Legal Cases Involving 911 Training Failures

911 dispatch liability has become a nationwide concern that has produced frequent and costly lawsuits. The best way to mitigate this problem is through proper 911 telecommunicator training, including adherence to dispatch best practices, national guidelines and standards.[1] Lack of training and proper quality assurance practices can lead to a number of dispatch danger zones,[2] -- recurring critical failures that expose a telecommunicator and a 911 center to a high degree of liability. The most common of these are:

- Failure to obtain and verify the caller's location and phone number correctly
- Failure to follow established call taking protocols
- Failure to provide pre-arrival telephone instructions when possible and appropriate
- Failure to follow organizational policies and procedures
- Unverified "calling party gone-on-arrival" assumed, resulting in call cancellation
- Judging the integrity or truthfulness of the caller
- Communication and staffing problems at shift change (and break times)
- Preconceived notions and imposed personal, negative impressions
- Mistranslation or misinterpretation of the caller's complaint
- More than one call for help – recognizing the risk

Numerous lawsuits in the past few decades have illustrated the problems with these 911 failures.[3] Included below is a summary of a few of the more high-profile cases:

McGhee vs. Pasco County (Florida 2007)[4]

Facts of the Case:

Nancy McGhee, age 37, choked to death when 911 dispatchers were unable to give her boyfriend proper instructions on how to administer emergency treatment recommended to dislodge a piece of steak.

Failures in the Case:

The dispatcher in this case was not certified as an emergency medical dispatcher; she was required to have a supervisor assist on this type of 911 call. On two attempts, no one answered the dispatcher's request for assistance as per agency policy. The lead communications officer refused to assist with the call. Eventually, the shift supervisor took over the call but did not provide prescribed instructions.

At the time of the incident, Pasco County dispatchers were allowed one year from their date of hire to become certified in emergency medical dispatch. This meant that if a person without training answered a medical call, the staffer needed to ask a supervisor for help. The state did not require dispatchers to have this certification at that time.

The event served as impetus to change several of the emergency call center's policies. In Pasco County, employees now must be EMD trained before taking 911 calls, which is 24 hours of training. Additionally, the state now requires employees to undergo 232 hours of training before they can answer 911 calls.

Ma vs. City and County of San Francisco (California, 2002)[5]

Facts of the Case:

In this case a young woman died of an asthma attack after a delayed ambulance response. The call taker – a trained paramedic – did not follow prescribed call taking procedures and delayed sending an ambulance because she assumed the patient was having a behavioral problem instead of a serious medical condition.

Failures in the Case:

The Court of Appeals of the First District of California overturned a lower court and imposed liability on the city and county for failure to properly train its dispatchers. It was determined that the 911 call taker did not receive the proper training in using medical dispatch guidelines that were the established standard in the 911 center at the time.

Gant vs. Chicago (Illinois, 2002)[6]

Facts of the Case:

A 19-year-old man died of an asthma attack while waiting for an ambulance after the patient's mother made several attempts to contact 911. The 911 center did not answer the original call immediately. When a second call was made, as the patient's condition deteriorated, the telephone rang 26 times with no answer at the PSAP. When the caller finally got through to 911, no CPR/resuscitation instructions were provided by the 911 operator. A jury awarded Gant's family $50 million. After an appeal, a new trial was ordered, and the case later settled for $2.7 million.

Failures in the Case:

A jury found the city's 911 system neglect to be "willful and wanton misconduct" by failing to properly staff the 911 system and not properly handling the emergency call. It was subsequently revealed in court that the supervisor and two other 911 center employees were at lunch at the time of the call, leaving the center understaffed. Minimum staffing requirements, as well as call answering performance standards were either not in place, or not followed at the time of the call for help.

Kazmierowski vs. Chicago (Illinois, 2000)[7]

Facts of the Case:

"At 7:55 a.m. on April 24, 1995, Renee Kazmierowski, suffered an asthma attack while at home at her apartment in Chicago. She called 911 to request help. She provided her address and telephone number to the 911 telecommunicator and said that she lived on the third floor of the building. The 911 operator replied that paramedics were on the way. The operator did not attempt to keep the caller on the telephone while the paramedics were responding to the call, as was required by agency standards.

A paramedic crew responded to what they were told was a 'heart attack' victim. They were allowed into the caller's apartment building by a neighbor in the building and went to the third floor. They asked the neighbor whether he had summoned help, and the neighbor replied that he had not. The paramedics then knocked on the door of the only other apartment located on the third floor, but they received no response. The neighbor escorted a firefighter, who had also responded to the call, through his apartment to the back of the building. The firefighter knocked on the back door, but he received no response and was not able to see into the apartment. While the firefighter was checking the back of the building, the paramedics called the dispatcher, who confirmed that they were at the correct address.

In response to the paramedics' questions, the dispatcher also said that the caller had not provided her age, and that an attempt to return the call had reached an answering machine. The neighbor told the paramedics that the apartment was occupied by a young couple, who did not appear to have any medical problems. The paramedics concluded that they were not needed at the address in question, and they left the scene.

That afternoon, the same paramedics returned to the apartment, again in response to an emergency call. On this occasion, a man let the paramedics into the apartment, and they found Ms. Kazmierowski lying dead on the floor. The front door was unlocked.

Failures in the Case:

The court determined that "locating a person in need of emergency medical treatment is the first step in providing life support services. "Not even that first step was taken here." Both the 911 dispatcher and the original paramedic crew that responded were determined to have engaged in willful and wanton misconduct. This case identifies several potential 911 policy and training failures, including staying on the line with an unstable caller who is alone, and confirming when a patient or victim has left the scene.

Hutcherson vs. the City of Phoenix (Arizona, 1998)[8]

Facts of the Case:

On a Saturday morning, Chiquita Burt called 911 to report she feared trouble with her ex-boyfriend, Craig Gardner, who had been harassing her, threatening to kill her and her family, and was now on his way over to her current location at her new boyfriend's apartment. Burt repeatedly told the 911 operator she feared for her safety right now. The 911 operator stated she would dispatch an officer, but only as a non-emergency, routine call, to take a report. Twenty-two minutes after this call to 911, Craig Gardner broke into the apartment and fatally shot Chiquita Burt and her current boyfriend, Darryl Usher. He then killed himself. The two victims' mothers brought wrongful death actions against the City of Phoenix for its handling of the 911 call. The plaintiffs claimed that the city was liable because the operator had improperly categorized Burt's call as Priority 3, the Phoenix Police Department's lowest rating. A superior court jury awarded the plaintiffs a total of 1.7 million dollars. The Arizona Supreme Court ultimately affirmed the superior court jury's award of damages.

Failures in the Case

The 911 operator did not properly prioritize the call, according to the jury and expert testimony. The delay in not assigning a high-priority to this case was a major cause of the victims' deaths. A lack of training in protocol use and call prioritization were major factors.

William Clay vs. City of Chicago (Illinois, 1987)[9]

Facts of the Case:

Nancy Clay, a 31-year-old production manager, died in a fire of undetermined origin while working overnight on a project for her firm on the 20th floor of One Illinois Center, a high-rise office building in downtown Chicago. *"The tragedy has called into question the procedures, policies and effectiveness of the Chicago Fire Department and has raised challenges to the capabilities of the city`s emergency 911 telephone system, a lifeline for those who call the number more than 3 million times each year."* After the first call the dispatchers and dispatcher aides failed to communicate to the responding personnel relevant information regarding the conditions of the incident, the location of Nancy Clay and her predicament. After the second call the dispatchers and dispatcher aides failed to communicate to officers and firefighters on the scene that Nancy Clay was in the northwest corner of the 20th floor.

Failures in the case:

- Failure to train dispatchers in how to properly use protocol flip cards
- Failure to train and supervise dispatch aides in eliciting information from 911 callers
- Failure to train dispatchers and dispatcher aides on how to give citizens seeking emergency assistance via the 911 system pre-arrival instructions or assistance

Conclusion

Many, if not all, of these lawsuits could have been avoided had the 911 centers involved followed accepted training standards and sound policies, along with robust quality assurance practices. The "*Recommended Minimum Training Guidelines for the Telecommunicator*," recently adopted by a host of nationally recognized 911 professionals and organizations, is designed as an elemental guide for all 911 centers to provide the best possible service to the communities they serve, and in so doing, avoid the most severe legal consequences.

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Updated July 11, 2017