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Superior Court
of the District of Columbia

IN THE SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
CIVIL DIVISION

AUJAH GRIFFIN
Individually and as the Personal Representative of the Estate of David Earl Griffin
23377 Superstition Way
California, MD 20619

Plaintiffs,

vs.

DISTRICT OF COLUMBIA
c/o Office of the Attorney General
400 6th Street NW
Washington, D.C. 20001

and

OFFICE OF UNIFIED COMMUNICATIONS
Serve: Deputy Director Heather McGaffin
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

and

MURIEL BOWSER
Individually and in her Official Capacity as Mayor for the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

and

CLEO SUBIDO
Individually and in her Official Capacity as Interim Director of the Office of Unified Communications
3213 Harbor Avenue SW, Unit 116
Seattle, WA 98126

and

Jury Trial Demanded

Civil Case No. 2024-CAB-001668

KARIMA HOLMES
Individually and in her Official Capacity as Interim Director of the Office of Unified Communications
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

and

JOHN DOE #1
Individually and in his Official Capacity as an Emergency Dispatcher
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

and

JANE DOE #1
Individually and in her Official Capacity as an Emergency Dispatcher
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

and

JOHN DOE #2
Individually and in his Official Capacity as an Emergency Dispatcher
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

and

JANE DOE #2
Individually and in her Official Capacity as an Emergency Dispatcher
2720 Martin Luther King Jr. Ave. SE
Washington, D.C. 20032

Defendants.

<u>COMPLAINT AND JURY DEMAND</u>

COMES NOW the Plaintiffs, Aujah Griffin, *Individually and as the Personal Representative of the Estate of David Earl Griffin*, by and through undersigned counsel, and sues the above-named Defendants, stating as follows:

<u>INTRODUCTION</u>

1. This action is brought by Plaintiffs as a result of the preventable death of David Earl Griffin ("**Mr. Griffin**") after emergency dispatchers improperly classified 911 calls for assistance as "Priority 2" rather than "Priority 1," which significantly delayed the response from emergency first responders. In addition, emergency dispatchers were provided with updated location information from the first EMTs responding on scene as the situation developed and Mr. Griffin moved to another location, but the dispatchers failed to relay that vital information to other responding personnel, including police officers, who were desperately needed on scene. Both the error in classification and the failure to provide correct location information delayed the response of emergency personnel and ultimately resulted in Mr. Griffin's death.

2. On March 14, 2022, Mr. Griffin as in the Southwest Waterfront area of Washington, D.C. when he experienced a mental health crisis. Bystanders called 911 at 6:15 p.m. to report Mr. Griffin's erratic behavior. As many as 10 calls were made to 911 within an approximate four minute time span, describing Mr. Griffin's behavior and reporting that he was yelling, jumping on cars, and scaring bystanders.

3. The emergency dispatcher improperly entered these calls as an "overdose" and classified the calls as a "Priority 2," a non-urgent call. Classifying the call as a Priority 2 meant that the response from emergency responders would be far more delayed than the response would be for

a Priority 1 call. At the time, emergency dispatchers knew or should have known that this was an emergency requiring an immediate response from police and medical personnel, because the 911 reports outlined a situation where there was an imminent threat to persons and a potential for significant property damage.

4. After the first EMTs arrived on scene, approximately eighteen minutes later, the EMTS contacted dispatch to report that the situation was dire and required immediate response from additional personnel. The EMTs reported that Mr. Griffin was running all over the place hurting himself and that the EMTs were unable to contain him. The emergency dispatchers kept the call classified as a Priority 2 overdose despite the additional reports again outlining that there was an imminent threat to persons and a potential for significant property damage.

5. At 6:38 p.m., Mr. Griffin began moving to another location and the EMTs called dispatch again, reporting the new location at least two blocks away. The emergency dispatchers failed to provide the updated location information to the additional emergency personnel that were responding to the scene.

6. At 6:42 p.m., the EMTs lost control of Mr. Griffin and called a 10-33 distress call to the emergency dispatchers. Only at this point, almost half an hour after the first call to 911, did emergency dispatchers upgrade the classification to a Priority 1.

7. The first police officers responded to the scene shortly thereafter but were unable to locate Mr. Griffin or the EMTs. The officers wasted valuable response time attempting to discern their location by asking bystanders.

8. The police officers were eventually able to find the location after other first responders on a boat in the channel saw Mr. Griffin struggling with the EMTs and reported the

location over the radio. At no point did the emergency dispatchers provide the location information to the responders, despite being aware of the change in location after the EMTs' report.

9. By the time police officers arrived where Mr. Griffin was, Mr. Griffin had escaped the EMTs and jumped into the Washington Channel. It took emergency personnel twelve minutes to pull Mr. Griffin out of the water. Mr. Griffin was unresponsive when he was pulled from the water and attempts to resuscitate him were unsuccessful.

10. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

11. Mr. Griffin was in crisis. Yet police did not even receive the call for about 22 minutes and did not respond for at least 30 minutes, an unconscionable delay in response due to the emergency dispatcher's incorrect classification of the call as a drug overdose warranting a Priority 2 response. That response was inconceivably delayed even further by the emergency dispatcher's failure to report to police officers the change in location the EMT personnel had reported when EMTs called dispatch pleading for assistance.

12. As a result of these failures, Mr. Griffin died.

JURISDICTION AND VENUE

13. This Court has jurisdiction pursuant to D.C. Code § 11-921, as the events and damages set forth herein occurred in the District of Columbia.

14. Written notice of the allegations and claims herein was given to the Defendants prior to the filing of this action. Plaintiffs provided notice of their claim on or about September 13, 2022, by filing a Tort Claims Act Notice through the District of Columbia Tort eFiling system.

PARTIES

15. Plaintiff Aujah Griffin ("**Plaintiffs**") is an adult resident of Maryland. Ms. Griffin is the daughter and next of kin of David Earl Griffin and is the Personal Representative of the Estate of David Earl Griffin. Plaintiff Griffin was appointed as the Personal Representative of the Estate of David Earl Griffin on or about February 16, 2023. Plaintiff Griffin brings this action in her individual capacity and as Personal Representative of Mr. Griffin's estate.

16. Defendant District of Columbia ("**Defendant DC**") is the municipal government of the District of Columbia. Defendant DC operates Defendant OUC and is capable, along with its subagency Defendant OUC, of being sued as a municipal corporation pursuant to D.C. Code § 1-102.

17. Defendant Office of Unified Communications ("**Defendant OUC**") is a government agency operated by the District of Columbia. Defendant OUC is charged with handling all 911 and 311 call-taking for the District of Columbia, including police, fire, and medical dispatch. Defendant OUC is also responsible for providing centralized, District-wide coordination and management of all public safety communication systems for District of Columbia government agencies. At all times relevant herein, Defendant OUC employed all emergency dispatchers referenced herein, including, but not limited to, the Defendant Dispatchers.

18. Defendant Muriel Bowser ("**Defendant Bowser**") is, upon information and belief, an adult resident of the District of Columbia and was at all times relevant to this Complaint employed as the Mayor of the District of Columbia. Defendant Bowser is named as a Defendant individually and in her official capacity as Mayor of the District of Columbia.

19. Defendant Cleo Subido ("**Defendant Subido**") was, upon information and belief, an adult resident of the District of Columbia at times relevant to this Complaint and was employed

by Defendant OUC. Defendant Subido was hired by Defendant OUC in January 2020 as Chief. In that role, Defendant Subido was responsible for providing training to all new employees and providing education and developmental training for existing employees, including frontline call takers and executive management. Defendant Subido was appointed as Interim Director of Defendant OUC on January 22, 2021, and served in that capacity until on or around March 2, 2022. Defendant Subido continued to work for Defendant DC after that transition and began employment with the District of Columbia Fire and Emergency Medical Services Department on or around March 22, 2022.

20. Defendant Karima Holmes ("**Defendant Holmes**") was, upon information and belief, an adult resident of the District of Columbia at all times relevant to this Complaint and was employed by Defendant OUC. Defendant Holmes was appointed as the Director of Defendant OUC by Defendant Bowser in 2016 and served in that capacity until her resignation on or around January 2021, when Defendant Subido was appointed as Interim Director. Defendant Holmes was reappointed as Interim Director on or about March 2, 2022 and served in that capacity until she withdrew her nomination for the Director position on or around December 6, 2022. Defendant Holmes withdrew her nomination after she lost the support of the head of the D.C. Council's public safety committee following a scathing audit and a string of failed dispatch calls, some of which resulted in deaths.

21. Defendant John Doe #1 was, upon information and belief, an adult resident of the District of Columbia at all times relevant to this Complaint and was employed by Defendant OUC as an emergency dispatcher.

22. Defendant Jane Doe #1 was, upon information and belief, an adult resident of the District of Columbia at all times relevant to this Complaint and was employed by Defendant OUC as an emergency dispatcher.

23. Defendant John Doe #2 was, upon information and belief, an adult resident of the District of Columbia at all times relevant to this Complaint and was employed by Defendant OUC as an emergency dispatcher.

24. Defendant Jane Doe #2 (together with Defendant John Doe #1, Defendant Jane Doe #1, and Defendant John Doe #2, "**Defendant Dispatchers**") was, upon information and belief, an adult resident of the District of Columbia at all times relevant to this Complaint and was employed by Defendant OUC as an emergency dispatcher.

FACTS

The Failed Emergency Response on March 14, 2022 That Led to Mr. Griffin's Death

25. On March 14, 2022, Mr. Griffin was in the Southwest Waterfront area of Washington, D.C. That day, Mr. Griffin was experiencing a mental health crisis and was reported as acting erratically by witnesses in the area.

26. Bystanders called 911 to report Mr. Griffin's erratic behavior. The first calls were made around 6:15 p.m. Upon information and belief, as many as 10 calls were made to 911, describing Mr. Griffin's erratic behavior and reporting that he was yelling and jumping on cars.

27. The emergency dispatchers, including, but not limited to, the Defendant Dispatchers, entered the initial 911 calls as an "overdose" and classified the calls as a "Priority 2," a non-urgent call. This was despite the numerous calls from bystanders describing Mr. Griffin's concerning behavior and outlining a desperate situation involving a man suffering a mental health

crisis. At this time, Defendants knew or should have known that this was an emergency that required an immediate response from police and medical personnel.

28. The first responders on scene arrived approximately eighteen minutes later. An EMT team with the designation A18 arrived and located Mr. Griffin.

29. Mr. Griffin, who was still suffering from his mental health crisis, was resistant to treatment. A18 was unable to render any care to Mr. Griffin without further assistance. A18 contacted emergency dispatch to request that additional assistance be dispatched to the scene. Despite A18's reports from the scene that Mr. Griffin was uncooperative, was actively harming himself, and that they were unable to contain him, emergency dispatch, including, but not limited to, the Defendant Dispatchers, failed to reclassify the call as a Priority 1.

30. As the call was still logged as a Priority 2, police officers from the Metropolitan Police Department were not dispatched until twenty-one minutes after the initial 911 call. The officers were finally dispatched at 6:36 p.m., while the call was still logged in the dispatch center computer as a Priority 2 overdose. This classification remained "non-urgent" despite the reports from bystanders and despite the urgent report from A18.

31. At 6:38 p.m., A18 reported to emergency dispatch that Mr. Griffin was moving from the initial location and that he was now at least two blocks away on P Street.

32. At 6:42 p.m., A18 called a 10-33 distress call, informing the emergency dispatchers, including, but not limited to, the Defendant Dispatchers, that the situation was continuing to escalate and that they were concerned they were in imminent danger.

33. By this time, approximately 28 minutes after the first call to 911, the police officers had finally responded to the initial scene. But Mr. Griffin and the ambulance team were no longer

there. Emergency dispatchers, including, but not limited to, the Defendant Dispatchers, failed to ever report to police officers that Mr. Griffin and A18 had moved to another location.

34. The responding police officers lost valuable response time speaking with bystanders at the initial dispatch location to locate Mr. Griffin and A18.

35. The police officers were only able to eventually locate Mr. Griffin and A18 because boats dispatched by the D.C. Police Harbor Patrol witnessed the A18 crew struggling with Mr. Griffin and notified the responding police officers of their location over radio.

36. Shortly after the harbor patrol notified responding police officers of Mr. Griffin's actual location, Mr. Griffin jumped into the Washington Channel. Mr. Griffin was already in the water before the first police officers on land arrived at his location.

37. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

38. Metropolitan Police Department harbor patrol and boats from the fire department were not able to remove Mr. Griffin from the river for twelve minutes.

39. By this time, additional medical first responders were dispatched to the scene. A paramedic unit, M08, was dispatched at 6:46 p.m., arrived at the scene at 6:55 p.m., and was only able to locate Mr. Griffin fifteen minutes after arriving at 7:10 p.m. By the time M08 arrived, Mr. Griffin had been pulled from the water and A18 was performing CPR. Mr. Griffin was transferred from A18 to M08's care, and M08 took over CPR attempts.

40. At 7:19 p.m., M08 transported Mr. Griffin to Medstar Hospital. Mr. Griffin was pronounced deceased after arrival.

41. According to the Metropolitan Police Department, General Order SPT.302.01, Calls for Service, a Priority 1 call is a call that "require[s] an expeditious response." If a call is classified as a Priority 1, "the dispatcher will broadcast an alert tone to notify field units of a priority one assignment within their patrol district. Members shall cease all but emergency radio transmissions and standby for dispatch of the priority one assignment. A supervisor shall respond to all priority one assignments." A Priority 1 call includes any call involving imminent threat to any person or the potential for significant property damage exists.

42. Within the first four minutes of the first 911 call, numerous callers called 911 and reported the following to dispatchers including, but not limited to, the Defendant Dispatchers:

a. There is a man on the ground yelling and screaming;

b. The man is jumping on vehicles; and

c. The man is scaring passersby.

43. Within eighteen minutes of the first 911 call, A18 reported to emergency dispatchers, including, but not limited to, the Defendant Dispatchers, the following:

a. The man is running all over the place hurting himself; and

b. We can't contain him.

44. Both the first set of calls within four minutes of the first 911 call at 6:15 p.m. and the calls from A18 to emergency dispatchers eighteen minutes later indicate that there was an imminent threat to persons and the potential for significant property damage existed. Yet emergency dispatchers, including, but not limited to, the Defendant Dispatchers, failed to properly classify the calls as a Priority 1 at the beginning or upgrade the classification to a Priority 1 after A18's initial report.

45. It was not until at least four minutes after A18's first report detailing the emergent nature of the situation that the first police officer from the Metropolitan Police Department was even dispatched. At this time, since the call was still listed as a Priority 2, the police officers were not supposed to respond with lights and siren, meaning that the officers took significantly longer than necessary to even arrive at the incorrect location provided by emergency dispatchers, including, but not limited to, the Defendant Dispatchers.

46. On March 25, 2022, Defendant OUC issued a statement. While Defendant OUC incorrectly and inappropriately contended that the initial 911 calls were properly classified, it confirmed that it had received several 911 calls regarding Mr. Griffin and classified those calls as a "Priority 2." This downgrade in priority meant that "no officers were available for immediate dispatch due to the volume of higher priority calls," an issue that would not have occurred had the 911 calls be given the appropriate priority classification. The classification was not upgraded by Defendant OUC until the fire crews called the 10-33 distress call, approximately thirty minutes after the first 911 call, after which police officers arrived in less than a minute.

47. The statement of Defendant OUC acknowledged that there were failures on the part of the dispatcher and its other staff, including, but not limited to, the Defendant Dispatchers, stating that "as a result of the investigation, the police dispatcher involved and the supervisory staff on duty that evening have been counseled to review how this might have been handled better." The statement failed, however, to even acknowledge the dispatchers' failure to provide the police officers with the accurate address.

The Numerous Audits Outlining Serious Systemic Issues With D.C.'s 911 Response

48. This incident occurred less than six months following the publication of a report by the District of Columbia Auditor outlining the problems with the District of Columbia's emergency

system. The report, titled *District's 911 System: Reforms Needed to Meet Safety Needs*, was prepared by Federal Engineering, Inc. to compare the effectiveness of Defendant OUC against national standards. *See* https://dcauditor.wpenginepowered.com/wp-content/uploads/2023/08/OUC.Report.10.19.21.pdf. The problems the report identified included:

a. Inadequate supervision of the call-taking and dispatch operations;

b. Inconsistent or ineffective use of call script protocols;

c. Inconsistent use of location determining technology tools to determine locations; and

d. Insufficient management follow-up on after-action reviews.

49. The report noted that lower priority calls were often overlooked: "Lower priority calls in a high-volume event environment do not receive the level of attention as do calls of a higher priority and may be overlooked by dispatch staff."

50. In addition to overlooking lower priority calls, Defendant OUC consistently fails to accurately identify the location of calls for emergency response. The report identified problems including:

a. Ineffective use of scripted protocol questions that result in certain questions being asked out of order or not asked at all;

b. Improvising or adlibbing questions during call handling resulting in inconsistencies in information collected;

c. Inconsistencies with the posing of questions regarding scene safety issues that include asking about the presence of weapons, alcohol or drugs, suspect descriptions, and direction of travel;

d. Inconsistent or ineffective use of the technique of "repetitive persistence" concerning caller management;

e. The provisioning and configuration of the CBD system as interfaced to the CAD system with an excessive number of Chief Complaint/Event types along with pre-assigned associated priorities;

f. A span of control of supervision that makes it impossible to provide adequate oversight to the floor operation, and no direct discipline monitoring of call-taking and dispatching;

g. Incomplete follow up of QA findings, to include employee performance issues and follow up; and

h. Inconsistent customer service to include unprofessional behavior.

51. Prior to this incident, there have been several other incidents involving emergency dispatchers, including, but not limited to, the Defendant Dispatchers, incorrectly handling calls or failing to either obtain correct location information or update changing location information. These incidents include, but are not limited to:

a. In June 2020, the thirteen-year-old daughter of Sheila Shepperd called 911 because her mother had collapsed. Records demonstrate that she provided the correct address in the northeast quadrant of the city, but the OUC telecommunicator erroneously entered the address as being in the northwest quadrant of the city. As a result of the error, first responders did not arrive at the correct residence for more than twenty minutes after the initial emergency call was placed. Ms. Sheppard was later pronounced dead.

b. On or around May 17, 2020, an OUC telecommunicator responding to a distress call concerning a newborn failed to follow OUC's address verification policy and, as a result, sent FEMS to the wrong address. Additionally, the call taker failed to provide appropriate life-saving pre-arrival instruction to the caller. When first responders finally arrived at the correct address over thirty minutes following the call's commencement, the newborn was in cardiac arrest.

c. On August 2, 2020, a Fire and Emergency Medical Services boat reported a possible boat collision to the emergency dispatcher. The boat personnel reported that the incident location was near Georgetown Waterfront Park. The emergency dispatcher incorrectly entered the location as the Anacostia Community Boathouse in the 1900 block of M Street. Additional units were sent to the incorrect location. Fifteen minutes later the situation had worsened and three people had fallen overboard. The original Fire and Emergency Medical Services boat reported the change in circumstances and requested additional support. The emergency dispatcher updated the event to a water rescue and dispatched additional support but did not correct the incorrect location. Additional support was also sent to the wrong location until the Fire and Emergency Medical Services boat corrected the dispatcher and all the additional personnel were routed to the correct location.

d. On August 25, 2020, a woman called emergency dispatch to report that daughter and a man had been shot by two male suspects. The woman was not at the incident location and initially reported that her daughter was at The True Gospel Church. Shortly afterwards, the woman corrected herself and reported to emergency dispatch that the actual location was 4405 Southern Avenue, approximately 4.6

miles from The True Gospel Church. The location was not updated, and responders redirected, until twelve minutes into the call.

e. On August 25, 2020, several callers reported to emergency dispatch that there had been a serious rollover motor vehicle accident. Callers reported that an ambulance would be required because it appeared that there had been airbag deployment and that it appeared a vehicle was on fire. Federal Engineering, Inc. concluded that the seriousness of the incident was underestimated and that the dispatchers made several errors during the response to this incident, including, but not limited to, failing to follow scripted protocols, entering inconsistent and contradictory information into the CAD system that did not convey what was reported by callers, and the dispatcher slurring and speaking too fast to the point of being unintelligible.

f. On May 9, 2022, emergency dispatch received a call reporting a medical emergency involving a woman who was not conscious or breathing and who could not be roused. The location was reported as 1222 I St. SE, but the emergency dispatcher incorrectly logged the address as 122 I St. SE, which sent initial responders to a location a mile away from the woman in medical distress. It took emergency dispatchers eleven minutes to re-route emergency responders to the correct address. When first responders finally arrived, the woman was pronounced deceased at the residence.

g. On August 9, 2022, emergency dispatch received a call from a father who told the dispatcher that his three-month-old baby was locked in a car and that the baby was not breathing. This call should have been dispatched as a high-priority, medical emergency, but the emergency dispatcher misclassified the call as a lock-in.

> Emergency dispatchers were simultaneously canceling fire and EMS crews on route to the scene while another dispatcher was on the phone with the parent giving CPR instructions. Due to the delayed response, the three-month-old child did not survive.

52. Another issue identified by Federal Engineering, Inc. related to the number of "Chief Complaints" in the system, writing that the system used by Defendant OUC is "a CAD system that has an excessive number of Chief Complaints and associated priorities creating confusion for call-takers when entering an event." The report recommended that Defendant OUC "develop a timeline and work plan for reducing the total number of Chief Complaints and associated priorities," which should include "reconfiguring the default priority to Priority 1 for high acuity low frequency event types."

53. As the audit recognized, the unnecessarily complicated chief complaint system can have dire consequences. "The selection of an incorrect Chief Complaint has a ripple effect on response including a default to a lower priority." This can result in the fatal misclassification of emergency situations, such as in this case.

54. Upon information and belief, in the period between December 2019 and September 2020, emergency dispatchers at Defendant OUC dispatched emergency personnel to wrong or nonexistent addresses more than three dozen times. Defendant OUC has failed to appropriately address these failures and emergency dispatchers, including, but not limited to, the Defendant Dispatchers, continue to dispatch emergency personnel to incorrect locations, including in this case. Many individuals, including Mr. Griffin, have died because of the delay in emergency response.

55. On September 9, 2022, Federal Engineering, Inc. issued a follow-up audit titled *911 Reform Status Report #1: Minimal Progress*. In the audit, the District of Columbia Auditor wrote to Defendant Bowser and the Chairman of the Council of the District of Columbia that "as the title indicates, very little progress has been made." Indeed, aside from "changes to the OUC management team" since the initial report, the auditor noted that "there is minimal progress on 24 or 77% of recommendations and two recommendations have no observed progress."

56. For example, the audit highlighted the lack of progress on most of the issues outlined above, including, but not limited to:

a. The recommendation to evaluate and reduce the number of event types and associated priorities, which had "minimal progress."

b. The recommendation to streamline the call entry data in the CAD system, which had "minimal progress."

c. The recommendation to assess and improve the integration of scripted protocols into the call handling process to reduce the omission of key questions that may result in incomplete or inaccurate event information, which had "minimal progress."

d. The recommendation to reduce improvising and adlibbing while call-taking, which had "minimal progress."

e. The recommendation to verify address information as defined in Defendant OUC's policies, which had "minimal progress."

f. The recommendation to use location technology to locate callers who are unable to state precise locations of an incident, which had "minimal progress."

57. On March 23, 2023, the auditor once again issued an audit stating that Defendants were *still* not in compliance with the recommendations made in the 2021 audit.

58. In a Public Oversight Roundtable on November 10, 2022, council member Charles Allen also highlighted the frequent failures dispatchers, including, but not limited to, the Defendant Dispatchers, have had regarding providing accurate information to emergency personnel and providing updated information when an emergency evolves. Councilman Allen noted that something is "not right" at Defendant OUC and while mistakes sometimes occur, failing taking the necessary steps to ensure that those mistakes do not repeat is unacceptable, especially when dealing with scenarios that often have life-altering consequences.

59. Defendant OUC claims that its mission is "to provide accurate, professional, and expedited service to the citizens and visitors of the District of Columbia." Defendant OUC has failed in its mission while handling Mr. Griffin's case and calls involving many others, including, but not limited to, the other incidents outlined herein.

Defendant Subido and Defendant Holmes Failure to Adequately Lead Defendant OUC

60. Defendant Holmes was appointed as the Director of Defendant OUC in 2016, and served in that capacity until she resigned on or around January 2021.

61. Defendant Subido was hired by Defendant OUC into a supervisory position reporting to the Director in January 2020, and continued to work for Defendant OUC in a role where she was responsible for providing training to all new employees and providing education and developmental training for existing employees, including frontline call takers and executive management, until Defendant Holmes' resignation.

62. After Defendant Holmes resigned, Defendant Subido was appointed by Defendant Bowser as Interim Director of Defendant OUC on or about January 22, 2021.

63. Defendant Subido continued to serve as Interim Director until Defendant Bowser decided to reappoint Defendant Holmes as Interim Director on or about March 2, 2022. Defendant Subido then transferred to another agency within Defendant DC and began employment with the the District of Columbia Fire and Emergency Medical Services Department on or around March 22, 2022.

64. Both Defendant Subido and Defendant Holmes held supervisory positions during times relevant to this Complaint. The serious and systemic issues plaguing Defendant OUC, which ultimately resulted in Mr. Griffin's tragic death, were not isolated. These were issues that began long before Mr. Griffin's tragic death and continued long afterwards, as demonstrated by the audit reports outlined above. Both Defendant Subido and Defendant Holmes held director positions during this period, and both Defendant Subido and Defendant Holmes failed to take any actions or enact any policies or procedures that would address the systemic issues that led to Mr. Griffin's death.

65. In fact, both Defendant Subido and Defendant Holmes consistently buried their heads in the sand during their respective tenures leading Defendant OUC and ignored the significant and systemic problems plaguing the agency. In a September 2020 interview, Defendant Holmes claimed that "there is not a systematic problem with DC 911," a statement that came not even a year before the first scathing audit was published and shortly after some of the other incidents outlined above.

66. While Defendant Subido later stated in a lawsuit filed in 2023 that she "was astonished to discover problems at OUC that were worse than previously publicized, and which exceeded any she had seen in her previous 31 years of experience as a public safety professional," Defendant Subido kept silent about these issues and failed to either effectively address these issues

or shed light on these issues prior to filing suit against Defendant Bowser and Defendant DC several years later. Defendant Subido claims that her own internal audit uncovered that Defendant OUC was understaffed, that the staff lacked adequate supervision, that absenteeism was extreme, and that the staff lacked adequate training—an unusual discovery only upon her audit upon assuming the Interim Director position, given that she had worked at Defendant OUC for an entire year prior and was responsible for providing the training that she now believed to be inadequate.

67. Despite the result of her internal audit, and despite the conclusions of the formal audit, Defendant Subido took no action to effectively address any of the issues identified.

68. Both Defendant Subido and Defendant Holmes contributed to and failed to address the issues that led to Mr. Griffin's death. Defendant Subido was the Interim Director in charge of Defendant OUC for nearly ten months before the issuance of the first audit outlining serious issues on October 19, 2021. Defendant Subido, during that tenure, failed to identify these issues and take any action to address them. Defendant Subido was the Interim Director for half of the year in between the issuance of the first audit and the issuance of the second audit indicating that very little progress had been made in addressing the issues, and, despite the audit identifying the issues and outlining clear recommendations, Defendant Subido failed to take any action to effectively address those issues.

69. Defendant Holmes was the Director during the period between December 2019 and September 2020, when emergency dispatchers at Defendant OUC dispatched emergency personnel to wrong or nonexistent addresses more than three dozen times. Several of the incidents outlined above also occurred during Defendant Holmes' first tenure. Yet despite the frequency of these incidents, Defendant Holmes refused to take any action to address these issues. When Defendant

Holmes returned as Interim Director in March 2022, she led the agency for six months before the second audit was issued declaring that very little progress had been made.

70. It is evident from the audits that neither Defendant Holmes nor Defendant Subido took appropriate action during either of their tenures, as the problems continued to persist.

71. These issues were so prevalent throughout the agency that Defendant Subido noted errors were being made on a daily basis. "In fact, Ms. Subido documented at least 10 instances in one day where OUC sent responders to the wrong address. Comparatively, Ms. Subido could recollect only one similar incident during her 13 years with SPD," Defendant Subido wrote in her lawsuit. But it is evident that despite this acknowledgement, Defendant Subido failed to effectively address these failures that were occurring multiple times every day and which eventually resulted in Mr. Griffin's death.

Defendant Bowser's Failure

72. While the Defendants were plagued by systemic failures that resulted in unconscionable delays in the provision of emergency services, and caused deaths including Mr. Griffin's, Defendant Bowser was attempting to cover up the ineptitude of the staff and leadership at Defendant DC and Defendant OUC.

73. Defendant Bowser, Defendant OUC, and Defendant DC fostered a culture of fear that made more errors and Defendant OUC was constantly faced with staffing shortages.

74. Defendant Subido stated in an interview that she attempted to identify the errors to fix them but was shut down at every turn. Defendant Subido discovered employees that were not working but were receiving pay and/or benefits, but she was told that she would be fired if she investigated. "So, at that point," Defendant Subido stated in the interview, "I had to completely ignore it."

75. Defendant Bowser, Defendant OUC, and Defendant DC attempted to keep the truth hidden about the failures of DC 911, denying 80% of Freedom of Information Act requests. Defendant Subido stated in an interview that she believes 95% of the denied requests were in violation of the law.

76. Defendant Bowser, Defendant OUC, and Defendant DC not only withheld information, but distorted information and lied to cover up the failures, including altering data on the number of calls where there were errors every year, data that was provided to the D.C. Council.

77. Instead of addressing the many serious and systemic issues, Defendant Bowser praised the workers and continued to ignore any problems. For example, during a July 2021 meeting, Defendant Bowser interrupted when a reported asked the police chief whether he was satisfied with how Defendant OUC operated, stated she had nothing to report on recruitment and failed to answer the question while also keeping the police chief from answering the question posed directly to him.

78. In another example, in response to a failure to appropriately respond to a house fire in 2019 that caused two individuals to lose their lives, Defendant Holmes staunchly defended the handling of the emergency call and asserted that the four minutes it took for Defendant OUC to dispatch responders—four times longer than the national standard— was "as fast as we could."

79. When asked by a D.C. Council Member why a fire engine couldn't immediately be sent in response to a fire, Defendant Holmes stated that the "dispatcher was not clear what type of fire it was" and suggested obtaining details about the fire was a reasonable justification for delaying dispatch in an emergency.

80. Defendant Bowser also repeatedly defended OUC and praised Defendant Holmes after Defendant Holmes stood by the actions of OUC. For example, shortly after the 2019 house fire incident, Defendant Bowser stated that D.C. residents were "lucky to have Karima Holmes run our 911 call center."

81. Defendants, including Defendant Bowser and Defendant Holmes, were so desperate to conceal the failures of Defendant OUC that they vehemently opposed the audits that ultimately exposed those failures and identified the systemic issues that ultimately caused Mr. Griffin's death, claiming that the audits would be unnecessary.

82. In a lawsuit filed in 2023, Defendant Subido claims that Defendant Bowser went so far to protect Defendant OUC that she would terminate the employment of any individual attempting to address the systemic issues. Defendant Subido writes that Deputy Mayor Geldart, her direct supervisor when she was Interim Director, "warned Ms. Subido to tread carefully and not pursue her concerns as it would upset Mayor Bowser and would likely result in Mayor Bowser firing Ms. Subido."

Defendant DC's Failure to Comply with the NEAR Act Contributed to Mr. Griffin's Death

83. In 2016, the D.C. Council unanimously passed a community safety law called the Neighborhood Engagement Achieves Results Act of 2016 (the "**NEAR Act**").

84. The NEAR Act required Defendant DC to make sweeping reforms including the creation of Community Crime Prevention teams, which were to be comprised of police officers and behavioral health specialists.

85. These teams would travel and respond together to cases such as Mr. Griffin's involving mental health crises.

86. These Community Crime Prevention teams were never created. Even worse, news reports around September 2022 found that Defendant Bowser's NEAR Act website claimed the teams had been fully funded and were operational, which was not true.

87. A report by the Office of the District of Columbia Auditor issued June 7, 2022 that found that full implementation of the NEAR Act was supposed to begin on October 1, 2017, after Defendant Bowser and the D.C. Council enacted the fiscal year 2018 budget. The implementation was supposed to include "deployment of Community Crime Prevention Teams pairing police officers with behavioral health specialists." Deploying these teams in coordination with the Department of Behavioral Health and the Department of Human Services is required under Section 105 of the NEAR Act.

88. Defendant DC was supposed to establish *at least five* of these Community Crime Prevention Teams and deploy at least one of those teams at all times of the day.

89. The implementation and deployment of these teams is a vital part of the NEAR Act and a recognition that "Police officers may not be equipped to understand and respond to the complex needs of these individuals," including those suffering from mental health crises like Mr. Griffin. The September 2022 report, however, concluded that "MPD, DBH, and DHS have not implemented this alternative response to people facing behavioral health crisis envisioned in the Community Crime Prevention Team Program." The report noted that "the failure to create the Community Crime Prevention Team Program may also have limited MPD's access to clinical expertise that could have improved its response to individuals facing mental health disorders, addiction, and homelessness."

90. The report recommended that "the Metropolitan Police Department should comply with the law by establishing the Community Crime Prevention Team program, in partnership with the Department of Behavioral Health and the Department of Human Services."

91. Had the program been implemented as required under law, at least one Community Crime Prevention Team would have been on duty at the time Mr. Griffin suffered his mental health crisis on March 14, 2022. That team's response may have saved Mr. Griffin's life and the failure of Defendant DC to fully comply with the law contributed to his death.

As a Result of the Defendants' Failures, a Loving Father and Grandfather Tragically Lost His Life

92. Mr. Griffin was in crisis. Yet police did not even receive the call for about 22 minutes and did not respond for at least 30 minutes, an unconscionable delay in response due to incorrect classification of the call as a drug overdose warranting a Priority 2 response by emergency dispatchers, including, but not limited to, the Defendant Dispatchers. That response was inconceivably delayed even further by the failure of emergency dispatchers, including, but not limited to, the Defendant Dispatchers, to report to police officers the change in location the EMT personnel had reported when EMTs called dispatch pleading for assistance.

93. Defendants greatly delayed emergency personnel when Mr. Griffin needed them most. As a result of that delay, Mr. Griffin died.

94. Mr. Griffin was a loving father and grandfather with ten children and seventeen grandchildren. But when he needed help, no one responded.

95. When the EMTs on scene needed help, no one responded.

96. This failure in responding was the proximate cause of Mr. Griffin's death.

COUNT I
Wrongful Death Claim

97. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

98. Defendants owed a duty to act reasonably towards Mr. Proctor and provide adequate emergency response services, including, but not limited to, adequately handling 911 call-taking for the District of Columbia, managing the centralized, District-side coordination and management of public safety communication systems, and provide emergency dispatch services.

99. Despite this duty, Defendants failed to provide adequate emergency dispatch services and adequately handle the 911 calls made in connection with the events addressed herein, which wrongfully caused or directly contributed to the death of Mr. Griffin.

100. Emergency dispatchers including, but not limited to, the Defendant Dispatchers failed to properly classify the initial 911 calls that were made by bystanders while Mr. Griffin was undergoing a serious mental health crisis. These initial calls, the first of which was made at 6:15 p.m., described to the dispatcher that Mr. Griffin was on the ground yelling and screaming, jumping on vehicles, and scaring passerby. These calls demonstrated that this call involved an imminent threat to a person and/or the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, emergency dispatchers including, but not limited to, the Defendant Dispatchers ignored the reports and instead classified the calls as a non-emergency drug overdose with Priority 2.

101. Emergency dispatchers including, but not limited to, the Defendant Dispatchers knew or should have known that Mr. Griffin's crisis required an immediate response from emergency personnel. Instead, the dispatchers used a classification that significantly delayed the response of first responders.

102. When the first EMT personnel arrived on scene, the crew of A18 called emergency dispatchers including, but not limited to, the Defendant Dispatchers and reported that the situation was dire. About eighteen minutes after the first call, A18 reported to dispatch that Mr. Griffin was running all over the place hurting himself and that A18 was unable to contain him. This call demonstrated that there was an imminent threat to persons, including Mr. Griffin himself and the A18 crew, and the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, emergency dispatchers including, but not limited to, the Defendant Dispatchers again ignored the reports and kept the classification as a Priority 2.

103. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known after A18's report that the situation was dire and required an immediate response from additional emergency personnel. Instead, the dispatchers left the classification as Priority 2, which significantly delayed the response of additional personnel.

104. After their first report, around 6:38 p.m., A18 reported to dispatch that Mr. Griffin was moving from the first location to a second location at least two blocks away.

105. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that this information was vital to provide to other emergency personnel responding to the scene, who would not be able to find Mr. Griffin and A18 without the updated location information. Instead, the dispatchers made no mention of the new location to any of the other responding personnel.

106. As a result of the failure to properly classify the call and the failure to provide updated location information, police officers did not arrive on scene until thirty minutes later, after Mr. Griffin had jumped into the Washington Channel. The officers were only able to find the

correct location because it was reported over the radio by other personnel on the water, not because the dispatchers ever provided the updated location information reported by A18.

107. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

108. In addition, Defendant DC had the duty to fully comply with all laws, including, but not limited to, the NEAR Act, which required Defendant DC to implement and deploy Community Crime Prevention Teams comprised of police officers and behavioral health specialists who would have the expertise to respond to individuals suffering mental health crises like Mr. Griffin.

109. Those teams were supposed to be implemented no later than October 1, 2017, following the allocation of additional budgeting in the fiscal year 2018 budget.

110. Defendant DC failed to enact and deploy those teams as required under law.

111. As a direct and proximate result of Defendants' failures and breach of duties owed to Mr. Griffin, for which Mr. Griffin would have been able to maintain an action and recover damages had he lived, Mr. Griffin sustained fatal bodily injuries and pronounced dead shortly after he was transported to MedStar Hospital.

112. As a direct and proximate result of Defendants' failures and breach of duties owed to Mr. Griffin, Plaintiffs have sustained injuries including, but not limited, pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of protection and loss of parental care.

WHEREFORE, Plaintiffs seek a monetary judgment against Defendants as allowed by law within the jurisdiction of this Court, in an amount to be determined by a jury at trial, a declaration

that the District of Columbia remains in violation of the NEAR Act, a court order requiring the District of Columbia to immediately comply with the NEAR Act, costs and interest and any other relief deemed appropriate.

COUNT II
Survivorship Claim

113. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

114. Plaintiff Griffin is the Personal Representative of the Estate of David Earl Griffin.

115. Defendants owed a duty to act reasonably towards Mr. Proctor and provide adequate emergency response services, including, but not limited to, adequately handling 911 call-taking for the District of Columbia, managing the centralized, District-side coordination and management of public safety communication systems, and provide emergency dispatch services.

116. Despite this duty, Defendants failed to provide adequate emergency dispatch services and adequately handle the 911 calls made in connection with the events addressed herein, which wrongfully caused or directly contributed to the death of Mr. Griffin.

117. The dispatchers, including, but not limited to, the Defendant Dispatchers, failed to properly classify the initial 911 calls that were made by bystanders while Mr. Griffin was undergoing a serious mental health crisis. These initial calls, the first of which was made at 6:15 p.m., described to the dispatchers that Mr. Griffin was on the ground yelling and screaming, jumping on vehicles, and scaring passerby. These calls demonstrated that this call involved an imminent threat to a person and/or the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers ignored the reports and instead classified the calls as a non-emergency drug overdose with Priority 2.

118. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that Mr. Griffin's crisis required an immediate response from emergency personnel. Instead, the dispatchers used a classification that significantly delayed the response of first responders.

119. When the first EMT personnel arrived on scene, the crew of A18 called the dispatchers, including, but not limited to, the Defendant Dispatchers, and reported that the situation was dire. About eighteen minutes after the first call, A18 reported to dispatch that Mr. Griffin was running all over the place hurting himself and that A18 was unable to contain him. This call demonstrated that there was an imminent threat to persons, including Mr. Griffin himself and the A18 crew, and the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers again ignored the reports and kept the classification as a Priority 2.

120. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known after A18's report that the situation was dire and required an immediate response from additional emergency personnel. Instead, the dispatchers left the classification as Priority 2, which significantly delayed the response of additional personnel.

121. After their first report, around 6:38 p.m., A18 reported to dispatch that Mr. Griffin was moving from the first location to a second location at least two blocks away.

122. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that this information was vital to provide to other emergency personnel responding to the scene, who would not be able to find Mr. Griffin and A18 without the updated location information. Instead, the dispatchers made no mention of the new location to any of the other responding personnel.

123. As a result of the failure to properly classify the call and the failure to provide updated location information, police officers did not arrive on scene until thirty minutes later, after Mr. Griffin had jumped into the Washington Channel. The officers were only able to find the correct location because it was reported over the radio by other personnel on the water, not because any dispatcher ever provided the updated location information reported by A18.

124. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

125. In addition, Defendant DC had the duty to fully comply with all laws, including, but not limited to, the NEAR Act, which required Defendant DC to implement and deploy Community Crime Prevention Teams comprised of police officers and behavioral health specialists who would have the expertise to respond to individuals suffering mental health crises like Mr. Griffin.

126. Those teams were supposed to be implemented no later than October 1, 2017, following the allocation of additional budgeting in the fiscal year 2018 budget.

127. Defendant DC failed to enact and deploy those teams as required by law.

128. As a direct and proximate result of Defendants' failures and breach of duties owed to Mr. Griffin, Plaintiffs have sustained injuries including, but not limited, pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of protection and loss of parental care.

WHEREFORE, Plaintiffs seek a monetary judgment against Defendants as allowed by law within the jurisdiction of this Court, in an amount to be determined by a jury at trial, a declaration that the District of Columbia remains in violation of the NEAR Act, a court order requiring the

District of Columbia to immediately comply with the NEAR Act, costs and interest and any other relief deemed appropriate.

COUNT III
Negligence

129. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

130. Defendants owed a duty to act reasonably towards Mr. Proctor and provide adequate emergency response services, including, but not limited to, adequately handling 911 call-taking for the District of Columbia, managing the centralized, District-side coordination and management of public safety communication systems, and provide emergency dispatch services.

131. In addition, Defendants owed Mr. Griffin a duty of reasonable care due to the special relationship between Defendants and Mr. Griffin.

132. Despite this duty, Defendants failed to provide adequate emergency dispatch services and adequately handle the 911 calls made in connection with the events addressed herein, which wrongfully caused or directly contributed to the death of Mr. Griffin.

133. The dispatchers, including, but not limited to, the Defendant Dispatchers, failed to properly classify the initial 911 calls that were made by bystanders while Mr. Griffin was undergoing a serious mental health crisis. These initial calls, the first of which was made at 6:15 p.m., described to the dispatchers that Mr. Griffin was on the ground yelling and screaming, jumping on vehicles, and scaring passerby. These calls demonstrated that this call involved an imminent threat to a person and/or the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers ignored the reports and instead classified the calls as a non-emergency drug overdose with Priority 2.

134. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that Mr. Griffin's crisis required an immediate response from emergency personnel. Instead, the dispatchers used a classification that significantly delayed the response of first responders.

135. When the first EMT personnel arrived on scene, the crew of A18 called the dispatchers, including, but not limited to, the Defendant Dispatchers, and reported that the situation was dire. About eighteen minutes after the first call, A18 reported to dispatch that Mr. Griffin was running all over the place hurting himself and that A18 was unable to contain him. This call demonstrated that there was an imminent threat to persons, including Mr. Griffin himself and the A18 crew, and the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers again ignored the reports and kept the classification as a Priority 2.

136. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known after A18's report that the situation was dire and required an immediate response from additional emergency personnel. Instead, the dispatchers left the classification as Priority 2, which significantly delayed the response of additional personnel.

137. After their first report, around 6:38 p.m., A18 reported to dispatch that Mr. Griffin was moving from the first location to a second location at least two blocks away.

138. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that this information was vital to provide to other emergency personnel responding to the scene, who would not be able to find Mr. Griffin and A18 without the updated location information. Instead, the dispatchers made no mention of the new location to any of the other responding personnel.

139. As a result of the failure to properly classify the call and the failure to provide updated location information, police officers did not arrive on scene until thirty minutes later, after Mr. Griffin had jumped into the Washington Channel. The officers were only able to find the correct location because it was reported over the radio by other personnel on the water, not because any dispatcher ever provided the updated location information reported by A18.

140. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

141. In addition, Defendant DC had the duty to fully comply with all laws, including, but not limited to, the NEAR Act, which required Defendant DC to implement and deploy Community Crime Prevention Teams comprised of police officers and behavioral health specialists who would have the expertise to respond to individuals suffering mental health crises like Mr. Griffin.

142. Those teams were supposed to be implemented no later than October 1, 2017, following the allocation of additional budgeting in the fiscal year 2018 budget.

143. Defendant DC failed to enact and deploy those teams as required by law.

144. As a direct and proximate result of Defendants' failures and breach of duties owed to Mr. Griffin, Plaintiffs have sustained injuries including, but not limited, pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of protection and loss of parental care.

WHEREFORE, Plaintiffs seek a monetary judgment against Defendants as allowed by law within the jurisdiction of this Court, in an amount to be determined by a jury at trial, a declaration that the District of Columbia remains in violation of the NEAR Act, a court order requiring the

District of Columbia to immediately comply with the NEAR Act, costs and interest and any other relief deemed appropriate.

COUNT IV
Gross Negligence

145. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

146. Defendants owed a duty to act reasonably towards Mr. Proctor and provide adequate emergency response services, including, but not limited to, adequately handling 911 call-taking for the District of Columbia, managing the centralized, District-side coordination and management of public safety communication systems, and provide emergency dispatch services.

147. The emergency dispatchers employed by Defendants acted with gross negligence when they failed to provide adequate emergency response services. The emergency dispatchers had no valid basis for denying Mr. Griffin timely emergency response services to address the emergency, Priority 1 mental health crisis that he was suffering.

148. The dispatchers, including, but not limited to, the Defendant Dispatchers, failed to properly classify the initial 911 calls that were made by bystanders while Mr. Griffin was undergoing a serious mental health crisis. These initial calls, the first of which was made at 6:15 p.m., described to the dispatchers that Mr. Griffin was on the ground yelling and screaming, jumping on vehicles, and scaring passerby. These calls demonstrated that this call involved an imminent threat to a person and/or the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers ignored the reports and instead classified the calls as a non-emergency drug overdose with Priority 2.

149. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that Mr. Griffin's crisis required an immediate response from emergency

personnel. Instead, the dispatchers used a classification that significantly delayed the response of first responders.

150. When the first EMT personnel arrived on scene, the crew of A18 called the dispatchers, including, but not limited to, the Defendant Dispatchers, and reported that the situation was dire. About eighteen minutes after the first call, A18 reported to dispatch that Mr. Griffin was running all over the place hurting himself and that A18 was unable to contain him. This call demonstrated that there was an imminent threat to persons, including Mr. Griffin himself and the A18 crew, and the potential for significant property damage, which should have been classified as a Priority 1 emergency call. Instead, the dispatchers again ignored the reports and kept the classification as a Priority 2.

151. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known after A18's report that the situation was dire and required an immediate response from additional emergency personnel. Instead, the dispatchers left the classification as Priority 2, which significantly delayed the response of additional personnel.

152. After their first report, around 6:38 p.m., A18 reported to dispatch that Mr. Griffin was moving from the first location to a second location at least two blocks away.

153. The dispatchers, including, but not limited to, the Defendant Dispatchers, knew or should have known that this information was vital to provide to other emergency personnel responding to the scene, who would not be able to find Mr. Griffin and A18 without the updated location information. Instead, the dispatchers made no mention of the new location to any of the other responding personnel.

154. As a result of the failure to properly classify the call and the failure to provide updated location information, police officers did not arrive on scene until thirty minutes later, after

Mr. Griffin had jumped into the Washington Channel. The officers were only able to find the correct location because it was reported over the radio by other personnel on the water, not because the dispatchers ever provided the updated location information reported by A18.

155. Had police officers arrived on scene before Mr. Griffin jumped into the Washington Channel, those officers would have been able to assist A18 in controlling Mr. Griffin, preventing Mr. Griffin from jumping into the channel and avoiding his death.

156. By knowingly, intentionally, and/or with reckless disregard failing to (1) appropriately classify the 911 calls, (2) appropriately upgrade the classification after the initial reports or after A18 arrived on scene and called emergency dispatch to report the emergent situation, or (3) provide police officers with the updated location information as the situation evolved, the emergency dispatchers, including, but not limited to, the Defendant Dispatchers, were acting with wanton and willful disregard of Mr. Griffin's rights as if such rights did not exist.

157. The emergency dispatchers' conduct constituted an intentional failure to perform their duty in reckless disregard of the consequences affecting Mr. Griffin's life or property. The emergency dispatchers exhibited a thoughtless disregard of the consequences of their actions without any effort to avoid such consequences.

158. In the alternative, the emergency dispatchers, including, but not limited to, the Defendant Dispatchers, were so utterly indifferent to Mr. Griffin's rights that they acted as if such rights did not exist, resulting in Mr. Griffin's death.

159. As a direct and proximate result of Defendants' failure and breach of its duties owed to Mr. Griffin, Plaintiffs have sustained injuries including, but not limited, pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of protection and loss of parental care.

WHEREFORE, Plaintiffs seek a monetary judgment against Defendants as allowed by law within the jurisdiction of this Court, in an amount to be determined by a jury at trial, a declaration that the District of Columbia remains in violation of the NEAR Act, a court order requiring the District of Columbia to immediately comply with the NEAR Act, costs and interest and any other relief deemed appropriate.

COUNT V
Negligent Training, Supervision, Hiring, and Retention

160. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

161. Defendants had a duty to use reasonable care to select employees who are competent and fit to perform the duties of an emergency dispatcher.

162. The emergency dispatchers, including, but not limited to, the Defendant Dispatchers, referenced herein were employees of Defendants at all times relevant hereto.

163. Upon information and belief, as outlined above, the emergency dispatchers, including, but not limited to, the Defendant Dispatchers, their supervisors, and other individuals employed by Defendants have previously committed violations such as those at issue here.

164. Defendants had constructive and/or actual knowledge of their employees' previous violations, including, but not limited to, the report published by Federal Engineering, Inc. and the District of Columbia Auditor outlining problems with Defendants' emergency system six months prior to Mr. Griffin's death and numerous prior incidents that arose from the same or similar conduct as the conduct outlined herein.

165. As outlined above, several other incidents have occurred that stem from the same failures and breaches of care outlined herein. For example, upon information and belief, in the period between December 2019 and September 2020, emergency dispatchers, including, but not

limited to, the Defendant Dispatchers, dispatched emergency personnel to wrong or nonexistent addresses more than three dozen times. Defendants failed to address the systemic issues that led to such failures at any point in the year and a half between September 2020 and Mr. Griffin's death in March 2022.

166. The prior transgressions of its employees and other officers are such to put Defendants on notice that its employees are unit for duty.

167. The prior transgressions of its employees are such to give rise to a duty to supervise, discipline, or terminate the employment of its employees and to enact policies and procedures to ensure that its employees competently perform the duties of an emergency dispatcher.

168. Despite having the duty and authority to discipline, supervise, and terminate the employment of its employees, and to enact policies and procedures to ensure that its employees adequately and competently perform their job duties, Defendants failed to do so.

169. As a direct and proximate result of Defendants' failures to supervise, hire, retain, and train, and failure to put into place sufficient policies and procedures to ensure that its employees performed their job duties competently, Defendants' employees were put in a position to commit the wrongs in this case.

170. Defendants knew or should have known that its supervision and training was inadequate to ensure that its employees do not engage in unlawful, unconstitutional, or tortious conduct and that its policies and procedures were deficient to ensure that failures such as those that occurred in this case do not occur.

171. This negligent training, supervision, hiring, and training has led to a pattern or practice of tortious conduct on the part of Defendants and their employees.

172. As a direct and proximate result of Defendants' failure and breach of duties owed to Mr. Griffin, Plaintiffs have sustained injuries including, but not limited, pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of protection and loss of parental care.

WHEREFORE, Plaintiffs seek a monetary judgment against Defendants as allowed by law within the jurisdiction of this Court, in an amount to be determined by a jury at trial, a declaration that the District of Columbia remains in violation of the NEAR Act, a court order requiring the District of Columbia to immediately comply with the NEAR Act, costs and interest and any other relief deemed appropriate.

COUNT VI
Declaratory Judgment

173. Plaintiffs adopt and incorporate by reference every allegation contained elsewhere herein verbatim with the same effect as if fully set forth herein.

174. The Parties have a viable, justiciable dispute related to the legal obligations amongst them.

175. The dispute is appropriate subject to judicial determination.

176. Resolution by this Court will resolve and avoid uncertainty regarding the law for the Parties and others.

177. The District of Columbia is in violation of the NEAR Act.

178. Without an Order of this Court, Defendant DC will continue to fail or refuse to bring its conduct within statutory boundaries.

WHEREFORE, Plaintiffs seek a declaration that the District of Columbia remains in violation of the NEAR Act and for this Court to issue appropriate injunctive relief including, but

not limited to, a court order requiring the District of Columbia to immediately comply with the NEAR Act and any other relief deemed appropriate.

JURY TRIAL DEMAND

Plaintiffs respectfully demand a jury as to all claims so triable.

Respectfully submitted,

HANSEL LAW, P.C.

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*/s/ Cary J. Hansel, III*__________
Cary J. Hansel, III, Bar No. 465242
2514 North Charles Street
Baltimore, Maryland 21218
Phone: (301) 461-1040
Fax: (443) 451-8606
cary@hansellaw.com

Counsel for Plaintiffs