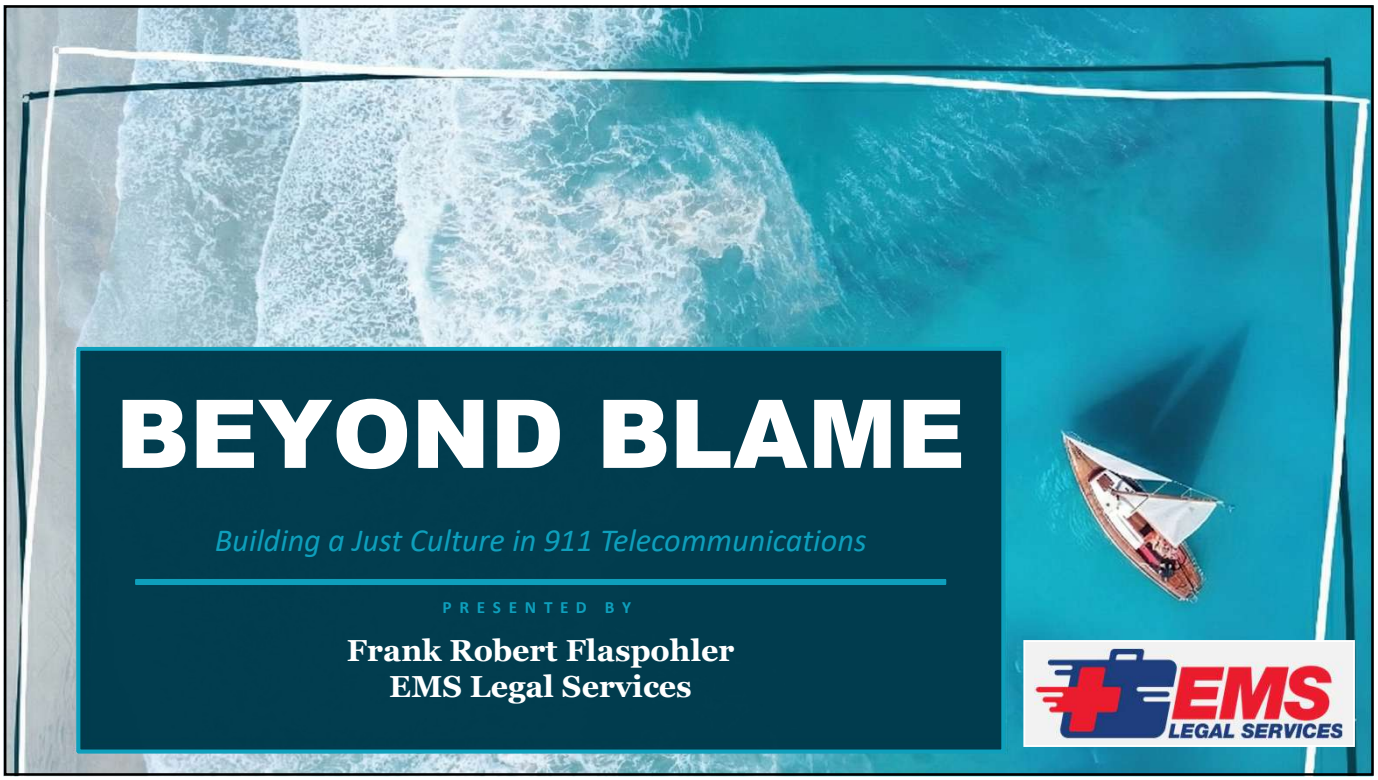


TODAY'S AGENDA

What We'll Cover in the Next 45 Minutes

01 The Operational Problem
Why blame-based culture fails agencies in court and in the call center

02 History & Theory
Aviation to healthcare to 911 — the Swiss Cheese Model

03 Three Behavior Categories
Human Error · At-Risk Behavior · Reckless Behavior

04 The Legal Defense
How Just Culture protects your agency from negligence claims

05 The Substitution Test
A step-by-step incident review framework for 911

06 Implementation & Q&A
Practical steps you can take starting Monday morning

"The goal is not to find the guilty party. The goal is to find the truth." — David Marx

THE PROBLEM

The Old Blame Culture Is Failing 911 Agencies



Near-misses go unreported
Staff hide mistakes. No data until the lawsuit arrives.

Outcome bias drives discipline
Luck — not behavior — determines who gets punished.

Morale and retention collapse
Punitive culture accelerates burnout and vacancy rates.

Legal exposure multiplies
No safety culture = "systemic neglect" claims in court.

Just Culture is not about eliminating accountability — it is about making accountability intelligent.

HISTORY & THEORY

How Aviation Gave Healthcare — and 911 — a Better Model

1970s	1999	2001	2010s	NOW
✈				🎯
Aviation	**Healthcare**	**Marx Algorithm**	**911 Adoption**	**Your Moment**
NASA creates anonymous near-miss reporting. Crash rates fall dramatically.	'To Err Is Human' — 98,000 preventable deaths spur Just Culture adoption.	David Marx defines three behavior categories requiring three different responses.	NENA and APCO begin incorporating Just Culture into PSAP supervision standards.	Workforce crisis and legal scrutiny make Just Culture operationally necessary.

Aviation learned: punishing honest mistakes produces fewer reports — and more crashes.

HIGH RELIABILITY ORGANIZATION

Five HRO Principles Applied to 911 Operations

1	2	3	4	5
Preoccupation with Failure	**Reluctance to Simplify**	**Sensitivity to Operations**	**Commitment to Resilience**	**Deference to Expertise**
Never assume safety is guaranteed — constantly ask what could go wrong next.	'Dispatcher error' is never the complete story — dig until the system picture is clear.	Leadership stays connected to actual call floor conditions — staffing, fatigue, system stress.	Build capacity to detect, contain, and recover — cross-train, redundant channels, escalation.	When a senior dispatcher flags a systemic risk, leadership listens — Just Culture enables that voice.

High reliability is not perfection — it is relentless organizational learning. Just Culture is the engine.

THEORY IN ACTION

Missouri 911 Liability Protection

Section 190.307.1 RSMo

No civil liability for operation of emergency system, giving or following emergency instructions, exceptions. — 1. No public agency or public safety agency, nor any officer, agent or employee of any public agency, shall be liable for any civil damages as a result of any act or omission except **willful and wanton misconduct or gross negligence**, in connection with developing, adopting, operating or implementing any plan or system required by sections 190.300 to 190.340.

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When the telecommunicator makes an error, every layer before them has already failed.

THE JUST CULTURE ALGORITHM

Three Behavior Types — Three Distinct Responses

TYPE 1 HUMAN ERROR



The Unintended Error

An inadvertent slip or lapse the dispatcher did not intend.

CONSOLE · FIX THE SYSTEM

Ex: Fat-finger CAD entry during high call volume

TYPE 2 AT-RISK BEHAVIOR



The Drift

A shortcut taken without recognizing the risk — normalization of deviance.

COACH · CORRECT THE DRIFT

Ex: Skipping EMD script because 'I know it by heart'

TYPE 3 RECKLESS BEHAVIOR



Conscious Disregard

A deliberate choice to ignore a known, substantial risk.

DISCIPLINE · TERMINATE

Ex: Intentionally hanging up on an active 911 caller

Categorize the ACTION — not the OUTCOME. The behavior category never changes based on what happened next.

The Honest Mistake: When the System Fails First

An inadvertent slip or lapse — not intended, not foreseen, and replicable by any similarly trained peer under the same conditions.

CAD interface error
Adjacent buttons selected under high call volume.

Wrong radio channel
Channel display toggled during an active transmission.

Address auto-fill error
CAD selects 'Street' over 'Court' with no disambiguation alert.

✓ CORRECT RESPONSE

- Console the dispatcher — no discipline
- Investigate system conditions that allowed it
- Fix the CAD, staffing, or policy gap
- Document the system fix for legal protection

✕ DO NOT DISCIPLINE

Punishing human error teaches staff to hide — not improve — mistakes.

Ask: Could three equally trained dispatchers, in the same conditions, have made the same mistake?

TYPE 2 — AT-RISK BEHAVIOR

The Drift: When Shortcuts Become the New Normal

A behavioral choice where the risk is not recognized or is believed to be negligible — 'normalization of deviance.'

⚠ WHY IT HAPPENS

- **"I always do it this way"**
  Habit overrides updated protocol.
- **"Everyone else does it"**
  Peer behavior normalizes the shortcut.
- **"The script is overkill"**
  Experience breeds overconfidence.
- **"Nothing bad has happened yet"**
  Absence of consequence reinforces the drift.

✓ COACHING RESPONSE

- **Name the drift without shame**
  "What were you thinking at that moment?"
- **Connect shortcut to specific risk**
  Concrete consequence — not abstract warning.
- **Rebuild the habit collaboratively**
  Let the dispatcher design their own correction.
- **Document the coaching session**
  Written record protects agency legally.

If multiple staff drift the same way, the system may be enabling the shortcut — audit first.

TYPE 3 — RECKLESS BEHAVIOR

Conscious Disregard: When the Choice Is Indefensible

A deliberate choice to ignore a known, substantial risk — with full awareness of the potential consequences.



Intentional Disconnection

Dispatcher ends an active 911 call out of frustration, knowing the caller may be in distress.



Working While Impaired

Reporting to shift while intoxicated, knowing it impairs safety-critical decision-making.



Falsifying Training Records

Supervisor signs off on certifications for training that was never completed.

🚫 **REQUIRED RESPONSE: Formal Discipline — up to and including Termination. Documents everything.**

Just Culture does NOT protect reckless behavior. Accountability here is ethically and legally required.

THE OUTCOME BIAS PROBLEM

Identical Behavior Must Receive Identical Assessment

SCENARIO A

Dispatcher sends units to
123 Main Street instead of Avenue.
Officer catches the error en route.
No patient harm.

→ Outcome: Near-miss caught.

"Be more careful next time." No documentation.

✓ No record
✓ No system review
✓ Same risk remains

VS

SCENARIO B

Dispatcher sends units to
123 Main Street instead of Avenue.
Units arrive at wrong location.
Patient found 15 minutes later.

→ Outcome: Adverse patient outcome.

Termination + Lawsuit.

✗ Dispatcher gone
✗ System flaw remains
✗ Next dispatcher inherits the risk

THE BEHAVIOR WAS IDENTICAL. Just Culture demands identical assessment — and identical root cause response — in both cases.

LEGAL DEFENSE

How Just Culture Builds Your Agency's Strongest Shield

⚖ NEGLIGENCE FRAMEWORK

1. **Duty**
   911 owes callers a duty of care — generally established.
2. **Breach of Standard**
   Plaintiff must show the agency fell below reasonable care.
3. **Causation**
   The breach must have caused the harm — docs narrow this.
4. **Damages**
   Documented response limits gross negligence exposure.

✓ HOW JUST CULTURE PROTECTS YOU

- **Documented Policy**
  Your Just Culture policy IS your standard of care.
- **Near-Miss Response Records**
  Proves agency actively managed foreseeable risks.
- **Training Documentation**
  Signed records prove staff knew the standards.
- **Coaching Logs**
  Progressive correction preempts 'ignored' claims.

An agency with a documented Just Culture demonstrates — in evidence — that it takes safety seriously.

THE SUBSTITUTION TEST

The Core Diagnostic: System Failure vs. Individual Failure

THE CORE QUESTION:

"Could three competent dispatchers having the same training, under the same conditions, and using the same software have made the same mistake?"

IF YES — SYSTEM FAILURE

- Error is a foreseeable product of the environment
- Agency must identify and fix systemic conditions
- Disciplining the individual is legally indefensible

ACTION: Fix the System. Document. Report.

IF NO — INDIVIDUAL FAILURE

- Behavior fell outside what a competent peer would do
- Reflects a personal choice or knowledge gap
- **Knowledge, Skills and Abilities…**

ACTION: Coach or Discipline. Then fix system gaps too.

The test asks: would a typical competent peer make this mistake — not would a perfect dispatcher.

SUBSTITUTION TEST — STEP BY STEP

The Five-Step Incident Review Framework

1	**Reconstruct the Conditions** *What were the staffing, system, and environmental conditions?*	*→ Staffing · Shift length · Call volume · System status*
2	**Define the Behavior Precisely** *Describe the exact action — not the outcome, the action itself.*	*→ Specific action, not vague summary: 'selected wrong unit'*
3	**Apply the Substitution Test** *Would three trained peers, in identical conditions, do the same?*	*→ Same training · Same system · Same shift length*
4	**Categorize the Behavior** *Human Error, At-Risk, or Reckless — independent of outcome?*	*→ What did they intend? Did they perceive the risk?*
5	**Respond and Document** *Console, Coach, or Discipline —record action and system fixes.*	*→ System fix · Coaching log · Discipline record · Near-miss report*

Print this slide. Post it at your supervisor workstation. Use it every time an incident review is triggered.

JUST CULTURE IN ACTION

Applying the Framework to Real 911 Scenarios

Early in the morning, Dee wakes to find her husband Fred making strange sounds. His eyes are wide open and glassy. She calls 911, and provider her address, but under her stress, her voice cracks while speaking. The telecommunicator, assuming this is a call from the area nursing home, dispatches EMS (which is only a few blocks from Dee's home), and assures her "help is on the way…"

Dee begin telecommunicator-assisted CPR, but it takes EMS 16 minutes to arrive on scene. Although Fred is revived on the way to the hospital, he suffers "severe and permanent injuries" to his brain, due to lack of oxygen.



What behavior is at issue?

1. Would another telecommunicator, with the same training, under the same circumstances and using the same equipment make the same error?
2. What was the type of behavior involved?

Human Error

Console and Educate
It is possible to improve the system?

Norg v. City of Seattle **(Washington Supreme Court, 2023)**

JUST CULTURE IN ACTION

Applying the Framework to Real 911 Scenarios

A telecommunicator is working a quiet overnight shift in a rural PSAP. To help stay awake and engaged, he begins using his personal smartphone to watch video at the console, keeping one earbud in while the radio remains on the console speakers. He's done this for several weeks without incident.

Friday evening, a local deputy keys up with a "Priority 0" call, but the telecommunicator misses the first call because he is distracted by the video. He catches the second transmission 15 seconds later. No injuries occur, and the situation resolves without incident



What behavior is at issue?

1. Would another telecommunicator, with the same training, under the same circumstances and using the same equipment make the same error?
2. What was the type of behavior involved?

At-Risk Behavior

Coaching

Are there environmental issues to address?

JUST CULTURE IN ACTION

Applying the Framework to Real 911 Scenarios

Sheri is dating one of the local police officers, and they have been having an argument this evening. The officer calls over the radio for a vehicle registration check, and Sheri mutes the radio to teach him a lesson. She turns to talk with her co-worker about weekend plans.

While muted, the traffic stop turns violent, and the officer begins screaming "Code 3" into the muted channel. His call goes unanswered for six minutes until a neighboring agency hears him on the radio and respond. He suffers minor injuries and recovers.



What behavior is at issue?

1. Would another telecommunicator, with the same training, under the same circumstances and using the same equipment make the same error?
2. What was the type of behavior involved?

Reckless Behavior

Severe Discipline

IMPLEMENTATION

Four Actions You Can Take Starting Monday Morning

1. Create a Near-Miss Reporting Mechanism

- Anonymous or non-punitive pathway for 'almost' errors
- Start simple — a 4-question paper form works
- Data reveals system vulnerabilities before harm occurs

2. Change the Language of Incident Review

- Retire: 'Who did this?'
- Replace: 'What happened?' and BE CURIOUS
- Post this shift on your supervisor bulletin board

3. Implement the Two-Minute Hot-Wash

- After every high-acuity call, take 2 minutes
- Ask: Did the system help or hurt? Did we drift?
- Builds safety culture in real time, every shift

4. Reform QA/QI to Safety-Critical Metrics

- Move away from 'gotcha' compliance checklists
- Focus on: address confirmed? EMD protocol followed?
- Measure the behaviors that actually prevent harm

Culture change starts with one conversation done differently. Start there, then build the systems.

AGENCY RESPONSIBILITY

Vicarious Liability and the Four Documentation Shields

RESPONDEAT SUPERIOR

Agencies are legally responsible for employees' actions within the scope of employment.

You cannot avoid this liability.

You can only demonstrate that you managed it responsibly.

If it isn't documented, it didn't happen.



Written Just Culture Policy

Distributed, signed, dated — your documented standard of care.



Near-Miss Response Records

Each report reviewed, actioned, acknowledged — proves proactive management.



Training Documentation

Signed attendance and assessments — proves staff knew the standards.



Consistent Coaching Logs

Progressive records — date, behavior, plan, dispatcher acknowledgment.

Your paper trail is your legal armor — in court and in culture.

SUMMARY

Six Key Takeaways

1. Just Culture is intelligent accountability — not no-blame.
2. Three categories: Error → Console. At-Risk → Coach. Reckless → Discipline.
3. Substitution Test: Would their peers make the same mistake? YES = system issue.
4. Outcome Bias destroys fairness — same behavior must mean same assessment.
5. Documentation is your legal armor — policy, coaching logs, near-miss records.
6. Start Monday: one form, one language change, one two-minute hot-wash.

"The goal is not to find who to blame — it is to build a system where blame is rarely the right answer."


Q&A
MPSCC SPRING 2026
Margaritaville
Lake of the Ozarks
Beyond Blame
Just Culture in 911
Questions, Discussion & Application
I welcome all questions — challenge me. That's how we get this right together.
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