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THE LOCAL GOVERNMENT
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Duty to Intervene Duty to Render Aid

By Jack Ryan, Attorney, Legal & Liability Risk Management Institute

In June of 2020, following the death of George Floyd in Minneapolis, activist groups, state and federal law makers, and local mayors have sought to create a duty on the part of law enforcement officers to intervene when they observe excessive force. There is little challenge to creating such a duty since all officers have had a Constitutional Duty to Intervene for decades.

The duty to intervene under the Constitution is broader than just use of force cases since it extends to the duty to intervene in any unconstitutional conduct. The federal courts in a number of cases over decades, has determined that officers have a constitutional duty to intervene in unconstitutional conduct and that the failure to do so leads to equal civil liability as the officer committing the unconstitutional conduct.

Officers should also recognize that an officer who fails to intervene in unconstitutional or illegal conduct is also violating their oath of office based on their oath to uphold the Constitution as well as state and federal law.

Some History

In *Priester v. City of Riviera Beach,* 208 F.3d 919 (11th Cir. 2000), the United States Court of Appeals for the 11th Circuit noted that the duty to intervene in excessive force was clearly established in 1994, the year when force was used on Priester. In doing so, the 11th Circuit cited prior cases that determined that an officer who fails to intervene will be civilly liable for such failure. The court cited language from *Byrd v. Clark,* 783 F.2d 1002 (11th Cir. 1986) that held: "If a police officer, whether supervisory or not, fails to intervene when a constitutional violation such as an unprovoked beating takes place in his presence, the officer is directly liable under Section 1983.). The Byrd court cited numerous decisions from other federal circuits in reaching this conclusion including a 1972 case decided by the United States Court of Appeals for the 7th Circuit which held:

> We believe it is clear that one who is given the badge of authority of a police officer may not ignore the duty imposed by his office and fail to stop other officers who summarily punish a third person in his presence or otherwise within his knowledge. That responsibility obviously obtains when the nonfeasor is a supervisory officer to whose direction the misfeasor officers are committed. So, too, the same responsibility must exist as to nonsupervisory officers who are present at the scene of such summary punishment, for to hold otherwise would be to insulate nonsupervisory officers from liability for reasonably foreseeable consequences of the neglect of their duty to enforce the laws and preserve the peace. *Byrd v. Brishke,* 466 F.2d 6 (7th Cir. 1972).

As such, the courts have held for nearly a half century, that officers have a duty to intervene in excessive force cases.

The duty to intervene may extend beyond excessive force cases and include a duty to intervene in any unconstitutional conduct. For example, in *Smith v. Hunt,* 2010 U.S. Dist. LEXIS 101526 (N.Dist. Illinois 2010), the court noted that a police officer "has a duty under §1983 to intervene to prevent a false arrest or the use of excessive force if the officer is informed of the facts that establish a constitutional violation and has the ability to prevent it."

Similarly, in *Bunkley v. Detroit,* 2017 U.S. Dist. LEXIS 147172 (E. Dist. Michigan), the Feral District Court held that since officers were on notice that they have a duty to intervene to prevent violations of constitutional rights, this duty extends to unlawful arrests and detentions.

Language from *Crawford v. City of Chicago* 2014 U.S. Dist. LEXIS 57720 (N. Dist. Illinois 2014), makes clear that there is an existing duty to intervene in any unconstitutional conduct where

the officer knows a constitutional violation is occurring and the officer has a realistic opportunity to intervene and prevent the harm from occurring. The court noted:

> An officer has "'an affirmative duty to intervene to protect the constitutional rights of citizens from infringement by their law enforcement officers.'" *Randall v. Prince George's Cnty.,* 302 F.3d 188, 203 (4th Cir. 2002) (quoting *Anderson v. Branen,* 17 F.3d 552, 556 (2d Cir. 1994)). This duty attaches when the officer "observes or has reason to know that a constitutional violation is being committed and possess a realistic opportunity to intervene to prevent the harm from occurring." *Yang v. Hardin,* 37 F.3d 282, 285 (7th Cir. 1994). Additionally, In order for an officer to be held liable under section 1983 in cases of inaction, the plaintiff must show (1) that excessive force was being used, (2) that a citizen has been unjustifiably arrested, or (3) that any constitutional violation has been committed by a law enforcement official; and that officer had a realistic opportunity to intervene to prevent the harm from occurring.

It should be noted that the language by the court does not limit intervention to use of force but instead includes any constitutional violation by a law enforcement official.

Thus, the law under §1983 is clear that officers have civil liability for a failure to intervene when they observe or become aware of unconstitutional conduct and have a reasonable or realistic opportunity to intervene and prevent the harm from occurring. It should be noted that some Circuits have not adopted the "all constitutional violations" and may place limits on the duty to just use of force events.

Some observations should be apparent, single strike use of force cases or sudden unanticipated gunfire are unlikely to bring about a failure to intervene claim against officers who did not use force, while multiple strikes, prolonged force or gunshots over a period of time are more likely to support a failure to intervene claim.

Some Practical Words on Intervention

As the result of the death of George Floyd, Officer Chauvin was charged with homicide, while the other officers present were also criminally charged based on a failure to intervene in Chauvin's 8 plus minutes of kneeling on the restrained Floyd's neck.

Every single officer should momentarily place themselves in Chauvin's current incarceration and ask themselves how badly Chauvin must wish that the other officers had intervened in his actions. By the same token the other officers, who are all criminally charged, how badly do they wish they had intervened in Chauvin's action.

The slight act of intervention may or may not have stopped the death of George Floyd, but it would clearly have led to an entirely different scenario for the four officers and the rest of law enforcement around the United States, who are bearing the brunt of the public's frustration with conduct that even law enforcement officers have universally condemned.

Some Cases on the Failure to Intervene

Sweet v. City of Hartford, 2018 U.S. Dist. LEXIS 87221 (D. Conn. May 24, 2018)

On October 13, 2013, Plaintiff met up with friends for dinner at a sports bar in downtown Hartford, and at around 9:30 p.m. Plaintiff drove home alone. While driving home, Plaintiff noticed lights in his rearview mirror, but did not see the lights again after he made a turn. Officers Fancher, Corvino, and Reeder were riding together in a police vehicle when they heard a dispatch which indicated that another officer had tried to stop a silver or grey SUV. Officer Corvino then observed a vehicle which matched the dispatch description and followed the vehicle to a parking lot of an apartment building. Officer Corvino then pulled up and stopped behind the vehicle, which was being driven by Plaintiff.

After Plaintiff parked, he saw lights and people coming towards his car. Officers Fancher and Corvino approach the front driver's door of Plaintiff's vehicle, while Officer Reeder approached and opened the passenger door. While Plaintiff was still in the driver's seat, Officer Fancher punched Plaintiff in the face. Plaintiff was pulled from the vehicle by officers and brought to the ground. Plaintiff was then handcuffed and arrested. As a result of the incident, Plaintiff brought suit against the officers.

As part of his lawsuit, Plaintiff asserted claims for failure to intervene against each of the Defendant officers. In analyzing these claims, the Court first noted that police officers have an affirmative duty to intervene to protect the constitutional rights of citizens whose rights are being violated by other officers in their presence. The Court then explained that an officer's liability for failure to intervene "may attach only when (1) the officer had a realistic opportunity to intervene and prevent the harm; (2) a reasonable person in the officer's position would know that the victim's constitutional rights were being violated; and (3) the officer does not take reasonable steps to intervene."

Turning to the facts of the case, the Court stated that surveillance video of the incident established that there was approximately twenty seconds between the Officers' first contact with Plaintiff and when Plaintiff was brought to the ground. The Court explained that a jury could find that Officers Fancher and Corvino had a brief opportunity to prevent each other's use of force. Moreover, the Court noted that a jury could find that Officer Reeder failed to intervene after Plaintiff was hit with the initial blow or when Plaintiff was on the ground being subjected to force. Therefore, the Court did not dismiss Plaintiff's claims for failure to intervene.

Lewis v. City of Chicago, 2005 U.S. Dist. LEXIS 7617 (N.D. Ill. Apr. 11, 2005).

On May 26, 2004, Officers Soto and Arnolts were working in plain clothes and were assigned to a Chicago Transit Authority (CTA) train. The Officers saw Christopher Hicks violate a CTA ordinance by walking between cars while the train was moving.

Officer Soto approached Hicks and Hicks ran from the train. The officers searched for Hicks and found him approaching a bus stop, Officer Arnolts then told Hicks, "Chicago Police, stop."

Under Plaintiff's version of the facts, Officers Arnolts and Soto then "jumped" Hicks as he was standing against a wall. The Officers repeatedly punched Hicks until he fell to the ground and rolled onto his stomach. Both officers kicked Hicks, and one of the Officers straddled Hicks and began to choke him. Two uniformed officers, Pena and De Van, then arrived on scene, and Plaintiff presented evidence that Officer Soto had Hicks in choke hold when the uniformed officers arrived. Officer Arnolts was laying across Hicks' legs. Officer Pena then performed a three-point kneeling stance to successfully handcuff Hicks. Hicks was unresponsive immediately after the handcuffing. According to Plaintiff, Officers Pena and De Van did not intervene to stop Officer Soto from choking Hicks.

Plaintiff argued that Officers Pena and De Van should have intervened to stop Officer Soto from choking Hicks. In discussing an officer's duty to intervene, the Court stated that, "[a] police officer who is present and fails to intervene to prevent other police officers from using excessive force can be liable under § 1983 if that officer has reason to know excessive force is being used and a realistic opportunity to intervene to prevent the harm from occurring." Turning to the facts of the case, the Court pointed out that Hicks was still alive when Officers Pena and De Van arrived on scene. Moreover, there was evidence that Officers Pena and De Van witnessed Officer Soto use the choke hold on Hicks for at least a couple of minutes. Other witnesses also stated that Officer De Soto had Hicks in a choke hold and not a head lock. Accordingly, this evidence created a genuine issue of material fact regarding whether Officers Pena and De Van saw Officer De Soto using the choke hold and whether the officers had a reasonable opportunity to intervene to stop the choke hold.

Dyksma v. Pierson, 2018 U.S. Dist. LEXIS 117503 (M.D. Ga. July 16, 2018)

Nicholas Dyksma died after Sheriff's Deputy Tommy Pierson pinned him to the pavement and used his knee to apply compression to Dyksma's neck. Pierson applied the compression once for a period of twenty seconds as Dyksma was being handcuffed and searched, and then applied the compression again for a period of seventeen seconds after Dyksma was handcuffed, physically incapacitated and no longer resisting. Officers had originally received a call of a person (Dyksma) slumped over the wheel of a pickup truck at a Circle K. When officers arrived Dyksma took off and led the responding officers in a pursuit, which ultimately ended with Dyksma being forced off the road. Dyksma was forcibly removed from the vehicle and placed face down on the shoulder of the road. While another deputy was handcuffing Dyksma, Deputy Pierson restrained Dyksma's upper body by placing his knee on Dyksma's neck for approximately twenty seconds. After Dyksma had been handcuffed and searched, Pierson and another deputy put Dyksma back in a prone position and Pierson again used his knee to press Dyksma's neck into the ground for another seventeen seconds. After these events, Dyksma was transported to a medical center but could not be revived.

In its analysis, the Court considered whether Deputy Pierson was entitled to qualified immunity from suit. The Court determined that it was not clear that the first twenty seconds of neck compression—while Dyksma was being handcuffed and searched—constituted excessive force under clearly established law. However, the Court then stated, "[b]y August 2015, it had long been clearly established that after a suspect is arrested, handcuffed, and completely secured, and after the risks of danger and flight have passed, significant force that is 'wholly unnecessary to any legitimate law enforcement purpose' is excessive." Therefore, the Court found "that on the date of Nicholas's death, it was beyond debate that a law enforcement officer who jams his knee onto the neck of a helpless and incapacitated arrestee violates that arrestee's Fourth Amendment right to be free from excessive force." Consequently, Pierson was denied qualified immunity.

The Court also considered whether the other officers who were present at the scene were entitled to qualified immunity on Plaintiff's claim for failure to intervene. The Court explained that although Pierson's second neck compression of seventeen seconds constituted excessive force, it was administered without warning. The Court found that given the limited duration of Pierson's actions and the unforeseeability of Pierson reapplying his knee to Dyksma's neck, it did not violate clearly established law when the other officers did not intervene. Thus, the other officers were entitled to qualified immunity on this claim.

Duty to Render Aid

In addition to a duty to intervene, law enforcement also has a duty to render aid with respect to arrestees and particularly those persons who have been subject to a use of force. While the death of George Floyd in Minneapolis raises issues related to force and the duty to intervene, the events also raised issues of failure to render aid when Floyd expressly asked for help indicating he could not breathe, his neck hurt, and his stomach hurt. Even in a case where force is reasonably deployed, the failure to render aid can be a Constitutional Violation.

The vast majority of these cases center on failures to get medical aid to a person who has been injured or is indicating, while in custody, that they are ill.

Reducing Liability of In-Custody Death

By Natalie Sellers, LGRMS Law Enforcement Risk Consultant

Suicide persists as the leading cause of inmate deaths in our nation's jails. According to the National Study of Jail Suicide: 20 Years Later, most of those suicides occur in jails operated by local jurisdictions. However, there is still a lot we do not know about causes of in-custody deaths. Since suicide has become the leading cause of death in local jurisdictions, the probability

of your facility having an in-custody death is increasing. To reduce your agencies liability should such an event take place in your facility, proper preparation begins before inmates ever enter the jail.

Types of Deaths

In addition to suicide, there are several in-custody deaths to take into consideration. Let's look at some.

Pre-Existing Medical Conditions

Most of the jail population has pre-existing medical conditions. Many of these conditions are left untreated until they arrive in custody. Pre-existing medical conditions can make taking care of inmates extremely difficult; especially when those pre-existing conditions are mental health related.

Slips, Trips, and Falls

Slips, trips, and falls can be a frequent event in the jail. Cleanliness in a jail is paramount. However, clean and shiny floors can be dangerously slippery for staff and inmates alike. Another consideration is a change in floor elevation in the housing unit. There is not only a potential for falls, but there have been documented cases of inmates committing suicide by jumping off the second floor.

Prisoner on Prisoner Violence

Prisoner on prisoner violence should also be a concern. Classification system upon entry is important in controlling violence amongst inmates.

As previously stated, suicide is the leading cause of death among inmates. Coming in second place is in-custody death that occurs in use of force to control inmates.

Use of Force to Control Inmate

Second to suicide, use of force to control inmates is another form of in-custody death. Two questions to be reminded of in use of force situations: a) Was the force necessary? b) Was it reasonable? Good training produces well-trained employees. Well-trained employees are vital to ensuring that both standards are upheld. One of the best practices out there is to review every use of force incident. Look for early warning signs of too much force being used to control inmates. Even though it may be necessary force used, could there have been anything done differently?

It is noteworthy to emphasize that up-to-date policy and training are important in use of force cases as well. Grand juries and plaintiffs' attorneys will be looking at reasonableness doctrine in order to find culpable negligence.

Policy – Training – Procedure

There is no question that good policy, training, and procedures are key to avoiding any civil litigation. This article will share best practices as provided by LLRMI Instructor, Jeff Carter. Jeff retired December 2018 as the Deputy Director of the Fayette County Detention Center in Lexington, Kentucky. Over his 20-year career, he has worked all levels of custody inside a 1300-bed correctional facility. He's trained and commanded the CERT team, as well as worked the Professional Standards Unit where he specialized in Internal Affairs investigations and Gang Intel for 7 years. As an expert in the field of corrections, Jeff's webinar on Administrative Investigations of In-Custody Deaths shares valuable information to avoid civil litigation. If you are looking for an easy, manageable way to train jail staff, there are many short webinars available for training and POST credit through The Bridge Training Management system. For more information, contact LGRMS.

Policy

Policies are imperative when it comes to risk reduction/avoidance and circumventing civil or criminal litigation. For this reason, it is essential that jail administrators undertake the task of developing and maintaining sound policies.

A lack of suicide prevention policies, procedures, and training is viewed as deliberate indifference by the courts and consequently, puts the agency on the hook for civil liability. In all civil liability with regards to jail suicide, the courts use the "foreseeability" rule. Plaintiffs must show: a) Officers knew the detainee presented substantial risk of suicide; and b) Failure to respond reasonably to the risk of suicide. (*Bowen v. Manchester,* Civ. No. 88-085-S) If you have a suicide prevention policy, good questions to ask are: "How comprehensive is your policy? Your suicide prevention program?" With the closing of more and more mental health facilities, jails and prisons have increased with individuals suffering from mental illness. Is your facility prepared?

Training

Mike Tyson once said, "everyone has a plan until they get punched in the mouth." In other words, we always think we are prepared for an event, until that event happens. So how does one prepare for something that may never happen?

Every jail should have an established training program that revolves around inmate suicide prevention. The old saying, "an ounce of prevention is worth a pound of cure" reminds us that preparation strategies are vital to avoid civil liability.

The National Commission on Correctional Health Care recommends best practices for anyone working in a jail. Those best practices are to attend 8 hours of Suicide Prevention training initially and a 2-hour refresher training every year.

Additionally, every person that works with inmates should be trained in medical first aid, CPR, use of AED, and any other form of life-saving training. Refresher training in first aid is also recommended every year.

Procedure

The National Study of Jail Suicide: 20 Years Later found that more suicides occur 2-14 days after entering the jail. Therefore, an intake assessment is great, but an ongoing assessment program would also refute any claim of deliberate indifference. Is the suicide screening used by your facility asking the right questions?

Intake screening for suicide risk can be included on the medical screening form or it can be a separate form. The screening process should include questions about past suicidal ideation and/or attempts; current ideation, threat, or a plan to commit suicide; prior mental health treatment or hospitalization; any recent significant loss (e.g., job, relationship, death of family member or close friend); history of suicidal behavior by a family member or close friend; suicide risk during prior confinement; and the arresting and/or transporting officer(s)' belief that the inmate is currently at risk. Specifically, the suicide screening process should determine the following:

- Was the inmate a medical, mental health, or suicide risk during any prior contact and/or confinement in this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the inmate is currently a medical, mental health, or suicide risk?
- Has the inmate ever attempted suicide?
- Has the inmate ever considered suicide?
- Is the inmate being treated for mental health or emotional problems, or has the inmate been treated in the past?
- Has the inmate recently experienced a significant loss (e.g., relationship, death of family member or close friend, job)?
- Has a family member or close friend ever attempted or committed suicide?
- Does the inmate feel there is nothing to look forward to in the immediate future (i.e., is the inmate expressing helplessness and/or hopelessness)?
- Is the inmate thinking of hurting and/or killing himself or herself?

*National Study of Jail Suicide: 20 Years Later – Lindsay M. Hayes, Project Director, National Center on Institutions and Alternatives; April 2010 NIC Accession Number 024308.

Once an inmate is placed under observation or on suicide watch, it is imperative to closely look after the individual. With staffing shortages though, this could be a challenge. Jeff Carter started using the inmate trustee program to sit, not talk, and observe other inmates on suicide watch when short staffed. He found this program to be most effective to monitor inmates under observation. The program even saved one inmate's life.

Should a suicide take place in your jail, will your staff know what to do? This is not an event that is commonplace, so making sure employees are trained on in-custody death policy and procedures is imperative to avoiding liability. It is also vital to better preparing jail staff if any type of in-custody death happens.

In preparation for such an event, training is recommended in the following areas:

- Mental Health Awareness
- Incident Management
- Lifesaving Medical Care
- Notification Requirements
- Responsibility for Criminal Investigation
- Responsibility for Administrative Investigation
- Responsibility and Priority for Staff Involved in the Incident
- Scene Protection
- Isolation and Management of Witnesses and Suspects
- Preservation of Evidence
- Documentation of the Incident and Actions of Staff Involved in the Incident

Developing a Critical Incident Book (CIB) can help with procedural guidance. It can also assist with administrative and criminal investigations by documenting crucial times, places, evidence, interviews, etc. This critical incident book should contain: how and who will respond, how to isolate and contain the scene integrity, report and record of witnesses, debriefing, times/dates, video and/or audio recordings, how to manage the incident, who needs to be called, death notification to the family, and who will conduct criminal and administrative investigations. An inmate death event can be very stressful for everyone involved. A CIB can help manage and control the chaos, as well as prepare for possible civil or criminal litigation.

Another best practice, to help manage chaos, is to have a book or packet prepared for use of force to control inmates. The packet should contain:

- A Use of Force Form
- OC Warning Sheet (If Used)
- Full Page Picture of the Inmate
- Copy of All Incident Reports
- Medical and Mental Health Reports
- Audio and Video of the Incident

The requests for some, if not all, on the following list are sure to be received with each inmate death:

- Incident Reports/Memos
- Shift and Unit Logs
- Observation Logs
- Phone Calls/Visitor Logs
- Coroner's Report/Outside Investigator Report
- Property Log
- Booking Paperwork
- Medical Records
- Mental Health Records/Behavioral History
- Video/Audio Recordings
- Grievance/Complaints/Requests
- Jail Inspections (Internal and External)

The final, but equally important, best practice when dealing with in-custody deaths is for the agency to complete two investigations following the event. Carter recommends a criminal investigation conducted by an outside agency and an administrative investigation completed internally. Bifurcated investigations will assist in making sure nothing criminal occurred. The administrative investigation will determine if there were any violations of policy that requires discipline or termination.

We hope this article has been informative on best practices involved with in-custody death.For more information on training or assistance with auditing current operations, contact your LGRMS Field Representative.

Crisis Risk Coordinator Program

As an elected official or key administrator, you have probably seen a local government in the news recently for such things as a cybersecurity breach, alleged discrimination, or excessive use of force. Situations such as this can escalate quickly into crises because social media and the news media may be spreading their own versions of the crisis before the organization's leaders are even aware of the situation! Late notice to leadership is a common reason for a difficult situation to turn into a crisis since the leaders do not have the proper time or information to be proactive.

ACCG and GMA recommend that Key Leadership in each city, county, or authority, identify at least one person as a Crisis Coordinator, who will be trained to:

- Recognize emerging crisis warning signs and circumstances;
- Identify the likelihood the circumstance could escalate to a crisis; and
- Alert leadership of the analysis in order to prevent, respond to or mitigate the situation.

The ACCG – Interlocal Risk Management Agency (IRMA) – and the GMA – Georgia Interlocal Risk Management Agency (GIRMA) – has worked with CrisisRisk™ through Local Government Risk Management Services (LGRMS) to develop a free, online Crisis Coordinator training program to help local governments be better prepared to respond in difficult situations. The CrisisCoordinator e-Learning and certification program was designed to provide virtual training and support to one or more people in your organization who can support leadership in this effort.

After completion, the Crisis Coordinator will receive a certificate and ongoing access to resources, tools, updates, webinars, and support.

Want more information?

- See the included one page summary.
- Review a short video overview: https://crisiscoordinator.com/about-the-crisiscoordinator-program/.
- Visit the CrisisCoordinator website for news, tools, and resources: www.crisiscoordinator.com.

If you would like to have a trained Crisis Coordinator within your organization, please take the following steps:

Meet with your organization's leadership (City or County Administrator/Manager, Mayor or Board of Commissioners) and identify candidates for the role.

We recommend you have at least one Crisis Coordinator, but you can have more if deemed necessary.

Most of our potential crises occur within law enforcement, so we recommend having a Crisis Coordinator either closely tied to or located within the law enforcement agency.

We developed the profile for a Crisis Coordinator, which may assist with identifying the right candidate(s):

Once your organization's leadership team has identified the candidate(s), register them for the eLearning program on this webpage: https://form.jotform.com/202515436421143 The Crisis Coordinator Candidate's Supervisor will be provided updates on the candidate(s) training progress.

- Ability to Consult Top-Level Leadership
- Communicates Well
- Ability to Make Decisions
- Attention to Detail
- Collaborates Well Across Organization
- Committed
- Recognizes the Need for Confidentiality
- Experienced Government Entity Employee
- Follows Instructions
- Good Performance Reviews
- Knowledge of Local Issues & Community Structure
- Ability to Recommend Use of Outside Crisis Communication Services

CrisisRisk™ will then send registration and other needed information to your candidate(s) so they can begin their training.

Should you have questions about this program or the Crisis Risk coverage provided to your organization within the ACCG or GMA Property and Liability Program, please contact Dan Beck, LGRMS Director, at dbeck@lgrms.com or 678.686.6279. You can also email Ashley Abercrombie at ACCG (abercrombie@accg.org), or Stan Deese at GMA (sdeese@gacities.com).

CRISIS COORDINATOR

Powered By: CrisisRisk™

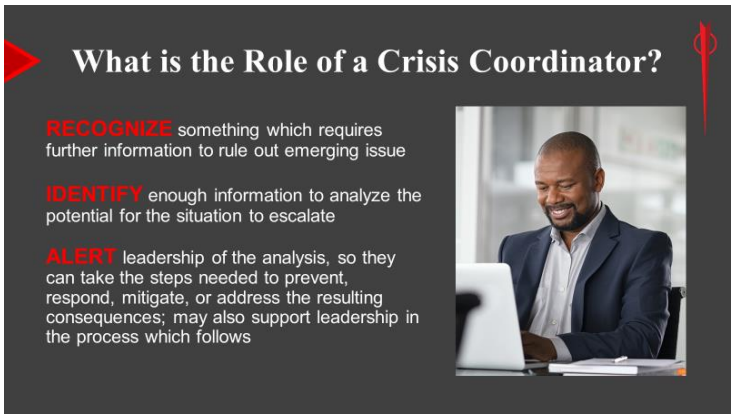
GMA, ACCG, and LGRMS worked with CrisisRisk to develop the Crisis Coordinator Certification Program™. The Crisis Coordinator e-learning training and certification have been designed to familiarize a crisis coordinator in each local government entity with the information needed to alert and support leadership before, during, and after a crisis.

In today's world, municipalities, counties, government entities, schools, and businesses experience critical incidents that can escalate quickly into crises before leadership is aware and can intervene. This late notice is a common failure in the prevention or mitigation of crisis consequences and impacts.

This training has been designed to empower Crisis Coordinators to recognize emerging crisis warning signs and circumstances, to identify the likelihood a circumstance could escalate to a crisis and alert leadership.

Everyone has a day job. It's business as usual in that day job. People are focused on performing their job duties and responsibilities as required. A crisis is the furthest thing from business as usual. It is business unusual. No one in most organizations is looking for events that may become crises.

They are not thinking about circumstances that could change the status quo from business as usual to business unusual. A Crisis Coordinator is the link between the two– business as usual and business unusual.



The Crisis Coordinator curriculum's dozen eLearning courses are based on years of crisis management experience and utilize learning objectives, animations, subject matter content, interactive decision questions, and quizzes. New courses will be added as new circumstances arise.

As part of the CrisisCoordinator Certification Program, CrisisRisk provides ongoing support through a Crisis Coordinators only Web portal as an important real time resource. The portal contains a calendar of upcoming CrisisCoordinator events, resource tools, forms, glossary, *LiveBreaking NewsFeed*, monthly HEADS-UP Newsletter, webinar recordings, new training courses, case studies, guest speakers, ASK an EXPERT, and an interactive forum to share information with other Coordinators. Crisis Coordinators can participate in live quarterly webinars and an annual virtual simulation exercise.

This Program provides the training and support to empower Crisis Coordinators with the skills to recognize, Identify, and alert you and leadership before circumstances escalate into a crisis.

Go to www.crisiscoordinator.com for more information.

LGRMS
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ACCG | GMA

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A Service Organization of the Association County Commissioners of Georgia and the Georgia Municipal Association

This Issue . . .

Duty to Intervene and Duty to Aid

In-Custody Death

Crisis Risk Coordinators

GEORGIA MUNICIPAL ASSOCIATION

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Advancing Georgia's Counties.