
New California AED Laws: Bull Rush From the Bear State?

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By [John Ehinger](#) | Feb 01, 2016

This past fall, California enacted two new AED laws (Senate Bills 658¹ and 287²). For the 87 percent of you who do not live in California, stay with me—the new laws will likely matter to you, too.

As some rough background on the laws themselves, S.B. 658 amends section 1714.21 of the CA Civil Code and section 1797.196 of the CA Health and Safety Code to substantially reduce the requirements placed upon AED owners to qualify for the Good Samaritan protections in the state (except for those in the Health & Fitness Club space). Most notably, the new law removes AED/CPR Training requirements and eliminates the need for a physician to oversee a company's AED program. In addition, the new law reduces the frequency with which AED owners need to check their devices and pares back documentation rules.

S.B. 287 requires AEDs in all new construction from January 2017 and forward in the following categories:

- Assembly buildings with an occupancy of greater than 300
- Business buildings with an occupancy of 200 or more
- Educational buildings with an occupancy of 200 or more
- Factory buildings with an occupancy of 200 or more
- Institutional buildings with an occupancy of 200 or more
- Mercantile buildings with an occupancy of 200 or more
- Residential buildings with an occupancy of 200 or more, excluding single-family and multifamily dwelling units

In short, AEDs will be required in almost any decent-sized, new commercial building.

You may view these two laws as mere administrative afterthoughts in the volumes of California state law. You also may assume that these changes do not matter to you if you do not operate in California. The reality is that the impact of these changes will likely be much further reaching. Here's why.

The New Legal Landscape

In June 2014, the California Supreme Court ruled on a lawsuit brought by the estate of Rose Mary Verdugo against Target Corporation. The plaintiff argued that Target had a common-law duty to have an AED available on site to assist someone in cardiac arrest, and the court's opinion ultimately came down in favor of Target. In the wake of the above legislative changes, the reasoning behind the court's decision bears re-inspection.

First, in its ruling, the court was clear in its view that California statutes do not "occupy the field" with respect to AEDs and that the courts are free to determine whether "California common law imposes on a business establishment a duty to acquire or make available an AED for the use of its customers in a medical emergency." So the door remains open to resolve the "duty of care" question via common-law mechanisms.

Second, in reaching its ultimate conclusion that Target did not have a duty to make an AED available, the court heavily weighed the requirements placed upon AED owners in order to qualify for immunity under California's AED Good Samaritan law. The court concluded that the then-prevailing statutes imposed "numerous obligations" on AED owners, including duties for training, administration, and maintenance, making AED ownership "more than a minimal or minor burden."

The passage of S.B. 658 significantly alters the landscape that the Supreme Court considered at the time it rendered its decision. Appreciating that the training obligations have been removed, inspection duties have been reduced by two-thirds, physician oversight is no longer required, and other administrative duties have been pared back, would the court view the new statute as imposing "more than a minimal or minor burden"? Equally, how will the courts view the impact of continued reductions in overall AED-related costs? Understandably, we will not know the answers until a new case is presented to the court, but it does seem likely that this point will be tested again soon.

With the passage of S.B. 658, an informed plaintiff's attorney will be able to lodge a very credible argument that the onus placed upon AED owners to qualify for Good Samaritan protection is no longer significant. Also, most plaintiff attorneys (claims of

social crusading aside) are in the business of trying cases to make a profit. As S.B. 658 reduces the obligations on AED owners, the law improves the risk/reward calculation for the plaintiff's bar, with the higher expected value creating greater inducement to litigate.

In reaching its decision in the Verdugo matter, the court also looked at whether there were statutory mandates requiring AEDs in businesses. At the time, the court noted that California's requirements were confined to health clubs, explicitly stating that "the Legislature has not imposed such a requirement on other types of business establishments." The passage of S.B. 287 obviously significantly expands the duty of coverage to include a wide range of establishments, again altering the complexion of the environment that the court considered in its prior decision.

Although S.B. 287 is focused on new construction, it will quickly impact numerous businesses, generating "comparatives" that have been considered favorably for plaintiffs in case law elsewhere. For example, in *Fowler v. Bally Total Fitness Corp.*, the court found that Bally could be tried for gross negligence for not having an AED—despite the lack of a state mandate—with a key part of the reasoning focused upon Bally's decision to adopt AEDs elsewhere. Thus, businesses need to decide whether covering some locations but not others will subject them to litigation exposure. While some (or even many) may initially decide that they are content to run this risk, others will not.

This choice is more complex when viewed through the lens of a company operating on a national basis. Historically, many companies have chosen to put AEDs in select locations but not all—such as a handful of sites where municipal ordinance requires them to do so. Supporting this approach in court seems much easier when confronted only with requirements from a few counties. But when sites are covered across an entire state (which also happens to be the world's eighth largest economy), a new rationale will be needed. How does one argue a logical "stopping point" in court? Is it dictated by state boundaries? How does the argument shift if a company's competitors take a broad approach to adoption (another point that courts have historically considered)? Taking this into account, there is meaningful potential for the impact of Senate Bills 658 and 287 to resound beyond California, as national operators may feel compelled to proactively reduce their risk and exposure.

New Data on SCA Foreseeability

Last, new data douses prior legal arguments as to reasonable foreseeability. A June 2015 Institute of Medicine report documented significantly higher numbers of cardiac arrests (600,000 annually) than previous benchmarks. Also, other research points to Hypertrophic Cardiomyopathy (HCM) impacting one out of every 200

people (more than double prior estimates).³

Historical perceptions that cardiac arrest is confined to the elderly are also being debunked. National EMS Information System (NEMSIS) statistics from 2013 through 2015 indicate that 21 percent of reported cardiac arrests were for victims 49 and younger and 38 percent were attributable to those under age 59.

Furthermore, better information is now available to indicate where cardiac arrest is most likely to occur. For example, the historical presumption for many was that health clubs/gyms are much more likely to experience an on-site cardiac arrest (which certainly explains the heavy concentration of state-level mandates requiring gyms to have AEDs). However, the actual risk profile looks a bit different. The same NEMSIS statistics referenced above reveal that cardiac arrest is almost two and a half times more likely to occur at a "Trade or Service (Business, Bar, Restaurant, etc.)" than a "Place of Recreation or Sport." As further confirmation, recent research by Marijon et al. analyzed 10 years of cardiac arrest data in the Portland, Ore., area and found that only 5 percent took place during sports-related activities.⁴ So locations presumed to be "safe" are not nearly so.

What does all of this mean for the OH&S professional? It depends. If you already have a robust AED program, the impact of the above is likely modest (and may enable you to streamline and simplify aspects of your program). Alternatively, if your sites do not yet have AEDs, it would be prudent to consider your current strategy and how it may or may not fit with the changing environment.

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