the above counties:

- (310) 391-1253

**Substance Abuse Hotline:**
(800) 564-6600

**Veterans Services:**
(877) 452-8387

**National Alliance on Mental Illness (NAMI):**
(800) 950-NAMI (6264)
www.nami.org

**Los Angeles Gay and Lesbian Center:**
(323) 993-7400

# EXHIBIT C

## 5-06/040.05 USE OF LESS-LETHAL WEAPONS

Only qualified Department personnel, who have successfully passed Department training and are currently certified in the use of the weapon, shall carry a less-lethal weapon. Less-lethal weapons include, but are not limited to, the following devices covered under this section:

- Baton Launching Systems;
- Electro-Muscular Disruption Devices (Taser);
- 12-Gauge stunbag;
- Pepperball launchers,Noise/Flash Diversionary Devices; and
- chemical agents (small aerosol containers).

Personnel carrying a less-lethal weapon system shall record the weapon's information per divisional directive (i.e., MDT/MDC entry, armory sign out log, or any other means a unit has adopted for accounting for these weapons).

The use of a less-lethal weapon will be at the discretion of the individual Deputy. Deputy personnel encountering a situation which may require the use of a less-lethal weapon system, when feasible, will immediately notify a supervisor.

Guidelines for the use of less-lethal weapon platforms fall under the "Situational Use of Force Options Chart." All Department personnel utilizing these weapons must do so only when objectively reasonable given the circumstances and shall be governed by MPP section 3-10/100.00, "Use of Force Review and Reporting Procedures."

**Revised 12/12/13**
**Revised 11/03/08**
**Revised 06/04/04**
**04/01/96 MPP**

## 5-06/040.95 ELECTRONIC IMMOBILIZATION DEVICE (TASER) PROCEDURES

The TASER is a less lethal hand held electronic immobilization device used for controlling assaultive/high risk persons. The purpose of this device is to facilitate a safe and effective response in order to minimize injury to suspects and deputies.

### Use of the Electronic Immobilization Device (TASER)

The following policy guidelines shall be adhered to:

- only a Departmentally approved TASER shall be utilized by personnel;
- a TASER shall be issued to and used only by those personnel who have completed the Department's TASER Training Program;
- personnel authorized to carry a TASER on duty, may purchase a Departmentally approved TASER for on and off duty use;
- prior to the use of the TASER, whenever practical, Department personnel shall request a supervisor;
- any individual subjected to an application of the TASER, in either the "probe" or the "touch/drive stun" mode, shall be taken to a medical facility prior to booking, for appropriate medical treatment and/or removal of the probes; and
- application of the TASER shall be discontinued once the suspect does not pose an immediate threat to themselves, Department personnel or the public.

Except in emergent circumstances, the TASER should not be applied to the following or used in any other situation where there is a reasonably foreseeable likelihood of severe injury or death. In the extraordinary instance that Department personnel feel compelled to utilize the TASER in the following circumstances, the conduct of the involved personnel shall be evaluated in accordance to the Use of Force policy with sound tactical principles.

- handcuffed persons;
- persons detained in a police vehicle;
- persons detained in any booking or holding cell;
- persons in control of a motor vehicle;
- persons in danger of falling or becoming entangled in machinery or heavy equipment which could result in death or serious bodily injury;
- persons near flammable or combustible fumes;
- persons near any body of water that may present a drowning risk; and
- persons known to have a pacemaker or known to be pregnant.

The Custody Division Manual may define criteria for a unique application of the TASER within a custodial setting.

### Verbal Warning

Unless it would compromise officer safety or is impractical due to circumstances, a verbal warning of the intended use of the TASER shall precede the activation of the device in order to:

- provide the individual with a reasonable opportunity to voluntarily comply; and
- provide other sworn personnel and individuals with a warning that a TASER may be activated.

The fact that a verbal and/or other warning was given or reasons it was not given shall be documented in any related reports.

Authorized Department personnel discharging a TASER shall request the response of a supervisor if not already en route or on-scene.

Reporting the Use of the Electronic Immobilization Device (TASER)

The use of the TASER, either by utilizing the probes or the touch/drive stun mode, shall be reported as a "significant" use of force as defined in the Department Manual of Policy and Procedures, section 3-10/100.00, "Use of Force Reporting and Review Procedures."

Whenever a use of a TASER requires force reporting, a download of the TASER stored data and video shall be conducted and submitted with the force package.

Personally Owned Electronic Immobilization Devices (TASER)

Authorized Department personnel shall only carry Department authorized Electronic Immobilization Devices (TASER) whether on or off-duty.

Personally owned TASERs shall be available for computer download upon the request of a supervisor. The device shall meet the specification of the Weapons Training Center, and shall only be used in accordance with this section.

Department personnel shall record all personally owned Department-authorized TASERs (carried on-duty and off-duty) with Personnel Administration when the devices are purchased or obtained, sold or disposed of, stolen or lost.

**Revised 12/12/13**
**Revised 06/20/11**
**Revised 02/07/11**
**Revised 11/03/08**
**Revised 08/10/05**

## CASE SUMMARY

## INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

| | | |
|---|---|---|
| CASE NAME | | Heather Kowalczyk v. County of Los Angeles, et al. |
| CASE NUMBER | | BC 531503 |
| COURT | | Los Angeles Superior Court |
| DATE FILED | | December 23, 2013 |
| COUNTY DEPARTMENT | | Sheriff's Department |
| PROPOSED SETTLEMENT AMOUNT | $ | 2,200,000 |
| ATTORNEY FOR PLAINTIFF | | Justin D. Feldman, Esq. |
| COUNTY COUNSEL ATTORNEY | | Brian T. Chu, Principal Deputy County Counsel |
| NATURE OF CASE | | On August 17, 2012, a Sheriff's Deputy, driving a marked patrol unit within the course and scope of his employment with the Sheriff's Department, was responding to a call for assistance from another patrol unit. While en route, he collided with another vehicle, driven by Heather Kowalczyk, an off-duty Los Angeles Police Officer, at the stop sign-controlled intersection of Barrell Springs Road and 47th Street East, in the unincorporated County area. Ms. Kowalczyk contends that the patrol unit entered the intersection without stopping. The County contends that a portion of her damages are unnecessary and excessive.<br><br>Due to the risks and uncertainties of litigation, a full and final settlement of the case in the amount of $2,200,000 is recommended. |
| PAID ATTORNEY FEES, TO DATE | $ | 67,440 |
| PAID COSTS, TO DATE | $ | 66,821 |

Case Name: Heather Kowalczyk v. County of Los Angeles, et al.

# 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: | Thursday, August 17, 2012; approximately 5:00 p.m. |
| Briefly provide a description of the incident/event: | **Heather Kowalczyk v. County of Los Angeles, et al.**<br>Summary Corrective Action Plan 2015-050<br><br>On Friday, August 17, 2012, at approximately 5:00 p.m., an on-duty Los Angeles County deputy sheriff, assigned to the Los Angeles County Sheriff's Department's Palmdale Station, was driving north on 47th Street East, south of Barrel Springs Drive, Palmdale (Unincorporated Los Angeles County), when the vehicle he was driving collided with the vehicle driven by the plaintiff. |

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

The **primary** root cause in this incident is the Los Angeles County deputy sheriff violating California Vehicle Code section 22450(a), *Stop Requirements* (**Exhibit A** – California Vehicle Code section 22450[a], Stop Requirements).

The **secondary** root cause in this incident is the Los Angeles County deputy sheriff violating Los Angeles County Sheriff's Department's Manual of Policy and Procedures section 3-01/090.07, *Use of Seatbelts* (**Exhibit B** – Los Angeles County Sheriff's Department's Manual of Policy and Procedures section 3-01/090.07, *Use of Seatbelts*).

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 the incident.

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

This incident was thoroughly investigated by representatives from the California Highway Patrol and the Los Angeles County Sheriff's Department. Following their investigations and subsequent reviews, it was determined employee misconduct was the primary causal factor in this incident. As a result, appropriate administrative action was imposed upon one member of the Los Angeles County Sheriff's Department.

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.

Los Angeles County Sheriff's Department

| | |
|---|---|
| Name: (Risk Management Coordinator)<br><br>Scott E. Johnson, Captain<br>Risk Management Bureau | |
| Signature: 155628 | Date: 9-23-15 |

CONTENTS
K. MANNIS
01-26-15
NOTED

| | |
|---|---|
| Name: (Department Head)<br><br>Earl M. Shields, Chief<br>Professional Standards Division | |
| Signature: Earl Shields, km | Date: 09-28-15 |

**Chief Executive Office Risk Management Inspector General USE ONLY**

Are the corrective actions applicable to other departments within the County?

☒ Yes, the corrective actions potentially have County-wide applicability.

☐ No, the corrective actions are applicable only to this department.

| | |
|---|---|
| Name: (Risk Management Inspector General)<br>Destiny Castro | |
| Signature: Destiny Castro | Date: 9/28/2015 |

# EXHIBITS

# EXHIBIT A

California LEGISLATIVE INFORMATION

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VEHICLE CODE - VEH

DIVISION 11. RULES OF THE ROAD [21000 - 23336] *( Division 11 enacted by Stats. 1959, Ch. 3. )*

CHAPTER 8. Special Stops Required [22450 - 22456] *( Chapter 8 enacted by Stats. 1959, Ch. 3. )*

**22450.** (a) The driver of any vehicle approaching a stop sign at the entrance to, or within, an intersection shall stop at a limit line, if marked, otherwise before entering the crosswalk on the near side of the intersection.

If there is no limit line or crosswalk, the driver shall stop at the entrance to the intersecting roadway.

(b) The driver of a vehicle approaching a stop sign at a railroad grade crossing shall stop at a limit line, if marked, otherwise before crossing the first track or entrance to the railroad grade crossing.

(c) Notwithstanding any other provision of law, a local authority may adopt rules and regulations by ordinance or resolution providing for the placement of a stop sign at any location on a highway under its jurisdiction where the stop sign would enhance traffic safety.

*(Amended by Stats. 2007, Ch. 630, Sec. 8. Effective January 1, 2008.)*

# EXHIBIT B

## 3-01/090.07 USE OF SEATBELTS

All personnel and passengers shall wear factory-installed safety belts and do so consistent with the recommendations of the manufacturer while operating or riding in County/Permittee vehicles unless exigent circumstances are present or it can be reasonably anticipated that a sudden exit from the vehicle is a greater safety consideration than the protection offered by the safety belt.

Seatbelt extenders shall be used as needed on a case-by-case basis. They shall be worn only as designed and consistent with the recommendations of the manufacturer. They shall only be permitted for use when they fit properly, their use is warranted by the vehicle manufacturer, and the user has been made aware of the risks associated with seatbelt extender use.

This order does not apply to passengers with physically disabling or medical conditions which would prevent the proper utilization of factory-installed or other Department-authorized safety belts.

Vehicles assigned to the Training Bureau, Emergency Vehicle Operations Center unit, for use in driver safety instruction may be equipped with a safety belt system which is superior to the factory-installed system.

**Revised 02/24/15**
**Revised 05/16/05**

# COUNTY OF LOS ANGELES CLAIMS BOARD

## MINUTES OF REGULAR MEETING

## DECEMBER 21, 2015

**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: Chair John Naimo, Steve Robles, and Patrick Wu.

Other persons in attendance at the meeting were: Office of the County Counsel: Brian Chu, Jonathan McCaverty, Millicent Rolon, Donna Koch, and Joyce Aiello; Sheriff's Department: Lt. Patrick Hunter, Sgt. Kevin Pearcy, Deputy Donald Moore, Commander Henry Romero, Sgt. April Carter; Department of Mental Health: Margo Morales; and Probation Department: Jacklin Injijian.

**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 9:32 a.m., the Chairperson adjourned the meeting into Closed Session to discuss the items listed as 4(a) through 4(e) below.

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

At 11:20 a.m., the Claims Board reconvened in open session and reported the actions taken in Closed Session as follows:

**a. <u>Juventino Astorga v. County of Los Angeles</u>**
**Los Angeles Superior Court Case No. BC 533 562**

This lawsuit seeks compensation for personal injuries sustained in an automobile accident involving a Los Angeles County Sheriff's Department patrol unit.

<u>Action Taken</u>:

The Claims Board approved settlement of this matter in the amount of $65,000.

Vote: Ayes: 3 – John Naimo, Steve Robles, and Patrick Wu

b. **Tonya Pate. v. County of Los Angeles, et al.**
**United States District Court Case No. CV 14-01395 MWF**

This wrongful death lawsuit concerns allegations of federal civil rights violations arising out of a shooting by Sheriff's Deputies during the execution of a search warrant.

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of $1,625,000.

Vote: Ayes: 3 – John Naimo, Steve Robles, and Patrick Wu

c. **Jaime A. Moreno, et al. v. Los Angeles County Sheriff's Department, et al.**
**United States District Court Case No. CV 13-07570**

This lawsuit seeks compensation for the death of an inmate while he was incarcerated at North County Correctional Facility

Action Taken:

The Claims Board recommended to the Board of Supervisors the settlement of this matter in the amount of $185,000.

Vote: Ayes: 3 – John Naimo, Steve Robles, and Patrick Wu

d. **Yvette Brown v. County of Los Angeles**
**Los Angeles Superior Court Case No. BC 381 838**

This lawsuit concerns allegations of retaliation by an employee of the Department of Mental Health.

Action Taken:

The Claims Board approved settlement of this matter in the amount of $95,000.

Vote: Ayes: 3 – John Naimo, Steve Robles, and Patrick Wu

e. **Brenda Vargas v. County of Los Angeles, et al.**
**Los Angeles Superior Court Case No. BC 545 896**

This lawsuit concerns allegations that an employee of the Probation Department was subjected to sexual discrimination, harassment, and retaliation.

Action Taken:

The Claims Board approved settlement of this matter in the amount of $99,000.

Vote: Ayes: 3 – John Naimo, Steve Robles, and Patrick Wu

5. **Approval of the minutes of the December 7, 2015, regular meeting of the Claims Board.**

Action Taken:

The Claims Board approved the minutes.

Vote: Ayes: 3 – John Naimo, Steve Robles, 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 11:25 a.m.

COUNTY OF LOS ANGELES CLAIMS BOARD

By Carol J. Slosson

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