

Annals of Emergency Dispatch & Response

The Official Research Journal of the International Academies of Emergency Dispatch

SPECIAL REPORT

Litigation and Adverse Incidents in Emergency Dispatching

Jeff Clawson, MD; Denise Jorgensen; Audrey Fraizer; Isabel Gardett, PhD; Greg Scott, MBA, EMD-QI; Brent Hawkins, JD; W. Ann Maggiore, JD, NRP; Christopher Olola, PhD



AIM

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Litigation and Adverse Incidents in Emergency Dispatching

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Keywords

Litigation, Lawsuits, Legal Obligations, Negligence, Abandonment, Adverse Incidents, Defendant, Plaintiff, Allegations, Emergency Dispatch Protocols, Pre-Arrival Instructions (PAIs), Priority Dispatch.

Citation

Clawson J, Jorgensen D, Fraizer A, Gardett I, Scott G, Hawkins B, Maggiore, Olola C. Litigation and adverse incidents in emergency dispatching. *Ann Emerg Dispatch & Response*. 2018; 6 (2s):3-11.

ABSTRACT

Introduction: Risk management is an area of critical importance for emergency services and public safety agencies, including emergency communication centers. However, almost no information currently exists regarding litigation against, or involving, emergency dispatch.

Objectives: The primary objective of this study was to characterize the most common types of adverse events, actions, and omissions of action that lead to lawsuits against emergency dispatchers and their agencies.

Methods: The study was a systematic literature review. Research and legal document databases were searched systematically for terms relating to emergency dispatch and litigation. The only data collected were publically available records, including legal documents from state, local, and federal case files, and documents pertaining to dispatch litigation obtained from research and news databases.

Results: 84 dispatch-related legal cases were reviewed, of which five were excluded for various reasons. Multiple (two or more) calls was the most common dispatch problem named as the issue in the suit, followed by delayed dispatch or response, customer service issues or mishandled calls, and failure to provide pre-arrival/post-dispatch instructions. A median \$1 million settlement or decision was awarded to plaintiffs.

Conclusions: This study identified a number of common and preventable dispatch errors that characterize the majority of lawsuits brought against emergency communication centers. Such problems increasingly leave emergency communication centers open to serious legal liability. Our findings indicate that there exists a clear, expected, and enforceable standard of practice for emergency dispatching, and that this standard is increasingly applied by both the courts and the public in judging the actions of emergency communications centers and individual dispatchers.

INTRODUCTION

Risk management is an area of critical importance for emergency services and public safety agencies, including emergency communication centers. As the professional status of emergency dispatchers has risen over the past several decades to match the true complexity and importance of the work, so have expectations regarding the quality of care and service they provide. Activities such as the provision of cardiopulmonary resuscitation (CPR), the Heimlich maneuver, and childbirth instructions over the phone, unheard-of 35 years ago, are now considered standard practice. Such fast-changing standards can raise questions about legality and liability, especially in the context of ever-increasing litigation for malpractice and negligence in other areas of patient care and public safety.

According to the United States Department of Health and Human Services' National Practitioner Data Bank, total payouts for medical malpractice in the U.S. in 2015 topped 3.8 billion dollars.¹ In the same year, lawsuits against just 20 of the largest U.S. cities cost them a combined 24.3 billion dollars,² with New York City alone paying an average of nearly three-quarters of a billion dollars each year between 2013 and 2015. While lawsuits against emergency medical services (EMS) and public safety systems have yet to reach such monumental levels, there is evidence that suits against prehospital providers are increasingly common.³

It has, so far, been unclear whether similar liability issues might apply to emergency dispatching. Some researchers have published reviews of litigation against EMS agencies and prehospital care providers,^{4,5} but these suits involve paramedics, ambulance drivers, emergency medical technicians (EMTs), and other responding

and on-scene response personnel as the key agents in the harm being disputed. Almost no information currently exists regarding litigation against, or involving, emergency dispatch. Understanding the kinds of errors, omissions, breaches in the standard of prehospital care and practice, and other dispatch-related actions or inactions that most often lead to litigation against the dispatcher or dispatch agency can help reduce both legal liability and potential harm to callers, bystanders, civilian rescuers, and responders.

Moreover, understanding the types of dispatch tools in place in agencies that experience lawsuits—especially repeated lawsuits—can help agencies make better decisions about what tools to purchase and how to implement them effectively. In the emergency dispatch environment, a number of different types of dispatch tools are available for handling emergency calls, including protocols, guidelines, and algorithms.

A protocol asks a series of questions based on clinical or other outcome objectives. For example, a question might ask about chest pain *in order* to identify potential myocardial infarctions. In a protocol, in other words, each question is specifically designed to achieve one or more *actionable* dispatch objectives. Questions that don't have any impact on dispatch objectives (triaging and prioritizing the call, identifying safety information for responders, dispatching the right response resources, etc.) are not included because they take up critical time without adding identifiable value. For example, early versions of the Medical Priority Dispatch System (MPDS) included a question for diabetic problems concerning whether the patient regularly took insulin; however, as this turned out, when scientifically evaluated, not to have any effect on any actual dispatch objective, the question was removed in favor of those that determined patient acuity and correct dispatch.

Guidelines and algorithms differ significantly from protocols. A guideline is a form of reference material, generally understood as a resource to be used when the dispatcher sees fit but not mandated or scripted. Generally, guidelines provide prompts rather than scripted questions, such as prompts to “rule out heart attack” or “ask about the presence of chest pain.” Guidelines leave much more to each individual calltaker's discretion and provide less direction, standardization, and clinical or legal support, meaning that dispatchers must “remember” or “think of” the specific actions, questions, and instructions to use for each call. This has been derogatorily described as “reinventing the wheel every time the phone rings.” Algorithms move in the opposite direction, prompting actions on the basis of each “yes” answer or “hit” in a series of yes/no questions. For example, if an algorithm asks a question about lacerations and gets a “yes” answer from the patient, it will prompt an immediate move to bleeding control instructions without waiting for further clarifying information. The difference between an algorithm and a protocol is that a protocol gathers a complete set of information to achieve its objective (such as prioritizing the call), then makes the determination based on all the information, rather than jumping to action at each “yes” node. For example, if a patient is reported first as having a laceration, the protocol may also go through a series of questions about breathing and alertness that could identify higher-priority problems before moving to the highest-priority instructions.

Identifying both the types of errors and problems that lead to dispatch lawsuits, as well as the types of dispatch tools in place in the agencies that are the targets of those suits, can help emergency communication centers better manage risk, avoid legal challenges, and provide the highest level of service for their constituents.

OBJECTIVES

The primary objective in this study was to characterize the most common types of adverse events or system situations, actions, and omissions of action that lead to lawsuits against emergency dispatchers and their agencies. A secondary objective was to determine which of these types of errors and events or situations lead to successful suits and to determine the specific best practices that most effectively guard against successful litigation.

METHODS

Design and setting

The study was a systematic case law and literature review. Research and legal document databases were searched systematically for terms relating to emergency dispatch and litigation (such as “emergency medical dispatch, emergency dispatch, emergency dispatch training, emergency medical dispatch (EMD), emergency police dispatch (EPD), emergency fire dispatch (EFD), 911 dispatch” and “lawsuit, legal, litigation, malpractice,” etc.) The only data collected were publically-available records, including legal documents from state, local, expert, and federal case files, and documents pertaining to dispatch litigation obtained from research and news databases. Newspaper databases (primarily NexusLexus) were also searched for references to dispatch-related litigation, and in some cases, this led to the discovery of additional cases for inclusion. All cases were cross-referenced to multiple sources before being included.

Study population

The study sample included all cases of litigation for which dispatch was one of the points at issue in the lawsuit. Specifically, any lawsuit that met the following criteria was included in the study: (a) The incident occurred in the USA or Canada; (b) Calls were made to a Public Safety Answering Point (PSAP); (c) Dispatch (a dispatcher or a dispatch agency) was specifically involved in, and was a direct cause of, the perceived negligence or action named in the suit.

Additionally, for a case to be included, one or more of the following had to be available: (1) court documents showing that the case was filed and/or went to court; (2) court or legal documents showing that the case was settled in or out of court; (3) depositions or other official documents collected from expert witnesses by the court; (4) multiple news and/or official documents relating to the event and its outcomes.

Data management

The information collected included: date of occurrence; location (city, county, state, province, or country); how the case was heard, e.g., circuit court, appeal, or trial by jury, and whether at the state or federal level); EMD issues(s) involved, e.g., lack of pre-arrival instructions (PAIs), failure to provide PAIs in compliance to the

standards for dispatch practice, or lack of training; final court decision (verdict); monetary damages awarded; punitive damages, if any; and work-related outcomes, e.g., dispatcher being fired or Standard Operating Procedures changing at the agency.

Outcome measures

The primary outcome measure was the specific point or points at issue in each case—i.e., the cause(s) of harm that led to, or were identified by, the litigation—as determined by review of the cases. Secondary outcome measures included: (1) whether any dispatching tool was in place in the agency at the time of the event, and if so, what type; (2) whether that tool was used as intended, including adherence to quality assurance review and training; (3) court-related outcomes, such as whether a guilty verdict or settlement was achieved against the defendant; (4) the type or amount of settlement or damages awarded; and (5) any changes to the defendant's system following the suit. In this study, "dispatch tool" referred to any guideline, protocol, or algorithm that dispatchers could follow or refer to, or were expected to follow or refer to; these included, for example, card systems that provided prompts for dispatchers to ask about certain symptoms, flow charts for call handling, and other more-or-less formal systems.

It was expected that not all of these outcomes would be available for every case. Any case that met the other inclusion criteria and provided at least the primary outcome was included.

Data analysis

STATA for Windows® software (STATA Statistical Software: Release 14 ©2015, StataCorp, College Station, TX, USA) was used for data analysis. Descriptive statistics were used to describe the study population, categorizing by year of case, status of dispatch tool use and compliance to it, origin of call, caller gender and party type, and victim mortality. Distributions for the most frequent event types, dispatch problems, case allegations, and dispatcher court-related and work-related outcomes were also assessed. Median settlement amount was also estimated, including the 25th and 75th percentiles, categorizing by year of case, nature of the settlement (in or out of court, sealed agreements or open), nature of incident (medical/police/fire), dispatch tool availability and use (yes/no), and victim mortality (died/survived).

RESULTS

Eighty-four dispatch-related legal cases were reviewed, of which five were excluded for various reasons, as shown on Figure 1. Of the remaining 79 (94.0%) cases, a majority (59.5%, n=47) had been initiated from a medical problem. Generally, the number of cases trended upward over the years from 1980 to 2015 (Table 1). Determining whether any dispatch evaluation and/or caller advice tool was in place at the time of the incident proved difficult for some cases, especially those occurring more than ten years ago. For the most accurate achievable information about the tool(s) in use—or lack of tools in use—in each agency at the time of the litigated incident, see Appendix A online. The largest percentage of calls (38.0%, n=30) were handled in the Midwest region of the USA.

Overall, 77 of the 79 cases (97.5%) had multiple calls associated with them; most of the initial calls were made by a first- or second-party caller (78.5%; n=62). A large majority (92.4%, n=73)

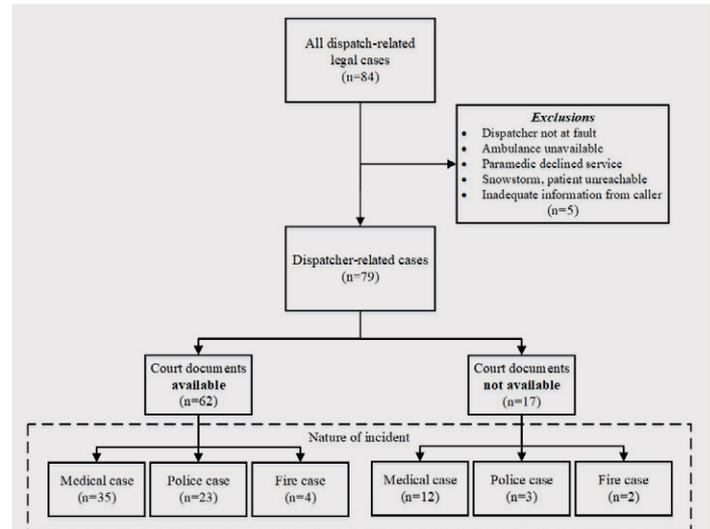


Figure 1. Study cases sampling process

Case Parameter		Cases (N=78) n (%)
Year	1980 – 1989	13 (16.5)
	1990 – 1999	19 (24.1)
	2000 – 2015	47 (59.5)
Call origin (Region)	Midwest	30 (38.0)
	South	19 (24.1)
	West	16 (20.2)
	Northeast	14 (17.7)
Number of calls per incident	1	1 (1.3)
	2 – 3	29 (36.7)
	4 – 5	7 (8.9)
	6 – 7	2 (2.5)
	>7	2 (2.5)
	Unknown	38 (48.1)
Caller party type	Second	39 (49.4)
	First	23 (29.1)
	Third	9 (11.4)
	Others*	8 (10.1)
Mortality	Died at scene or within 24 hours	73 (92.4)
	Survived†	6 (7.6)

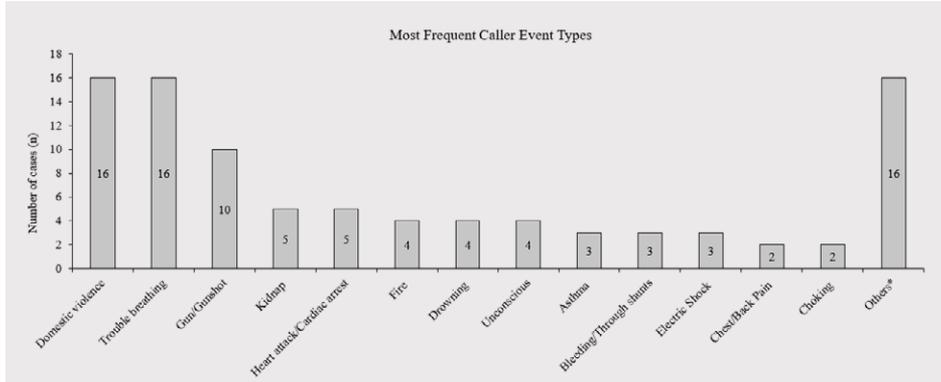
*A combination of two or more of the three (first, second, and third) caller party types.

†These survivors include any person(s) who may have died more than 24 hours later.

Table 1. Characteristics of the dispatcher-related cases

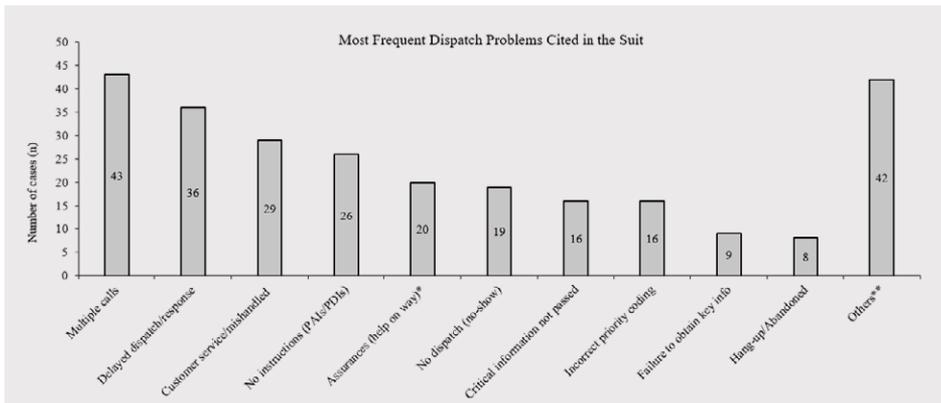
of the cases involved one or more victims who died at scene or within 24 hours, with a total of 94 deaths overall. Domestic violence/domestic abuse and trouble breathing were the most common event types (20.3%, n=16) (Figure 2). The other common events were incidents reported as guns/gunshots (12.7%), kidnapping (6.3%), and heart attack or cardiac arrest (6.3%).

While multiple calls were made for 77 of the 79 calls overall, "multiple calls" was actually named as one of the reasons for a suit being brought in 43 (54.4%) of the cases (Figure 3). The other common dispatch problems included delayed dispatch or response (36 cases—45.6%), customer service issues or mishandled



*Cannot walk, intruder, auto accident, vehicle in water, unable to speak, abdominal pain, hyperventilation, heart problems, “attack” (assault), dizzy/sweating, stabbing.

Figure 2. Most common event types



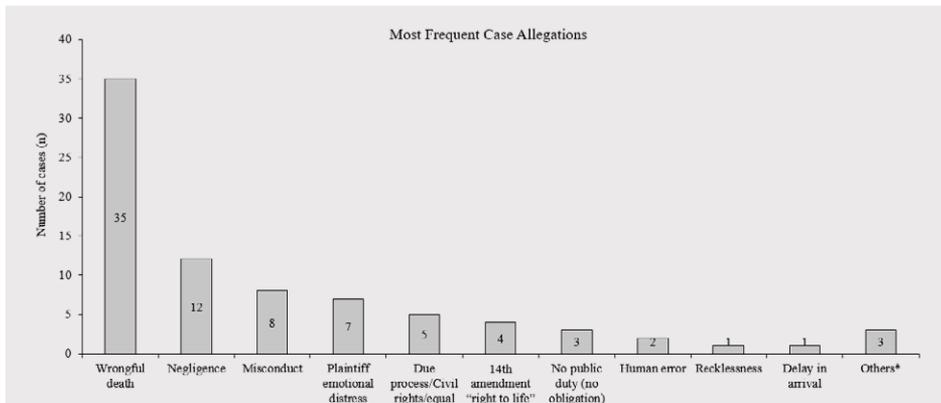
PAI—pre-arrival instructions, **PDI**—post-dispatch instructions

*Counted when referred to by plaintiffs as one reason for the suit, always in conjunction with failure to send and/or delayed response.

**Kept caller on long holds, responders left/wouldn't enter, failure to follow regulations/standard operating procedures, failure to train/improper training, ad lib instructions, wrong address, call transfers, calls not answered at 911, dispatch “diagnosis” of caller’s problem, multiple changes in responding units.

Note: Overlaps exist, so cases may have more than one named dispatch problem.

Figure 3. Most common dispatch problems, of those cited as reasons for bringing a suit



* Negligent training and supervision, failure to provide rescue services.

Figure 4. Most frequent case allegations

calls (29 cases—36.7%), and failure to provide adequate pre-arrival/post-dispatch instructions (26 cases—32.9%). In 23 of these cases, no pre-arrival instructions were provided at all; in three cases, “ad-libbed” instructions were provided, and these were deemed inadequate.

Wrongful death was the most common legal allegation against the defendant (35 cases—44.3%) (Figure 4). The other common allegations were negligence (12 cases—15.2%), misconduct (8 cases—10.1%), plaintiff’s emotional distress/suffering (7 cases—8.9%), and lack of due process, civil rights, or equal protection (5 cases—6.3%).

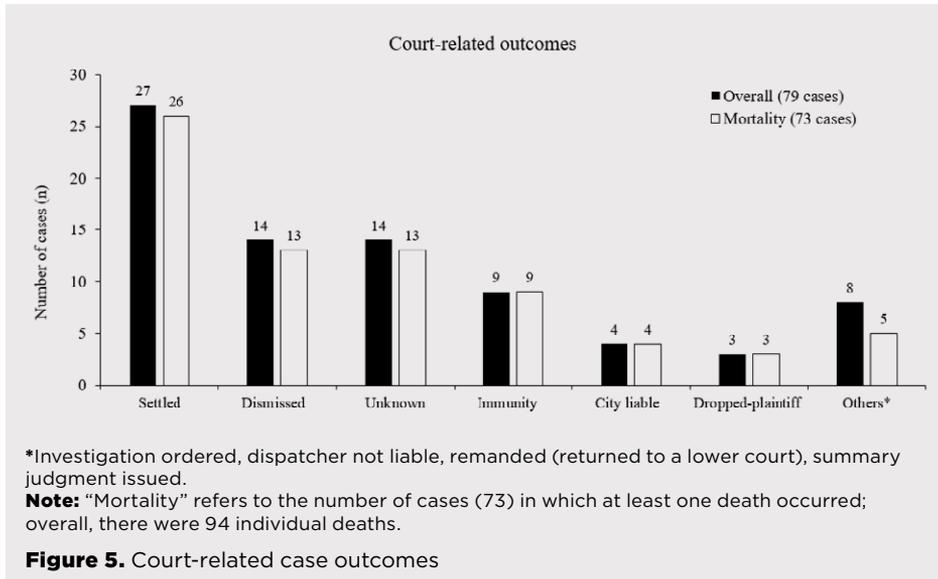
Overall, 35.4% of the cases were either dismissed (n=14) or had an unknown status (n=14); another 34.2% (n=27) reached a settlement, and the dispatcher was determined to have immunity in 9 (11.4%) cases (Figure 5). The city or county of jurisdiction was found liable in 4 (5.1%) of the cases, and the plaintiff dropped 3 (3.8%) of the cases. Of the cases involving the death of the victim or patient, a settlement was reached in 26 (35.6%) of the cases, a case was dismissed 17.8% (n=13) of the time, 17.8% (n=13) of the time court outcome was unknown, and 12.3% (n=9) of the time the dispatcher or agency had immunity.

In a majority of cases (86.1%, n=68), employment-related outcomes (such as a dispatcher being suspended or fired following an incident) were unknown. For cases involving deaths, dispatcher employment-related outcome was unknown for 84.9% (n=62) of the cases, and the dispatcher was either fired or suspended in 8.2% (n=6) of the cases in which a victim died.

Overall, a median US \$1.0 million settlement was awarded to each victim when a settlement was awarded (Table 2). Generally, the monetary settlement amounts have tended to be on an upward trend over the years. The median settlement amount was highest in the West (\$1.5 million) and lowest in the South (\$885,000).

DISCUSSION

Both the public and the courts—through the suits brought against emergency communication centers and the judgments handed down in those suits—have made it clear that there is an existing,



expected, and enforceable standard of care and practice in emergency dispatching. Although such suits remain relatively rare compared to, for example, clinical malpractice suits, their numbers are increasing. Moreover, findings about what constitutes effective, appropriate, and defensible emergency dispatch practices are remarkably consistent across all the cases, whether litigated or settled.

Measure		(N = 24) n	Settlement amount (US\$ in thousands) Median (Q1; Q3)*
Year of case occurrence	1980 – 1989	3	450 (1; 1,700)
	1990 – 1999	8	1,250 (775; 2,200)
	2000 – 2015	14	1,068 (150; 2,000)
Case settlement	In court	18	1,375 (500; 2,300)
	Out of court	6	450 (7.5; 1,500)
	Midwest	11	1,000 (500; 2,700)
	South	4	1,150 (475; 3,500)
	West	5	885 (75; 1,250)
	Northeast	5	1,500 (450; 1,700)
Nature of incident	Medical	16	945 (500; 1,700)
	Police	5	1,250 (450; 2,300)
	Fire	3	753 (5; 1,500)
Mortality	Died w/in 24hrs	24	1,000 (450; 1,700)
	Survived‡	0	-
Overall		24	1,000 (450; 1,700)

*25th/75th percentiles of the median settlement.

‡Six patients survived longer than 24 hours (two died of related causes within 1-2 years, others suffered long-term injuries); none of these cases received a monetary settlement..

Table 2. Amount paid in case settlements for cases in which settlement amount is known

What is the Standard?

The most obvious standard expressed in these cases is that a call for help must actually generate a response. Having to make multiple calls for the same incident, experiencing delays in the

response, or finding that no dispatch was made at all were issues in almost every one of the cases reviewed in this study. Failure to dispatch was, for example, the point at issue in one of the most notorious emergency dispatch lawsuits in history, *Lam vs. City of Los Angeles* (1987),⁶ in which a dispatcher decided that the patient's reported symptoms were the result of "hyperventilating" and told her to breathe into a paper bag. When that failed to help, and with worsening symptoms, the patient's family called again, at which point another dispatcher suggested that the patient might have "food poisoning" or "anxiety," and the family should take the patient to the doctor. While trying to get into the car, the patient collapsed. A third call to 911 finally triggered a dispatch, but the dispatcher

hung up without providing any instructions. This case was one of the first to demonstrate not only the problem of failure to send a response, but also many of the other critical problems that have led to litigation against dispatch centers since then, including dispatcher diagnosis, failure to use a protocol, failure to correctly identify a problem as high in severity, failure to provide pre-arrival instructions, not initially responding, and poor customer service. All of these have, in one way or another, been identified as failures to uphold the standard of care and practice for dispatchers in the cases reviewed here. (See online Appendix for complete list of cases and related issues.)

As in the *Lam* case, dispatcher failure to accurately identify a problem of high severity was at issue in many of the cases. Often, the lack of a protocol to direct the dispatcher in assessing the call and assigning the correct dispatch priority level was cited as one of the reasons for that failure—and one of the direct causes of liability for the defendants. In *Hutcherson vs. the City of Phoenix* (1998),⁷ Chiquita Burt called to report that she feared trouble with her ex-boyfriend, Craig Gardner, who had been threatening and harassing her and her family, and who was now on his way to her location. The dispatcher said she would dispatch an officer, but only as a non-emergency, routine call; she did not believe that the case was serious. Twenty-two minutes after the call was made, Gardner broke into the apartment, where he fatally shot both Burt and her current boyfriend, then killed himself. Not only did a jury determine that the city was liable because the operator had improperly categorized the call as low-priority; they specifically mentioned that a lack of protocol use and resulting improper call prioritization were major factors in their decision to award the plaintiffs \$1.7 million.

Similarly, in *Cukor vs. City of Berkeley* (2012),⁸ a 67-year old man reported an intruder trying to get into his home, and the dispatcher promised to send someone soon. However, because Cukor spoke in a calm tone, the dispatcher assumed there was no serious problem and did not ever request a police officer to respond to the call. In fact, when an officer called-in to say that he could respond, he was told not to go. Cukor was killed by the

intruder, and the city agreed to implement significant changes to the system, which the plaintiffs accepted in lieu of settlement. Providing protocols for dispatchers to follow, and training them in how to correctly use those protocols to differentiate high- and low-acuity cases, is increasingly recognized as one of the elements of the basic standard of practice for emergency dispatch—as in the American Society for Testing and Materials (ASTM) Standard Practice for Emergency Medical Dispatch (ASTM F1258⁹ and F1560¹⁰), which calls for all EMDs to have access to a medical priority dispatching system, in addition to their training. As the National Highway Traffic Safety Administration (NHTSA)¹¹ recognized even in 1996, “dispatch protocols [are] needed to help the dispatcher allocate the appropriate level of help based on medically sound and clinically based decisions.”

In addition to having access to a protocol, dispatchers are expected to know how to use it. In other words, there is an expectation that emergency dispatchers receive training and certification, including continuing dispatch education and recertification to maintain skills. Although training problems and lack of certification were not necessarily listed as named initial complaints, a number of cases identified them as the underlying reasons for the failures named in the suits. In several instances, these suits led directly to changes in system practices. In *McGhee vs. Pasco County* (2007),¹² for example, the court found serious problems with an agency policy allowing dispatchers to take live emergency calls for a year before receiving certification, as long as they asked a supervisor for help in handling medical calls. In this case, two supervisors (including the lead communications officer) refused to assist the calltaker, who was not trained or certified and could not provide instructions to save the caller’s choking girlfriend, who died. As a direct result of the case, Pasco County began requiring calltakers to become certified EMDs before taking any calls. Interestingly, in *Ma vs. City and County of San Francisco* (2002),¹³ the training issue was considered so central that the Court of Appeals of the First District of California actually overturned a lower court and imposed liability on the city and county for failure to train dispatchers in the proper use of the calltaking tool being used in the center.

Also very evident in these cases is the expectation that emergency dispatchers must provide a high level of customer service as a basic standard of operations. Such a requirement is broad in application and includes such elements as not questioning the veracity or integrity of the caller, not making assumptions about callers based on prejudices or preconceived notions, and not denying service based on caller behaviors (such as anger or bad words). These types of customer service expectations are not merely “window dressing” or kindness; very often, poor customer service leads to other serious and actionable problems. For example, in *Ma vs. City and County of San Francisco*,¹³ the calltaker (a paramedic) delayed sending an ambulance because she did not believe the caller’s statements and assumed the patient was having a behavioral problem rather than a serious medical condition. The patient was suffering from a severe asthma attack and died as a result of the delay. Similarly, in *Hendon vs. DeKalb County* (1992),¹⁴ a dispatcher downplayed

the importance of the caller’s serious breathing and speaking problems, accusing him of “playing” on the phone and actually threatening him with jail if that was the case. After keeping him on the line for over 50 minutes, the dispatcher did eventually dispatch police officers to the call, but as a low-priority situation; an officer who arrived at the house reported that the caller “refused” to come to the door—and left. The following day, the caller’s son found him in on the floor in severe distress, having had a stroke, and expert testimony indicated that the delay in the receipt of medical care significantly contributed to his permanent neurological damage. In these and many of the other cases reported in the study, failure to accept caller statements at face value and other serious customer service problems led to negative patient outcomes and significantly increased liability.

Perhaps the clearest standard is the expectation that pre-arrival instructions will be provided, especially in drownings, cardiac arrests, choking, and other cases involving not-breathing patients. Some observers still, even today, express fear that providing CPR and other life-saving instructions over the phone to laypeople might lead to lawsuits, but this study shows the exact opposite. The courts have clearly upheld the idea that such provision is expected as a minimum standard of care; nearly half of all the cases reviewed here involved the failure to provide pre-arrival instructions as one of the litigated issues. *Gant vs. Chicago* (2002)¹⁵ is a particularly egregious example that demonstrates how multiple problems, including the failure to provide pre-arrival instructions, can cause a situation to deteriorate very quickly. In this case, a 19-year-old man died of an asthma attack while waiting for an ambulance after his mother made several attempts to contact 911. The center did not answer the first call, and when a second call was eventually made, the telephone rang 26 times with no answer. Finally, the caller got through to 911, but no pre-arrival instructions were provided. Problems with staffing, lack of training, lack of “call performance standards,” failure to follow the procedures that were in place, and delay in dispatching—as well as obvious problems with customer service—were all in effect in this case, which was settled for \$2.7 million against the agency. However, the immediate cause of the patient’s death, and the reason the family brought the suit, was the failure to provide instructions. This case is also a reminder that CPR instructions are not the only instructions dispatchers must be able to provide; choking, drowning, bleeding, overdose, allergic reactions, environmental hazards, and complications with pregnancy are among the many situations that require some form of instruction for the patient or caller.

Of all the standards implied or stated in the case reports, the requirement to provide pre-arrival instructions is also the most clearly articulated. The American Heart Association¹⁶ has stated that “dispatchers have a unique opportunity to provide a real-time, high-yield intervention” for out-of-hospital cardiac arrest by providing CPR instructions and that dispatcher-assisted CPR should be provided in all cases identified as cardiac arrest.¹⁷ Even earlier, the National Association of EMS Physicians¹⁸ went further in a position statement, referring to the provision of pre-arrival instructions as “a mandatory function of each EMD in a medical

dispatch center” and a “moral necessity.” As early as 1990, the original ASTM F-1258 standard⁹ called for the use of “telephone medical intervention” instructions, and in 1996, the National Highway Traffic Safety Administration¹⁰ produced a national standard curriculum for emergency medical dispatch specifically stating that the dispatcher “needs to give verbal instructions over the telephone to the victim or bystander before the crews arrive.”

Moreover, the general public expects to receive instructions for any serious medical condition they report, including cardiac arrest, choking, bleeding, and others. One study¹⁹ found that more than 91% of all respondents in an area that was already providing instructions expected to receive them, while another²⁰ found that 87% of all respondents expected instructions even in areas where they were not already provided. As one 13-year-old girl demanded of a dispatcher in Florida when her 18-month-old sister drowned, “*Can’t you tell me what to do?!’*”²¹ After years of watching “Rescue 9-1-1” and seeing news stories about some of the more prominent court cases, the public expects to be “told what to do” in all kinds of emergency situations.

Implicit in all of these cases is the expectation that dispatchers will not only collect all relevant information, but also pass it to responders. In *William Clay vs. City of Chicago* (1987),²² for example, 31-year-old Nancy Clay died in a fire because dispatchers failed to communicate to the responding personnel relevant information regarding the conditions of the incident, Clay’s location in the building, or the fact that she was trapped. Even after a second call from Clay, now clearly dying on the phone, dispatchers failed to communicate her condition and known actual location within the building. In this case, failures in training were identified in multiple areas, including proper use of the dispatching tool in place, how to elicit information from callers, and how to provide pre-arrival instructions or assistance. The primary issue in the case, though, was the failure to communicate critical caller-provided information to the responders.

One of the most interesting findings of the study was the clear difference between the possession of a dispatch tool in the communication center and the implementation of that tool as part of a comprehensive system. In the majority of cases, no tool was available to dispatchers at all; these cases led to higher settlements overall and included most of the cases for which PAIs were not provided. Not unexpectedly, the court often mentioned the lack of any support tool for emergency dispatchers as an element of liability for the agency. However, the findings in these suits also reflect a clear increase in liability for agencies that have purchased a dispatch tool or made it available to dispatchers, as compared to those who implemented a tool as part of a comprehensive, controlled, standardized emergency dispatching system. In every one of the cases in which a tool was present, dispatchers noted that the tool was simply “around”: that it was available, somewhere, for them to use, but its use was neither mandated nor reviewed. The depositions in the cases sound eerily similar, with dispatchers reporting that “some cards” or “a cardset” or “guidecards” were available somewhere in the center but not necessarily knowing where they were located or when to use them. Others reported that while a tool had been purchased

and was used in the center, they personally had never been trained or certified in its use—an oversight named as a specific reason for liability in each of those cases. Indeed, no individual dispatcher defendant had been actually using such a tool when any of these disputed cases occurred, even in centers in which such tools were supposedly available.

The outcomes of these suits suggest that the purchase of a tool is not sufficient. Emergency dispatchers must be individually trained and certified to use the tool and must use it for all cases, not just when they feel like it. They must use it consistently, with consistency and compliance measured regularly through a quality assurance review process.²³⁻²⁵ They must have repeated, ongoing education in the use of the tool and its place in the customer service work of the agency. In other words, the outcomes from these suits indicate a clear differentiation between a *tool* and a *system*,²⁶ while providing emergency dispatchers with a tool is a necessary element of the standard, it is not sufficient to reduce risk for the agency and the community. The tool must be integrated as part of a comprehensive system. Indeed, *no case* could be found in which an agency using a comprehensive system of the type described here was named as the defendant.

It is worth noting that these standards are neither new nor local in their application. In 1994, the National Institutes of Health published an EMD Position Paper²⁷ that outlined the use of protocols, the provision of pre-arrival instructions, and the maintenance of certification through continuing dispatch education as critical requirements for effective emergency dispatch practice. Model legislation for state implementation of training and protocol standards have been in place since at least 2001,^{28,29} and emergency medical dispatch has been identified as a critical component of emergency medical services by agencies as diverse as the American College of Emergency Physicians, the EMS for Children Program at the U.S. Department of Health and Human Services, the National Association of State EMS Directors, the American Society for Testing and Materials, and the National Highway Traffic Safety Administration.

What are the Potential Liabilities?

What is at stake for agencies implicated in not meeting the expected standard of care goes beyond monetary settlements and awards. Emergency communication agencies that engage in problem behaviors lose the trust and support of their communities and local governments, often finding themselves having to reorganize their entire systems to meet the standards following a publicized lawsuit. Many of the agencies named in these suits substantially restructured their emergency response systems following these incidents, implementing protocol tools, training, and quality assurance to ensure that no such problems occurred in the future. Others, however, have not made changes—and as a result, have suffered lawsuit after lawsuit. Chicago, for example, has been sued regarding dispatch issues 12 times since 1987, paying millions in settlements and damages and causing increasing ill will between the city’s emergency services and its citizens.

Many of these actions may also leave the dispatch center open to specific legal charges of negligence, abandonment, and

“dispatch malpractice.” Negligence is “the failure to provide the degree of care (as defined by a community or national standard) normally associated with a set of circumstances requiring care.”³⁰ Forty years ago, emergency dispatch may not have had an articulated standard of care, but that is clearly not the case now. Over and over, the courts have found that the standard, as outlined in training documents, textbooks, position statements, and white papers from dozens of national public safety organizations, is both clear and enforceable. The elements of that standard are defined above; the failure to meet them can lead to findings of wrongful death, negligence, misconduct, recklessness, and even violations of the 14th Amendment.

Abandonment refers to situations in which care is being provided and then is suddenly stopped. It has been defined as “the unilateral termination of the provider/patient relationship at a time when continuing care is still needed.”³¹ In other words, for abandonment to occur, the provider of care must terminate that care without the consent of the patient. The failure to provide pre-arrival instructions is the clearest example of dispatcher abandonment. When a caller reports a problem by calling an emergency number, he or she is requesting help. By picking up the line and taking the call, the communication center agrees to provide that help based on accepted or recognized standards, and ending the call while the patient is still in distress and in need of care constitutes abandonment of that patient.

Taken together, these constitute the elements of what can be termed dispatcher malpractice: the failure to meet the standard of care and practice for emergency medical, fire, or police dispatch. As the rise in litigation against emergency communication centers—and the rise in both successful suits and settlement amounts—demonstrates, the courts and the public are increasingly invested in holding emergency dispatch agencies to a standard. In fact, standards are applied even to emergency services personnel in jurisdictions with state-imposed limitations on liability. Even in these states, acts performed “in a grossly negligent manner,” “with wanton disregard,” and/or “not performed in good faith” can be held liable.³² Many of the cases reviewed here were found to meet that test, particularly when it could be shown that the dispatcher or agency knew, or should have known, the standard of care, but did not follow it.

What Can Emergency Communication Centers Do?

The question for emergency communication center leaders, in light of the findings of this study, is what they can do to avoid litigation and mitigate or avoid risk for the communities they serve. Fortunately, the standard of practice is clear. Agencies must implement protocols with which emergency dispatchers can collect the relevant information for the case, accurately differentiate high- and low-priority calls, and ensure appropriate, timely dispatch, as well as accurate and immediate relay of critical and safety information to responders. In addition, agencies must apply a structured program of quality assurance and quality improvement to ensure that dispatchers comply with protocols and standards.²³ One of the most common themes in the lawsuits was the liability caused by the failure of emergency dispatchers to use protocol tools compliantly. Thus, in addition

to quality assurance, agencies must also provide sufficient training, including ongoing Continuing Dispatch Education, and must ensure that their dispatchers are certified by a nationally qualified certifying body. In several of the lawsuits, lack of certification specifically led to increased damages or increased liability for the agency in question.

In addition, emergency communication centers must provide pre-arrival instructions, not only for telephone CPR but for the broad range of possible emergency situations callers may report. And they must utilize a tool that provides scripted instructions, not simply guidelines, “prompts,” “reminders,” or training alone. No dispatcher—no human being—can possibly remember all the relevant questions and instructions related to every possible emergency type, no matter how fully they may be trained. Thus, as the National Institutes of Health’s “EMD Position Paper” puts it, “it is important that EMD’s carefully adhere to protocols for the provision of telephone-instructed treatment in a standard, nonarbitrary, and reproducible way.” They go on to make a clear distinction between true pre-arrival instructions and what they term “telephone aid.” Telephone aid, they write, is the provision of instructions that are “ad-libbed” by dispatchers, whereas true pre-arrival instructions are scripted and followed essentially verbatim. “Telephone aid,” they stress, “may only ensure that the dispatcher has attempted to provide some sort of care to the patient through the caller but does not ensure that such care is correct, standard, and medically effective or even necessary in the first place.”²² Only the use of scripted, clinically-driven protocols, supported by regular quality assurance and training, can ensure these necessary outcomes.

Conclusion

It is evident from this first-ever historical review of lawsuits brought against emergency communication centers that there exists a clear, expected, and enforceable standard of practice that is understood, and applied, by both the public and the courts.³³ Organizations ranging from the National Association of EMS Physicians and the American Heart Association to the National Institutes of Health, the National Highway Traffic Safety Administration, and the International Academies of Emergency Dispatch have issued documents that have laid out these standards in detail, starting as early as the late 1980s. Fortunately, there are specific, available preventive measures that can be taken by any agency to avoid all or most of the potential liability, including the implementation of scripted protocols and specific training in their understanding and use, supported by high-functioning quality assurance and quality improvement measures, continuous dispatch education and ongoing training, and certification through a nationally recognized certifying body.

Litigation against emergency communication centers, like all types of malpractice suits, is likely only to increase in the foreseeable future, especially as more and more members of the public become aware of the existing standards and repeatedly demand their correct application to themselves. Agencies without the recommended practices in place should be prepared to defend their practices in court—and in the court of public opinion.

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