Gary v. City of Calumet City

Appellate Court of Illinois, First District, First Division

October 26, 2020, Decided

No. 1-19-1812

Reporter
2020 Ill. App. Unpub. LEXIS 1819 *

SALLY GARY, as Administrator of the Estate of AMANDA GARY, deceased, Plaintiff-Appellant, v. CITY OF CALUMET CITY, Defendant-Appellee.

Opinion

[*1] JUSTICE COGHLAN delivered the judgment of the court.

Presiding Justice Walker and Justice Pierce concurred in the judgment.

ORDER

1 *Held*: After 31-year-old died of asthma complications, her estate brought a wrongful

death suit against the city, alleging that improper treatment by the city's paramedics

caused her death. We affirmed summary judgment for the city, finding the city immune

from suit under the Emergency Medical Services Act because there was no evidence of

willful and wanton misconduct.

2 On October 12, 2014, 31-year-old Amanda Gary suffered a severe asthma attack. Her

mother, plaintiff Sally Gary, called 911. Paramedics from the Calumet City Fire Department

administered treatment to Amanda and brought her to the hospital. Amanda died ten days later.

Sally, as administrator of Amanda's estate, brought a wrongful death suit against Calumet City,

alleging that improper treatment by the City's paramedics proximately caused her daughter's

death.

3 Under the Emergency Medical Services Act, the City is immune from civil liability for

the provision of medical services in good faith, except in cases of willful and wanton

misconduct. 210 ILCS 50/3.150(a) (West 2014). The trial court found [*2] that the evidence did not

support a conclusion that the City's paramedics acted willfully and wantonly, and it granted

summary judgment for the City. Plaintiff now appeals. For the reasons that follow, we affirm.

4 BACKGROUND

5 In her amended complaint, plaintiff alleged that the responding paramedics made a series

of errors that led to her daughter's death. First, although Amanda's blood oxygen levels were

dangerously low when the paramedics arrived on the scene, the paramedics unnecessarily

delayed intubating her for 14 minutes. Second, when they finally did intubate her, they inserted

the breathing tube into her esophagus rather than her trachea. Third, they failed to monitor

Amanda's blood oxygen level after intubation and, therefore, failed to discover the tube was

placed incorrectly.

6 In support of her complaint, plaintiff submitted a healing arts malpractice affidavit by Dr.

John Ortinau pursuant to section 2-622 of the Code of Civil Procedure (735 ILCS 5/2-622 (West

2014)). Dr. Ortinau opined that the aforementioned errors constituted deviations from the

standard of care, and they contributed to a prolonged state of hypoxia (i.e., absence of sufficient

oxygen to maintain bodily functions) [*3] which led to Amanda's death.

7 The following facts were adduced in discovery, which included the depositions of the

paramedics and doctors who treated Amanda. On October 12, 2014, at approximately 10:30

p.m., Amanda was at home when she suffered an asthma attack. Sally called 911, and

paramedics Ryan Banks and Chris Pierce responded to the scene. Banks observed that Amanda

was in severe respiratory distress; she was wheezing and unable to speak in complete sentences.

He gave her a breathing mask and administered albuterol. Pierce placed a pulse oximeter-a

device which measures a patient's pulse and the amount of oxygen saturation in their blood-on

Amanda's finger. Amanda had a blood oxygen level of 54%. (A normal healthy person has a

blood oxygen level above 96%.) Amanda commented that the number was low, then fell

unconscious.

8 According to Banks and Pierce, when a patient falls unconscious, it indicates that not

enough oxygen is reaching her brain, and it is important to supply her with oxygen as soon as

possible. However, they decided not to intubate Amanda in the house for multiple reasons: her

mother was nearby and "really anxious"; a child was screaming; and it [*4] was dark and difficult to

see. Instead, Banks gave Amanda some assisted respirations with a bag valve mask, and then he

and Pierce brought her to the ambulance. She was still breathing on her own at this time.

9 At the ambulance, before the paramedics intubated Amanda, they spent five minutes

establishing an intraosseous line (*i.e.*, into bone marrow) through which they administered

Versed, a paralytic drug. Pierce explained that even with an unconscious patient, Versed must be

administered prior to intubation if the patient has a gag reflex, because otherwise the patient

might vomit and then aspirate the vomit.

10 Pierce then performed the intubation. Because Amanda's trachea was swollen from her

asthma, he had to use force to insert the breathing tube. He stated that he was sure he placed the

tube in her trachea and not in her esophagus. He estimated that it took around 12 minutes from

the time she fell unconscious to the time she was intubated. Banks, observing the intubation,

saw the tube pass through Amanda's vocal cords, an indication that the tube was in the right

place.

11 After a patient is intubated, paramedics consider multiple factors to determine whether

[*5] the tube has been performed correctly: lung sounds, lack of abdominal sounds (which would

indicate placement in the esophagus), chest rise and fall, CO2 readings, and pulse oximeter

readings. Banks and Pierce heard only "diminished" lung sounds, but they did not hear any

abdominal sounds, and the CO2 detector reflected a positive change. Banks also observed

Amanda's chest rising and falling. Thus, they concluded that the intubation was a success.

12 However, Banks and Pierce did not record any pulse oximeter readings from Amanda

after the initial 54% reading in her home. Banks stated that the pulse oximeter "[p]robably" fell

off her finger in the house, but, in any event, they would not have used that pulse oximeter in the

ambulance; they would have used the one attached to the cardiac monitor. But no such readings

were listed in their incident report, and Banks did not independently recall if they obtained any

such readings.

13 Once the intubation was complete, Pierce called St. Margaret North Hospital to inform

them that a critical patient was incoming. The drive to the hospital took three to four minutes.

At the hospital, the paramedics transferred care to emergency [*6] room personnel. Both Banks and

Pierce did not believe Amanda was in pulseless cardiac arrest at the time. Pierce specifically

recalled she had a pulse when they brought her out of the ambulance.

14 Hospital records indicate that Amanda was admitted at 11:02 p.m. She was treated in the

emergency room by Dr. Maria Cole, an internal medicine physician who is also board-certified

in emergency medicine, and Dr. Lisa Mussman1, a third-year resident assisting her. Neither

1 Dr. Mussman is sometimes also referred to as Dr. Johnson.

doctor watched the stretcher being removed from the ambulance and brought inside the hospital

doors, but they were both waiting and ready to interact as soon as Amanda arrived.

15 Within a minute of Amanda's arrival, Dr. Cole and Dr. Mussman observed she had no

pulse and was in cardiac arrest. She was not making any breath sounds, and there were audible

sounds over her stomach, indicating that the breathing tube was in her esophagus. Thus, the

doctors removed the tube and reintubated her at 11:05 p.m.

16 Dr. Cole opined that Amanda was improperly intubated prior to arrival, because her lack

of pulse indicated that she had not been properly oxygenated. [*7] She had no opinion as to how long

Amanda had been improperly intubated, though she stated it generally takes five to seven

minutes without oxygen for a person to go into cardiac arrest. She acknowledged it was possible

that the breathing tube was initially placed properly but shifted when Amanda was transferred

from the ambulance to the hospital, but she "[v]ery rarely" observed such shifts in other patients.

17 Dr. Mussman opined that the breathing tube had been in Amanda's esophagus for "quite a

while" based on her pupils, which were fixed and dilated. She said it would generally take at

least 10 minutes without oxygen for a person's pupils to reach that state, although the exact time

could vary based on the individual. She further opined that it was not possible for a properly

placed tube to shift into the esophagus, because "[i]t's a very long airway and they are two

separate tubes side by side." In her four years of residency, she estimated that she had to

reintubate patients in only 1 to 3% of cases.

18 Banks did not dispute that the hospital staff found the breathing tube in Amanda's

esophagus, but he denied that it was originally placed there. He speculated that [*8] the tube moved

when Amanda was transferred from the stretcher to the hospital bed. Pierce similarly speculated

that because Amanda's trachea was so tight, the tube "slipped out."

19 Dr. Bruna Arrentegui-Rodriguez treated Amanda starting on October 13, 2014, the day

after she was admitted to the hospital. At the time, Amanda was in the intensive care unit, in

cardiac arrest and experiencing seizures due to brain damage caused by lack of oxygen. She

never regained consciousness. On October 22, 2014, she was declared brain-dead and life

support was withdrawn.

20 Dr. Arrentegui-Rodriguez stated that if a patient is improperly intubated, the resulting

lack of oxygen can lead to respiratory failure. But she could not say with 100% certainty that

improper intubation caused Amanda's condition, since it was impossible to know what would

have happened if she had been properly intubated from the start. Regarding the possibility that

the tube shifted, Dr. Arrentegui-Rodriguez stated that moving a patient could dislodge a properly

placed tube, but she did not think the tube could move into the esophagus.

21 All three doctors were asked to comment on the paramedics' care of Amanda [*9] based on

the paramedics' incident report. Dr. Cole stated that the paramedics' report did not reflect that

they incorrectly intubated her. Dr. Arrentegui-Rodriguez stated that monitoring a patient's pulse

oximeter readings after intubation would be "helpful" and "appropriate" (though she declined to

state that it was "necessary"). Finally, Dr. Mussman stated that in a hospital setting, she would

"definitely" monitor pulse oximeter readings on an intubated patient, because if the tube was

placed incorrectly, the patient's oxygen saturation could decrease. However, she stated that pulse

oximeter readings can be inaccurate, and she cited a number of other factors to consider,

including seeing the tube go through the vocal cords, listening for lung sounds, using a CO2detector, and watching for condensation in the tube. Dr. Cole and Dr. Arrentegui-Rodriguez similarly acknowledged that pulse oximeter readings can be inaccurate for a variety of reasons, including nail polish and skin temperature.

22 Finally, in regards to their training, both Banks and Pierce referenced various Standing

Medical Orders (SMOs) that they were trained to follow. SMO Code 75, governing intubations,

called [*10] for "[c]ontinuous pulse oximetry and cardiac monitoring." However, deputy fire chief

Peter Bendinelli, who was in charge of the fire department's EMS training from 2009 to 2017,

opined that pulse oximeter readings were not important in assessing an intubation. He gave two

reasons: First, the readings might be inaccurate. Second, even if accurate, a drop in blood

oxygen levels might be caused by patient heart failure rather than an error in intubation. Thus,

rather than relying on a pulse oximeter, Bendinelli would consider lung and abdominal sounds,

chest rise and fall, CO2 monitoring, the presence of condensation on the breathing tube, and the

color of the patient's skin. Bendinelli trained ambulance crews in accordance with this protocol.

23 Based on the foregoing facts, the City moved for summary judgment, arguing that

plaintiff had presented no evidence that would support a conclusion that the paramedics' actions

were willful and wanton. The City argued that (1) the evidence showed that Amanda was

intubated at the earliest possible time; (2) even assuming *arguendo* that the intubation was

performed incorrectly, the paramedics' error would not constitute willful and wanton [*11] conduct in

light of the "difficult and chaotic emergency circumstances"; and (3) the paramedics used

reliable methods to assess and monitor the intubation (CO2 monitoring and listening to the lungs

and abdomen).

24 In response, plaintiff argued that the issue of willful and wanton conduct was a question

of fact for the jury to decide. In particular, she argued that the incorrect placement of the

breathing tube was willful and wanton, particularly in light of the paramedics' failure to obtain

any pulse oximeter readings after the initial 54%.

25 On August 9, 2019, the trial court granted the City's motion for summary judgment,

stating that "[t]his is precisely the type of case that falls within the EMS Act." The court found it

particularly significant that "the paramedics did check multiple times and in multiple ways to

ensure that the intubation was done correctly." In light of this fact, the court stated the

paramedics' failure to obtain pulse oximeter readings "does not amount to negligence, let alone

willful and wanton." The court also declined to consider Dr. Ortinau's affidavit as competent

evidence, since Dr. Ortinau formed his opinion prior to any discovery and [*12] the record did not

reflect that he maintained his opinion after reviewing the entire discovery.

26 ANALYSIS

27 We review the trial court's grant of summary judgment *de novo* (*Williams v. Manchester*,

228 Ill. 2d 404, 417 (2008)), keeping in mind that summary judgment is only appropriate where

"there is no genuine issue as to any material fact and *** the moving party is entitled to a

judgment as a matter of law." 735 ILCS 5/2-1005(c) (West 2018). Thus, we construe the record

strictly against the movant and liberally in favor of the nonmoving party. *Williams*, 228 Ill. 2d at

417. To prevail, the nonmoving party must present some evidence that would arguably entitle

her to recover at trial. *Keating v. 68th & Paxton, L.L.C.*, 401 Ill. App. 3d 456, 472 (2010).

28 Plaintiff argues that the trial court erred in finding, as a matter of law, that the City was

immune from liability under section 3.150(a) of the EMS Act. That section provides:

"Any person, agency or governmental body certified, licensed or authorized pursuant to

this Act or rules thereunder, who in good faith provides emergency or non-emergency

medical services *** in the normal course of conducting their duties, or in an emergency,

shall not be civilly liable as a result of their acts or omissions in providing such services [*13]

unless such acts or omissions *** constitute willful and wanton misconduct." 210 ILCS 50/3.150(a) (West 2014).

The purpose behind such immunity is "to encourage emergency response by trained medical personnel without risk of malpractice liability for every bad outcome or unfortunate occurrence."

Gleason v. Village of Peoria Heights, 207 Ill. App. 3d 185, 188-89 (1990). Emergency situations are often fraught with tension and confusion, and medical personnel "must not be afraid to do whatever they can under less than ideal circumstances." *Id.* at 189.

29 Nevertheless, section 3.150(a) provides no immunity for willful and wanton misconduct, which is defined as conduct exhibiting " 'an utter indifference to or conscious disregard for a person's own safety or the safety or property of others.' " *Bowden v. Cary Fire ProtectionDistrict*, 304 Ill. App. 3d 274, 280 (1999) (quoting *Pfister v. Shusta*, 167 Ill. 2d 417, 421-22 (1995)). Such conduct lies between intentional and merely negligent conduct. *Kirwan v.Lincolnshire-Riverwoods Fire Protection District*, 349 Ill. App. 3d 150, 155 (2004). The Restatement, which terms such behavior "reckless misconduct" (see Restatement (Second) of Torts 500, Special Note, at 587 (1965)), explains:

"[Reckless misconduct] differs from that form of negligence which consists in mere inadvertence, incompetence, unskillfulness, or a failure to take precautions to enable the actor adequately to cope with

a possible or probable future emergency, in that reckless misconduct requires a conscious choice of a course of action, either with knowledge of the [*14] serious danger to others involved in it or with knowledge of facts which would disclose this danger to any reasonable man. *** [T]he actor to be reckless must recognize that his conduct involves a risk substantially greater in amount than that which

is necessary to make his conduct negligent." Restatement (Second) of Torts 500,

Comment g, at 590 (1965).

30 Here, plaintiff argues that genuine issues of material fact exist regarding whether the

paramedics acted with reckless disregard for Amanda's well-being. Courts have considered this

issue many times in the context of emergency responses to asthma patients and/or patients with

difficulty breathing. In *American National Bank & Trust Co. v. City of Chicago*, 192 Ill. 2d 274

(2000), and *Abruzzo v. City of Park Ridge*, 2013 IL App (1st) 122360, there was a question of

fact as to whether the responding paramedics acted willfully and wantonly. But in *Bowden*, 304

Ill. App. 3d 274, and *Fagocki v. Algonquin/Lake-In-The-Hills Fire Protection District*, 496 F.3d

623 (2007), there was not, and defendants were entitled to judgment as a matter of law. For the

reasons that follow, we find the instant case analogous to *Bowden* and *Fagocki* rather than

American National Bank and *Abruzzo*.

31 In *American National Bank*, 192 Ill. 2d at 276, the decedent suffered an asthma attack

and called 911, saying that she thought she was going to die. [*15] The dispatcher did not try to keep

her on the phone, and the responding paramedics left after receiving no response to knocks at her

apartment, even though her door was unlocked. *Id.* at 276-77. Based on these allegations, our

supreme court held that the complaint stated a cause of action for willful and wanton conduct,

explaining: "Locating a person in need of emergency medical treatment is the first step in

providing life support services. Not even that first step was taken here." *Id.* at 286.

32 In *Abruzzo*, 2013 IL App (1st) 122360, Larry Furio entered the bedroom of his 15-year-

old son Joseph and found him purple, gasping for breath, and unresponsive. Larry called 911

and administered CPR to Joseph. By the time paramedics arrived, Joseph had regained

consciousness and was able to sit up and say some words. The paramedics visually assessed

him, said words to the effect of "He looks alright I guess," and left without providing treatment.

Id. 8. The next morning, Larry found Joseph unconscious and blue. He called 911 again, and

Joseph was transported to the hospital where he was pronounced brain dead. *Id.* 28. The

Abruzzo court found a question of fact as to whether the paramedics who responded to the first

911 call acted with conscious [*16] disregard for Joseph's safety by failing to treat him and bring him

to the hospital. *Id.* 84.

33 By contrast, in *Bowden* and *Fagocki*, no willful and wanton misconduct was found where

the responding paramedics provided extensive treatment to the decedents. In *Bowden*, 304 Ill.

App. 3d at 276, Bowden had a severe asthma attack in his home, and his son called 911. The

responding paramedics assessed Bowden's medical condition, obtained his medical history,

"bagged" him with high-flow oxygen, and brought him to the ambulance for immediate transport

to the hospital. En route, he went into full cardiopulmonary arrest. Per hospital instructions, the

paramedics stopped the ambulance and attempted to intubate Bowden, but they were

unsuccessful. Again per hospital instructions, they did not try a second time but administered

additional oxygen while continuing to the hospital. There, Bowden was maintained on life

support until he died eight days later.

34 Under these facts, the *Bowden* court held that summary judgment for defendant was

appropriate. The court explained: "[I]n light of the undisputed evidence of the extensive

treatment provided by the EMTs, there simply is no evidence that they [*17] showed an utter

indifference to the decedent's safety." *Id.* at 282. The court further stated that "[a]lthough there

is no question that the result here was tragic, it is inappropriate to examine the case in hindsight

and second-guess every action taken by the EMTs in rendering emergency treatment to the

decedent." *Id.* at 283-84.

35 In *Fagocki*, 496 F.3d at 624, the decedent had a severe allergic reaction to peanuts, and

her husband drove her to a nearby immediate-care center. Staff at the center saw her condition

and called 911. When paramedics arrived, they administered Benadryl and brought her into the

ambulance. They attempted to intubate her, but discovered her jaws were clenched shut and

administered Versed to her intravenously. After the Versed took effect, they attempted to

intubate her a second time (unsuccessfully) and a third time (successfully, or so they thought).

Upon her arrival at the hospital, emergency room staff discovered that the breathing tube was in

the decedent's esophagus rather than her trachea, and they reintubated her properly. *Id.* at 626.

By then, she had suffered severe brain damage precipitating her into a vegetative state from

which she never recovered.

36 The *Fagocki* court reversed the [*18] trial court's judgment for the estate, holding that the

paramedics' actions were not willful and wanton as a matter of law. *Id.* at 630. In doing so, the

court explicitly rejected the proposition that the improper third intubation was willful and

wanton, stating: "No one supposes an incorrect insertion itself, in a moving ambulance,

negligent." *Id.* at 628. The court further stated that the paramedics' failure to detect the incorrect

tube placement "may have been negligent *** [but] would not amount to willful and wanton

misconduct without circumstances of aggravation." *Id.*; see also *Brock v. Anderson Road Ass'n*,

287 Ill. App. 3d 16, 26-27 (1997) (paramedics who provided "extensive care" to heat stroke

victim did not act willfully and wantonly despite multiple alleged errors in care; even if errors

were negligent, they did not indicate an utter indifference to patient's safety).

37 In the instant case, as in *Bowden* and *Fagocki*, and unlike in *American National Bank* and

Abruzzo, it is undisputed that the paramedics engaged in extensive efforts to save Amanda's life.

They administered albuterol and measured her blood oxygen level; when she fell unconscious,

they gave her assisted aspirations with a bag valve mask and brought her [*19] to the ambulance.

There, they administered Versed to prevent her from vomiting and aspirating her own vomit, and

then Pierce intubated her. After the intubation, they observed multiple factors that led them to

believe it had been performed correctly: they heard sounds from her lungs (albeit diminished),

did not hear sounds from her abdomen, and saw a positive change in the CO2 detector. Banks

also observed her chest rising and falling.

38 Construing the record liberally in favor of plaintiff

(*Williams*, 228 Ill. 2d at 417), a

reasonable finder of fact could conclude that Pierce performed the intubation incorrectly by

inserting the tube into Amanda's esophagus rather than her trachea. A finder of fact could also

reasonably conclude that this error might have been discovered and fixed prior to Amanda's

arrival at the hospital if the paramedics had used a pulse oximeter to continuously monitor

Amanda's blood oxygen levels. But even taking these things as true, such errors do not reflect

"an utter indifference to the decedent's safety" (*Bowden*, 304 Ill. App. 3d at 282) as required for a

finding of willful and wanton misconduct. This is particularly true where, as here, the

paramedics utilized multiple other methods to assess the intubation [*20] in a tense and time-sensitive

emergency situation. In this regard, this case contrasts starkly with *Abruzzo*, 2013 IL App (1st)

122360, where the responding paramedics gave only a cursory visual assessment to the decedent

before concluding that he "look[ed] alright" and leaving.

39 Plaintiff nevertheless argues that the present case is analogous to *Meck v. Paramedic*

Services of Illinois, 296 Ill. App. 3d 720 (1998), and *Prowell v. Loretto Hospital*, 339 Ill. App.

3d 817 (2003). We find these cases inapposite.

40 The sole issue in *Meck* was proximate causation-specifically, whether the decedent's

estate was required to prove the decedent had a greater than 50% chance to survive absent the

paramedics' alleged misconduct. *Meck*, 296 Ill. App. 3d at 725-26. The *Meck* court answered

this question in the negative and reversed summary judgment for defendants on that basis alone.

Id. at 726-27. The parties did not argue, and the *Meck* court did not discuss, whether the

paramedics' actions could be construed as willful and wanton.

41 As for *Prowell*, 339 Ill. App. 3d at 818, it is readily distinguishable on its facts. The

decedent in *Prowell* was transported to the hospital by ambulance. Upon arrival, as she was

removed from the ambulance on a stretcher, she fell onto a concrete ramp and sustained injuries

that resulted [*21] in her death. The *Prowell* court found a question of fact as to whether the

paramedics acted willfully and wantonly, based on evidence that they had actual knowledge that

the stretcher was not secure (*id.* at 824) and that they left the stretcher unattended, allowing it to

roll into a pothole (*id.* at 825-26). But in making this finding, the *Prowell* court explicitly

distinguished *Bowden* on grounds that "the factual questions [in *Bowden*] concerned the quality

of the EMTs' efforts to provide care to the decedent." *Id.* at 825. Here, too, the factual questions

concern the quality of the paramedics' efforts to provide care to Amanda. Accordingly, *Prowell*

is inapposite.

42 Finally, plaintiff argues that there is an issue of fact as to whether the City committed

willful and wanton misconduct in its training of ambulance crews. She cites the deposition of

Bendinelli, who stated that he trained ambulance crews not to rely on pulse oximetry to measure

the success of an intubation but, instead, to consider lung and abdominal sounds, chest rise and

fall, CO2monitoring, the presence of condensation on the breathing tube, and the color of the patient's skin. Bendinelli explained that pulse oximeter readings could be inaccurate [*22] and did not always reflect whether the breathing tube was placed correctly.

43 To defeat summary judgment, plaintiff would have had to present evidence that the City

either knew Bendinelli's training imperiled patients, or

that the City failed to recognize this

danger through recklessness. *Affatato v. Jewel Companies, Inc.*, 259 Ill. App. 3d 787, 800

(1994). Plaintiff presented no such evidence. On the contrary, all three of Amanda's treating

physicians corroborated Bendinelli's statement that pulse oximeter readings can be inaccurate. In

light of their testimony, plaintiff has not presented an issue of fact as to whether Bendinelli's

training reflects an utter indifference to patients' safety. See *Bowden*, 304 Ill. App. 3d at 282.

44 CONCLUSION

45 For the foregoing reasons, we affirm the trial court's grant of summary judgment for the

City on the basis of immunity from suit under the EMS Act.

46 Affirmed.
