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The International Academies of Emergency Dispatch

January | February 2013

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The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,078,065; 6,078,994; 6,198,459; 6,607,491; 7,068,835; 7,084,301; 7,045,294. The PPDS is protected by U.S. patent 7,436,937. FPDS patents are pending. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.
SHAWN MESSINGER
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CONTRIBUTORS
Dear Reader

Down And Out In Salt Lake
Highway is closed

Audrey Fraizer, Managing Editor

The office Internet is down. Nobody's fault but still a drag. It's Friday and the information highway is closed for rerouting in preparation for our move to a building a block and a half away. Oh yeah, we can call people on the telephone, actually stroll to a coworker's desk, or—heaven help us—just down a message for interoffice delivery. We could walk three blocks to the city library or to a local coffee shop for a Wi-Fi connection or use our smartphones. We could also crawl into a hole to hibernate, at least for the duration.

It's not as if we surf the Web from 8 to 5, or spend company time indicating something like posting comments on our favorite social media page. We did create a Facebook page for The Journal's Readers Board and Editorial Board and have a website dedicated to the Academy's interests. We miss access to those sites, however, it's the gulf generated by the obstructed flow of information for our stories that bothers us in editorial.

Sports politics, celebrity "news"—which Senior Editor Jim Thalman likens to a junk-food addiction (stuff we crave but will never admit to enjoying)—might be on tap at home. In the office, it's nothing that meets the eye. Our time on the telephone, actually stroll to a coworker's desk, or—heaven help us—just down a message for interoffice delivery. We could walk three blocks to the city library or to a local coffee shop for a Wi-Fi connection or use our smartphones. We could also crawl into a hole to hibernate, at least for the duration.

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**President’s Message**

**Take The Initiative**

Local ballots place priorities

Scott Freitag, IAED President

_C_ all me a busybody but after each election I actually look forward to browsing the results of ballot initiatives involving 9-1-1 services and talking to public safety officials I heard were going to voters to approve local projects.

In many ways, these results are more fascinating than the returns for the political parties—particularly those for national office—because they offer greater insight into the issues facing a certain demographic spread. They are a form of direct democracy; the process gives citizens the power to place measures on state and local ballots for a public vote. Consequently, the returns pinpoint concerns and show the length residents are willing to go or not go in achieving the goals they believe best for their community and state.

I also find returns useful for business and professional reasons. Collectively, results indicate wider trends: the direction the country is going in terms of meeting the demands of 9-1-1 imposed by technology and public expectations and the ways in which the initiatives will be financed, if approved. On the local level, we can get a handle on projects neighboring jurisdictions found important enough to put to the voters and gauge, by voter response, the possibility of succeeding with a similar—albeit customized—plan among our own taxpayers.

As far as the numbers go for this past year’s ballot initiatives, voters in 38 states considered 172 statewide measures on Nov. 6 (42 were citizen initiatives and 12 were popular referenda), of which 42% were voter approved. While emergency communications might be a priority for us, the issue did not make it among the top trends noted during the 2012 election. The popular issues included education (and funding through tax increases), drug policy, marriage, healthcare, and animal rights. This is not an easy year to monitor trends in public service.

Although not all initiatives are successful, monitoring them does tell us a lot about the perspective and priorities of a community and the shape 9-1-1 services are taking across the country. After all, rapid changes in telecommunication technologies pose significant policy and funding challenges for public service agencies and state lawmakers. Broadband, enhanced 9-1-1, Next Generation 9-1-1, wireless communications, and the equipment and training required are not optional for a 9-1-1 system that keeps pace with its citizenry.

For the most part, emergency communication initiatives appearing on ballots this past year considered technology: phone surcharge increases to make up for losses in 9-1-1 services now that the number of cell phone users is far surpassing the number of landlines in homes, and increased tax assessments to fund narrowbanding requirements and other 9-1-1 mandates.

While I don’t consider two initiatives a “trend,” voters in two counties in Michigan approved increases in tax assessments to fund enhanced 9-1-1.

Antrim County (Mich.) went to voters on a combined appeal and won the levy for a tax assessment of up to one-half of one mil for six years. A half of one mil translates to 50 cents for each $1,000 of assessed valuation and will make up for budget shortfalls resulting from a state mandate in 2007 to decrease the phone surcharges; the 9-1-1 emergency telephone and dispatch system was also losing revenue to cell phone users paying the surcharge to the county where the owner claims residence, without benefit in case of an emergency involving 9-1-1 in Antrim County. Upstate Antrim County is a vacation cabin get-away spot for downstate residents.

The shortfall was projected to increase in 2013—if the levy failed to pass—because of necessary equipment upgrades needed to conform to state-mandated narrowbanding requirements.

A mid-term ballot initiative in Eaton County (Mich.) won voter approval—by almost a two to one margin—for renewing the current 9-1-1 emergency levy and increase it by a rate of 95 cents per $1,000 of assessed valuation for the next five years to continue funding for the county’s Enhanced 9-1-1 Emergency Telephone and Central Dispatch System.

Deschutes County (Ore.) 9-1-1 wasn’t so lucky, and by a relatively slim margin. An initiative to create a 9-1-1 emergency district in the county with a levy at a permanent cap of 39 cents per $1,000 assessed valuation was defeated by about 1,500 votes of the 29,500 votes cast. The funding would have supplemented a grant already secured for a new building and equipment and, in the long haul, prepare the county for NG9-1-1 technology.

The results were not what Deschutes County communications was looking for, of course. But that doesn’t mean they plan to give up.

Ballot initiatives give citizens the opportunity to participate in the decision-making process and, because of that, I consider initiatives at the cutting edge of political participation. They can have huge consequences.

And, win or lose, at least a defeated initiative forces the public and legislators to think about it.
**The Right Amount**

MPDS attempts to satisfy most through information gathered

*Jeff Clawson, M.D., Brett Patterson*

---

**Dr. Clawson:**

I attended a Q Instructor Academy in October and I’m also a PDC™ software instructor. My (new) home agency is planning on implementing the Medical Protocols in spring, and I’d like to be ready for one question that’s going to come up.

In the past I’ve had an EMT or paramedic working dispatch wanting more justification for why certain questions appear in the Medical Protocols.

Recently, I was challenged on the Key Question (KQ): “Has the patient taken any drugs or medications in the past 12 hours?” One medic said, “We don’t care what meds the patient is on, we’ll find out when we get there.”

What’s the principal intent of asking the question? Is this information generally considered of value in other EMS systems?

Art Braunschweiger
Union County Police Department
Westfield, N.J., USA

---

**Art:**

I’ve asked Brett Patterson to help you with your question.

---

**Dr. Clawson**

Each question in the MPDS™ has at least one of four primary objectives. That particular question, as you correctly speculate, has to do with both responder information and, also, dispatch triage. I’ll address the latter first, understanding that the question does not ask the patient to list all medications, but rather were any drugs or medications taken within the last 12 hours.

A patient under the age of 35 with chest pain and no other priority symptoms is not likely to be having a heart attack. However, the enzymes present in cocaine predispose people to ventricular arrhythmias, which is why cocaine was included in the CHARLIE level (patient needs ECG monitoring, at minimum).

If the chest pain patient has recently taken blood pressure or cardiac medications, especially nitroglycerin (NTG), this is useful information for the responder, especially diagnostically if multiple doses were taken; it may also explain on-scene blood pressure issues.

The medic you spoke with is assuming the patient will be able to speak for her/himself upon arrival. However, as we know, this is not always the case.

I have been a medic for over 30 years now and have had the privilege of teaching EMD™ to many medics and EMTs. I have learned that opinions vary. I would encourage you to conduct an experiment. Ask your EMT and paramedic students to write down the information they would like to have before arrival for both medical and trauma patients. My experience has been that these opinions vary greatly, and are based on experience. The MPDS attempts to provide the Four Commandments, any relevant safety information, and a very brief recent past history via Key Questioning. While this may be too much or too little for some, it really does satisfy most, once the method and rationale are understood.

Brett A. Patterson
IAED™ Academics & Standards Associate Medical Council of Standards Chair
Active assailant (shooter) incidents are one of the most dynamic and difficult situations law enforcement officers encounter. These incidents develop quickly and often happen when and where law enforcement least expects them; they are historically over in a matter of minutes. These factors make quick response by our first responders essential to saving lives.

The law enforcement community has learned painful lessons from events such as the shootings at Jonesboro, Ark.; Virginia Tech; and of course Columbine, Colo. They forced us to rethink response to these types of events, moving from a mentality of surround and call SWAT to one of rapid deployment. We had to re-evaluate policies involving patrol officer use of rifles and other equipment.

Despite this training and quick response by officers in the field there will be, in most instances, several minutes between the time a 9-1-1 call is made and the time officers arrive on scene. Add in the time it may take to corner or neutralize the assailant(s) and these agonizing minutes can stretch considerably. During this response time, this sort of emergency “no man’s land,” calltakers have an opportunity to make a difference. The Police Protocol gives calltakers the critical instructions necessary to help keep callers safe, while also providing the tools for gathering information.

The latest addition brings us back where I started the article.

The International Academies of Emergency Dispatch® (IAED™) partnered with the National Tactical Officers Association (NTOA) and together with Police Priority Dispatch System™ (PPDS®) users from California, Colorado, New York, Maryland, Florida, North Carolina, Washington, D.C., Canada, and the United Kingdom, designed an Active Assailant (Shooter) Protocol. The protocol provides specific questions and instructions to more effectively bridge the gap between the time of the call and officer arrival during an active assailant situation.

The protocol’s addition fills a piece that had been missing in the response puzzle, although it takes other pieces to complete the picture. Community outreach and education through pre-planning of responses to active assailant events greatly improves the chances of minimizing the loss of life.

As I said when presenting active shooter response talks to schools and businesses: Trying to make up response to an active shooter event while it’s happening is like trying to put your seatbelt on during the middle of a car crash.

I encourage agencies to work with their responders and to consider practicing roles and responsibilities in unconventional ways to best achieve the goals of the active assailant response. For example, in jurisdictions with limited field staff on duty, the communications center staffed by a police dispatcher can function as the Incident Command post until officers arrive on scene and assume the role. The dispatcher has the best overall picture of the situation and can help officers coordinate deployments more effectively. This allows the limited number of first responders to focus on the information relayed and how best to deploy at the scene. For this role shift to occur, however, communication staff would require training to understand officer deployment and the type of information the command post tracks during an active assailant incident.

It might be helpful to consider the following:

- Are my dispatchers familiar with the responses officers use so that they can better anticipate the information needed?
- Have we taken active shooter response education into the community?
- Are policies covering agency notifications, radio traffic, and the possibility that you or your staff may have family involved in the incident?
- Do calltakers have the training to quickly make the mental switch from taking a cold theft report to the fast pace and urgency of an active assailant incident?

Sadly, for the people involved in an incident, this new protocol won’t stay new for long; it will be tested. I know that as I write this there is probably someone somewhere planning the next terrible event. We cannot stop the next active assailant incident from occurring, but we can help mitigate the severity of the event. Our professionally trained dispatchers working closely with responders can make a difference.

Are you ready to make the commitment?
As emergency telecommunicators, we're trained from day one to value customer service and teamwork. Then we're handed headsets and spend the rest of our careers tethered to phones and radios that often connect us to emotional callers or complaining responders. These stressors add up and have a cumulative effect on our mental, and often physical, well-being. Stress relief is an important part of our health, but how we choose to “blow off steam” often affects our jobs as well. Yelling at the caller is poor customer service. Taking frustrations out on your responders is not conducive to good teamwork. Often, dispatcher turns on dispatcher and center morale becomes an issue. As we’re now in the digital age, public safety professionals are increasingly utilizing the Internet and social media to air their grievances, post complaints, and in general, vent their frustrations.

Is this an appropriate way to de-stress?

Considerations

The Internet is a public forum. Even when comments or posts are sent directly to a specific distribution group or only shared with “friends” there is nothing stopping these individuals from forwarding, reposting, or sharing with others. There is nothing more embarrassing than complaining about a coworker (or your boss) only to have him or her eventually receive and read your comments.

Venting through a keyboard is anonymous. Anonymity factors highly in the tone and content of messages. Consider a disagreement or an argument with your officers, firefighters, or EMTs. Is the issue addressed differently face-to-face than it is over a radio? Often, it is our inner voice that winds up punching the keys and providing an outlet for our subconscious. As a result, a casual complaint or professional observation might come across as a rant or personal attack.

Consider privacy issues. Venting about incidents and callers can be healthy, but when posted online, we must consider the implications of violating protected health or patient information. In addition to external privacy issues, we’ve seen photos posted online of dispatchers clowning around or sleeping at their workstations. Circulating these photos can be damaging to that employee as well as to the agency and public safety as a whole. Is that how we want to portray our positions and jobs to the general public?

Mobile devices provide instant access to social media. Continually updating your status or routinely checking your accounts can affect your ability to monitor radio traffic or answer phones. In some cases, social media becomes an addiction that affects judgment in terms of prioritizing responsibilities.

Blasting anyone or anything related to your job is a hot issue. On the one hand, comments posted through the employee’s personal accounts or applications should be protected as “free speech.” On the other hand, most employers have polices clearly defining what can, and should, be shared, posted, or blogged, no matter the account’s owner.

Regardless of legal ramifications, slamming an employer or coworker creates an uncomfortable work environment—which has the opposite effect of relieving stress and resolving internal conflict. Even if your current employer does not address the content of social media, future employers might. Many employers include some form of Internet content review in their background investigations prior to hiring.

Forethought (or proofreading) must be applied prior to publishing to the world. Before having a confrontational conversation, or writing an angry letter, follow the sound advice to let the issue rest for a few hours or days before “shooting from the hip” and acting out of anger or frustration. Immediately venting or posting while upset often overvalues the emotion rather than the message and can create larger problems out of minor issues.

Value

There is value in social media. Social media lets us connect to a larger audience and provides an opportunity to interact with like-minded individuals who share the same experiences and are more objective or compassionate. Engaging in positive, constructive exchange with other public safety professionals is a great way to “recharge your battery.” Networking also provides an opportunity to exchange phone numbers or addresses.

An agency can also use social media for the public’s good. In addition to posting practical information—such as road closings and storm warnings—an agency can show a friendlier side of doing business through Facebook and other social media outlets.

Balancing some considerations with value, many of the issues and problems that arise are based upon how the technology is used rather than the fact that it is being used at all. Public safety will continue its journey into the next generation of the digital age. It is up to us to determine what role, if any, social Internet applications should have.
Taking aspirin helps during a heart attack.

In fact, it can save your life.

According to a research article available through the American Heart Association (AHA): Getting an aspirin early in the treatment of a heart attack, along with other treatments EMTs and emergency department physicians provide, can significantly improve your chances of survival! 1

Why? Aspirin “greases” the blood platelets and helps prevent blood clots from forming or occluding the arteries when taken routinely in low-dose form.

Yet, despite all the medical evidence leading to that conclusion, aspirin is often the missing link of at-home prehospital emergency care for suspected cardiac arrest, particularly among older patients. Not everyone keeps a container within the expiratory date handy in his/her home’s medicine cabinet.

Perhaps the reason aspirin is not readily on hand relates to the analgesic’s correlation to long-term use to prevent a first heart attack, or a dose prescribed by the family doctor to prevent a second heart attack. People of any age without a history of heart attack might not understand the benefits of aspirin therapy in case of a heart attack.

Pre-Arrival Instruction

Based on aspirin’s survival significance in prehospital treatment for heart attack, the International Academies of Emergency Dispatch® (IAED™) established the Aspirin Diagnostic and Instruction Tool™ (ADxT) within the Medical Priority Dispatch System™ (MPDS®). Since 2008, (MPDS Version 12.0) Pre-Arrival Instructions have directed callers, where appropriate, to administer aspirin for potential acute coronary syndrome (ACS)/acute myocardial infarction (AMI) patients at the scene of their emergency, prior to the arrival of the ambulance.

The European Resuscitation Council Guidelines have also advocated the use of aspirin, as soon as possible, in all patients with ACS.

As you might know, the IAED never stops evaluating a new tool or protocol. While scientific research and beta testing precede release, research also continues throughout the life of the product or instruction.

The IAED incorporates new findings into protocol modification. Users can initiate the process themselves through the Proposal For Change (PFC) process.

Research

A recently published multi-center (international) study—Aspirin Administration by Emergency Medical Dispatchers™ Using a Protocol-Driven Aspirin Diagnostic and Instruction ToolF—looked at whether EMDs™ can successfully complete the ADxT process and, if appropriate, provide instructions to administer aspirin in the earliest possible stage of the emergency, prior to the arrival of trained responders.

The study analyzed six months of EMD data collected between September 2008 and June 2010 and included all calls recorded under MPDS Chief Complaint Protocol 10: Chest Pain (Non-Traumatic), and Protocol 19: Heart Problems/Automated Internal Cardiac Defibrillator. Results were based on the number of times the ADxT was used, the number of times it was successfully completed, the number of times aspirin administration was advised, as well as the percentage of patients who took aspirin when advised.

Results and conclusions

The authors concluded that a standardized protocol, used correctly by EMDs, supports early aspirin therapy to treat potential ACS/AMI prior to responders’ arrival. The inability to complete the instruction was overwhelmingly due to the arrival of response (48%), followed by the call being lost or the caller hung up (19%).

At the same time, the authors found disparities in actual follow through. In a substantial number of cases (40%), the EMD never opened or used the ADxT, even though the patients met the necessary inclusion criteria.

Other reasons for the tool not being completed related to the caller.

Overall, age played a significant part in the results. The patient’s mean age was higher when the ADxT was completed, although the patients who took aspirin once advised were significantly younger than those who did not. Neither gender nor caller-party type radically influenced aspirin-taking frequency once advised.

As indicated at the beginning of this article, the unavailability of aspirin at the scene was the major non-medical (situational) reason why patients did not take aspirin as directed by EMDs. Of all patients qualifying for potential aspirin treatment, 44.3% had no aspirin to take at the time of a medical emergency.

Recommendations

As often is the intent of research, the study raised additional questions for further investigation. For example, the authors recommend studi-
Intense Flu Season
Influenza activity at high levels but seasonal peak still to come

Greg Scott

Influenza activity continues to increase in North America, with most regions reporting high levels of influenza-like-illness (ILI), and the seasonal peak still yet to come, according to the Centers for Disease Control and Prevention (CDC) and Public Health Agency of Canada.

Arthur Yancey, M.D., medical director for Grady Emergency Medical Services in Atlanta, Ga., and medical adviser for the International Academies of Emergency Dispatch’ (IAED™) Chemical, Biological, Radiological, and Nuclear (CBRN) Committee said the state of Georgia is experiencing the worst flu season since 2009-2010.

“We’re definitely seeing more cases in the emergency department at Grady this year,” he said.

Several key indicators, updated weekly by both the CDC and Public Health Agency of Canada, are pointing to a virulent and still-intensifying North American (2012-2013) flu season. In the U.S., 47 states are reporting widespread geographic influenza activity for the week of Dec. 30–Jan. 5, an increase from 41 states the previous week. Twenty-four states and New York City are experiencing high ILI activity. Boston, Mass., has declared a public health emergency.

Influenza A (H3N2), 2009 influenza A (H1N1), and influenza B viruses have all been identified in the U.S. this season. During the same week, 4,222 influenza-positive tests were reported. Two influenza-associated pediatric deaths were reported, bringing the total number of confirmed pediatric deaths to 20 this season.

In Canada, a total of 4,632 laboratory detections of influenza were reported for the week ending Dec. 29, 2012, of which 97.7% were for influenza A viruses, predominantly A (H3N2). New influenza outbreaks totaled 127, of which 87 were in long-term care facilities. There were 114 new pediatric influenza-associated hospitalizations reported through the countrywide IMPACT network and 176 hospitalizations, including 15 deaths among adults up to 20 years of age, according to aggregate surveillance.

For severe flu outbreaks, the Academy provides ProQA® software users with an SRI (Severe Respiratory Infection) surveillance tool allowing EMDs™ to capture specific flu symptoms from callers reporting suspected flu patients. The use of this feature is optional (and not part of the standard MPDS® Protocol questioning), to be used at the discretion of the system’s medical director.

Protocol 36—a also available to ProQA users—is for the most extreme flu outbreaks (disaster-level), and not recommended by the IAED for use anywhere in the world at the time the article was written (Jan. 11, 2013). All 9-1-1 agencies, however, should have a modified response matrix prepared for situations of extreme EMS system overload, as part of their pandemic flu preparedness plan.

The CDC recommends influenza vaccinations for people who have not yet been vaccinated this season and antiviral treatment as early as possible for people who get sick and are at high risk of flu complications.

ProQA® Paramount © 2004-2013 PDC.

Check out the CDC’s FluView reporting site at www.cdc.gov/flu/weekly/ summary.htm and the Public Health Agency of Canada’s FluWatch site at www.phac-aspc.gc.ca/fluwatch/index-eng.php

Sources:
Pam Farber contributed to this article.
Academy makes its move

The International Academies of Emergency Dispatch (IAED), which has literally been making the world a better place for more than 30 years, now has a better place for its world headquarters.

The Academy, the global leader in the training, certification, and quality assurance of police, fire, and medical dispatching, and Priority Dispatch Corp. (PDC) are expanding into a 9-floor, 72,000-square-foot building constructed in 1997 that until October 2010 housed a daily newspaper.

More than twice the space, dual elevators at twice the speed, and 10 times the daylight are among the amenities of the new headquarters. The plate glass-dominated structure is both the literal and metaphorical reflection of a company with a bright future. At last count, 54,101 IAED-trained dispatchers are answering emergency phone calls in 19 languages in 2,861 call centers in 43 countries.

Among the most recent dispatch centers set up by the IAED is the main emergency communication hub in Sao Paulo, Brazil. Emergency services administrators in Riyadh, Saudi Arabia, are about to adopt the Academy’s standardized protocol system for their centers.

The new building gives the company the room to monitor the rapid expansion of the Academy method globally. There’s a lot to keep tabs on. For example, the number of annual dispatcher education and trade conferences for dispatchers and their supervisors sponsored by the IAED has increased from three in 2011 to seven in 2013. NAVIGATOR conferences will be held this year in the United States, the United Kingdom, Austria, Qatar, Malaysia, Australia, and Ireland.

The whole wide world looks within reach standing at one of the new building’s huge picture windows that form the exterior walls of the workspaces. The world in panorama is also on display in the building’s northeast corner, which has been rounded off by a spiral staircase and is encased in a turret of solid glass.

PDC President Alan Fletcher said having new headquarters marks the meridian between the organization’s four decades of improving emergency dispatching across the United States and the Academy’s full realization of its role internationally. “We couldn’t ask for a better location,” Fletcher said. “We’re in the heart of a downtown that’s turning heads here and abroad. We’re very excited about making the IAED a visible part of this city’s influence around the world.”

The move to the new location began in mid-November. Settling in will take a number of weeks, with full occupation expected by early January.

Effects of bath salts make drug a medical emergency

Lt. Thomas Reagan is a go-to officer for reasons he’d rather not be.

Lt. Reagan, Bangor (Maine) Police Department night commander and drug recognition expert, is an authority on the bath salt epidemic that chose Bangor as one of its northern U.S. gateway cities. Since the drug’s debut two years ago, Lt. Reagan has held the unenviable position of being an expert on the drug and the crisis it’s creating across the country in every direction.

The firsthand knowledge the officer has collected makes him a sought-after speaker in the interests of both law enforcement and first response. In fact, the unpredictable affect the drug has on a user’s behavior and the potential medical consequences, he says, put the primary focus—in terms of user care—on the side of a medical emergency.

“These are medical emergencies,” Reagan said in a WCSH TV interview conducted while he was in Portland, Maine, on bath salt business related to first response. “They just present themselves as law enforcement issues. These people need medical help more than law intervention.”

The mix of drugs used to produce bath salts and the mix of ingredients drug dealers use to cut the drug make it so no one knows what they’re actually buying or the responders know what they’re actually treating.

Overall, however, users tend to experience increased heart rate, agitation, anxiety, panic attacks, and a decrease in the need for food or sleep. Once the muscles break down, the possibility of kidney failure increases. The immediate hallucinations or paranoia are known to come back days later with a vengeance. Other serious side effects from higher doses or prolonged use include seizures, severe paranoia, and increased body temperature.

Bath salts first appeared as a recreational drug in 2007 in Germany, where
The science-based research preceding the 1979 introduction of emergency dispatch protocols is standard the Academy continues more than 30 years and 3,500 communication center implementations later.

Emergency dispatch research findings, however, also tend to be less widely read outside readership of a few select journals. Not anymore.

In this issue of The Journal of Emergency Dispatch, the Academy introduces a column highlighting summaries of research projects performed in the continued evaluation of the medical, fire, and police protocols. Tracey Barron, IAED™ clinical studies officer and Research Council chair, will write the column published in each issue.

In her column, Barron, who also chairs the U.K. Clinical Governing Group, will synthesize research conducted both in the U.S. and abroad. The governing group is divided into two sections: the governing group that determines clinical relevance of subjects for research, and the working group that gathers the data necessary to conduct the chosen study.

She said the format should make research findings easily accessible and understandable to the non-scientific reader.

“There won’t be the jargon defining the more academic journals,” she said. “That’s not to say we’re dumming down the material, but we are making it more accessible for members interested in research and its results without the jargon.”

The introductory column in this issue of The Journal of Emergency Dispatch describes research related to the Aspirin Diagnostic and Instruction Tool (ADxT) within the Medical Priority Dispatch System™ (MPDS®). This article was previously published in the Emergency Medical Journal on July 25, 2012 (Emerg Med J doi:10.1136/emermed-2012-201339).

“The column is the perfect platform to demonstrate the importance of research and development in emergency dispatch—the cornerstone of emergency care,” Barron said.
phone numbers and are prohibited from calling any of the numbers.

The 9-1-1 registry will operate similarly, with public safety answering points (PSAP) given the latitude to determine which of their numbers to register; they can include non-emergency or administrative numbers that might be used for inter-agency contact and coordination during an incident.

PSAPs will be required to review their registered numbers annually to confirm the accuracy of the list. Companies using auto-dialers must access the list, which will display only the registered numbers and not any PSAP information, and must provide the FCC with their list of outbound calling numbers to assist in tracking down Do Not Call violators. The FCC set fines of up to $1 million for disclosing the PSAP numbers.

First time a winner for New Orleans EMS

Barbara Ireland knew the package they submitted was good, and her hopes were high, but that didn’t make the announcement any less exciting.

“We’re really thrilled,” Ireland said. “We have an incredibly strong service that’s grown a lot since Katrina.”

Ireland is the communications director for the City of New Orleans Emergency Medical Services (NOEMS) that on Oct. 30, 2012, received the 2012 Dick Ferneau Paid EMS Service of the Year Award. The National Association of Emergency Medical Technicians (NAEMT) and EMS present the annual award in conjunction with the National EMS Management Association (NEMSMA) and the National Association of EMS Educators (NAEMSE).

The award recognizes not only outstanding patient care but, also, an agency that embraces the latest science in pre-hospital medicine, community education, and has developed capabilities such as tactical medic division, swift water rescue, urban search & rescue medics, and bicycle medics for large-scale outdoor events.

Ireland emphasized the center’s use of the medical ProQA® and the partnership between the 9-1-1 and field emergency medical responders.

“We’re all one service,” she said. “The award recognizes us in entirety.”

Following are a few NOEMS features that led to the award selection:

• NOEMS implemented therapeutic hypothermia for cardiac arrest patients and intervention for time-sensitive STEMI and stroke patients.
• In the field, crews are equipped with tools like ResQPODs and LUCAS devices, CPAP, tourniquets, hemostatics, video laryngoscopes and IO systems, as well as powered cots and reflective apparel.
• Disaster resource includes trailers, shelters, boats, and a mass-casualty bus.
• NOEMS personnel train and work closely with firefighters at primary extrication and rescue scenes.
• A dedicated education/training division oversees employees’ orientation, training, and continuing education.
• Under the VIGOR program (Volunteers in Government of Responsibility), more than 100 volunteer EMTs and paramedics join crews to help provide care during peak times and major events.
• A paramedic/RN is devoted to identifying frequent nonemergency 9-1-1 users and connecting them with resources to meet their needs.

The Denise Amber Lee Foundation will be participating in the second annual 36-Hour Giving Challenge in Sarasota, Fla., on March 5 and 6.

The 36-Hour Giving Challenge is the signature online fundraising event for 300 charities demonstrating non-profit industry best practices and completed extensive donor profiles in The Giving Partner’s database.

The 36-Hour Giving Challenge inspires philanthropy at all levels, according to Mark Lee, of the Denise Amber Lee Foundation.

“It also allows the Denise Amber Lee Foundation to engage its national community of supporters and elevate the ‘Giving Partner’ as a tool to empower informed charitable giving,” he said. “It’s huge.”

Last year’s challenge raised $2.4 million through 10,700 online donations, distributed to 110 organizations. With 300 qualifying organizations participating in 2013, it is anticipated that totals will again exceed the $2 million level. There is also more than $600,000 in matching grant money. Donations last year originated from all 50 states and 24 countries.

For more information on the 36-Hour Giving Challenge and how you can help the Denise Amber Lee Foundation in achieving uniform training, standardized protocols, and technological advances to the 9-1-1 system, visit the foundation’s website.

Let it snow!

Bestowing the title “snow capital” of the U.S. might have seemed accurate following Buffalo’s (N.Y.) winter of 1976–77, figuring winds that exceeded 69 mph and temperatures that gave the feeling of 60 degrees below zero. The storm was so sudden and...
strong—more so the wind than the snow—fall—that it stranded thousands of people coming home from work for as many as four days. Abandoned cars and trucks made transportation nearly impossible along city streets and highways.

The title might again have been apropos during subsequent snow events, such as the record 38 inches that fell in 24 hours in December 1995 and the seven feet of snow burying the city over a five-day period beginning Christmas Eve 2001.

But, alas, Buffalo is a snow underdog. The city averages a comparatively meager 93.6 inches of snow each year, which doesn’t even qualify for the top 10 snowiest places in the U.S. (mountain locations included). As No. 11 on the snow charts, Buffalo falls below Blue Canyon, Calif. (240.3”); Marquette, Mich. (141.0”); Sault Ste. Marie, Mich. (117.4”); Syracuse, N.Y. (115.6”); Caribou, Maine (111.6”); Mount Shasta, Calif. (104.9”); Lander, Wyo. (100.3”); Sexton Summit, Ore. (97.8”); and Muskegon, Mich. (96.1”).

The list, as you might note, does not contain any entries for Alaska. If it did, Valdez, Alaska, would be hands-down winner at an average of 326.0” a year.

As far as protocol’s relation to snow, each set—medical, police, and fire—approach severe weather from the consequence side of response. For example, EFDs™ would send response to a reported avalanche (54: Confined Space/Structure Collapse), while the EMD™ might send response for a crushing injury (30: Traumatic Injuries (Specific)) incurred during the same incident. An EPD™ might follow up with an urgent request to check the well-being of a person (125: Public Service) who might have been trapped in the avalanche.

Need to hire 40 emergency medical dispatchers™ at three different centers? Need them within three months? No problem. At least that was the BC Ambulance Service (BCAS) Communications team’s response when presented with the issue in late June. By September, they had the numbers necessary and more, while also defining and describing the critical role an EMD™ plays without violating patient privacy or jeopardizing the confidentiality of the job.

What’s their secret?

The team decided on a two-pronged approach: First, create videos that would show just what’s involved in the job of an EMD, and second, invite media inside dispatch training rooms so reporters could test-drive for themselves the role of an EMD—and provide information for readers, viewers, and listeners about just how dedicated the EMDs are.

First up: YouTube videos featuring two experienced EMDs talking about their profession, including what’s the best part of their job and why they love it. Then another two videos with EMD trainees who spoke about why they wanted to work with BCAS, described what the training was like, and provided “words of wisdom” for anyone thinking of a dispatch career.

Next up was the “Taste of Dispatch,” which had nothing to do with sharing favorite food recipes. Rather, BCAS Communications offered to share the EMD experience by inviting print and broadcast journalists to a taste of answering emergency calls in the dispatch training rooms in the three dispatch locations in Victoria, Vancouver, and Kamloops, which are located throughout the vast province of British Columbia. For three days in August, a combined 16 journalists sat behind the controls and were put through their paces by BCAS Provincial Dispatch Training Officer Corinne Begg.

“We invited them in for part of a day,” said Catherine Bianco, the Communications team member in charge of the exercise. “Each reporter sat next to an EMD and worked through scripted scenarios to learn how the system works. When the journalists published their stories, the public could experience what dispatch is all about. We were letting the public share something completely new and different.”

The results were beyond what she had anticipated. Nine newspapers ran first-person, uniformly positive accounts, while TV and radio stations provided video and audio coverage. The project also accomplished BCAS goals. External applications for EMD positions increased nearly 300%: 436 applicants followed the one blitz compared to 125 during all of 2011.

Anecdotally, Communications heard that people in Kamloops were knocking on the doors to apply. Overall, the response was incredible, Bianco said. “It worked.”

EMAS, which was presented with its first ACE in 2006, provides emergency 9-9-9 and urgent care services to 4.8 million people within the Derbyshire, Leicestershire, Rutland, Lincolnshire, Northamptonshire, and Nottinghamshire regions of the U.K. (approximately 6,425 square miles). The 3,200-member staff is divided among 70 locations, including two control centers, and responds to more than 670,000 emergency calls per year.

EMAS uses the Advanced Medical Priority Dispatch System™ (AMPDS™) Protocol and, like all NHS Trust ambulance services, must respond to 75% of emergency calls classified RED within 8 minutes. These calls can include patients experiencing cardiac arrest or severe breathing difficulties.

**Quality assurance**

A set of Clinical Quality Indicators makes it possible for EMAS to identify areas of good practice and areas needing improvement. Green calls mean that patients get the right treatment at the right time. If the patient’s condition is life threatening or serious, the patient receives an ambulance response and a face-to-face assessment. If the condition is non-life threatening, a skilled clinician conducts a telephone assessment and directs the patient to the right care. This could be to visit his or her GP, a minor injury unit, call NHS Direct, or a non-emergency ambulance will be sent to assess the patient face-to-face.

EMAS NHS Trust members attending the re-ACE award presentation included Deputy Director of Operations Paul St Clair; Assistant Medical Director Steven Dykes, M.D.; Audit & Training Manager Hilary Yates; and QA/QI team members Sheridan Halton and Jonathan Pearson.

**Academy’s U.K. office lands prestigious address**

The International Academies of Emergency Dispatch® (IAED™) and Priority Dispatch Corp.™ (PDC™) have a habit of finding the prestigious addresses to locate their offices. And the latest move by the IAED/PDC team in the U.K. just goes to prove it.

As of Sept. 28, 2012, the combined offices took up residence at the Spectrum, a five-floor glass-paneled building fronting Bond Street and opposite Cabot Circus, a 1-million-square-foot shopping center.

The 2,260-square-foot IAED/PDC suite on the Spectrum’s fourth floor is divided into six offices, a boardroom, test lab, and stock room. Four staff members work full time from the office.

Not only does the office suite accommodate growing operations in the U.K., but the landmark building is easy to find and close to several modes of transportation.

PDC Clinical Support Representative Louise Ganley calls the new digs nothing less than spectacular.

“The views are particularly striking,” she said. “With so little space available, and the need to expand, we feel very lucky to be here.”

**Let’s take a road trip**

Twelve days on the road gave eight agencies in Ireland a first-rate experience in the use of MPDS® Version 12.2 in ProQA® and AQUA® by PDC™ Clinical Support Representative Louise Ganley and PDC Implementation Specialist Mario Foletti.

“We’ve been through this before,” Ganley said. “But this time we gave ourselves a little extra time to admire the beautiful countryside and visit with the dispatchers. They are very nice, caring people.”

Visits to the eight agencies in Ireland were divided into 10 days of business travel, separated by two days of motoring Ireland’s scenic A2 highway along the Antrim coastline. They traveled a total of nearly 800 miles and put nearly a full working day into each center on a course, starting at Wexford on the southeastern coast of Southern Ireland, and from there made stops at Cork, Limerick, Castlebar, Bally Shannon, Letterkenny, then north to the Republic of Ireland to visit Belfast, and then south again for stops in Navan, Tullamore, and Dublin.

The Tullamore call center, in Ireland’s midlands, has been using the Advanced Medical Priority Dispatch System™ (AMPDS™) Protocol for several years and in 2012 achieved the award of a re-Accredited Center of Excellence (ACE) in Ireland. It is also
the site of a current study IAED™ Clinical Studies Officer Tracey Barron is leading to compare AMPDS v12.1 and v12.2 CPR Pre-Arrival Instructions.

In between stops at the various centers, Ganley and Foletti had a two-day break to get a closer look at the countryside. They hiked at the Giant’s Causeway, an area of about 40,000 interlocking basalt columns resulting from an ancient volcanic eruption, and they walked across the Carrick-A-Rede Rope Bridge. The one-kilometer (0.8-mile) bridge made of planks strung across wire sways nearly 100 feet above waves crashing against rock walls in the chasm below. It’s not for the acrophobic.

A most memorable stop was in Limerick where Foletti presented the local museum with a 1789 agreement signed by Hugh Massy, 2nd Baron Massy of Duntrileague, for the marriage of his daughter Jane Massy to Maj. William Greene. Hugh Massy held the office of sheriff of Limerick in 1763. He succeeded to the title of 2nd Baron Massy of Duntrileague, co. Limerick on Jan. 30, 1788.

Mario and his wife Aileen discovered the 14-page betrothal document of ink on vellum (animal skin) while sorting through the attic of Aileen’s parents. The document, they later learned, was given to Aileen’s father by his uncle, an attorney, and was still folded in the style of legal manuscripts from that period.

Aileen, an Oxford University English local history graduate, immediately recognized the historical value of the document and, concerned about its preservation, made a series of inquiries. She finally was able to talk to the acting director of the Limerick City museum, who then arranged to pick up the document from Mario and Ganley.

“He was very excited to receive it,” Aileen said. “And I was very pleased to know it was going home where it belongs.”

Ganley, a history enthusiast, was more than happy to make the stop.

“It was very exciting,” she said. “Mario was thrilled to make the donation on the behalf of Aileen.”

Ganley splits her time almost evenly between traveling and the PDC office in Bristol, and she puts in thousands of miles each year. She stops at least twice each year at all 29 centers (in 12 agencies) covered by the U.K. office (England, Wales, Scotland, Isle of Man, and Southern Ireland). She and Foletti team up when the destinations require his operational/technical expertise.

“We enjoy visiting the centers,” Ganley said. “They’re always very welcoming and know they’re making a difference in people’s lives.”

Source

1 The Peerage, A genealogical survey of the peerage of Britain as well as the royal families of Europe, person pages 21124 and 24830, http://thepeerage.com/p21124.htm#i211238 & http://thepeerage.com/p24830.htm
A police dispatcher posted derogatory comments on Facebook about the police department following an incident of mistaken identity she said resulted in the death of her nephew. In a situation involving an emergency services employee working for a private ambulance company, an EMT posted disparaging remarks about her boss and then traded Facebook messages she received in response with other employees.

Although in some ways the social network workers might have done everything right—the Facebook pages were private and the initial postings did not occur during scheduled work time—the comments resulted in unintended consequences, at least for the employees. They were both fired.

“Everything we do reflects upon our profession,” said Priority Dispatch Corp. Consultant Ross Rutschman during the NAVIGATOR 2012 social media presentation How To Get Fired on Facebook. “What happens when the media picks something up? Should First Amendment rights come into play when we make a blunder on Facebook that might affect our agencies?”

**Protection under the law**

Like it or not, free speech protections are at best nebulous when it comes to job security in the public sector and social media. According to the report Balancing Act: Public Employees and Free Speech, while the First Amendment prevents police from arresting a person for publicly criticizing the chief of police, the mayor, the governor, or even the president of the United States, the job of a public employee who speaks critically of his or her employer may or may not be protected by the First Amendment. If a reviewing court determines that the employee’s speech was disruptive or subversive to the employer’s interest in maintaining an efficient workplace, the employee may lose the case.

But there’s a second layer to consider. The National Labor Relations Act (NLRA), established in 1935, protects workers engaged in “concerted” (i.e., collective) activities to improve workplace conditions. In some cases, the National Labor Relations Board (NLRB) might consider Facebook “Likes” and associated comments enough to satisfy the NLRA requirement. If comments were about making positive changes to the workplace—and an employee was terminated for the post—there might be cause to appeal on grounds of unlawful termination.

In other words, maybe the offended party found the remarks disruptive, while the intention was actually to the contrary. “People have the right to speak without interference from government but people don’t always understand the impact of what they’re posting,” said Louise Ganley, PDC clinical support representative and co-presenter for the NAVIGATOR session on social media. “It becomes a question of where do you, as an agency, draw the line.”
Think about it

Perhaps the best protection for a public employee is withholding judgment from a very public place, like Facebook or Twitter. After all, a social media posting can take on a life of its own and, no matter how unintentional to offend, turn an innocuous ripple into one of tsunami proportions.

Ganley suggests standing back and taking a deep breath before diving headfirst by hitting the send button.

“What you post on Facebook doesn’t go away,” Ganley said. “The wrong thing might stick just because someone didn’t take a minute to think about it.”

The potential for bad outcomes prompted Montgomery County 911 (Clarksville, Tenn.) Director Betty Miller to develop a Social Media and Social Networking Policy. The policy neither forbids employees from establishing Facebook accounts nor does it discourage them from engaging in other forms of social media when not at work. At the same time, Miller does not consider a policy suggesting discretion at all times an infringement of Free Speech protections.

“That’s something I can’t and wouldn’t do,” she said. “But, as I told my people, be cautious about what you say and think before doing. Any mistake you make is there for the world to see.”

The policy provides guidance regarding use of the Internet as a medium of communication affecting the E9-1-1 center. While the policy includes improper use of the Web in general, the focus lies in social communication.

Miller said she was concerned about comments or actions that could erode public trust of 9-1-1; she was concerned about giving information they find or how it might be never know what people will do with the information. “You don’t know what some people might use against you,” he said. “You don’t want to be the next Facebook blunder.”

Rutschman also advised picking your friends wisely if you would rather stay employed at your current position.

“You don’t know what some people might use against you,” he said. “You don’t want to be the next Facebook blunder.”

How to save your job

Ganley and Rutschman recommended the following points for those eager to leave their current job and, possibly, not find another. While they certainly apply to an agency’s created and maintained site, they are also important considerations for social networking from the perceived privacy of your own site.

• Bad-mouth your employer, agencies your center serves, and callers
• Display sexually explicit or other potentially offensive graphic photos
• Release confidential information
• Brag about doing something illegal and how you got away with it
• Post derogatory, insensitive, and inflammatory remarks about an individual’s race or sexual orientation
• Post all the fun stuff you’re up to on the day you called in sick
• Blog about inappropriate topics
• Pick a public fight

National scope

Lively is co-chair of the National Emergency Number Association (NENA) PSAP Operation Committee. In August 2012, the [subcommittee] Social Networking Workgroup released an 18-page document of recommendations for developing social media policies exclusive to agency dissemination. Nothing in the policy addresses personal use by social media account owners.

Sources

Stroke Or Seizure?
Which protocol addresses the symptoms caller describes?

Brett:
A caller reported a 93-year-old male that has "tremors, shaking, difficulty swallowing, speaking, and is confused." Patient was awake and breathing. The following summarizes the call and provides the protocol assigned.

Dispatcher: "When you say tremors, can you describe what he is doing?"
Caller: "Very uncontrollable twitching and shaking."
Dispatcher: "Is it a seizure?"
Caller: "It almost looks like it, but it has been constant all day; I hope it’s not. And it gets more intense when he tries to speak."

The dispatcher coded the call as a "12" since she didn’t know what other medical problem it could be.

Was Protocol 12: Convulsions/Seizures the correct choice based on the information given?
Someone else at the center suggested that the dispatcher should have used Protocol 28: Stroke.

Karen Lord, EMD-Q®, Biddeford Police Department, Biddeford, Maine, USA

Karen:
A seizure is very unlikely in this case, mainly because of the duration. The typical seizure causes unconsciousness, followed by intense spasms, jerking, then twitching, and the patient is generally not breathing for a minute or two. The patient then starts to breathe, wakes up, and appears confused for a little while. Getting consistently back to normal is very indicative of a seizure.

A sudden onset of trouble speaking and confusion is symptomatic of stroke. If a caller describes symptoms noted in the STROKE Symptoms list on Protocol 28, this protocol should be selected. The difficulty swallowing, speaking, and the confusion associated with your example patient leans heavily toward stroke. We ask "Tell me exactly what happened?" to try to get a recent history and the reason for the call.

When the dispatcher asked "Okay, tell me exactly what happened?" is when the caller stated: "He is having tremors, shaking, difficulty swallowing, speaking, and is confused." She heard the caller say "tremors and shaking" but didn’t put two and two together about the speech and confusion.

Karen:
you could use either Protocol 17: Falls or Protocol 30: Traumatic Injuries (Specific) for your second example, although Protocol 30 is probably best since we know what caused the fall and that it wasn’t a long fall. Protocol 30 also covers spontaneous fractures.

Keep in mind, however, that if the dispatcher should have used Protocol 28, the caller might not have known about the fall and the dispatcher’s decision might have been more appropriate. The dispatcher could have asked about the fall and the patient’s condition during the call to better understand what happened. The dispatcher should have also asked about the patient’s health history to better assess the situation and make a more informed decision.

Brett A. Patterson
IAED™ Academics & Standards Associate
Medical Council of Standards Chair
Two Florida Centers Now Double ACEs
Medical and fire dispatch brings in awards

Lee Control was awarded medical accreditation in March 2009, the 126th member call center so designated. “But we had the wholehearted endorsement of the Association of Fire Chiefs here and we responded with wholehearted effort to improve the case review scores. We decided it wasn’t about doing what being an ACE required but how those requirements literally improve our service to the public. The ACE confirms that, and, more importantly, our center knows it, the numbers show it, and our fire chiefs believe it.”

The center, located in the southwest quadrant of the state, has to be better than good. Their staff of 33 dispatchers responds to dramatic fluctuation in Lee County’s population that goes from 635,000 in the summer to 1.2 million when the “sun birds” descend out of the cold winter up north from January through April.

“The call volume obviously goes up with that kind of population increase,” Taviano said. “That’s why it’s vitally important that we prioritize our resources. Everyone feels more confident and competent in matching the response to the call. Before, when we got a fire call, it was like we sent the cavalry.”

Fire response might not seem that important, given that Florida is mostly known for its tropical, wet weather and not so much for wildfires, at least to people outside Florida. “Weeks and weeks go by without a drop of rain,” said Rob Fewell, Lee’s new dispatcher training and quality assurance coordinator. “It becomes both a matter of public safety and making the most efficient use of fire department resources during those months. Any agency’s goal is to have the right equipment making the right response. These are the most effective guidelines we’ve found.”
About 180 miles to the north and about 25 miles west of Orlando is Lake County. About 300,000 residents are in the good hands of 33 full-time dispatchers who have made it a joint goal to be regarded as the best of the best in the business. Lake EMS became an EMD ACE in February 2009, the 125th IAED-trained agency so named.

“I live and breathe dispatching; I’m in it deep,” Stephens said. “We’re very proud that we could earn this designation. We’re always talking about how we can do the job better. The ACE lets us know that we really do know all that we think we know.”

Stephens said the word that best describes Lake County communications is “consistency.” That means the center is consistently ready for anything coming in, and that’s a big relief both to the 9-1-1 caller and to the dispatcher.

Stephens, who has been a dispatcher since 1985, said she takes any opportunity to tell anybody with the slightest interest about the inner workings of being a dispatching center. “I’m often surprised how little people know about, let alone understand, what it is exactly that we do,” she said. “And if they hear about [dispatching] at all, it’s usually when a call has gone badly.”

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“Florida has had more than its share of calls gone badly, some of them infamously. In April 1995, a convenience store clerk in Tampa made a frantic call to 9-1-1 attempting to report a kidnapping in progress. Rather than reassuring the caller and directing police officers to the scene, the dispatcher argued with the store clerk and never sent police. The victim was found murdered minutes later. In August 1995, 28-year-old Sara Rodriguez was shot to death in a Tampa convenience store during her usual night shift.

Despite having a police cruiser less than three blocks away, the dispatcher didn’t send help for 13 minutes.

“What people here and around the country have come to realize,” Stephens said, “is it’s actually the telecommunicator who is the conduit to help. The more capable the dispatcher is, the less likely an incident will end tragically. In fact, those using the Priority Dispatch System™ will have substantially mitigated the potential for injury by providing relevant information to responders. It just makes so much sense.”

So much so that a year ago Florida approved the Denise Amber Lee Act requiring state certification, continuing education, and recertification every two years. A 232-hour curriculum was established with the Florida Department of Education. The urge to certify dispatchers is spreading. Members of the Denise Amber Lee Foundation this past fall conducted two days of training with Chicago-area 9-1-1 telecommunicators and were asked to meet with the Illinois committee working on a similar standard and legislation for their state the same month.

“The dispatcher becomes a factor in incidents that go wrong,” Stephens said. “The fact is, dispatchers are factors in all emergency communications, no matter how well or poorly the outcome. When they can act with confidence, it makes all the difference. When the dispatcher can tell a caller, ‘Stay on the line and I’ll tell you exactly what to do next,’ that is very comforting to the caller and very empowering to the dispatcher.”

The next step in quality improvement for Lake County is moving along with the sheriff’s department into a new facility. The two will remain separate agencies, but all of emergency services for Lake County will be located in a single location.
View From The Start
NAVIGATOR comes home in 2013

By Audrey Fraizer

NAVIGATOR 2013 will give you a view of emergency communications like you've never seen before.

And, that's no exaggeration.

For starters, the conference features a 25% increase in the number of speakers (from an average of 95 speakers to 122), and many of these are new to the NAVIGATOR speaker scene. Not that the "tried and true" were dropped from the pack but, rather, the conference introduces people eager to get their first NAVIGATOR shot in the classroom.

They have speaking experience, explained Conference Coordinator Claire Colborn; however, their public speaking resumes are not specific to NAVIGATOR.

The conference committee choosing from among the close to 200 applications submitted did so on purpose.

“We anticipate the same caliber of speaker our audience expects,” she said. “It’s just that this year, we had more people from outside the familiar list of names sending in proposals for presentations. We thought it would be great to encourage the variety.”

The nearly 100 sessions scheduled retain the five new tracks added in 2011—Motivation, Stress Management, Human Resources, Next Gen 9-1-1, and ACE—and the traditional tracks in leadership, operations, management, protocol usage, quality assurance, technology, continuing dispatch education, and training.

The popular Special Interest track highlights operational continuity (think the EF5 tornado that hit Joplin, Mo., on May 22, 2011, and other natural and manmade hazards), shiftwork survival, and PSAP challenges in border communities. Motivational speakers will address improving morale and dispelling negative behavior, while sessions in the management column provide building a dream team and surviving the changes ahead. The latest about the Police, Fire, and Medical protocols will be on tap—as always—the same with quality improvement and technology.

“The best advice I can give is look at the schedule [in this issue of The Journal],” Colborn said. “I think our audience will be surprised by the extent of presentations. No two sessions are the same.”

Almost every bit as exciting to Colborn and the NAVIGATOR marketing team is the chance to show off Salt Lake City and the range of activities available close to downtown and at world-famous national and state parks within less than a day’s driving distance for those deciding to extend their stay or return at a later date.

But don’t despair if you can’t take extra time away from work.

Director of Marketing and Communications Kris Berg and her staff of designers—with a little help from local outdoor enthusiasts—are taking the feel of mountains, desert red rocks, and alpine forests to
a downtown venue (called the Salt Palace) favored twice each year by the Outdoor Industry Association.

“If you’ve never climbed a rock realistic landscape, here’s your opportunity,” Berg said. “We’ll have the safety equipment and holds for creating a climbing adventure without the dangers. It’s a real friendly introduction to one of Utah’s most popular sports.”

The fun and adventure doesn’t stop at the wall, however.

Other sports to try on the inside will include slightly above the floor slack lines, stationary bike races, and as close as we can get to a winter sport experience without the snow. Box lunches, vendor exhibitions, continental breakfasts, and all the other trappings of NAVIGATOR will also be in store, along with nationally known keynote speakers such as Olympian Jim Shea, Jr. a retired American skeleton racer who won the gold medal at the 2002 Winter Olympics in Salt Lake City.

Everything is within a mile radius; although, if walking’s not your thing, chartered buses will be providing shuttle service between the Salt Palace and Grand America Hotel and from those two locations the buses will also make stops at the new IAED™/PDC™ building. Tours to the new public safety building are also scheduled four times each for two days.

NAVIGATOR 2013 will be the show of shows, at least until 2014, Colborn said.

“This is where it all started and we’re eager to show off Salt Lake and how far protocol has come over the past nearly 35 years,” she said.

NAVIGATOR was last held in Salt Lake City 20 years ago, when the title was coined to foster the connection between contemporary dispatch and protocol. The Medical Priority Dispatch System™ (MPDS®) was taking off big time, and there had to be someplace people from all over the world could go to:

- Learn best practices
- Stay on track
- Network

“The idea was to bring people together,” Berg said. “Our priority was to show that they are part of a career and, maybe more importantly, a community of people committed to what they do. It didn’t matter where they lived. They belonged.”
### Wednesday, April 17th

#### 8:30–10:30 AM
- **Opening Session**
  - 8:30–10:30 AM

#### 10:30 AM–12:30 PM
- **Special Interest Sessions**
  - [Medical](#)
  - [Leadership](#)
  - [HUMAN RESOURCES](#)
  - [POLICE](#)
  - [FIRE](#)
  - [Exhibit Hall](#)

#### 12:30–1:30 PM
- **Decision Making**
  - 12:30–1:30 PM

#### 1:45–2:45 PM
- **Training**
  - 1:45–2:45 PM

#### 3:00–4:00 PM
- **Situational Awareness and Crew Resource Management**
  - 3:00–4:00 PM

#### 4:15–5:15 PM
- **Special MPDS Protocol Situations**
  - 4:15–5:15 PM

#### 6:00–8:00 PM
- **Continental Breakfast & Registration Open**
  - 6:00–8:00 PM

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### Thursday, April 18th

#### 9:00–10:00 AM
- **Continental Breakfast & Registration Open**

### Exhibitor Gala Reception

- **Exhibitor Gala Reception**
  - **Wednesday, April 17th**
  - **8:30–10:30 AM**

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**Topics and speakers are subject to change. Visit [www.emergencydispatch.org](http://www.emergencydispatch.org) for more information.**
**CONFERENCE REGISTRATION OPTIONS**  
APRIL 17-19, 2013 (WEDNESDAY–FRIDAY) 
Passports INCLUDE admission to all regular conference sessions, the Opening Gala,  
the Exhibit Hall, and two box lunches.

<table>
<thead>
<tr>
<th>Option</th>
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<tr>
<td>Conference Passport</td>
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<td>NENA Membership (ID: ______________________)</td>
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<td>or IED Membership (ID: _____________________)</td>
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<td>or Group Rate (if more from same agency, submitted at the same time)</td>
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<tr>
<td>(Admission only to Exhibit Hall; includes two lunches and Opening Gala)</td>
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**SPECIAL EVENTS**  
Closing Luncheon, Friday, April 19, 1:00 PM–2:30 PM  
$25  
12th Annual NAVIGATOR Golf Tournament, Tuesday, April 16, 8:00 AM–1:00 PM  
$65

**PRE-CONFERENCE PROGRAM SUMMARY**  
APRIL 14–16, 2013 (SUNDAY–TUESDAY) 
IAED CERTIFICATION COURSES  
(Prices as marked. IAEI materials and testing fees INCLUDED)

<table>
<thead>
<tr>
<th>Date</th>
<th>Course Description</th>
<th>Price</th>
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<tr>
<td>3 DAYS, SUN—TUE, APRIL 14–16, 8:30 AM–5:30 PM</td>
<td>EMDO: Emergency Medical Dispatch® Certification Course</td>
<td>$295</td>
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<tr>
<td></td>
<td>EPD: Emergency Police Dispatch® Certification Course</td>
<td>$295</td>
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<tr>
<td></td>
<td>ETC: Emergency Telecommunicator® Instructor Course</td>
<td>$475</td>
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<td>2 DAYS, SUND—WED, APRIL 14–15, 8:30 AM–5:30 PM</td>
<td>EMDO: Medical Dispatch QI Certification Course (Class 1)</td>
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<tr>
<td></td>
<td>EPDO: POLICE Dispatch QI Certification Course</td>
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<tr>
<td>2 DAYS, MON—TUE, APRIL 15–16, 8:30 AM–5:30 PM</td>
<td>EMDO: Medical Dispatch QI Certification Course (Class 2)</td>
<td>$550</td>
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<tr>
<td></td>
<td>EPDO: FIRE Dispatch QI Certification Course</td>
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NENA, IAEI, and PSTC SPECIAL TOPIC WORKSHOPS

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<td>1 DAY, MONDAY, APRIL 15, 8:30 AM–5:30 PM</td>
<td>NENA: Recertification Workshop</td>
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<td>PSTC: It’s Your Ship, Navigate it!</td>
<td>$190</td>
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<tr>
<td>1 DAY, TUESDAY, APRIL 16, 8:30 AM–5:30 PM</td>
<td>IAEI: Recertification Workshop</td>
<td>$250</td>
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<tr>
<td></td>
<td>NENA: Overcoming Negativity in the Communications Center</td>
<td>$190</td>
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<td></td>
<td>PSTC: The Fire Within!</td>
<td>$190</td>
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<tr>
<td>½ DAY, TUESDAY, APRIL 16, 8:30 AM–12:30 PM</td>
<td>IAEI: Executive Workshop</td>
<td>$95</td>
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<tr>
<td></td>
<td>IAEI: Data Mining 101</td>
<td>$95</td>
</tr>
<tr>
<td>½ DAY, TUESDAY, APRIL 16, 1:30 PM–5:30 PM</td>
<td>IAEI: Accreditation Workshop</td>
<td>$95</td>
</tr>
<tr>
<td></td>
<td>IAEI: Data Mining 201</td>
<td>$95</td>
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**METHOD OF PAYMENT**
Registration WILL NOT be accepted without one of the following:

- Check/Money Order Payable to: IAEI
- Purchase Order #  
  (A copy must accompany the registration form)
- Credit Card
  - MasterCard  
  - Visa  
  - American Express

Card # ___________
Card Exp. _______/______
Cardholder Name ____________________________
Signature __________________________________

**HOW TO REGISTER**
MAIL: IAEI | Attn: NAVIGATOR 2013 | 139 E. South Temple, Ste. 200 | Salt Lake City, UT 84111 USA
INTERNET: www.emergencydispatch.org/NAVIGATOR
PHONE: (888) 725-5853 USA  
(801) 746-5853 Local/Intl
FAX: (801) 359-0996

- We may share your contact information with NAVIGATOR 2013 Exhibitors. If you do not wish to share your information, please check the box.

**CANCELLATION POLICY**
Please provide cancellations in writing no later than March 22, 2013. Your registration fee will be refunded, minus a $25 processing fee. Thereafter, no refunds will be issued.
Smartphone App 101

The world in a rectangle

Audrey Fraizer
What is a cell phone application?

A cell phone app—sometimes called a mobile app—can be pre-installed on phones during their manufacture, downloaded from mobile software distribution platforms. There are also Web applications that provide an “app-like” experience within a Web browser. No matter the source, the add-ons intensify the phone’s use beyond simply making a phone call, ranging from just about anything you could want to apps you never even knew would or could exist.

How long have they been around?

Smartphones have been around a lot longer than the five years since Apple launched the iPhone in 2007, but Apple was the first to make the technology accessible to the average consumer. One year after Apple’s release of the combination phone, media player, and Web browser, the company introduced the concept of third-party applications and opened the App store, according to eHow Contributor Eleanor McKenzie. Success has, of course, bred stiff competition. The South Korean firm Samsung (Android operating system) overtook competition. The South Korean firm Samsung (Android operating system) overtook Apple in 2011 to become the world’s largest smartphone maker.

What do they offer?

Early cell phone apps integrated computer-like functions, such as e-mail and a Web browser into a phone. While these are still popular apps, stand-alone software is now the norm for playing games, reading books, and keeping up with pop culture newsfeeds.

What good are they?

Apps are also the greatest of time killers, considering the number of apps available. There are 707,000 (and counting) approved apps in the iTunes app store, a number that has certainly increased since plucking the statistic from the Internet (148Apps.biz) in August. An Android platform supports 600,000 apps and games available on Google Play. An estimated 37% of all iPhone apps are free, although the majority can be added at an average cost of $1.94. Games are the most popular apps, followed by education, entertainment, books, and lifestyle.

Down the line

Apps will only increase and get better in line with technology. They certainly won’t go away now that they command a market generating several billion dollars. A study conducted by Juniper Research estimates $25 billion in direct and indirect revenues from the sales of mobile applications over the next two years.

Do any app to emergency services?

While most apps are geared to providing a diversion anyplace, and anytime, others can be actual lifesavers. While the Good Samaritan and emergency notification tools have a fairly specific target audience, the few apps we spotlight are good examples of how an app can be a useful and comprehensive resource in emergency situations. There are many more EMS apps available, although not dispatch specific, and for a more definitive list, check out Keith Widmeier’s story at JEMS.com (April 30, 2012, EMS Apps Assist Providers in the Field, www.jems.com/article/technology/ems-apps-assist-providers-field).

AN INTERNET SEARCH USING THE KEY WORDS “EMS APPS” FOUND:

CPR notification app

Released last year, this app is free and provided through the nonprofit PulsePoint Foundation. The San Ramon Valley Fire Protection District, an Accredited Center of Excellence (ACE), developed the app with the expertise of Northern Kentucky University and its College of Informatics to bring help faster to victims of sudden cardiac arrest. A story describing the app is included in this feature section.

MyFlare (Android app)

There is a one-time fee. Features: Calls 9-1-1 or the user’s designated non-9-1-1 emergency contact; automatically texts and e-mails up to 10 pre-selected contacts a customized distress message, along with your GPS location; delivers text and e-mail messages every three minutes to pre-selected contacts with updated GPS location; capable of sending 20-second video recordings capturing present environment (optional), which are attached to the delivered e-mails every few minutes as determined by the user.

EMS iPhone Apps

EMS1 created an iPhone application to provide EMS professionals with a free resource for breaking EMS news, tips, photo reports, and an archive of EMS1 articles. The list of iPhone applications includes: EMT Skill Scenarios, Dopamine Calculator, Emergency Response Guidebook, EMS Meds, Paramedic Review, EMT Review, EMS Logger Plus, Medical Spanish, Emergency Radio, Instant ECG, MCI Triage, BGluMon (blood glucose concentration), 12 Lead ECG Challenge, and ICEdot. You can download the whole shebang at www.ems1.com/ems-iphone-apps.

FireRescue1 iPhone app

FireRescue1 created an iPhone application that provides a free resource for breaking firefighter news, tactical tips, photo reports, and an archive of articles. The list of iPhone applications includes 911 Toolkit (reference for incident response checklist, EMS, training/study guides, HAZMAT), Rescue Field Guide, Emergency Response Guidebook for hazardous materials, Emergency Radio (listen to live police, fire, EMS, railroad, air traffic, NOAA weather, coast guard, and other emergency frequencies), and—for your amusement—Fire Truck Lite puzzle. You can download the package at www.firerescue1.com/firefighter-iphone-apps.

WISER

The Wireless Information System for Emergency Responders (WISER) from the National Library of Medicine is a free resource to aid in hazardous material incident response. Its searchable database includes material identification, health impacts, and recommendations for managing the incident. The WISER mobile app is available for Apple, Windows, Blackberry, and Palm devices.

To determine which of the 5,000 Hazardous Substances Data Bank (HSDB) substances to include in the core dataset of WISER, selection was based on chemical hazardousness and likelihood of exposure. Key information about the substance (i.e., what the ER needs to know immediately) is provided, as well as a pull-down menu of information categories for accessing the detailed information pages. By identifying victim symptoms, substance physical properties gathered by observation or sensors, and hazard values from placards, WISER can help a first responder identify and validate the unknown substance. As the ER selects observed properties and symptoms, WISER looks in its database for chemical substances that have these characteristics. The list of candidate chemicals decreases in response to more user-provided information about the substance.

For more information and free download, go to wiser.nlm.nih.gov.
Finding The Right Apps
Might be closer than you think

Joel Gallant is quick on his seat. Actually, that’s just a turn of the phrase considering Gallant was on his feet on July 12 when he made a first of its kind rescue from the Ambulance New Brunswick (ANB) (Canada) communications center.

Gallant, ANB operations manager, was on his way to the dispatch floor after a meeting when he heard a fellow operations manager giving directions over the phone to the Sussex Fire Department. Curiosity got the better of him and then the best of him when he glanced at the calltaker associated with the request for response.

“She was looking for an app on her iPhone,” Gallant said.

And, of course, he asked her why.

The calltaker was looking for a mobile application that could pinpoint the whereabouts of three backpackers on the Fundy Park trail system in southwestern New Brunswick. The section of trail they were hiking winds along one of the few remaining coastal wilderness areas between Florida and Labrador and opens up previously unreachable areas of the Bay of Fundy coastline, according to the Fundy Trail visitors bureau.

“It’s remote,” said Gallant, who left the banking business five years ago to pursue a career in public safety. “It’s a very rugged trail.”

A satellite view Gallant later pulled up proved his picture. It showed a canopy of trees so dense in the area they were hiking that it obscures any hint of trail below. The Sussex Royal Canadian Mounted Police (RCMP) had activated ground search and rescue volunteers.

Gallant didn’t describe the hikers as acting in a flustered sort of way; rather, the caller was anxious to find the shortest and fastest path to a road on day two of their planned three-day backpack. One of the hikers was ill and needed help out.

“The caller was calm,” Gallant said. “She was familiar with the area.”

Gallant’s brain flashed to the “Find My iPhone” app he had installed on his iPad in case it was ever lost or stolen. When logged
in, the application can target the missing device and using a blue dot highlight the missing device. The user can zoom in and out of the map available with the application and view the location in a variety of modes.

And that’s basically what Gallant did, except for reversing identity. He asked the caller for the password she uses to enable the app. He logged in on his iPad and entered the caller’s information. That brought up their place in the woods.

“I instantly knew where they were,” he said.

The ambulance was sent on its way and to conserve the minimal power available on the caller’s phone battery, Gallant had her switch to text messaging. Without a signal, he could not maintain a fix on the device. Once they started hiking, he would lose them.

The backpackers were about a mile from a road, although a road far too rugged for the ambulance to travel. Instead, a 4x4 vehicle was sent to pick up the 21-year-old hiker, and he was transported to the hospital by an ambulance waiting at the nearby Algonquin Resort. Gallant led them to the trailhead in the virtual sense allowed by technology, and that saved a trip by the rescue helicopter called to find them.

The hiker was treated for severe dehydration. His two friends, also in their early 20s, might have continued on their hike. Gallant said he doesn’t know. The story has received a fair share of exposure by the press in Atlantic Canada.

The attention the “rescue” has received doesn’t bother Gallant. Truth be known, he would prefer a wider net of publicity. From his subsequent research, this was the first time the iPhone app had been applied to a rescue involving other than a stolen or missing electronic device.

“This was the obvious next step in finding them, and it worked,” said Gallant, who plans a visit to the park someday in the near future. “The greater picture is taking advantage of the technology we have available.”

ANB President Alan Stephen is understandably proud of the center and the fast-thinking Gallant.

“We train people to understand policy, procedure, and protocol and to adapt that understanding to what’s happening at that time,” he said. “We’re very proud of what Joel and others [in the center] are able to accomplish by living through our values and mission statement.”

NEWS FLASH: Gallant used the same technology we have available.”

Staying Alive,” Clarkson said.

“He wasn’t breathing. Within two minutes, everyone’s phone lit up at the same time.”

The man gained consciousness in seconds but if he hadn’t, there were 13 people ready and willing to compress his chest to the lifesaving beat of the Bee Gee’s big hit “Staying Alive,” Clarkson said.

“The Rotary Club is all about service and this is a great way to help our community,” he said.

How it works

The CPR notification alert is a software-as-a-service pre-arrival app developed by the SRVFPD and an IT team from Northern Kentucky University under the direction of Chief Information Officer and Associate Provost for Information Technology Tim Ferguson. Where the app is adopted, everyday citizens—and mayors—indicating they are trained in CPR can literally become lifesavers to victims of Sudden Cardiac Arrest (SCA).

When a SCA occurs in a public place, the app notifies users, within covered communities, simultaneous to 9-1-1 dispatch of advanced medical care. Notification isn’t based on where the subscriber purchased the phone. The alert includes both the SCA victim’s location and where to find the nearest Automated External Defibrillator (AED) device.

SRVFPD Fire Chief Richard Price came up with the idea in much the same manner as Mayor Clarkson—over lunch. The chief heard a siren and saw an ambulance drive into the plaza and stop at the store next to the deli where he was eating in response—as he soon learned—to a 9-1-1 call involving an individual who had experienced SCA.

“As fire chief I don’t receive pages for medical calls,” Chief Price said during a EMS 12-Lead Podcast recorded July 12, 2012. “If I had heard, or if someone else close by had been notified, that could have made all the difference in that man’s life.”

When time counts

SCA is survivable, given prompt administration of CPR. According to the American Heart Association (AHA), it occurs when electrical impulses in the heart become rapid or chaotic, which cause the heart to stop beating. A victim of SCA has only about 10 minutes to live, although brain damage begins several minutes before that. With immediate CPR or AED intervention, the victim’s chances increase dramatically. Despite the odds, however, CPR is only performed in about 25% of out-of-hospital
cardiac arrest cases. AEDs are retrieved and used only 1% or 2% of the time when available primarily because people don’t know where to find them, Chief Price said.

The Rotarians were among the first to receive CPR training and download the app all in the same day, but they are far from the last. The mobile CPR app, in testing for more than a year prior to its official release on Feb. 13, 2012, has been picked up by Alameda County, Calif., and the San Jose Fire Department service area. So far, there are more than 12,000 using the app.

On the research front, Toronto EMS has partnered with the resuscitation research group Rescu, based at St. Michael’s Hospital at the University of Toronto, Canada, to evaluate the app’s ability to increase bystander CPR rates and AED use for out-of-hospital cardiac arrest victims. Dr. Steven Brooks, a clinician-scientist and emergency physician at Queen’s University in Kingston, Ontario, and an affiliate scientist at Rescu, is the principal investigator for the three-year study funded by the Heart and Stroke Foundation of Ontario.

Dan Cottom, Toronto EMS System Operations superintendent, said a large EMS system and call volume combined with their ability to capture high quality data make Toronto EMS the ideal partner in the pilot project.

“Our service is research-oriented and we do a lot in the line of outcome-based medicine,” he said. “We’ll collect the data and, unless there’s a problem, which I don’t foresee, help introduce it to other parts of Toronto.”

He anticipated the app to be up and running by mid-September.

Chief Price said several other cities and countries have showed an active interest, especially since they created the nonprofit PulsePoint Foundation last year to distribute and support the application.

**Load ‘er up**

To install, users in an area where the app has been implemented simply search PulsePoint in the Apple App Store or in Android Apps on Google Play. Real-time alerts once the app is downloaded—and the phone turned on—are based on the user’s location at that moment in relation to the victim within a specific radius as configured by the covered agency. For security purposes, a call from a private residence does not activate notification.

The app works in conjunction with each level of response, beginning at the call to 9-1-1. If through questioning the dispatcher determines a patient in SCA, the ECHO-level Determinant Code the dispatcher selects activates PulsePoint response. The app does not contradict Pre-Arrival Instructions for bystander CPR or hinder the arrival of emergency vehicles. The process continues as scripted in the Medical Priority Dispatch System (MPDS”). Three people arriving on scene are never a crowd since “extras” are then available to assign tasks, rotate turns at CPR, retrieve the closest AED, or clap to the CPR beat.

But CPR is only the beginning, said SRVFDPD Communication Center Manager Sean Grayson.

“This applies to a variety of people interested in emergency response,” he said. “It also provides real-time access to emergency activity as it occurs.”

Wondering if a traffic accident in another lane is causing the pile-up on the expressway or where a passing fire engine or ambulance is heading? Users can tap the application to find the incident location or plan an alternate route, according to the PulsePoint Foundation press release. It also acts as a modern-day scanner, allowing users to listen in on live emergency radio traffic.

Chief Price, who serves as president of the nonprofit PulsePoint Foundation, said the response has been positive, with signs of success evident in the momentum it’s gaining. The money the foundation raises is used in development and bringing the application to other areas.

“The app magnifies the good work people are already doing in the chain of survival,” he said. “It gives us another opportunity to deliver people alive to the hospital after suffering a SCA.”

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**THE JOURNAL | January/February 2013**
The Democratic and Republican National Conventions are two of the United States’ most important and highest stakes gatherings. As thousands of elected officials, delegates, and media representatives descend on the respective host cities, public health and safety officials from the local, state, and federal levels know that preparing for threats that could disrupt the conventions—manmade or natural—is paramount.

2012’s Republican National Convention (RNC) held in August in Tampa, Fla., and Democratic National Convention (DNC) held in September in Charlotte, N.C., were no exceptions. In August, a FBI security bulletin warned of possible violence by anarchists during the Republican convention, according to media reports. At the same time, officials in Tampa and along the beach communities of Pinellas County, where many of the pre-convention events were to be held, kept a wary eye on Tropical Storm Isaac.

Because conventions are designated National Special Security Events by the federal government, the Secret Service is the lead agency for the design and implementation of the security plan. But key to the plan is partnering and coordinating with state and local law enforcement and public safety officials, according to the U.S. Secret Service website, particularly in communications.

Planning starts early in North Carolina

“We started planning for the convention in February 2011, 16 months before the event,” said Kevin Staley, deputy director for the Mecklenburg EMS Agency (Medic) in Charlotte. “A National Special Security Event comes with a lot of additional preparations.”

In Charlotte, those preparations included setting up and staffing 20 command and control operations centers, including a Multi-Agency Command Center (MACC) in a large office building near the airport that housed some 50 different agencies ranging from the FBI to Amtrak; a Command Center at the Charlotte-Mecklenburg Police Department, which housed police, fire, EMS, and some federal officials; and a Joint Medical Operations Center in the Charlotte-Mecklenburg’s Police and Fire Training Academy, which was staffed primarily by medical professionals—EMS, physicians, hospitals, and local and state public health officials.

To monitor health-related threats, the Mecklenburg EMS Agency turned to First-Watch Real-Time Early Warning System, which tracks information entered into computer-aided dispatch (CAD) systems, ProQA, and electronic patient care records in real-time and immediately sends an e-mail or text alert to public health and safety officials if it detects certain symptoms or trends of concern.

Prior to the convention, Staley and his team identified “triggers” that could indicate a chemical or biological attack, such as a sudden spike in calls, or specific symptoms including fever, rash, cough, altered mental status, bloody diarrhea, and seizure.
“If we received three or four calls over a six-hour period about the same complaint, that would get our attention,” Staley said. Information generated by the system at the Command Center at the Charlotte-Mecklenburg Police Department was also shared with the Joint Operations Medical Center. In addition to looking out for terrorism, they also set triggers to look for signs of illness outbreaks, such as food poisoning.

“There were so many banquets and parties with prepared food to feed thousands of delegates,” Staley said. “We were also providing boxed lunches for law enforcement and paramedics while they were on duty. You don’t all of a sudden want a lot of police officers or medics that can’t function.”

Finally, they set up a “geo-fence” around high-threat areas, including the convention center (the Time Warner Cable Arena) and other key convention locations: hotels where delegates were staying and nearby businesses that could be potential targets for protestors or terrorists such as Bank of America and Wells Fargo headquarters and Duke Energy.

While the Mecklenburg EMS Agency had been monitoring calls prior to the convention to looks for spikes in flu activity and other trends, the convention “was a great opportunity to really test it,” Staley said. “It would be impossible to have someone looking at every CAD report to see if there is something we should be taking a closer look at,” he said. “With FirstWatch, you have a system that is looking at calls in real-time and mining your CAD, ProQA, and patient care report data that automatically alerts you if there is something that might need to be looked at more closely. The beauty of it was we’re not finding out 24 hours later something might have happened, I’m finding out literally as it’s happening. Then your subject matter experts can dig into it right away.”

### Tropical Storm Isaac throws a wet blanket on RNC

While the RNC was held in Tampa in Hillsborough County, neighboring Pinellas County was playing host to numerous pre-convention events, while most convention delegates and other attendees were staying in hotels along its beaches. To gear up for the influx, Sharlene Edwards, public health preparedness manager for the Pinellas County Health Department, took a look at the county’s surveillance systems. They were already using Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) to analyze data from hospital emergency rooms for outbreaks of illness, but there was an approximately one-day delay in getting the information from hospitals. To improve that, Edwards had them upload their data every two hours instead of daily.

They also turned to FirstWatch to monitor data in real-time from the CAD at Pinellas County Central Dispatch, ProQA, and electronic patient care reports. “We looked at all of our surveillance systems and asked, ‘What are we getting now and is there anything we’d need to get from them more urgently, more timely, or in a different way to accommodate the RNC?’” Edwards said. “With FirstWatch, we could see things before the person even hit the hospital.” Like Charlotte, they set up triggers based on symptoms, location, and key words found in the CAD, ProQA, or the patient care report, such as “anarchist,” “RNC,” “delegate,” or “white powder,” which could indicate anthrax.

In the end, after more than a year of planning, Tropical Storm Isaac threw a wet blanket over the event. There were only 15 calls related to the RNC, said Stephen Fravel, EMS coordinator. The RNC cancelled the first day of the convention. The pre-convention parties on the beaches were canceled due to weather. Even the protestors seemed to stay home. While they were initially worried that protestors might try to block the three bridges between Tampa and Pinellas County, “there were more police than there were protestors.”

In Charlotte, MEDIC dispatchers sent EMS resources to 91 incidents, mostly related to the heat, in and around the convention center. “The actual incidents related to the DNC were the same as we normally handle,” said Medic Operations Manager Todd Sims. “There wasn’t an explosion of calls or something we aren’t used to dealing with. But you always learn from experiences like this the things you need to continue to do and what you need to tweak for the next time.”

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Paying Close Attention In Charlotte: A political convention coming to town means watching for unusual signs including trends in the nature of complaints coming into 9-1-1 centers.
Republican National Convention
Preparation two years running

The future looked packed although quite doable despite a national political convention two years down the road when Thomas Wolff took over as manager of the Tampa Police Department (TPD) Communications Bureau in November 2010.

The retired major knew the outside workings of the bureau through a 30-year career that included his command of police communications.

Wolff also had experience in crowd control, which naturally comes with the territory for police in a city that hosts mega-events like the Gasparilla Pirate Festival, Guavaween, and the parade of multicultural fairs held year-round.

He figured that inclement weather might be an issue during the three days the Republican National Convention (RNC) was in town, and both events would add to the hundreds of 9-1-1 calls coming into the center daily. The TPD Communications Bureau processes more than a million calls each year, of which—in 2010—386,488 calls were placed directly to 9-1-1.

“I had a year, year and a half to get ready for the convention,” Wolff said. “I knew from the start, it would take a lot of preparation and a lot of hours.”

Wolff set out his game plan, beginning with a system check to assess the known factors to better prepare for the looming convention. While the federal government handles the bulk of security, it was up to Tampa Police to pick up the balance.

On the plus side

The TPD Communications Bureau regularly assigns dispatchers to a Special Operations channel during major events. Six dispatchers and 14 calltakers are available on every shift for the six police sectors in the city’s three primary police districts.

The number of delegates, alternate delegates, Republican staff and speakers, and credentialed media inside the convention hall would add up to far less than the 70,774 fans crowding Raymond James Stadium in Tampa for Super Bowl XLIII. The roughly 50,000 convention visitors would make up the difference, and just like in sporting events, not everyone would be cheering for the same side.

Planning phase

Wolff organized committees to complement RNC priorities, outlined concerns, and scheduled several conference calls with agencies in Denver, Colo., and St. Paul, Minn., which hosted the Democratic National Convention (DNC) and RNC, respectively, in 2008. He asked lots of questions.

“Probably the same questions someone will ask me in two years,” he said.

The TPD Communications Bureau training room was converted to a dedicated RNC operations center, with 10 dispatch positions and flat screen televisions to provide live feeds from helicopter links. He added dispatch positions and put 30 dispatchers through tactical dispatch training. All dispatchers working the main RNC talk grounds during the week were part of the TPD Tactical Dispatch Team. He talked to police about keeping radio traffic down and methods for keeping peace among the political activists. He made contingency plans in case of power outages, the radio system going down, or CAD malfunctions.

On the days immediately before the convention, he monitored the path of Tropical Storm Isaac, which forced convention planners to scrap the first day of scheduled events.

“We were in RNC and hurricane mode,” Wolff said.

The same applied to the Hillsborough County Sheriff’s Department, which Acting Manager Gordon Silver estimates the reverse of TPD’s job during the week.

“We were certainly ready but our involvement for the convention was maybe two to three percent,” Silver said. “We had a special radio channel set up but didn’t use it other than testing it every day. We were more involved with the storm, which we believe kept many people away.”

Silver credits the TPD for a “very uneventful week” in his 37-year career.

“They were on it,” he said. “Even the special arrangements at the center, like meals and snacks, I heard went well.”

Wolff is, of course, relieved that everything went off without a hitch. He never had to fall back on contingency plans and the activists, although noisy at times, stayed inside their designated protest area. Only two people were arrested, compared to the hundreds arrested four years earlier at the RNC held in St. Paul, Minn.

Did he like their part in hosting the national event? Very much so and for reasons beyond the glitter and ceremony.

“The RNC gave the Tampa Police Department the ability to show the country and the world the professionalism of not only the men and women of its agency but of all the law enforcement agencies throughout Florida who assisted in making this a successful and peaceful event,” he said. “The many hours that were spent in preparation and training by the dispatchers helped build comradery within Communications and gave them invaluable training for any future events that Tampa may experience.

“Never before had they had to dispatch to thousands of officers from numerous different agencies, each with their own radio system and unique system of dispatch, and they stepped up to the challenge and were successful,” Wolff continued. “They should all be proud of their accomplishment.”

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Democratic National Convention

Preplanning for event imperative

There was more to the 2012 Democratic National Convention (DNC) held at the Time Warner Cable Arena in Charlotte, N.C., during the first week of September than the politicians and delegates gathered to nominate their candidates. Local, state, and federal agencies came together to make the convention a safe event for not only the DNC attendees but, also, the entire Charlotte community.

For their part, Mecklenburg EMS Agency (Medic), switched to “12 on, 12 off” shifts and suspended time-off and vacation requests; all hands needed to be on deck. Medic personnel were scheduled for 12-hour shifts inside the secured zones as well as throughout the entire county. Medic dispatchers worked 12-hour shifts either at Medic’s Central Medical Emergency Dispatch center (CMED) or at the Emergency Operations Center (EOC) at the Charlotte-Mecklenburg’s Police and Fire Training Academy.

Although Medic has prepared for many mass gatherings like the DNC, the agency had never planned for anything with such a massive security component, which included both a sitting president and vice president.

Charlotte-Mecklenburg Police Department, along with police from neighboring agencies, patrolled Charlotte’s Uptown area, referred to as the hard zone during the week. Medic Deputy Director Barry Bagwell described DNC security as multiple layers, each surrounded by a fence. The first layer—the tier with the largest circumference—involved the lowest level of security, with each succeeding smaller layer demanding even higher levels of security, identification, and government clearance.

“Preparations focused on both security and interagency coordination,” Bagwell said. “This was particularly outside the perimeter of the hard zone, where a large police presence was needed to help control the protest environment.”

Medic relied heavily on local and state partnerships built prior to the DNC. Preplanning for the DNC was imperative. Medic leadership met with Denver’s Emergency Medical Services (EMS) Department (Denver was the 2008 DNC host city).

“We did the pre-work and we were ready,” said Bagwell, who is in his 27th year at Medic. “In fact, we were many steps ahead of the game before the DNC even started. The week of the event turned out to be relatively calm for us.”

As for Medic’s dispatch center, the information and call flow were adjusted to allow communication between radio dispatch at the EOC and the many dedicated units in and around the hard zone, such as the mobile hospital, police and bicycling patrols, SWAT teams, and EMS crews.

“It would have been an absolute nightmare if when people arrived, each used a different vocabulary for the same incident,” Bagwell said. “There has to be structure, a common language, just like there is with Medic’s Medical Priority Dispatch Protocol.”

Medic dispatched 161 resources for the 91 incidents requiring response, with the majority of EMS issues relating to the heat.

“The event was a snapshot of what we always handle, but we did have a full court press in case anything did happen,” said Operations Manager Todd Sims.

At the same time, business as usual meant keeping close tabs on morale during an intense operation. To keep all employees informed and gauge employee morale, leadership kept in constant contact with employees whether in person at Medic’s headquarters, in the hard zone, or at the EOC.

The “what could happen?” thought a week prior was the most trying part of the event for Sims.

“That’s what made me nervous,” he said. “But it turned out to be an excellent learning experience putting theory into action. The agency is better prepared in many ways because of our response to the DNC.”

Medic’s responsibilities span 544 square miles, including the city of Charlotte. The agency’s EMS 9-1-1 dispatch center received 110,180 calls in fiscal year 2012, and during any given 24-hour period, 150 to 300 calls are dispatched. Medic’s Central Medical Emergency Dispatch has been an Academy Accredited Center of Excellence (ACE) since 2002.
OnTrack

Active Shooter
New protocol helps minimize assailant’s aim

The first call came in to Clackamas County (Ore.) Emergency Management at 3:29 p.m. on Tuesday, Dec. 11, 2012. A gunman wearing dark clothing, a white mask, and [what appeared to be] a bulletproof vest had opened fire in a crowded suburban Portland mall.

One minute later, police were on the scene, and by 3:51 p.m., police had discovered three victims, in addition to the gunman, and his AR-15 semi-automatic rifle. The shooter, who died of a self-inflicted gunshot wound, had apparently fired at random; there was no known connection between the shooter...
and the two people he had killed—45-year-old Steven Mathew Forsyth and 54-year-old Cindy Ann Yuille—and the teenager he had wounded—15-year-old Kristina Shevchenko.

The gunman, 22-year-old Jacob Tyler Roberts, was an active assailant.

As such, he met the International Academies of Emergency Dispatch’s (IAED™) definition for ACTIVE ASSAILANT (SHOOTER) recently released in Protocol 136 as a Special Update to the Police Priority Dispatch System™ (PPDS®) v41a. Roberts was an armed person who had used a weapon to “inflict deadly physical force on others” and continued to do so “while having unrestricted access to additional victims.”

The qualifier “unrestricted access to additional victims” distinguishes the use of Protocol 136: Active Assailant (Shooter) from the existing PPDS Protocol 106: Assault/Sexual Assault. While Protocol 106 refers to an “unlawful attack, or attempted attack, on another person”, which may include multiple victims, Protocol 136 more specifically addresses active assailants in wide-open places offering a large number of potential victims such as shopping centers, school campuses, movie theaters, and parking lots.

Priority Dispatch Corp.™ (PDC) Police Consultant Shawn Messinger said Protocol 136 gives communication centers a better weapon in the broader picture of “neutralizing” the opportunist assailant and securing scene safety.

“Our tools for dispatchers have always been there, the new protocol is specific to active assailant incidents to better address these situations,” he said. “The new Pre-Arrival Instructions give dispatchers even more of an opportunity to make a difference and help save lives.”

The active assailant

The active assailant has a singular motivation: to cause as much human carnage and mayhem as possible in a location that ideally provides ample and “unrestricted access to additional victims.” Research has shown that active assailants (shooters) apparently have no trouble “pulling the trigger;” they seldom plan to live past the brutal experience, believing they have nothing left to lose and desiring to take others with them.2

Clackamas County Sheriff Craig Roberts told ABC’s “Good Morning America” the shooting at the Portland mall was an apparent act of sheer randomness. The shooter was not carrying out a vendetta against a specific individual, and an estimated 10,000 people were at the mall at the time of the shooting.3

“It really was a killing of total strangers, to my knowledge at this point in time,” Sheriff Roberts said. “He was really trying to kill as many people as possible.”4

The factors of randomness and potential magnitude explain why active shooters choose soft targets such as shopping malls, movie theaters, and school campuses. They want areas of known or probable low security—where the people are preoccupied by their surroundings—to enhance the potential for a higher number of targets.

Assailants also tend to prefer open areas with limited egress and buildings with exits easy to block and booby trap to increase the number of casualties while, also, impeding response by law enforcement. They do not generally want to “waste” time attempting to force entry into closed or locked offices.

Police strategy

Prior to the mass shooting at Columbine High School, the traditional law enforcement response favored an attempt to cordon off the area and await the arrival of Special Forces, such as SWAT teams. However, this strategy resulted in time lost waiting for other units to take over and more opportunity for the active shooter to engage innocent victims and raise the level of pandemonium.5

Law enforcement agencies across the country have since moved to a more aggressive response to limit the number of casualties. The first responding officer conducts a “Movement-to-Contact-to-Fix” military type offense. Although specific tactics vary by agency, underlying goals favor immediate pursuit by police with the goal of containing or neutralizing the killer(s) as quickly as possible.

“As a profession, we had to rethink response to these types of events and re-evaluate tactics, training, and equipment.”

– Shawn Messinger

Protocol 136

The new Protocol 136: Active Assailant (Shooter) reflects this current and evolving tactical philosophy as it provides calltaker questions and instructions that complement police procedures in response to these situations. The information calltakers gather through Key Questions can heavily influence deployment tactics used by responders, law enforcement administration, and assisting EMS and fire agencies.

How it works

The Active Assailant (Shooter) Protocol adds another ECHO determinant to the PPDS to allow for early dispatch initiation to address specific immediate dangers and minimize the loss of life.

However, unlike most ECHO determinants, the pathway for Protocol 136 does not immediately direct the calltaker to Pre-Arrival Instructions (PAIs) from Case Entry, nor does it link to the Caller In Danger (CID) Protocol.

Callers reporting an ACTIVE ASSAILANT (SHOOTER) should always be considered to be in imminent danger, but these incidents are best addressed on Protocol 136 as it includes specialized questions and instructions for these high-risk situations.
For active assailant situations discovered during Case Entry, the EPD™ should initiate a 136-E-1 response, provide Case Entry PDI-a, and then go to Protocol 136 immediately after completing Case Entry.

The links to PAIs appear within the Key Questions section of the Active Assailant (Shooter) Protocol. This allows the EPD to first address critical responder safety questions before beginning PAI Protocol S and immediately instructing the caller on the best actions they can take to save lives (either evacuation or LOCKDOWN).

The critical role of the EPD

Active assailant situations change rapidly and can quickly overwhelm the capacity of emergency service agencies with overloaded phone lines, overwhelmed available police resources, and the number of victims exceeding the capabilities of paramedic crews and emergency room space.

This places 9-1-1 in a critical role with the ability to contribute to a more positive outcome via the collection of necessary information to assist police with deployment and the EPD’s provision of lifesaving instructions to callers.

Specialized Key Questions

The Key Questions on Protocol 136 are specifically designed to quickly collect the information responders need to address these unique incidents, as discussed here:

- “What type of weapons are involved?” The risk associated to responding officers differ greatly depending on the type of weapon the assailant is using. As a new addition to the PPDS, the weapons suffix code “M” for “Multiple weapon types” has been added to the existing codes (C,E,G,K, and O).
- “Does the suspect appear to be wearing a bulletproof vest or body armor?” Body armor on suspects limits the effectiveness of responders’ weapons.
- “Did you see the suspect carrying anything?” This question can elicit information to indicate the use of explosives, chemical or biological weapons, or other weapons that will hinder a law enforcement response.
- “Did you hear the suspect saying anything?” This question can help provide insight into the suspect’s motives, level of preparation, and intended target.
- “When was the last time you heard shots fired?” This question aids the calltaker in determining: 1) Activity level of the assailant at the time of the call; 2) Callers with the most up-to-date information because of their proximity to the assailant.
- Pre-Arrival Instructions

Since phone contact with the caller can be lost at any time, the EPD must give PAIs early in the call to address critical responder safety questions, as mentioned, and to prepare the caller to escape (evacuation), to move to a confined space and further safeguard him or herself from the assailant(s) (LOCKDOWN), or to prepare to defend him or herself if found.

These specific instructions can prevent a panicked caller from making the situation worse, as illustrated with the following Evacuation instructions:

- “Take an evacuation path that’s away from the suspect.” The shortest route out of the area may not be the safest. A panicked caller might not give second thought to the potential danger associated with the shortest route without the calltaker’s cautionary instructions.
- “Do not attempt to move wounded people.” Attempting to move wounded individuals slows the evacuation and puts the caller and others at further risk.
- “Do not rush towards officers, keep your hands visible at all times, and follow all of their commands.” Panicked callers swarming responders hinders their ability to assess and address possible threats and puts victims at risk of accidentally moving into the line of fire.

Callers unable to safely evacuate should remove themselves from plain sight and conduct what is commonly referred to as a LOCKDOWN. The simple act of securing everyone into a room with a locking door, or a door that can be barricaded, gives the shooter fewer targets and poses greater difficulty. Sitting or lying on the floor right next to the wall with the door minimizes the danger from bullets fired through the door.

Oftentimes, the suspect might hunt down victims, at random, once through the initial shooting. Individuals caught in the “hunt” and who cannot flee from the active assailant should be mentally prepared to fight for their lives, by using weapons, throwing objects, acting aggressively, and yelling. Instructions for self-defense can help change the mind-set from victim to fighter.

Community awareness

Unfortunately, mass shootings are not isolated events.

“You’re fooling yourself if you don’t think this can happen in your community,” Messinger said. “It can and does happen everywhere as we have seen in recent years.”

And while the Active Assailant (Shooter) Protocol provides a proactive emergency communication center response, Messinger also suggests development of preplanning strategies that apply to the public and responders.

For example, since the shooting five years ago at Virginia Tech that left 32 dead, schools have staged drills with law enforcement agencies and installed additional security cameras. Agencies may also consider assigning Incident Command responsibilities to the communication center and EPD the moment the first call comes in reporting an active assailant, just in case.

“This allows the limited number of first responders to focus on the information being relayed and how best to deploy at the scene, rather than multitasking,” Messinger said.

“That might sound unconventional, but how many communication centers are already performing this function without any specific training at all,” he continued. “Professionally trained calltakers and dispatchers working with their responders can make a difference in our callers’ lives.”

Sources

3 See note 1
6 See note 2.
YOU MUST BE POLICE CERTIFIED TO TAKE THIS QUIZ.

CDE-Quiz Police

Answers to the CDE quiz are found in the article “Active Shooter,” which starts on page 38.

Take this quiz for 1.0 CDE unit.

1. What is an important qualifier distinguishing Protocol 136: Active Assailant (Shooter) from the existing PPDS Protocol 106: Assault/Sexual Assault?
   a. the suspect’s “unrestricted access to additional victims”
   b. the type of weapon used
   c. the number of people killed and/or wounded
   d. the age of the assaulter

2. Prior to the mass shooting at Columbine High School, the traditional law enforcement response to an active assailant favored:
   a. making radio/voice contact with the suspect before going into the area.
   b. sending in one marksman.
   c. alerting administrators on scene to relay information while coordinating the building’s evacuation.
   d. an attempt to cordon off the area and await the arrival of Special Forces, such as SWAT teams.

3. Protocol 136 adds which of the following to the PPDS?
   a. a DELTA determinant
   b. an ECHO determinant
   c. a “G” suffix to delineate a gun was used
   d. a checklist describing the suspected assailant

4. For active assailant situations discovered during Case Entry, the EPD should:
   a. initiate a 136-E-1 response.
   b. provide Case Entry PDI-a.
   c. go to Protocol 136 immediately after completing Case Entry.
   d. all of the above

5. Unlike most ECHO determinants, the links to Pre-Arrival Instructions (PAIs) appear within the Key Questions of Protocol 136, rather than directly from the Dispatch Life Support (DLS) Links in Case Entry.
   a. true
   b. false

6. The new weapons suffix code “M” stands for:
   a. Machine gun
   b. Machete
   c. Multiple weapon types
   d. Mobile attack

7. The Key Question “When was the last time you heard shots fired?” aids the calltaker in determining:
   a. activity level of the assailant at the time of the call.
   b. callers with the most up-to-date information because of their proximity to the assailant.
   c. both a and b

8. Individuals on scene should be encouraged to move the wounded, despite the continued threat of an active assailant.
   a. true
   b. false

9. A LOCKDOWN situation refers to:
   a. immediate evacuation through the nearest exit.
   b. getting individuals on scene out of plain sight, such as telling them to go into a confined space and locking the door.
   c. surrounding the suspect until police arrive.
   d. police attempts to put the suspect in a locking hold.

10. Individuals who cannot flee from the active assailant should never be told to mentally prepare to fight for their lives; instead, they should be told to talk the active assailant into giving up his or her gun.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 02/28/14. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
Suicidal callers often want to be heard

By Audrey Fraizer

Editor’s Note: Results of a recent Journal survey showed interest in the topic of suicide and the use of protocols. While the bulk of this article provides new information, we are also providing protocol-specific information from the Jan/Feb 2011 issue.

Cindy Agacki had just started working the 7 a.m. to 3 p.m. shift on Oct. 2, 2011, at Wood County (Wis.) Dispatch when she answered a call that jump-started her day.

“The caller was suicidal,” she said. “He pretty much told me right away. He said I needed to get someone there right away because he was suicidal.”

The already urgent phone call turned even more desperate in the moments to follow. The VOIP 9-1-1 call was mapping him in the city of Marshfield in Wood County, although the caller said he was (nearly 145 miles away) in Green Bay (Brown County). Agacki’s coworker notified authorities in Marshfield and then Green Bay once it became clear where he was.

For the next 14 minutes, Agacki stayed on the call.

The caller told Agacki that he had a gun (.357-caliber Magnum) and had his house rigged to kill anyone who tried to enter or leave the house.

She listened and acknowledged what he was saying, relying on experience from nearly eight years in emergency communications and skills she had learned in a hostage negotiation course sponsored by the Federal Bureau of Investigation—skills that keep hostages out of harm’s way and end with no one getting hurt.

“I knew I needed to stay on the phone with him,” Agacki said. “I was nice to him. I tried to establish rapport, to let him know that I was really there to help.”

Agacki changed her line of questioning to go with the flow of interrogation. She ultimately convinced him to come up out of the basement and surrender himself and his gun to deputies. The man surrendered, and no one was hurt.

Agacki doubts she will forget the call she answered in October 2011. For a call unique because of the routing from Green Bay and Agacki’s skills at talking to the caller, she was honored with the Dispatcher of the Year/Critical Incident Award from the Wisconsin chapters of the National Emergency Number Association (NENA) and the Association of Public-Safety Communications Officials (APCO).

The statistics

Data available from the Centers for Disease Control and Prevention (CDC) shows that 38,364 suicide deaths were reported in the U.S. in 2010, placing suicide as the 10th
leading cause of death in the U.S. Every 13.7 minutes someone in the U.S. dies by suicide; people aged 18–24 years had the highest rate of homicide in 2009, whereas people aged 45–54 years had the highest rate of suicide. The rate has been increasing since 2000.

Ninety percent of suicides are the result of a diagnosable mental illness, according to the National Suicide Prevention Lifeline. The three leading disorders that cause suicide are: bipolar disorder and depression, alcohol abuse, and schizophrenia. Experts have also said the increases might also be a reflection of the nation’s economic hardship.

Wood County Dispatch Director Kelly Zenz attributes depression accentuated from factors such as a stumbling economy and unemployment to the increase in the number of calls related to suicide. The unemployment rate in Wood County was 7.3% in August 2012, although the rate varies partly due to the cluster of seasonal industries such as leisure and hospitality. The housing slump produced a 122% decrease in construction jobs between June 2010 and June 2011.

Although reasons leading to self-destruction vary and generally involve more than one factor, there are similarities in the reasons people call and the response they receive. “Sometimes the callers want someone who will listen, while a couple of times the person doesn’t wait for help to arrive,” Zenz said. “The majority of the time, it’s someone calling for the suicidal person. No matter, we treat each caller with empathy and respect.”

Unpopular topic

Despite the prevalence of suicide and the increasing number of people attempting and actually committing suicide, it’s not a topic discussed at any length during dispatcher training courses. According to statistics from Public Safety Training Consultants (PSTC), suicide is discussed for less than 30 minutes in most POST-approved dispatch academies; for every one successful suicide, there are 50 others calling 9-1-1 or suicide prevention lines before or during an attempted suicide.

“People don’t want to talk about things that stress them, especially in professions where stressful situations happen all the time,” said Jim Marshall, a mental health clinician and 911 Training Institute director.

But just talking to a person threatening suicide isn’t something that should be done on the fly. In fact, while establishing rapport is vital, the ability to manage the call effectively also takes intensive training through a course backed by research-driven processes for assessing the caller’s risk, Marshall said.

“Managing suicide calls takes knowledge of the science behind mental health issues and a conscious process on the part of the dispatcher to manage (his or her) stress response,” he said.

Marshall, who presents mental health seminars to help 9-1-1 dispatchers manage stress, said effective call management requires dispatchers to turn their physiological and emotional reaction to the suicidal caller into positive energy that builds a life bridge for the caller.

“That may sound cheesy,” he said. “But we have to acknowledge our own ambivalence. Part of you is telling you to distance your emotions from the caller, while the other part is telling you to help the best way you can. The point is becoming aware of your own stress cues so that you can take effective action.”

Recognizing the physiological impact—such as a "gut reaction"—can turn the "I can't get close to this caller" ambivalence into "I can do this." It's a matter of the dispatcher balancing empathy with detachment. In other words, the dispatcher can assist the caller while, at the same time, manage his or her own well-being. That ability to push toward a connection, rather than over distancing for the sake of protecting the dispatcher's feelings of vulnerability, can provide a buffer to keep the person from falling off a cliff.

“Yes, the dispatcher’s primary job is to assure the safety of the caller and all those on scene, but equally important is building a life bridge of empathy,” Marshall said. “By doing that, you’re showing the caller you can listen carefully. You’re trying to help the person choose life, instead of death, as a solution while waiting for the field responders to arrive. They know they are truly being heard and cared about.”

Marshall also strongly advised a direct approach to the call.

“Now is not the time to indirectly ask about intent,” said Marshall, who specializes in training in building life bridges to suicidal callers. “While you may be afraid that asking, ‘are you thinking of killing yourself’ will increase the risk, the research doesn’t support this. You can ask the question. A caller is apt to feel more understood if asked directly.”

Agacki, who has answered several 9-1-1 calls from suicidal individuals, said empathy is an important first step in approaching the caller. “Once they know that you are there for them, things tend to go more smoothly,” she said.
Ultimately, however, the outcome is up to the caller; no one can control another individual’s behavior or choice.

“If they really want to end their life, they will,” Agacki said.

Marshall, who has gone through the emotional pain of suicide among people he has counseled, said the chance of that happening might take a readjustment to the way a dispatcher frames the idea of success.

“Success is not solely dependent on you saving a life,” he said. “It’s awesome that you can, but it’s not your job to save lives; it’s your job to help save lives.”

Protocols

The Medical and Police Protocols take the guesswork out of interrogating 9-1-1 callers, which is particularly important when confronted with someone suffering from severe depression and on the edge between life and self-administered death. Although some dispatchers still think protocols are a “check your brain at the door and just read what’s on the screen (cards),” nothing could be further from the truth. Protocols require thinking, intelligence, and judgment. But more than anything else, they require active listening.

Unlike other protocols, the Chief Complaint of suicide poses one instance in which the dispatcher is put in the position of enhancing the conversation when talking to the first-party caller.

“The call puts the dispatcher in the position of negotiation,” said Marie Leroux, consultant, Priority Dispatch Corp.™ “This might sound like a heavy responsibility, but, in most cases, the suicidal person is asking for help. What you say and how well you listen might be the consoling voice the distraught caller requires.”

The Police Priority Dispatch System™ (PPDS®) and the Medical Priority Dispatch System™ (MPDS®) delineate responsibilities involved in a combined law enforcement and medical incident.

The PPDS Protocol 127: Suicidal Person/Attempted Suicide Key Questions concentrate on scene safety: whether weapons were involved or mentioned, what type, and the danger a suicidal person may present to the caller or others potentially in immediate danger. Key Questions for first-party or suspect callers (person threatening suicide) also focus on the intended weapon, the person’s description, the person’s feelings of violence, and others who might be with the person in relation to scene safety.

MPDS Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt focuses on the type of medical help the individual may require in a suicide attempt. The Key Questions include a weapons check, but unlike the PPDS, different methods of an intended suicide attempt may shunt to a different protocol to appropriately handle the situation. For example, a suicide attempt involving hazardous materials calls for the use of Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/CBRN, while an intentional overdose of tricyclic antidepressants is best handled using Protocol 23: Overdose/Poisoning (Ingestion).

“What you say and how well you listen might be the consoling voice the distraught caller requires.”

– Marie Leroux

It is important to note the difference between a “suicide attempt” and a “suicide threat.” A suicide attempt is considered an act toward ending life that has been committed. THREATENING SUICIDE is a defined term on Protocol 25, which states: “Persons who are threatening to commit suicide but have not yet done anything to harm themselves.” A specific Determinant Code (25-B-3) exists for local assignment to formulate the appropriate response for these situations.

Determinant Descriptors tell the rest of the story, distinguishing the principal elements governing the protocols and their main priorities: PPDS—scene safety and control, and MPDS—scene safety, medical care, and response.

In the PPDS, Determinant Codes may be given suffixes to delineate the specific type of weapon, especially in response to an ATTEMPTED SUICIDE or THREATENING SUICIDE situation. This suffix provides law enforcement with vital information about the weapon in order for responders to secure scene safety upon arrival. For example, the suffix code G indicates to a responder that an individual on the scene may be in possession of a gun; the suffix code K indicates a knife, etc.

In the MPDS, the level of response is based on the individual’s medical condition. The dispatcher would initiate a DELTA-level response for a person who is not alert (25-D-1) or a patient with a DANGEROUS hemorrhage from the armpit, groin, or neck (25-D-2). An ALPFA-level response would indicate a person who is non-suicidal and alert (25-A-1) or suicidal (not threatening) and alert (25-A-2).

“Once agencies understand the differences in the protocols, it becomes clear to them why both systems may be needed to address the situation,” according to Brett Patterson, Academics & Standards associate and Medical Council of Standards chair for the International Academies of Emergency Dispatch™ (IAED™). “If the scene is not volatile and the primary concern is clinical, as is the case with an unconscious overdose patient, the Medical Protocol is generally primary, with a secondary police response to address the intentional act. However, a volatile situation, such as a person threatening suicide with a weapon, is likely to require a primary police response, with a locally determined medical response, perhaps in a staging mode.”

But that doesn’t mean the protocol systems are exclusive of one another.

The MPDS Protocol 25 includes a Determinant Code for a defined THREATENING SUICIDE situation, for which the EMD may assign a law enforcement response with or without an ambulance and address scene safety issues in the Post-Dispatch Instructions (PDI) with advice to continuously observe the individual and protect the person from doing harm to her/himself, if it’s safe to do so. For volatile/criminal situations, a Case Entry item refers the dispatcher to check applicable law enforcement protocol.

Sources
5. Fred Hurtado, The Formidable Four: Correct use of these four protocols takes an extra dash of listening, Journal of Emergency Dispatch, November/December 2007
1. Where does suicide rank in the leading causes of death in the U.S.?
   a. 1st  
   b. 4th  
   c. 10th  
   d. 25th

2. Which age range accounts for the highest rate of suicide (2009)?
   a. 18–24  
   b. 25–44  
   c. 45–54  
   d. 55–69

3. Ninety percent of suicides are the result of a diagnosable mental illness.
   a. true  
   b. false

4. For every one successful suicide, how many others are calling 9-1-1 or suicide prevention lines before or during an attempted suicide?
   a. 10  
   b. 25  
   c. 40  
   d. 50

5. The Chief Complaint of suicide poses one instance in which the dispatcher is put in the position of enhancing the conversation when talking to the first-party caller.
   a. true  
   b. false

6. The PPDS Protocol 127: Suicidal Person/Attempted Suicide Key Questions concentrate on:
   a. scene safety.  
   b. type of medical help an individual might require.  
   c. mechanism of injury.  
   d. foremost symptom.

7. In the MPDS, a suicide attempt involving intentional overdose of tricyclic antidepressants is best handled using:
   c. Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/CBRN.  

8. PPDS suffixes appended to the Determinant Code for ATTEMPTED SUICIDE and THREATENING SUICIDE delineate:
   a. condition of the suicidal individual.  
   b. whether hostages are involved.  
   c. type of weapon involved.  
   d. where the individual is located.

9. In the MPDS, an ALPHA-level response would indicate a person:
   a. who is not alert.  
   b. with a DANGEROUS hemorrhage from the armpit, groin, or neck.  
   c. who is non-suicidal and alert.  
   d. who in the past has attempted suicide.

10. The MPDS and the PPDS are exclusive of one another when determining response for a threatened or attempted suicide.
    a. true  
    b. false
Bouquets of flowers, chocolate-covered fruit, care packages with personal messages attached, and hundreds upon hundreds of e-mails and cards flooded the New-town (Conn.) Emergency Care Center (N.E.C.C.) on the day of and several days after a lone gunman repeatedly shot and killed 20 students and six faculty members at the Sandy Hook Elementary School.

“Every good dispatcher knows what a dispatcher needs at a time like this,” said N.E.C.C. Director Maureen Will. “It’s comfort food; it’s messages of hope; it’s whatever they would like if the same thing happened at their center.”

Two dispatchers and Will were on duty at the N.E.C.C. on Friday morning, Dec. 14, 2012, when the first call came in at 9:35 a.m. indicating someone shooting a gun inside the elementary school. According to local news stories, the caller reported hearing gunfire, and said she believed the gunman was still inside the building. The rapid-fire shooting was heard coming from the school over a period of about 11 minutes. By 10 a.m., first responders were beginning to discover the extent of carnage.

While Will could not speak directly on the incident or response because of ongoing investigations, she did acknowledge the tremendous outpouring of support and compassion that pulls hard on her emotions and those of her dispatchers.

“I am so proud of being part of the telecommunications community,” Will said less than a week after the tragedy. “Centers from all over this country and Canada came together to show us their love and support. It’s been phenomenal.”

Will, who has 35 years public service, stayed throughout the long morning extending late into the day, answering calls alongside her dispatchers, constantly monitoring her crew for signs of stress. The Connecticut State Patrol had three dispatchers and a trooper working during the shooting.

A N.E.C.C. dispatcher on duty during the distressing incident returned to work five days later anticipating—and answering—a large volume of calls that had since progressed to the stage of grief and mourning.

“The funerals are now starting, and it’s difficult,” Will said. “My dispatchers have been incredible. They are doing very well, but I’m keeping my eye on them. I take care of my people. We take care of each other.”

Will printed each and every e-mail, coming in by the hundreds, and placed them on the consoles to read when the dispatchers have a chance to look through the notes of compassion and gratitude.
“I will respond to everyone when I can,” she wrote in a message posted on the 911 Cares activation site. “The tears do come but we are standing tall and proud knowing that we did our best.”

**Extending care**

The profession’s universal caretaker—911 Cares—responded immediately on the morning of the shooting, arranging for a local pizza parlor to deliver three of their most popular pies and, as their way to help, the pizza parlor (Carminuccio’s Pizza) promised to make sure the dispatchers received pizza and salads throughout the day and night at no charge.

“This is the best analogy for 911 Cares,” 911 Cares Founder Kevin Willett wrote on the activation site. “People want to help or appreciate or honor or mourn. Dispatchers want to support their own.”

911 Cares also dedicated a Web page to news updates and addresses to send well wishes and activated a free and confidential critical stress e-mail for telecommunicators needing an “ear to listen or a shoulder to lean on.” The e-mails were directed to a team of 9-1-1 dispatchers trained in stress management.

Several other organizations also sent or posted messages of support.

On Monday, Dec. 17, the National Emergency Number Association (NENA) posted the following message on its website: “At NENA, our thoughts and prayers are with the Newtown, CT, families, first responders, and 9-1-1 call takers. We are moved by the many acts of heroism and selfless public service that occurred amid this terrible tragedy, and we are mindful of the profound responsibility that 9-1-1 professionals bear in such situations.”

That outpouring of support means a lot to the Newtown ECC staff.

“We feel the love from our community and know that this is going to help us through a long rocky road,” Will wrote in the message posted on the 911 Cares site. Then later over the phone she said, “We are eternally grateful to be part of a community that cares so much about one another and constantly looks out for one another.”

The Newtown ECC dispatches police, fire, and EMS for Newtown. The staff of 10, including Will, answered 7,068 emergency 9-1-1 calls in 2010. Two dispatchers are on duty at all times.

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**REALPEOPLE**

**Coming Back From The Abyss**

A PTSD/EMS survivor tells his story

By Michael Swainson

For the first 18 years of my career as an EMT/primary care paramedic in the Yukon Territory in Northern Canada, I could not wait to get to work. I loved what I did and I was good at it. If I was not working my regular shift, I was working overtime, volunteering for the Canadian Ski Patrol, or teaching EMT classes, disaster management, or auto extrication. I became my job and never turned off “Michael the Medic.”

As an EMT with Yukon EMS, it was part of the job to take a regular turn as the EMS dispatcher. As with street work, I thrived on the adrenaline of 9-1-1. I was “being given the ball” to manage the caller’s emergency.

In the end, the ball nearly knocked me out. After 21 years in emergency care, I was diagnosed with post-traumatic stress disorder or PTSD.

Even in a small service provider like Yukon EMS, critical incident stress is present. Critical incident stress can come in large doses (e.g., the death of a child) and small doses (e.g., a car accident with a fatality, or giving CPR instructions to someone who refuses to listen). No matter the intensity, every bad call adds a rock to your emotional backpack. Some rocks are small, some are mid-size, and some are downright huge.

Most of us don’t pay attention to the small rocks. While people outside the field of medical emergency response might consider a fatality something more than a small rock, it’s an all too common part of our profession; everyone in the field has responded to the scene or dispatched a unit to a fatality. During my 21 years of combined work on the street and in dispatch, I probably dealt with about 150 to 200 fatalities. The majority—95%—was people with no link to my life, although each call would add another small rock to my emotional backpack.

Let’s think about this emotional backpack. If I put a small rock in my emotional backpack can I still jump up and down? Yes, I can. What happens though when I put 150 small rocks in my backpack? Can I jump up and down? No, I can’t. Now what happens when I put those 5 or 10 big rocks in my backpack from the dead children or dead friends that I saw in my career? Or worse, I add those 5 or 10 really big rocks to the 150 little rocks already in my backpack. What happens then?
Some might not fall down. They’re the ones taking care of themselves, listening to cues, and paying attention to the signs of stress. Others, like me, who never put the job away, aren’t so lucky. Eventually, we keel over under the weight.

My advice: “Do not let this happen to you!”

Dispatching first response is an incredibly stressful profession: lousy hours, too much caffeine, junk food instead of healthy selections, and taking abuse from callers complaining about “all of your stupid questions.” Throw in a management team that never shows their appreciation for their communications officers and where do you think you will end up?

During my EMS career, I had what I like to refer to as “The Big 3”: three very traumatic calls to me personally without my seeking critical incident stress management (CISM) for any of them. I was not a big believer in “sitting around, holding hands, and singing Kumbaya.” This was my very wrong impression of critical incident stress management. The big three were:

1. The death of an infant from sudden infant death syndrome was unbelievably traumatizing to me, the responder on the call. I did not sleep for a week after this incident and found myself wanting to hug my infant son constantly.

2. I still remember quite vividly trying to ventilate a patient with a bag valve mask and seeing blood, saliva, and air coming out of two holes in his forehead after an industrial accident. About 20 minutes after arriving at the hospital with him, I discovered he was a friend of mine. This was the only time in 21 years that I had to sit down after a call.

3. The most traumatizing call in my career is a failed rescue. I responded to a car accident that involved a minivan in a head on collision. We tried for over an hour to extricate her from the vehicle. We pushed, we pulled, we twisted but nothing worked. She died right in front of us. I knew her. Her son and my son were in the fifth grade at their school and I had seen her in the school only a couple of days before. The call happened late in the afternoon and I just knew that her family was thinking, “How come mom is late for dinner?”

These three calls—the big rocks—added heavily to the weight of the many other smaller rocks accumulating in my backpack. I had never emptied any of them and suffered the consequences. I couldn’t turn off the stress and it was getting progressively worse.

I understood why so many first responders turned to addictive behaviors—alcohol, over-the-counter medications, gambling, shopping, computer gaming, and sex. Addictions take away from the pain, at least temporarily. And when they stop working? Your mind tries to turn off the pain permanently. Suicide is the last act of somebody so incredibly desperate to turn off the pain. I wasn’t there, but almost. I came to view PTSD as a workplace injury. It is not a mental illness. PTSD is a normal human response from repeated exposure to horrific trauma either experienced over the phone or in person on the scene of the emergency.

The Yukon Workers Compensation Board (WCB) and I fought over compensation for 13 months, and in the end I won. For me it was not about the money or getting my sick time back. I wanted the board to acknowledge PTSD as a workplace injury. Apparently, the board did. Six months ago I lost a staff member to repeated traumatic exposures from his time as an EMD™ and a street medic. The Yukon WCB approved his claim in two weeks.

My advice to you

You need to look after yourself. When you have a bad call, tell someone about it. If you have had a run of bad calls go see your employee assistance program (EAP) provider or a counselor. If your agency provides a Peer Support Team, go and see them. If you don’t have a Peer Support Team, talk to your supervisor or chief about establishing one. Talk to a peer, go to a debriefing after a critical incident, eat right, get exercise, and, most importantly, take time away from the job to do something relaxing just for you. It will help get your head back in the right place.

If you plan to survive as an EMD, find that escape. I live in a small city surrounded by mountains covered with snow six months of the year. When I put on my helmet and hop on my snowmobile, I leave the EMS Communications Centre that I supervise a million miles behind me. Find something! Don’t let the rocks crush the life out of you!

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#### GIVING BACK

**Heartfelt Legacy**

AED gift commemorates donor’s better half

Elizabeth “Betty” Dunn’s tendency to make decisions based on another’s feelings complemented her husband William’s more logical approach to problem solving. She was the better of the two, “Bill” would insist, and her legacy represents the very best of both of them.

Bill and Betty met some 55 years ago at a social event. The two, both in their early twenties, developed a friendship, but it wasn’t until six months later that the relationship took a turn from the platonic. Bill was scheduled for knee surgery at the same
Betty entered nursing as a student at Clatterbridge Hospital and after qualifying as a state registered midwife she started again as a surgical ward sister at the same hospital. Part II of that training, the practical section, was conducted on the Isle of Wight where some of her patients were inmates at HMP Parkhurst.

Betty qualified as a state registered midwife and returned home to Wirral, but her next appointment put her back at Clatterbridge in charge of an operating theater. Betty’s move to St. Catherine’s Hospital as surgical ward sister represented the epitome of her career. She shined. Responsible for a “Nightingale ward” of 32 surgical beds, she worked 24/7 in split shifts, and during surgeon-scheduled operating days, she would stay well past her normal finishing time to coordinate her patients’ continued care.

“There were many times when I picked her up that we were too late to even get a take-away meal,” Bill said.

Betty was headstrong, Bill said, but that only lent itself to her impeccable reputation among the surgical and medical staff. Retired Surgeon and Physician R.B. Crosbie, who worked with Betty at St. Catherine’s (later at Arrowe Park Hospital), told Bill that she managed the most efficient and hygienic surgical ward sister represented the epitome of her career. She shined. Responsible for a “Nightingale ward” of 32 surgical beds, she worked 24/7 in split shifts, and during surgeon-scheduled operating days, she would stay well past her normal finishing time to coordinate her patients’ continued care.

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“Seventeen years without any patient coming down with a post-operative infection is an incredible record,” Dr. Crosbie said and, with a wry smile added, “I like to think that the contagious bugs were afraid of her.”

Betty’s headstrong nature also meant a bee in her bonnet would never buzz its way out until acted upon. The resolve tied to her greatest fear produced a way Bill could give back to the community in memory of his wife of 51 years.

“She didn’t like it when people got the wrong impression about a medical procedure,” Bill said. “We were chatting about this and it really bothered her how TV portrayed the use of a heart defibrillator. She knew how they worked but the way it was showed she said would put the fear into people. They would never want to use one in case of an emergency, even if one was available.”

Before Betty’s death, the couple agreed to donate an automated external defibrillator (AED) to a charitable cause, and that’s where Beverley Logan, accreditation officer, International Academies of Emergency Dispatch (IAED™), comes in.

Bill, who is a member of the West Lancashire Chapter of the Masonic Brotherhood, and others from lodges in Lancashire and Cheshire, attended a CPR talk Logan was giving at the Bryn Masonic Hall in Wigan; Bill was immediately impressed and afterward approached Logan about his desire to keep his promise to Betty.

Logan was intrigued.

“My personal objective has been to increase the number of AEDs in the community and his quest was to continue with his wife’s lifelong commitment to helping others,” Logan said. “I agreed to help.”

Since that fateful meeting two years ago, Logan and Bill have teamed up to urge public support of critical care for out-of-hospital victims of cardiac arrest.

He has donated three AEDs to three separate Masonic Halls and arranges training from the North West Ambulance Service National Health Service (NHS) Trust, who is in constant and daily use of the Cardiac Science Defib. Certification is maintained on the NHS database. Prior to Bill’s announcing the donation, Logan preps the audience on the importance of bystander intervention and the 9-9-9 process.

“How people understand how emergency services work and the guidance and support available when making the 9-9-9 call, they will have the confidence to do the right thing,” Logan said. “And that’s helping patients survive.”

Logan and Bill have become mutual admirers. She admires his devotion to Betty’s memory and the civic good of Free Masonry; he admires her dedication to pre-hospital care and AEDs.

“Beverley is a lovely person,” Bill said. “Nothing is too much for her when asked to help and she never rushes with her audience. She makes sure everyone understands and without that understanding the whole gifting would be pointless.”

Life-Sustaining Gift Bill Dunn has donated three AEDs in memory of his beloved wife Elizabeth, a former nurse.
Changing Places
New digs accommodate growth in central downtown setting

Audrey Fraizer

Windows mathematically designed to the exact measurements of the columns in the daily newspaper supported the Deseret News’ “masthead” at the top of the nine-story building. A staircase enclosed in a circular glass tower running parallel to the columns suggests a newspaper’s fold, an inviting offer to imagine the stories percolating inside.

The company selected to design and construct the future 72,000-square-foot D-News headquarters anticipated the challenge it would find in combining “progressive” and “traditional” appeal to reflect the past while, also, reinforcing the future of the 147-year-old daily newspaper.

But that’s the way it had to be. The newspaper was an institution that the new high-tech facility could help move into the future.

“Any institution which has served continuously since 1850 is entitled to a new building,” said President Gordon B. Hinckley of The Church of Jesus Christ of Latter-day Saints at the building’s dedication on May 28, 1997, and attended by more than 200 invited guests. “With this new facility, one of many it has occupied during its long history, it is poised to move forward to a better day than it has ever known.” (Deseret News, Wednesday, March 28, 1997)

For more than a decade, the 180 members of the newswriting staff produced a daily newspaper in an efficient and technically building savvy architects believed essential for the deadline driven newspaper staff. The “color palette” of the interior created a calming environment and the large exterior windows provided spectacular views of the city and, to the east, the Wasatch Mountains.

The views, central location, exterior aesthetics, and unique floor plan made the building the ideal choice for the International Academies of Emergency Dispatch (IAED™) and Priority Dispatch Corp.” (PDC™).

“We couldn’t ask for a better location,” said PDC President Alan Fletcher. “We’re in the heart of a downtown that’s turning heads here and abroad. We’re very excited about making the IAED a visible part of the progress we’ve seen in the past several years.”

While the move also makes sense for practical reasons—projected company growth, for example—there will always be a bit of nostalgia attached to 139 E. South Temple. South Temple has been Salt Lake City’s most prestigious address since the city was settled and Dr. Jeff Clawson, Academy co-founder, had long admired while growing up not far from the offices the IAED occupied for a quarter century.

The original home of Lodge No. 85 of the Benevolent and Protective Order of Elks
(B.P.O.E.) was constructed in 1923 at a cost of $300,000, which paid for the 1,300-seat lodge room, a grand dining room, an extensive library, billiard and card rooms, and more than 50 sleeping rooms. The main entrance, reached by the stairs on either side of the tunnel, opened (and still does open) into a lobby featuring marble-sheathed columns and gold-leafed ceiling moldings.

The Roman-arch tunnel between the building proper and the South Temple sidewalk led to a gymnasium where many boxers practiced their first punches. The Elks introduced West Jordan, Utah, native and former Middleweight Champion of the World Gene Fullmer to the sport through the Intermountain Amateur Athletic Union (AAU). The Elks hosted Golden Gloves matches held in the commodious lodge room.

The Elks sold the building in the mid-1970s. Several additions were made to accommodate the tastes of the new tenants, including a sixth story on the roof and a two-story glass enclosure on the east side. The patio below was the outdoor section of the city’s hot spot bar on the Wasatch Front and written up by Playboy Magazine as one of the country’s 20 best. You could dine on Northern Italian cuisine at the Confetti Restaurant, open on the ground floor in 1983.

Senior Journal Editor James Thalman, a former Deseret News health and business writer, remembers attending a Three Dog Night concert on the ground floor during the 1970s and any boxing fan will tell you about the matches held in the former lodge room.

The Academy started on one floor (the sixth floor) and expanded to offices on the second, fourth, and fifth floors and warehouse space on the ground level.

Tudy Benson, IAED director of European Relations, recalls her arrival 17 years ago, hired as the Academy’s German translator. Dr. Clawson was in the office Fletcher occupied until December’s recent move of less than a half-mile south and west and Academy Co-founder Bill Lloyd was in the corner office behind her.

The small group shared a mutual admiration for the building, both the architecture and interior design (such as the crown molding on the second floor), Benson said.

“Change is the way the future reveals itself,” he said.