Going Places
Advances in science begin with a question

Not Always a Pretty Picture
Uncertain world guarantees something bad happening

Service Gene
Answering emergencies carries down the line

The International Academies of Emergency Dispatch

January | February 2014

THE JOURNAL
OF EMERGENCY DISPATCH

Take A Little Trip
Visit communication centers that vary just like the people staffing them

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at the **right** time.

to the **right** people
—every call.
Protocol Fits All Sizes

We introduce you to two centers—one in West Virginia and the other in South Carolina—and a business pushing its way past the perception of being the red-headed stepchild of emergency communications.

Anticipating Mass Casualties

A two-hour multi-agency field exercise manages to provide a reality check for handling the mother of all emergencies—the mass casualty incident.

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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; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234. 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.
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8 | ACADEMY RESEARCH

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9 | POLICE BEAT

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10 | HEADSET CONFESSIONS

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**Red Light, Green Light**

It’s not a game when lives are involved

**Audrey Fraizer, Managing Editor**

D o you remember playing the game “Red Light, Green Light” as a child? Most people played that game growing up, but as adults, it seems many have forgotten what it means when the light turns red.

Simply speaking, it can kill people; we die because drivers run light’s on red turned to red before they reach the intersection.

This afternoon during my daily walk, I saw examples epitomizing negligent driving. A middle-aged man in black pickup truck gunned the engine when the light turned red, and he was still at least 50 feet from the corner. He was hunched over the steering wheel as if living a Walter Mitty fantasy of racing in the Indianapolis 500.

It’s not only men that are culpable of automobile homicide.

Three blocks farther along during my afternoon walk, a woman close to my age (middle-aged plus) bolted right on a red without so much as glancing at the crosswalk. She was far too busy driving to wherever she was going to care about the people her red SUV could have barreled down dead.

From where I stood, neither of these drivers appeared to have cellphones in hand, although I certainly see a lot of that during my daily bike rides and walks.

I don’t think the problem is specific to Utah roads and the state’s failure to enforce traffic laws, and I certainly don’t think the majority is out to put others in danger. They essentially put others in. They essentially distrusted by their worlds; they fail to recognize the jeopardy they are putting others in. They essentially don’t care.

The aggressive driving behavior bugs me to no end, especially when looking at the statistics.

Red-light running is the leading cause of urban crashes and, according to the Federal Highway Administration, about 100,000 accidents and 1,000 deaths occur in the U.S. each year because one of the drivers involved was in too much of a hurry to stop at a red light. The driver accelerates instead, jeopardizing drivers, bicyclists, and pedestrians.

Fridays and holidays are the most hazardous along with certain holidays. Memorial Day is the worst.

A crash caused by a driver who runs a red light is more likely to result in serious injury or death because they’re almost always T-bone crashes, where the front of one vehicle collides with the side of another. Since the side of an automobile is one of the weakest points, it is far more vulnerable to an impact. Most of the victims are the drivers of the other car or pedestrians.

Running a red light might save—at the most—two minutes. Two minutes. It’s about the same amount of time it takes to play a round of rock-paper-scissors or fill and drink a glass of water. Two minutes. Does that justify the potential of taking somebody’s life? I don’t think so. And I wish more people would think about that the next time they are given the choice to stop or run.
**One Out, Then Home Run**

New public safety building took a couple at bats

Scott Freitag, IAED President

Before I launch into describing Salt Lake City, Utah’s, new Public Safety Building (PSB) and the benefits to 9-1-1 communications, I offer my apologies to others that have gone—or are going—through these same processes of facility development and consolidation. I certainly do not intend to downplay another center’s achievement.

As Salt Lake City’s 9-1-1 Communications Bureau director, however, this is where I am most familiar, having been involved from the start. I would venture that our experience mirrors that of others, and that includes overcoming obstacles in funding, which is an important point I want to make.

Our first referendum to fund the new PSB was voted down. Post-election analysis determined voters saw the urgent need for a new public safety facility, but felt the proposal was both too costly and too vague.

Heeding the message, Salt Lake City Mayor Ralph Becker directed city staff to develop a more detailed proposal focused on immediate public safety needs, a more cost-effective facility, and potential partnerships with other governmental agencies. After nearly a year of public input, study, and analysis, the city presented a scaled-back proposal consisting of a new Public Safety Building and Emergency Operations Center with potential build sites. This time 65% of voters approved the measure.

The 172,000-square-foot PSB houses police, fire, and emergency operations. Because of equipment and testing, dispatchers anxiously bided their time and were the last department to move in. We went “live” at 2 a.m. on Oct. 1, 2013.

A week prior to our move from our former space, Salt Lake City Police Chief Chris Burbank invited me to help host a video tour of the building as part of the chief’s ongoing series to improve public understanding of the police department. Burbank works hard to keep the public informed about his department and, aside from that, we didn’t want cameras and lights interfering with emergency response.

The video gives a quick review of the technology governing the 9-1-1 system, with the emphasis on the 80 people—calltakers, dispatchers, and supervisors—who handle an estimated 550,000 calls a year.

Time on camera was short and dialog was to the point.

I opened with the “different as night and day” understatement, comparing the new center to former dispatch operations housed in an office building (circa 1957) never intended for emergency services. Ceilings leaked, elevators stopped between floors, plumbing clogged, and office space was so limited that closets large enough to accommodate a desk were assigned to an increasing number of first responders and administrators needed to run public services.

The former building was a hazard waiting to happen. The only existing evidence of its recent past is in storage, and Salt Lake City police were (at this writing) in talks with a neighboring city with a proposal to create a joint evidence and crime lab. However, storage areas at risk of flooding will require structural repair.

Our new building is designed for emergency services. Starting from the ground level, architectural precast concrete panels inset with a terra-cotta veneer were designed to withstand an earthquake of up to a magnitude of 75, the predicted scale of the “big one” estimated to hit anytime along the 240-mile Wasatch Fault. The building is designed to be fully operational immediately following such an earthquake. And it’s set back 50 feet from the street to ensure the structural integrity of the building in the event of a vehicular explosive device.

Police, fire, and medical dispatchers are answering 9-1-1 calls and sending response from the same room (before the move, public safety operations were separated between floors and an annex building). Everyone is cross-trained and certified in the use of the police, fire, and medical protocols, and the Internet-based system gives us the ability to send and accept calls from the other communication centers in the valley.

During the July open house, many people noted the “light sabers” at each console. The color-coded lights (each having a stack of red, yellow, green, and blue lights) blink to indicate the status of a call, giving supervisors seated in an elevated portion of the center a full view of what’s going on.

Burbank was genuinely enthusiastic about the technology and aesthetics; however, he also made sure he gave the highest praise to the calltakers and dispatchers carrying the load. “The bells and whistles and technology are incredible,” Burbank said. “But, as we can all agree, the people who will work here are the most important. They are the ones who make the difference.”
**Why Do I See Red?**

Lines in cardset emphasize important instructions

_Brett Patterson & Irena Weight_

_D_

o Academy experts have all the answers? Generally, yes, but sometimes even the people constantly immersed in the development of the Medical, Police, and Fire Protocol find questions requiring clarification from experts closer to the subject. When that happens, we assume that the same question or, at least, a derivative of the question must be circulating among our membership. In a nutshell, that’s why _The Journal_ will periodically feature the column “Experts Ask The Experts.”

In way of introduction, we have expert Brett Patterson, Academics & Standards associate and Medical Council of Standards chair for the International Academies of Emergency Dispatch (IAED), asking a question answered by expert Irena Weight, PDC, director of Translations, Standards, and Logic Design.

_Brett’s Question:_

Is there some purpose for the light red lines around certain PAI panels in the MPDS® cardset, i.e., Panels C17/15a, B12/18/18a?

_Irena’s Answer:_

I wouldn’t say they are completely unexplained. They were first added in v11.3, and the reason would require some digging in our old protocols drafts, which likely are already archived off-site, to pinpoint the exact time when this happened, although the archives may still not contain the exact explanation of why the lines were added.

I recall that they were added to graphically group all of the panels pertaining to breathing evaluation. The idea was that EMDs using a cardset only, without ProQA®, could go to this block of PAI panels at any time they questioned the patient’s breathing. This would be similar to how ProQA users can open the Agonal Breathing Diagnostic in ProQA in the same circumstances.

_Thanks,_

Irena

_SOMETIMES EVEN THE PEOPLE CONSTANTLY IMMERSED IN THE DEVELOPMENT OF PROTOCOL HAVE QUESTIONS._

_Brent’s reply:_

I had a chance to speak with Dr. Clawson today and he basically confirmed your recollection, at least with regard to the grouping of very important information or instruction. The original idea was to group areas of PDIs that we wanted EMDs to, in Doc’s words, “be absolutely sure to get it right.” This makes complete sense with regard to breathing evaluation, breathing status, and use of the AGONAL BREATHING Diagnostic in the PAI sequence. If a patient is reported to have started breathing during CPR, we better make absolutely sure the patient is actually breathing before we stop compressions and move to the Maintain and Monitor panel.

As you know, information concerning this graphic is not currently included in the EMD curriculum. Instead, in v12.2 we created a new symbol [see red question mark above] for the mandatory use of the AGONAL BREATHING Diagnostic that is situated in the ABC protocols next to the “Started Breathing” links. This symbol was added to create a concrete link between the report of a patient in arrest starting to breathe and the definitive use of the AGONAL BREATHING Diagnostic. The red lines remain as a remnant and a subtle reminder to “be absolutely sure to get it right” in these very important sections of the protocol.

I have been associated with the MPDS for more years than I care to recall and yet I still seem to learn something new about it on a regular basis. You, and other dedicated people like you, continue to make this complex and yet elegantly simple tool the best it can be!

_Brett_
Going Places

Science requires peer-reviewed literature to advance

Tracey Barron

Scientists conduct research for many reasons and while findings could mean the next Nobel Prize in medicine, chemistry, or physics, recognition cannot be the motivation that, for example, leads to understanding a cell’s transport systems, G-protein-coupled receptors, or (a personal favorite) discovery of the elements radium and polonium by Marie Curie, which received the Nobel Prize in chemistry in 1911.

In other words, research doesn’t have to be groundbreaking, although the quest does originate because of curiosity or the need to solve a problem. Few scientists have the freedom and luxury to select their own problems to solve but instead are employed in an industry and part of a multi-disciplinary approach to develop greater expediency and cost-efficiency in comparison to the competition.

No matter the reason prompting research, every scientist must define the problem in a way that arrives at a conclusion—something to act upon and which lends to the growing body of literature available on the topic. Most often subjects chosen for study have a history—a procession of scholars and academia—and the existing literature requires a systematic review prior to launching what might lead to groundbreaking results.

A library of literature is a priority, and something emergency dispatch was lacking when Jeff Clawson, M.D., proceeded on his idea to develop a medical protocol for the dispatch environment nearly 40 years ago.

At that time—the mid-1970s—dispatchers and dispatch services were the last to receive public funding set aside for emergency services, if considered at all. Moves to recognize dispatch as a profession meant Dr. Clawson starting without a past to fall on; he began dispatch research and experimentation at square one.

Since few, at that time, considered emergency dispatch as any sort of link in the chain of survival, Dr. Clawson first had to establish its value as an early prioritization point. He had to prove the value of dispatchers as providers of responder information and providers of instructions that could help save a life prior to the arrival of response on scene. He needed science to validate the value.

Over the years, the College of Fellows that Dr. Clawson created within the Academy has conducted ongoing review of “standards of care and practice” and an evaluation of the tools to meet or exceed these standards. Its findings have been influential in developing systems to improve dispatchers’ ability to identify and triage a caller’s problem, provide the appropriate instructions or help, and send the most appropriate response safely.

Research and findings have led to recognition of dispatch as a vital link in the chain of survival. The science of dispatch hasn’t stopped. Well-conducted scientific research is adding to an existing although still minimal body of literature providing meaningful interpretation to an increasingly complex system.

How much do we have to draw on?

That was a question asked in a recent study into past, present, and future emergency dispatch research. The team conducting the study reviewed existing literature—a total of 149 papers (114 original research, and 35 seminal concept papers)—to identify both gaps in research and potentially fruitful extensions of current lines of study.

The results weren’t groundbreaking. The curiosity to ask the question and the ability to design the research, however, did provide the first systematic review of dispatch research. The results gave us a catalog of the literature available and identified the gaps in research. We have clearer avenues for future study.

The systematic review revealed four major issues that continue to dominate dispatch studies: dispatch as first point of care, standardization of the dispatching process, resource allocation, and best practices for dispatching. The gaps include a lack of consistent metrics, the near-nonexistence of research in fire and police dispatching, and a relative lack of studies in many areas of interest.

Overall, results indicate a need for greater participation in research by communication center administrators and others “on the ground” in emergency dispatch, as well as increased collaboration between research organizations and operations personnel.

That’s what research is about. We discovered the gaps and, also, have the base of work on which the future progress of emergency dispatch—and future evolution—will be built. For this reason, this is a prime moment in which to identify the priorities around which such progress should grow.

I don’t know if anyone involved in the science of emergency dispatch will ever be nominated for the Nobel Prize. I doubt that’s on any of our agendas. The work has led to the goals of research—knowledge, greater understanding, and the ability to devise new applications—and if that’s the only ground broken, that’s all the motivation I need to continue.
Are you getting everything you want out of your Priority Dispatch System? Much like any other complex system, routine maintenance can go a long way in keeping things working at peak performance. With the hustle and bustle of the holiday season behind us and spring approaching, now is a much-needed time to regroup.

For those not sure where to start, here are my suggested tune-up topics to help reboot your Priority Dispatch System.

ProQA® and AQUA® reports
When was the last time you pulled some of the very informative reports from your system? These reports can provide a wealth of information about how your communication center is really running. How long does it take us on average to complete Case Entry? How long is our average time to cue? Who is doing really well; who is struggling and where?

In working with center staff, they have a “feeling” about how things are going. These reports can help confirm those feelings. With this knowledge, any needed adjustments to training, policy, or procedure can be made based on data rather than emotion. Many centers are closer to ACE standards than they've imagined, and they might already have the documentation to prove it. If you’re already doing the work you might as well get credit for it.

Case evaluations and feedback
Do you have your quality assurance person in place, and is the person reviewing calls? If you have a quality improvement program, is it supported?

Case review and appropriate feedback are vital to a system and as important and comprehensive as the Priority Dispatch System. Case review lets you know how your staff is doing and provides the feedback valuable to performance.

No matter what model of QA you use, case review needs to be done in a timely fashion. If your QA person also has other duties in your center, help them to prioritize the workload by setting aside days solely for reviewing calls and make that known to your staff to keep distractions to a minimum.

In addition, your quality improvement personnel should be looking for ways to support staff in honing their skills and knowledge based on information gathered from case review.

Case review is also the ideal source for continuing dispatch education (CDE) based on the needs of a single person, a shift, or the entire center to maximize performance.

Dispatch committees
Do you have a Dispatch Review Committee and a Dispatch Steering Committee? If you do, are you still meeting and discussing call data, trends, and issues within the center? Meeting with representatives from the agencies you provide services for brings the various facets of public service together and allows for system changes based on a process, in an informed manner, and with contributions from all. A regular review of data, training model, and policies and procedures gives the opportunity to evaluate the entire call processing and dispatching system to ensure you’re providing the best service possible for those served. We may not always agree on everything but, in this way, everyone has a voice in the process.

Response configurations
So far, we have discussed case review, providing feedback to our staff, and meeting together to discuss issues and our call data. Now we can look at our response configurations. Are the appropriate levels of response still matching how you’re doing business today? Are we over, or under, sending on calls? Do we have adequate CADs to accurately portray an incident to our responders?

In working with centers, I have found that many have never gone back to make these tweaks or because of changes in staff or leadership, the knowledge of this process and how to carry it out has been lost.

Getting everything you want out of your Priority Dispatch System starts with you. If you are having issues, these topics are a great place to start to get you back on track. And you’re not alone. If any of these topics sound foreign to you, or you just feel like you need help, contact the Academy and ask about how to get some assistance.
I’m lucky to be a DINK (double income, no kids).

That means my kids are grown and out of the house, and I don’t have the same income and time constraints that I experienced when they were younger and living at home. That means I can enjoy some of the finer things in life, like a foot massage every once in a while and a pedicure every three to four weeks. There is nothing like soaking my feet and having them pampered.

Now this is going to sound strange, and it’s just my own opinion; feet are just plain ugly. If you pay attention to the feet around you, there’s not much in the way of pretty to observe about them. Some are chubby, some are skinny, and some have bunions. The heels of my feet are calloused and the area of skin gets even tougher in the summer from going barefoot.

Toes are really no better looking. They’re ugly and come in funny shapes. Some have hammertoes and some have stubby toes. No matter how hard anyone might try, slipping jewelry on toes or painting pretty colors on toenails doesn’t make toes attractive.

But why in the world am I even bringing this up? Because it’s been my experience that life is full of things that are not pretty. Emergency communication types work in a world full of ugly. We can’t get away from the ugly. We try to dress it up by laughing our way through, but it doesn’t take away from the fact that our world, no matter how hard we try, is full of ugly.

Salt Lake City, Utah, where I work, has dealt with several crazy things that have been downright ugly, and many so ugly that the city made national news.

There was the 17-year-old young man who walked into a shopping mall, carrying three guns and a backpack filled with ammunition. He opened fire, killing five people and injuring four before he was shot dead by police.

A story that continues to make news—first for its terrible nature and, now, for the resilience of its victim—was the self-proclaimed religious radical Brian David Mitchell, who kidnapped then 14-year-old Elizabeth Smart and held her against her will for several months.

It’s hard to find the words to express the hell of working in a 9-1-1 center at the time of such a high profile event. We could set our clocks by Larry King during the first weeks after Elizabeth was kidnapped; every time King talked about it on his TV show, our phone lines were overwhelmed with calls. We handled multiple calls from armchair detectives and psychics. A few psychics actually told us some accurate information that hadn’t been released to the public, but there was no way we could distinguish the credible psychics from the total whack jobs and sickos. Talk about ugly, one “psychic” said he could find our missing girl if we sent him an article of her clothing.

Life in the communication center returned to a steadier state of routine when Elizabeth was found, along with her abductor, in a city close to Salt Lake City. She had talked Mitchell into returning to Utah from California.

In our world of 9-1-1, however, another something ugly is bound to be waiting in the wings, and that’s the degree of normal we always face.

For Salt Lake City, a child again went missing, but this time the story didn’t end well. Her body was found in a neighbor’s home. Next, the body of a beautiful young woman was found wrapped in a bag at the garbage dump because her husband, who reported her missing, decided it would be better to kill her than face up to the multiple lies he had told her.

This is just my city. It’s not a large city. It’s generally quiet. But when I think about the violence here, and magnify that by the rest of the world, it’s easy to let ugly consume me. And the same probably goes for all of us.

How do we deal with the ugly? How do we escape?

I find that battling the ugly takes acknowledging the pretty that exists. The focus has to lie in the life outside our work. The pretty can be our families. The pretty can be our friendships. The pretty can be the ways we indulge ourselves. My feet and toes might never be pretty, but the foot massages and pedicures every few weeks sure help the ugly go away, at least for the moment.
Streamlined
IAED releases version 4.2 of the Police Priority Dispatch System

The International Academies of Emergency Dispatch® (IAED™) has just released an updated version of its Police Priority Dispatch System™ (PPDS®).

Version 4.2 includes several protocol changes that will generally make interrogations for dispatchers processing several types of emergencies, including minor traffic accidents to descriptions of suspects at a crime scene, more succinct.

The changes were two years in the making and based on Proposals for Change (PFC) submitted by current users of the PPDS and reviewed by the law enforcement experts on the IAED’s Police Council of Standards. Combining the PFCs with current research and field expertise, the Council of Standards, on behalf of the College of Fellows, determined the proposals accepted, and how they should be implemented.

Version 4.2 highlights include:

• Collecting descriptions of the demeanor of suspects at the scene as well as possible vehicles involved as part of a new Key Question sequence in Protocol 105: Animal.

• Several changes to definitions and Determinant Codes have been made to emergency calls involving animals, public disturbances, vehicular crashes, and weapons-involved incidents.

“Several elements have been refined and more terms defined, all in an effort to get to the relevant details with far fewer questions,” said Dave Warner, police consultant with Priority Dispatch Corp.™ who helped draft the changes and organize beta testing of the changes.

ProQA® Paramount software is the exclusive operational system for PPDS v4.2. These changes help decrease call taking times, increase accuracy and efficiency, and enhance the user experience. For more information about ProQA Paramount or PPDS v4.2, go to www.prioritydispatch.net or email epd.standards@emergencydispatch.org.
**MPDS use is the law in San Francisco**

Updated minimum medical dispatch standards in the California Health and Safety Code designates in writing that the Medical Priority Dispatch System™ (MPDS™) is the authorized emergency call processing protocol for use within the San Francisco emergency services catchment area.

Not only must each dispatcher have current certification as an Emergency Medical Dispatcher (EMD) to work in a comm. center serving the three million residents in the region, but as of Sept. 9, 2013, Policy 3000.1 of the code requires that the MPDS “must be used on every request for medical assistance” coming through the 9-1-1 emergency call network.

The revised policy also states that MPDS cardsets or the computerized version of them—ProQA®—“must be used on every request for medical assistance.” Calltakers must also follow the script of pre-arrival instructions (PAIs) when appropriate.

The new language, which also includes a brief description of how all comm. centers must maintain a current and regularly refreshed disaster training and disaster staffing plan, also requires that San Francisco Emergency Medical Services must monitor the compliance of all comm. centers with the standards. If a center fails to comply or achieve the minimum passing score of a review, EMS can drop a comm. center from the emergency call network.

The new standard gets strict about quality improvement of individual dispatchers by requiring each center to make available any requested tapes or call logs to San Francisco emergency services agencies that ask for it.

**Florida outlaws texting while driving**

Digital billboards along Florida’s highways are now carrying the message, “Don’t text and drive. It’s the law,” as part of the “Put It Down” campaign promoting a state law prohibiting the potentially lethal form of distracted driving.

The law is a secondary offense in Florida, meaning an officer must witness an offense, such as the motorist swerving or missing a stop sign while texting. The penalties are $30 plus court costs for a first offense and $60 for a second offense.

Florida was the 41st state to regulate texting for drivers, and according to the law’s provisions, there are still instances when texting is still within a driver’s rights. Texting is allowed in hands-off, high-tech cars, when a car is stopped at a red light or in a traffic jam, and to report criminal activity.

**Oakland scores a hat trick**

Oakland County Sheriff’s Office (OCSO) in Michigan became a top tier communication center with its recent incorporation of all three protocols when the center went live with the Police Priority Dispatch System™ (PPDS®) in September 2013. EMD and EFD protocols have been used for more than 10 years.

“I am extremely proud of our dispatch, and how they continue to be on the cutting edge of new technology and professionalism,” said Sheriff Mike Bouchard. “This, in turn, brings a higher level of service and safety to our community available to a select few.

**High school course encourages dispatch profession**
A course preparing high school students for jobs in emergency dispatching provides a link to adult careers that Holland Myers wants to grab.

“Careers in emergency communications have been around for a long time but never advanced in the same way as careers for firefighters or police officers,” said Myers, who designed the course for juniors and seniors attending Center High School in Antelope, Calif., near Sacramento. “This has changed with recognition of the people skills and technological smarts necessary, making the course both relevant and important to future competency on the job.”

The course is divided into two one-year sessions. During the first year, students can certify in CPR and in the use of an AED; they can also certify as emergency telecommunications, and they’re given the opportunity to train in the fire and police protocol systems developed by the IAED™. By the end of the second year, they are eligible to test and certify through the IAED as an Emergency Medical Dispatcher (EMD), Emergency Police Dispatcher (EPD), or an Emergency Fire Dispatcher (EFD).

Myers has high expectations for the program and his students.

“By the end of this year, I hope all of my students will have passed the IAED test for certification as an emergency telecommunicator and passed the test for CPR/AED,” he said. “Even more, I hope those students will have helped me to train 200 more of our school’s students to certify them also as trained in CPR/AED. I hope to have the highest percentage of CPR/AED trained students of any high school in the United States.”

**Study questions death risk from drinking coffee**


**NAVIGATOR 2014 goes Disney**

NAVIGATOR 2014 puts popular demand at the forefront during three days of pre-conference (April 27–29) and three days of conference sessions and events (April 30–May 2).

The number of speakers keeps increasing (130 this year compared to 122 in 2013), with educational sessions (96) combined with pre-conference workshops and courses (27) also on the up curve.

Sure to please repeat Florida conference goers and those new to NAVIGATOR is the return of the Beach Party at Disney’s Typhoon Lagoon Water Park, featuring rushing rapids, sandy beaches, and the lazy river raft ride.

New events include a heartier than coffee and sweet rolls breakfast available in the Exhibit Hall on the second morning of NAVIGATOR and 20-minute Power Sessions on Thursday styled similarly to Euro NAVIGATOR.

To say Claire Ulibarri, conference coordinator, is looking forward to spending the week in Lake Buena Vista, Fla., at Disney’s Coronado Springs Resort is an understatement mixed with the usual pre-NAVIGATOR jitters.

“I’m always a bit nervous in how well new events go over with our guests,” Ulibarri said. “Sometimes, it means dropping events that have been less popular and hoping that doesn’t upset anyone. On the other hand, if the new event proves a success, we’re certainly glad we gave it a try and people can anticipate a return to NAVIGATOR the following year.”

Of course, Ulibarri said, there are exceptions based on where NAVIGATOR is held. A beach party, for example, wouldn’t have worked in 2013 at the Salt Lake City conference—the Great Salt Lake is not the ideal venue for swim flippers. Power Sessions, however, could easily become a mainstay, depending on the reception.

Gernot Vergeiner, an Austrian EMS provider, and Tudy Benson, International Academies of Emergency Dispatch™ (IAED™) director of European operations, introduced Power Sessions at Euro NAVIGATOR based on Vergeiner’s experience at the conferences he attends in Europe. Power Sessions are divided into blocks, and presentations are clustered around common topics and areas of interest. The blocks allow time for discussion between the speakers and session attendees.

“We’ve received very good response, so it was decided to give them a try at this year’s NAVIGATOR in Florida,” Benson said. “I think they will complement the existing format and everything else Claire has put together.”

An example of a Power Session, or forum, at the upcoming NAVIGATOR conference is the IAED research-oriented grouping moderated by Chris Olola, Ph.D., IAED director of biomedical informatics and research. The 30-minute segments in this two-hour session will provide insight into stress at the dispatch workplace; challenges with bariatric patients in dispatch; geospatial techniques in dispatch research; and characterizing distributions of the Emergency Communication Nurse System™ (ECNS™) most frequently used protocols.

Carlynn Page, IAED associate director, will moderate an ACE forum, and Keith Griffiths, IAED Alliance board chair, will moderate forums examining National 9-1-1 issues, data, and analytics.

Sessions scheduled during the familiar one-hour slots fall into categories to include the medical, fire, and police protocols; CDE and Training; Operations; Stress Management; Quality Assurance; Motivation; Technology; Management; Leadership; Special Interest; and Next Generation 9-1-1.

Popular mainstays on the schedule include: the Opening Gala Reception; the Exhibit Hall; the Opening Session with a keynote speaker from the Disney Institute, the presentation of the Dispatcher of the Year Award, and stage recognition for new and re-accredited Accredited Centers of Excellence (ACE); and the Closing Luncheon featuring keynote speaker Pat Williams, the presentation of the Dr. Jeff Clawson Leadership Award, and recognition of the Communication Center Manager (CCM) course graduates.

As cited by Vega, the study had major limitations: coffee consumption measured only at baseline, natural limitations to an observational study, and no adjustment to results based on laboratory data such as lipid levels. Other research, he noted, has suggested to the contrary, finding that coffee can reduce the risk for diabetes and cardiovascular events.

Overall, he writes, patients will probably have far more to gain by addressing other lifestyle and diet issues besides coffee drinking in their quest for a longer, happier life.

Shift workers, which include emergency dispatchers, are among the highest consumers of coffee, and many studies show that ingesting caffeine actually helps workers perform better, especially if they're working when their circadian clocks say they should be sleeping. Research focusing on night shift workers found coffee is effective in countering the “sleepy effect,” and caffeinated shift workers made fewer errors than their decaffeinated colleagues.

According to trade association reports, 83% of U.S. adults now drink coffee, a 5% increase since 2012 and part of an upward trend over the past two decades. The majority of Americans drink coffee on a daily basis, and the average number of cups per day among daily drinkers is 3.

**Cincinnati regulates EMD**

A new regulation in Cincinnati, Ohio, requires all 9-1-1 dispatchers to be trained as Emergency Medical Dispatchers (EMD). The regulation, which is written into the city’s municipal code as part of Employment Regulations (308-31), states that “emergency service operators and dispatchers” must successfully complete a nationally recognized training course for public safety telecommunicators involving a minimum 40 hours of instruction and a nationally recognized EMD course. The courses must be completed prior to handling calls.

The amendment to municipal code was sparked by a local TV reporter’s investigation of mandatory overtime in communication centers, inconsistency in EMD certification among dispatchers, and having non-certified dispatchers answering emergency calls.

**SLCFD celebrates 130th anniversary**

Salt Lake City Fire Department (SLCFD) celebrated its 130th anniversary on Oct. 1, 2013, as a paid professional public safety organization. SLCFD has been using the MPDS® for 30 of those years—the world’s first 9-1-1 center to implement the protocol—and achieved tri-ACE status last year in its use of the MPDS®, FPDS®, and PPDS®.

Prior to October 1883, a volunteer operation created by mayoral declaration in 1853 answered all fire calls, with a decision to form a paid, full-time fire department three months after fire destroyed several buildings in the downtown area. No lives were lost in the fire, probably due to the time the fire started—close to midnight—and its location—inside the city’s wagon depot.

According to an anniversary story in The Salt Lake Tribune, the firefighters of 1883 had 36 leather buckets, 21 ladders, and a pump they manually operated to douse fires. SLCFD now employs 313 firefighters and 15 civilian employees serving 14 fire stations, including two fire stations at the city’s international airport.

Salt Lake City’s 9-1-1 Communications Bureau went online in a new, improved facility at 2 a.m. on Sept. 17. It is the largest municipal 9-1-1 center in Utah with about 70 dispatchers, and consolidates dispatch centers for police, fire, and emergency medical services.

**Nearly all PSAPs have some wireless capability**

Less than 3% of U.S. Public Safety Answering Points (PSAPs) might have difficulty locating someone making a 9-1-1 call on a wireless phone, according to recent statistics from the National Emergency Number Association (NENA).

The percentages, released in September 2013, show that 98.5% of the country’s PSAPs have at least “some” Phase I capability, while 97.5% have at least “some” Phase II capability.

The term “some,” as defined by NENA, means that some or all wireless carriers have implemented either Phase I or Phase II service in the PSAPs. In order for any carrier to provide service, however, the PSAP must be capable of receiving the service.

Wireless Phase I automatically delivers the caller’s cellphone number to the PSAP and, also, gives the location of the cell tower handling the call. In Phase I, the call is routed to a PSAP based on cell site sector information. Phase II provides both the caller’s wireless phone number and the location information (not the point of subscription but the location of where the call has originated). In Phase II, the call is routed to a PSAP based on either cell site/sector or caller location information.

Phase II is compatible with Enhanced 9-1-1 (E9-1-1) objectives that a PSAP has the equipment and database for the calltaker to see a display of the caller’s phone number and address, and can selectively route the caller’s location.

As of September 2013, the United States had 6,083 primary and secondary PSAPs. An estimated 240 million calls are made to 9-1-1 each year, of which one-third are made through wireless services.
“Rocky” EMD is Queensland Dispatcher of the Year

Narelle Smith, a Queensland (Australia) Ambulance Service (QAS) EMD, seldom looks back on her former career in the insurance industry. It’s not that she disliked the business or was actively looking for a new job at the time; she was, however, suddenly faced with two life-changing options.

Smith could move to Brisbane when the company’s branch office in Rockhampton closed or drop the insurance line to start a new career. She chose the latter, and five years down the road emphatically believes she made the right choice.

Smith, who has been with the QAS Rockhampton “Rocky” Operations Centre since 2008, received the Emergency Dispatcher of the Year Award at the QAS Star Care Awards ceremony held in September 2013 in Kedron. During a brief acceptance speech, Smith said the award was very humbling, thanked her peers for the nomination, and insisted her co-workers were equally as deserving.

“This award doesn’t just belong to me,” she said. “We work as a team at QAS.”

Smith said her decision to stay in Rockhampton and change careers has been the most rewarding she’s ever made.

“I now can’t imagine doing anything else,” she said.

Queensland is the second largest and third most populous state in Australia. QAS serves the entire state and is divided into seven regions; each region has its own communication center to answer calls and dispatch response—the Rockhampton center is in the Central Region.

QAS dispatchers are EMD certified. There are five levels of EMDs, with levels III and up qualifying for the annual award. Other Star Care Awards were presented to the Paramedic of the Year, Station of the Year, and Young Hero of the Year.

England’s NWAS assists in providing AEDs

A project teaming England’s North West Ambulance Service (NWAS) with the Bolton ICD (Implantable Cardiac Defibrillator) Group and the Bolton Wanderers Community Trust has proven a winning combination during its first year of operation.

The groups are promoting and funding the placement of automated external defibrillators (AEDs) where there is a higher risk of cardiac arrest, such as sporting facilities, shopping centers, and areas known for a high volume of tourists.

The first two AEDs were presented to Bolton Rugby Club and Harper Green School, and their placement has certainly added to the awareness of “the chain of survival” in saving lives in the event of cardiac arrest.

Rugby fan Derek Smith and his granddaughter Natalie Smith will be among the first to agree.

Derek Smith, 79, had a heart attack inside a car on the way home from a match between Blackpool FC and the Bolton Wanderers. The driver, Smith’s stepson, pulled over, and his scream for help alerted a police officer on duty at the station close to where the car was stopped. The officer’s action to provide CPR attracted several other people to the scene, including Tracey Garde, ICD chair and a registered nurse.

Next on scene came Lesley Hough, duty manager at the Bolton Arena where the game had ended minutes earlier. She had received the call from police and was carrying a portable defibrillator.

Derek Smith was “shocked” four times before the ambulance arrived, and he was taken to Royal Bolton Hospital. He was later transferred to Blackpool Victoria and made a full recovery.

Garde later posted a message on Facebook to illustrate the importance of learning CPR and the chain of survival.

“It was fantastic teamwork, and we all pulled together to fight for this lovely chap,” she said. “So pleased our efforts paid off and he is doing well—worth more than anything to hear that as so many out-of-hospital cardiac arrest patients don’t survive.”

Steve Nicholls, a community resuscitation development officer at NWAS, said the lifesaving actions of the team show the need for defibrillators in public places (Amanda Alcock, Grandad, 79, “brought back to life” after collapsing at Bolton Wanders Match, The Bolton News, May 9, 2013).

“I am delighted with the outcome of this incident, it was a real team effort,” he said. “Effective CPR and having quick access to an automated external defibrillator (AED) ultimately gave this gentleman the best chance of survival. This incident really cements the fact that they do save lives.”
They might occupy just a corner of that wind-scoured stretch of North American terrain known as the Great Plains, but the roots of emergency services in Weld County, Colo., were set down long ago, and they just keep running deeper.

The designation of Weld County Regional Communications Center (WCRCC) in Greeley as a medical dispatch Accredited Center of Excellence (ACE) is the latest achievement in a long history of providing exceptional public health and safety programs in that part of the West.

To know the center is to know a little geography. Greeley and its sister town of Evans are situated 50 miles west of the Rocky Mountains and are flanked to the east by land affectionately described by locals as “a tabletop, only flatter.” The Greeley-Evans region is home to 200,000 residents who are spread across wide stretches of cattle and sheep ranches, wheat, corn, hay, bean, and sugar beet fields, which in effect gives emergency services responsibility to provide services pretty much as far as the eye can see.

To describe the region as remote isn’t much of an exaggeration, agency managers said, and having it named one of only 179 call centers worldwide good enough to be designated an ACE is an immediate source of pride.

“This is a distinction and a huge honor,” said Mike Wallace, director of public safety
communication, when the International Academies of Emergency Dispatch™ (IAED) announced the ACE in October. “Most of all, it is a testament to the great work the men and women in the call center do day in and day out for our community.”

The MPDS is used in 3,600 call centers in 44 countries, making it the most widely used medical emergency dispatch method in the world. Accreditation demands careful and consistent MPDS compliance with IAED standards, practices, and quality assurance requisites. To become an ACE, all calltakers in a communication center must be certified professional dispatchers.

“Going the extra mile is just kind of the way things tend to operate around here,” said William Garcia, Weld County Commission chairman. “That seems to be the pace we’ve set, and we’ve made some big strides just in the past few months.”

One of the big strides that will mean something to people in dispatch, he said, is the recent activation of the new 800 MHz Simulcast System for police, fire, and medical dispatch. The system cost $3.9 million and provides four more communication channels in addition to the usual eight, plus it offers much stronger signals that can better penetrate buildings.

“The county has continually invested in the infrastructure and tower system for our public safety communications, and today’s event is one more example of the county’s dedication to providing high-quality services in the county,” Garcia said.

The new system increases response times because it enables information to be relayed simultaneously from the area’s three transmission towers.

“We are actually able to handle more radio traffic, and that will decrease the ‘busy’ signals first-responders sometimes receive when radio traffic is high,” Wallace said. “That fact alone automatically increases public safety, not to mention the safety of our scene responders. I have to say again that we all should take comfort and pride in the news that the dispatchers in this county are among the best in the world.”

Wallace is himself part of the success story of Weld County emergency services. In March, Weld County hired him as director. In June, the county named Debbie Nasta director of operations. Their combined experience of the emergency services management in the county jumped by nearly 50 years.

ACE designation was more a matter of when, not if, for the 54-member dispatch staff. They have an active quality assurance/quality improvement program that often involves case review by fellow dispatchers, not just by designated ED-Q™ supervisors.

The Weld comm. center was formed in early 1993 when the City of Greeley and Weld County Commissioners consolidated public safety communications for most of the police and fire agencies in the county. Since then, the center has evolved from conventional band radios into a statewide radio network that allows Weld public safety agencies to stay in touch, not only within northern Colorado but across the state. The center itself takes 360,000 telephone calls per year and processes dispatch for 17 law enforcement agencies, 21 fire departments, and two ambulance services.

Keeping tabs on how well the Medical Priority Dispatch System™ is being followed by calltakers is one of the key elements of achieving ACE status from the IAED. The 20 criteria a center must meet to be designated an ACE are directly linked to the quality of calltakers consistently meeting performance standards set by the IAED.

“Weld has never used its size nor location as excuses to not to have an active case review and quality assurance program. They’re the reasons that they do,” Brian Dale, chairman of the accreditation board with the IAED, said when asked about the center. “Some of the most engaged and energetic and memorable Q courses I’ve taught happened there. This is not a center that goes through the motions, they do it for real, and always getting better is just who they are.”

There is a commitment level at the center that seems to occur without much prodding, said Anne Mioduski, communication center supervisor. People at other centers say they have trouble getting staff excited about becoming an ACE. Achieving the 90th percentile performance standard takes work, she said. “The trick I think is not to make it so much about the score, but what the score means in how well a center is serving the public.”

One way Weld serves the public is being serious about its community outreach efforts. It hosts an annual open house at the center, and folks in Greeley tend to show up. The goal is to put a face on the people behind the scenes of emergency response.

The center is also actively involved with local schools, and staff never miss a chance to take an opportunity to visit a campus or promote their helpful hints list for calling 9-1-1.

“It’s surprising how much that has helped smooth out calls,” Mioduski said. “I think because we’re part of the community and maybe better known in the community, maybe what we do is better understood.”

The tip list is:

• Dial 9-1-1 for emergencies.
• The non-emergency number for the center is 970-350-9600.
• If you do not have a police/fire/medical problem but need another type of help, the Weld County United Way 2-1-1 line may be able to provide you with help.
• If you need updates on road conditions, dial 5-1-1 from your cellphone or visit www.cotrip.org.
• Sometimes it may seem that a dispatcher is asking a lot of questions when you call for emergency services. Please know that while the calltaker is asking questions, he or she is relaying the information to responding units. The information you provide to the calltaker will help determine the type the services you need, which may include law enforcement, fire and/or emergency medical help.
• Remember, disconnected cellphones are still able to dial 9-1-1. Unfortunately, these hang-up calls create unnecessary workload for dispatchers in any emergency dispatch center. Please take the batteries out of disconnected cellphones to prevent these accidental 9-1-1 calls.

The Weld dispatch center will be formally awarded an accreditation plaque in April 2014, and staff will be recognized at the annual NAVIGATOR conference scheduled for April-May in Florida.
Bad Behavior Fixes
Changing co-workers begins with you

The toolkit Darcy Lord lugged to NAVIGATOR certainly could mean a lighter load for others when it comes to getting along in the communication center.

“You absolutely have the ability to create your own relief from people and things that don’t behave,” said Lord, who has a doctorate in somatic education from the Ohio State University. “Even if you don’t believe it.”

Somatic studies address the mind-body connection, Lord explained in her presentation: “I’d be fine if it wasn’t for you! What to do when people (and things) won’t behave,” and through the three tools presented, she had her at-capacity audience ditching their baggage—at least for the time devoted to unpacking.

“You become your own agent of change,” Lord said.

The change, she said, comes from turning others’ bad behavior around, which also means shifting your own perspective regarding the thing or individual causing discomfort. It’s like a win-win for stress reduction.

“Things start to swing around when you find something to appreciate about the individual,” Lord said. “You begin seeing what you’ve considered difficult people and situations from positive emotions.”

Stress is a known commodity in the workplace and most agree that the stress results from the interaction of the worker and the working conditions. However, what is stressful for one person may not be a problem for another.

Sources can also vary according to the job. Heavy equipment operators, for example, might worry about their safety in the ‘danger zone,’ the place where contact with large machinery can cause accident and injury. In contrast, employees working together in jobs that put a lot of people in the same space more often creates the pressure of trying to get along with difficult personalities. There may be inherent traits such as aggression or impatience, or the “know-it-all” who refuses to take anyone’s advice.

Emergency communications can add layers of frustration and feelings of helplessness to the pressures already associated with actual or perceived bad co-worker behavior. Life-threatening crises, frantic callers, shift changes, pace, the demands of multi-tasking, imbalances between work and home, and feelings of “low social value” can snowball into a working environment rife with harmful conditions.

So what happens when stress shakes its ugly head?

“We age; we gain weight,” Lord said. “We sleep badly. We might feel depressed or anxious.”

People near the edge are more likely to become distracted and make errors in judgment. Warning signs may go unnoticed or the individual might ignore the signs, hoping they will go away. An employer acknowledging stress might take steps to prevent or alleviate the pressures from becoming negative stressors.

But that might not solve every problem.

“What about the co-workers who might be causing the distress?” Lord asked. “What can you do when people don’t behave?”

That’s where the toolkit comes in. Achieving balance often means putting the weight in your corner.

In other words, you become the change you want to see in others. Lord presented three tools to her audience.

Tool No. 1: Take a physiological break

Shift your physiology back into balance and get yourself to a more positive or neutral experience by focusing on your breathing and recalling something that you enjoy. The way you breathe affects your whole body, Lord said. Deep breathing—long, smooth breaths—sends a message to your brain to calm down and relax. Your brain relays the message to your body.

“Do this at anytime,” she said. “Don’t wait
Chest Pains
EMD listens for signs and symptoms

Brett:
In Protocol 19: Heart Problems/A.I.C.D., if the patient is also having chest pains, should we switch to Protocol 10: Chest Pain (Non-Traumatic)? Also, if the patient is not having chest pains, should we use the Aspirin Diagnostic and Instructions (ASA)?

Michelle Schill
Central County Emergency 9-1-1
St. Louis, Mo., USA

Michelle:
The chest pain Key Question and associated CHARLIE code was added to Protocol 19 to avoid a shunt to Protocol 10. So, use Protocol 10 if the complaint is chest pain. If chest pain is “discovered” on Protocol 19, stay on Protocol 19. As always, the EMD needs to determine exactly what happened at Case Entry to obtain a sign or symptom, rather than the caller’s “diagnosis” of the problem.

With regard to your aspirin question, all qualified patients should receive aspirin therapy. In version 12.2 of the Medical Priority Dispatch System™ (MPDS®), we changed the related Critical EMD Information (CEI) to read:

“Utilize the Aspirin Diagnostic & Instructions Tool – if authorized by local Medical Control and the chest pain (Heart Attack Symptoms) patient is alert and >= 16 years old.”

Additionally, we have added two new Rules in v13.0 that clarify the use of the Aspirin Dx & Instructions Tool further:

“(>= 16) When the complaint description involves both NON-TRAUMATIC chest pain/heart attack symptoms and breathing problems, choose the Chief Complaint Protocol that best fits the patient’s foremost symptom, with ECHO-level conditions taking precedence. Use the Aspirin Diagnostic and Instructions Tool on either protocol as appropriate.”

“The Aspirin Diagnostic should be used for all qualified patients presenting with heart attack symptoms.”

Thank you for your interest in the MPDS!
Brett A. Patterson
IAED™ Academics & Standards Associate Medical Council of Standards Chair

Tool No. 2: Find the opposite in the negative qualities perceived or known

Maybe you witness behavior you believe isn’t aboveboard. For example, if someone at work is not following policy (e.g., fails to follow protocol), and you do not have control over remedying the situation, you could practice the feeling of “I love being around people I trust who act with high levels of integrity.” It’s not about the words; it’s about getting to the feeling that brings relief. Do this for a whole week even if it doesn’t feel practical. Things will begin to shift.

You could also visualize behaviors you would like to see in the individual. Instead of impatient, imagine a person who is calm and persevering; instead of cranky, imagine a person who is good-humored.

Tool No. 3: Play the appreciation game

Lord encourages a sincere attempt to finding something to appreciate about the individual driving you to distraction. It could be as simple as noticing the picture of a child or pet the co-worker keeps in a frame next to the console and realizing the care and love for others that isn’t obvious to you in the workplace.

You might have to dig deeper. For example, you could actually approach the co-worker and engage in conversation. You might open with questions about the person’s hobbies or favorite restaurants. You two could find you share something in common, and that could help bridge past disagreements and resentment and even move the relationship to a positive track.

“When you start doing this, people start changing,” Lord said. “And it’s your own relief providing the best reason for you to try.”

Source
Pick Your Place

Protocol delivers in all sizes

Audrey Fraizer
On occasion, *The Journal* likes to feature stories about centers for no bigger reason than a curiosity about the geography, demographics, and issues that more often than not are common to the general landscape of emergency communications.

In the past, we have visited centers inside national parks and other out of the ordinary places, talked to administrators in Next Generation 9-1-1 readiness mode, and adjusted our clocks to contact centers way outside of our North American time zones. We like to pass on information passed on to us from Accredited Centers of Excellence and the dispatchers and calltakers willing to share their stories.

We’re always gratified by the reception and the result, we hope, are stories that give our readers a bird’s-eye view of people and places outside their natural circles. In this issue, we introduce you to two centers—one in West Virginia and the other in South Carolina—and a business pushing its way past the perception of the red-headed stepchild of emergency communications.
When it Rains, it Snowballs
Consolidation, new building, double-ACE all part of the package

Ask Sharon Martin about transferring into a police/fire/EMS consolidated communication center that more than triples the size of the city’s police primary PSAP that she had worked at for 20 years.

Then ask the former floor supervisor about adjusting to dispatch protocol and certification, accreditation, longer shifts, and working in the same space as 160 other people after being accustomed to the noise of one-tenth that number.

“Of course, I was worried,” Martin said. “Everything would be new and a big change from the way we had been doing things.”

Finally, ask her if she would now have it any other way.

“It’s turned out so much better than I had anticipated,” she said. “There’s a lot more opportunity.”

Martin is support services manager for the Charleston County Consolidated 9-1-1 Center in North Charleston, S.C. She oversees the training section, Freedom of Information Act (FOIA) section, the National Crime Information Center (NCIC) data, and manages the quality assurance section.

Her first job in public service was as a records clerk for North Charleston Police Department. She applied for a position in emergency communications after presenting a training course for dispatchers on the use of the NCIC database.

“I can do this,” Martin said. “I really thought dispatch would be for me.”

She did, and it was.

Martin rose through the ranks, hitting the ceiling as an Operator 3 and shift supervisor prior to the consolidation. Once that happened, she was presented opportunities for career growth, and in three years, achieved a goal she thought would take closer to five years to accomplish.

“Yeah, it’s been great,” she said. “I was concerned about not having any say when we transferred, but it hasn’t been that way at all. I’ve had a say from the start.”

A cooperative, multi-jurisdictional Consolidated Dispatch Board of law enforcement, fire, and EMS officials within Charleston County was organized in 2006 to lead the move toward a consolidated dispatch center. An intergovernmental agreement signed by participating agencies included provisions relating to direction and funding, with the county taking full financial responsibility following a two-year startup period.

A national search for a person to direct the center resulted in hiring Jim Lake, a former program director for the Massachusetts State 911 Department.

Lake’s public service résumé included two prior consolidation projects, and he was also a consultant for L. Robert Kimball & Associates, which assisted in preparing the consolidation feasibility study for the Charleston County Consolidated 9-1-1 Center. He fully intended to continue at the same consulting firm once the plan was completed.

“It was a difficult decision leaving the job at L. Robert Kimball, but Charleston County seemed to be a great place to go next,” said Lake, who took over as director in 2008. “The county was determined to do it right, and the county never backed down from that. Even when the economy was at its worst, Charleston County continued to fund the project, and it went on.”

During the past five years, Lake has lived the timeline he helped develop. He arrived shortly before North Charleston’s call center merged with the Charleston County Sheriff’s Office and EMS Dispatch. Just over four years later, in March 2013, with 15 agencies on board, Lake cut the symbolic ribbon in the center’s move to the 38,000 square-foot, two-story communication and emergency operations center. The center now serves 21 police, fire, and medical agencies.

From the start, and before the move, Lake had listed buy-in and participation as top priorities. He wanted staff involved, which was something suiting the talents and temperament of Jon Schebesta.

Schebesta, a jack-of-all-trades, has earned a reputation on the dispatch floor as the go-to guy for computer troubleshooting. He is now a certified multi-function calltaker, law enforcement dispatcher, and fire/EMS dispatcher, giving him the ability to step into any position “at a moment’s notice.”

It was Schebesta’s prior experience, however, that caught Lake’s attention. Schebesta is a former upstate New York firefighter and EMT. He made the tough decision to go inside seven years ago when injuries from a traffic accident made it so he could no longer fight fires. The move was difficult, and that’s an understatement.
“I FELT LIKE I WAS LEAVING MY HOME AND GOING INTO A FOSTER SETTING.”
– Josette Middleton

“Smaller agencies were concerned about losing local control and the personal connection, such as knowing the citizen by the sound of their voice before asking their name,” Lake said. “Some people didn’t like going from a quiet community to a larger center with the potential of violent crimes. We lost people, and I fully understand why.”

Josette Middleton numbers among the 99% who were not so eager. She was in her third year at the EMS secondary PSAP where she alternated between calltaking and dispatching for EMS and fire. After consolidation, she would be dedicated to calltaking, at least at the beginning.

“I was OK with that, and ready to take on the challenge,” Middleton said. “But I felt like I was leaving my home and going into a foster setting. It wasn’t about my taking on new responsibilities, but I would no longer be part of a dispatch family.”

Instead, Middleton was swept up in the move. She served on the chair and uniform selection committees, and toured the new facility during various stages of construction. She has since been promoted to supervisor, certified to dispatch EMS and fire, and anticipates earning her credentials for dispatching police calls.

“We were part of every decision—the color of the walls, the type of chair—and we selected committees based on who we thought would best represent us,” she said. “We’re no longer the stepchildren. We are part of this.”

Everyone, of course, played a part in the fire and medical accreditation, and, currently, in completing the 20 Points of Accreditation required for the police ACE.

Lake coaxed Charlotte Hughlett out of retirement to help achieve the ACEs, and she didn’t have to be asked twice to accept the provisional position.

Hughlett and Lake first worked together in 1998 when the Academy pulled them in as part of the group developing police and fire protocols. Hughlett had the fire and medical background, while Lake offered police and fire expertise.

Hughlett also had ACE experience. Her first ACE was at the Colorado Springs (Colo.) Police Department in 1998, when she was the training and quality assurance manager. She serves on the Academy’s Board of Accreditation and is an ACE reviewer.

Her primary orders of business for the Charleston County Consolidated 9-1-1 Center were “talking up what the ACE means” and “team building,” with more than 100 people with a diversity of experience and abilities that consolidation was stirring into one pot.

“There was so much they had to learn,” she said. “Protocols, SOPs. How the new agency was going to work. It was a matter of keeping them motivated.”

Hughlett concentrated on making the process fun; for those agencies still waiting to join the consolidation, she scheduled classes convenient to the 12-hour shifts and monitored daily progress. She traveled every other weekend to her home in Florida and set a dual ACE deadline of 18 months.

Having experienced a consolidation and bringing that agency to the ACE level simultaneously, she understood the frustrations of Charleston County staff. It’s not an easy process, especially when doubled.

“They were ready with everything but the numbers, so it took a little longer than I had anticipated,” she said. “I was always confident it was going to happen, and encouraged everyone knowing that it would work once they gave it a chance.”

Lake wouldn’t have it any other way; ACE was a goal from the start.

“ACE is testament to the quality of service we provide to the public,” he said. “ACE tells the community we care, and we’re doing it right. When you call our center, you’re going to get the same level of care regardless of who answers the phone.”

Every time it looks like Lake might reach the end of the “to-do” list he started, he finds other projects lending to his goal of making Charleston County Consolidated 9-1-1 the model for South Carolina. He stays busy with projects ranging from accreditation to technology projects to the statewide adoption of NG9-1-1 technology.

But it’s the people that are his primary reason for staying.

“The challenge is different than it used to be for me,” Lake said. “Those that succeed in 9-1-1 have the heart for public safety. It’s my job to find those people, mentor them, and prepare them as our future stakeholders of 9-1-1.”

“It was horrible,” Schebesta said. “I used to be the one sent and going to the scene. It was very difficult to get over that.”

His firefighting experience, however, proved invaluable in Charleston.

Schebesta was tapped to assist in developing Charleston’s fire dispatch training program. He had the knack for navigating urban geography and provided a step-phased training approach to teaching the county’s road system. He and two others created the SOPs for the harbor channel used in communicating with the U.S. Coast Guard and Charleston County Metro Marine Unit. He is still active in search and rescue dive operations.

“Jim recognized my strengths and made use of them,” said Schebesta, who in December transferred to the center’s Information Technology section. “That’s his style. He walks through the center at least once a week, shaking hands and asking people what he can do to help. He’s very open to input.”

The combined center has everything in terms of technology, security, and comfort control. As they say, it’s state of the art. The building is built to withstand hurricanes and earthquakes, and the 8-foot perimeter wall complements the distancing from residential and commercial development.

The computer-aided dispatch terminals are new, and the same goes for everything else in the building, from furnishings to hardware down to the nuts and bolts. There is dedicated space for 9-1-1 calltaking, police dispatch, and fire/rescue/EMS dispatch. A fitness center, kitchen and breakroom, and a quiet room are accessible 24/7, and bunks are available when an emergency demands long hours and increased staff. And it has lots of “green” features, making it a LEED Gold-certified building.

Windows providing a view of the outside was a big plus, so is an indoor sound system isolating the noise of a ringing phone to the ear of the next calltaker in the queue, rather than dispersing the noise throughout the space.

The people on the second floor of the building include 135 dispatchers, calltakers, and supervisors, and many are cross-trained to answer phones and radio dispatch; certification in the police, fire, and medical protocols is required. Most are from agencies existing prior to the consolidation, and despite guarantees in pay and job security, only about 1% looked forward to the merger and shared space.

Lake wouldn’t have it any other way; ACE was a goal from the start.

“ACE is testament to the quality of service we provide to the public,” he said. “ACE tells the community we care, and we’re doing it right. When you call our center, you’re going to get the same level of care regardless of who answers the phone.”

Every time it looks like Lake might reach the end of the “to-do” list he started, he finds other projects lending to his goal of making Charleston County Consolidated 9-1-1 the model for South Carolina. He stays busy with projects ranging from accreditation to technology projects to the statewide adoption of NG9-1-1 technology.

But it’s the people that are his primary reason for staying.

“The challenge is different than it used to be for me,” Lake said. “Those that succeed in 9-1-1 have the heart for public safety. It’s my job to find those people, mentor them, and prepare them as our future stakeholders of 9-1-1.”
Familiarity can be good and bad in small town emergency communications.

On the positive side, knowing that a street goes by three names does assist in locating the person or incident when any of the three are used, and recognizing a number gives an indication of the person calling if the voice can’t be heard.

On the negative side, something bad happening to someone you know can bring added stress to the job, and the business of what transpired during the call might soon become the business of everyone in town.

It’s not that the dispatchers in small towns are prone to gossip about their calls, let loose a barbed response, or apt to stay on the line to chat with the person recognized from the voice. But there are those high expectations and responsibility—professional and personal—tending to weigh extra-heavy on the calltaker/dispatcher.

“These are neighbors, friends, and people sitting next to each in church,” said Zachary Caldwell, director of Morgan County 9-1-1 in Berkeley Springs, W.Va. “These are the same people drinking coffee each morning at the diner or sitting next to you in the pew. It might be a mother, a father, a husband, a sister, an aunt, or an uncle, and they’re depending on you whenever things suddenly go to hell in a handbag.”

That’s the primary reason Morgan County 9-1-1 is a three-seat communication center specifically designed for emergency operations following the events of Sept. 11, 2001. Morgan County officials applied for the increased federal funding available after the terrorist attacks in New York City, N.Y.; they used the money received to move dispatch from War Memorial Hospital to a double-wide trailer behind the hospital’s former building.

“ Calls had been answered and dispatched from the registration desk,” Caldwell said. “They were using seven-digit numbers for police and EMS.”

A new $30 million, 87,000 square-foot facility housing War Memorial Hospital and the comm. center opened in April 2013.

Caldwell’s attention to Morgan County 9-1-1 is relatively recent. He was a local radio personality out of high school, and when that lost its allure, he enlisted in the U.S. Army. He was assigned to the military police, serving in Baghdad, Iraq, during Operation Iraqi Freedom and as the guy answering the radio at his base’s Tactical Operations Center (the Army’s equivalent to 9-1-1).

Back in the states following an honorable discharge, he worked protective services, taught at a school for troubled boys, and wore out his shoes looking for a job during seven months of unemployment.

“I applied for an opening at the dispatch center, and they decided that I was the guy they wanted,” he said.

That was in April 2012, and that’s where the story actually begins.

Caldwell was selected as Deputy Homeland Security and Emergency Management director in January 2013 and shortly afterward, he accepted a second promotion to 9-1-1 director. He oversees nine full-time and three part-time calltakers/dispatchers, working three shifts, answering an average of 212 calls—emergency and administrative—coming over six 9-1-1 trunk lines to three CADs.

Their service area covers 300 square miles and 17,000 residents, a number that fluctuates with the season in the largely rural county that generates tourism.

Caldwell’s military experience taught him a good deal about preparedness and, of course, protocol—not the scripted kind that he later insisted went into the center, but guidelines for what to do in a given situation.

“There wasn’t much of anything in the way of training standards or policies and procedures,” he said. “Calltaking was based on what we thought about asking.”

The lack of clear guidance, he knew, might mean getting something terribly wrong from his end of the line during the most critical moments of a person’s life. He wanted calltakers/dispatchers to have the capacity to make people feel at ease when they called, both with themselves and with the situation.

Caldwell looked at options, including a stack of cards nobody was using. He and co-worker Heath Fleming, a former U.S. Army combat medic hired at about the same time as Caldwell, read through them.
It was an early version of the Medical Priority Dispatch System™ (MPDS®).

“We were amazed,” Caldwell said. “Here was this card set full of wonderful things, and we’re not using them.”

Caldwell contacted PDC™ Regional Account Manager Dixon Brown, discovered that Morgan County 9-1-1 had been a one-time user of the MPDS, and, during the lapse, had actually fallen out of compliance with state regulations.

In 1994, West Virginia passed a mandate (State Code 24-6-5) requiring all public safety telecommunicators to complete a 40-hour basic training course from an accredited agency within one year of hire. Dispatchers were given one year to complete a similar course to keep their jobs.

Recent state legislation, effective July 1, 2013, requires center directors to implement policies and procedures for a nationally recognized EMD program or an EMD program approved by the West Virginia Office of Emergency Medical Services.

Caldwell chose the MPDS since it was the same system as the cards that he and Fleming had been reviewing. He also preferred keeping it simple because of mutual aid. It was the same system used in neighboring jurisdictions.

“I SAID WE DO THIS OR YOU LOSE THE COUNTY’S 9-1-1.”

– Zachary Caldwell

Caldwell read the statutes “chapter and verse” to county officials who responded with the funds for training and protocol.

“I said we do this or you lose the county’s 9-1-1,” he said.

Two weeks after the center went live with the MPDS, Fleming helped save the life of a man choking on a piece of food. The man had given the caller the universal choking sign, prompting the call, and his body was going limp by the time Fleming intervened. Granted, his military EMT training and service came in handy, but, at the same time, he was relieved to have the MPDS to follow.

“I would have given the instructions for the Heimlich and CPR without the cards, but with them I’m confident I’m not missing anything,” he said. “They leave no room for error.”

The caller’s abdominal thrusts, based on Fleming’s instructions, dislodged the food, and when the ambulance arrived 10 minutes later, the patient refused transport.

“He said he was fine,” Fleming said. “The caller scooped the food right out, and he didn’t want to go to the hospital.”

Caldwell spent the next several months writing the center’s policies and procedures, job descriptions, and training manual. He constantly endeavors to keep up standards, drilling on Case Entry questions, Key Questions, Determinant Descriptors, and instructions.

Since the county responds to a higher volume of law enforcement calls, compared to medical or fire, the center went live with the Police Priority Dispatch System™ (PPDS®) in August. He plans to start working on the Fire Priority Dispatch System™ (FPDS®) in January 2014.

A sign Caldwell posted on a wall in the communication center succinctly summarizes the strict attention Caldwell expects to be paid to protocol: Blatant deviation constitutes a breach of duty.

“There’s no reason we shouldn’t be doing this, and doing this the best we can,” he said. “I grew up in this town. We’re vested in our community.”

Just Ahead

The next issue of The Journal will give readers an up-to-date look at pandemic flu and the broader infectious diseases threats through the perspective of Dr. Alexander Garza, medical director for FirstWatch. Garza has written extensively on issues involving EMS and security, and he is considered an expert in health threats to national security, and strategic and operational excellence. FirstWatch, implemented in 1999, turns raw data into information critical to situational awareness, operational performance, and clinical assessment.

The Academy’s Medical Protocol 36: Pandemic/Epidemic/Outlook (Surveillance or Triage) will be the topic for the Medical continuing dispatch education (CDE) article. The protocol, which exists in both card format and the ProQA computer program, is designed to give information needed to implement at dispatch, correctly triage, and set up potentially decreasing response levels to possible flu patients during an officially declared flu outbreak.

A second feature will examine career paths in emergency communications, and The Journal will also describe the genesis of Pre-Arrival Instructions.

Readers always benefit from the CDE education articles—with each offering one CDE for completing the accompanying quizzes—and Frequently Asked Questions answered by IAED Academics and Standards Associate Brett Patterson.
Sound the Alarm
Rescue Alert takes the MPDS charge ahead

Medical alert companies’ dispatchers and calltakers get the bad rap from contemporaries working at PSAPs. “They’re not taken seriously,” said Erin Trumpler, EMD and trainer at Rescue Alert in South Jordan, Utah. “There’s a stigma. They work for alarm companies. I thought the same when I was a 9-1-1 operator in Los Angeles (Calif.).”

Trumpler has since changed her opinion, and it’s not because she had to in the interest of her current employment. She accepted the job and soon realized that although “we’re not a replacement for 9-1-1,” there is certainly a time and place for the service provided.

“We’re here for people who can’t always get to the phone to dial 9-1-1,” Trumpler said. “We’re their connection before help arrives.”

Rescue Alert calltakers provide that calming voice to reassure callers in an emergency armed with the medical instructions available in the Medical Priority Dispatch System™ (MPDS™).

Response Center Director Michael Bangerter said Rescue Alert undertook the initiative in 2003 for much the same reason 9-1-1 center administrators. “We wanted it so our calltakers could do more than wait on the line and tell customers help is on its way,” he said. “The ability to give medical assistance is a moral imperative, and that’s why we chose the MPDS.”

Within one week of becoming EMD certified, Bangerter gave a caller instructions for the Heimlich maneuver. “If we hadn’t been using the MPDS, the outcome for this caller, and the others we have helped since then, could have been much different,” he said. Rescue Alert subscribers wear a button on a pendant or wristband that they can push in an emergency. The signal initiates two-way communication between the caller and Rescue Alert call centers in South Jordan and St. George, Utah, providing subscribers with a radius of 600 feet from the Rescue Alert device hooked to the phone jack in their home. If the caller is unable to speak, the signal serves as the alert to get help on the way. The system also works with cellphone technology.

Although 95% of the calls involve nonemergencies, the company’s calltakers have assisted in many medical emergencies, including childbirth-delivery and stroke, and have alerted appropriate agencies in situations involving domestic violence, strokes, and fires. The company’s false alarm rate is less than 1%.

The 55 Rescue Alert calltakers are EMD certified and adhere to the same requirements, such as continuing dispatch education to qualify for recertification. Their EMD calls are also quality checked. Training lasts six weeks, with two more weeks on the floor with a mentor before flying solo.

The two centers combined receive an average of 24,000 alarms each week, although volume can double and triple during a critical mass incident. The busiest hours are between 9 a.m. and 2 p.m. in all time zones.

Rather than sitting back and waiting for the calls to come in during a bad stretch of weather or disaster, calltakers provide welfare checks. A bedridden female subscriber in Baltimore (Md.) was able to receive needed help from a Rescue Alert calltaker making the phone rounds during Hurricane Sandy.

“We were able to contact a pastor of her local church who, in turn, sent [church] missionaries over to check on her and found that she had one can of tuna left to wait out the storm,” Bangerter said. “That’s how we’re different from 9-1-1, and why our subscribers stay with us.”

Lisa Wolfley, a supervisor in the St. George center, said the personal contact and the potential for knowing subscribers fuel her passion for the job.

“We can provide medical help, but a lot of our callers need someone to talk to,” she said. “A subscriber had fallen hard on the floor and she was crying from fear. A friend had been dead on the floor for almost two days after a fall, and she was very scared of the same happening to her. We talked the 15 minutes it took for response to arrive and help her.”

Similar to the development of protocol, the Rescue Alert system evolved from an idea to provide greater help in an emergency. Nearly 30 years ago, Michael Bangerter’s father, Richard Bangerter, read an article in Reader’s Digest about the emerging 9-1-1 and that set the wheels in motion; the first device was released in 1986.

Several models have been released since then, with the two most recent models being a cellular-connected device, requiring no landline in the home, and another model that is compatible with emerging telephone systems, such as VoIP lines. Both systems are available for use in the U.S. and Canada.
Your newest trauma tool isn’t in here.

Seriously injured patients rely on you to give the best medical attention and care. To do that, you need knowledge, experience and the proper tools. That’s why the Centers for Disease Control and Prevention (CDC) has released the widely endorsed Field Triage Decision Scheme: The National Trauma Triage Protocol to help EMTs and paramedics choose the best transport destination for trauma patients. Designed in partnership with other leading organizations and experts in injury care, the Decision Scheme has been published in the prestigious MMWR Report & Recommendations. It’s a valuable tool that can help your EMS system save lives.

Get a free copy of the Field Triage Decision Scheme: The National Trauma Triage Protocol, the MMWR and other free resources at www.cdc.gov/FieldTriage
The mass shooting and bomb blast at a huge movie theater complex south of Salt Lake City on Oct. 23 was as fake as a Halloween beard. But the two-hour multi-agency field exercise still managed to provide a reality check for handling the mother of all emergencies—the mass casualty incident.

MCIs—mass shooting incidents in particular—have nearly tripled their five per year rate in 2008, according to figures from U.S. Attorney General Eric Holder. In 2013, there were 14 as of October.

The number of MCI mass shooting drills have jumped as well during the past five years. Emergency responder agencies that have usually held one mock disaster drill a year are now staging full-dress, multi-agency MCI practices at least twice a year, with some putting on three or more.

Utah, for example, holds one large MCI drill per year for its “Big One” event—a massive earthquake. Since 2011, a Utah coalition of public and private emergency services response agencies have been conducting almost one drill per month. The October drill was one of six mass shooting drills in 2013.

“Mass shootings and other man-made, high-count injury incidents aren’t the big one, but they’ve now moved into the ‘not if, but when’ category in every emergency response agency I know of,” said Jack Meersman, head trainer for Gold Cross Ambulance and dispatch team leader for the mock MCI at the movie theater.

Center stage at the October mock MCI was a mass shooting by a lone gunman who also detonated a bomb. Seven people were killed immediately, and 40 seriously injured. The shooter fired his final fatal shot at himself. The training was scripted close to the real-life shooting at a movie theater in Aurora, Colo., on July 20, 2012, and was to test how well area emergency responders coordinate efforts during such events now dubbed by the U.S. Department of Homeland Security as “low-tech terrorism.”

A shooter in a crowded and confined place can be very effective at producing the injury and mayhem he is looking for, all without much funding, training, or planning, said Shawn Messinger, a former SWAT team leader and a consultant with Priority Dispatch Corp.®, during a mass shooting discussion at the NAVIGATOR 2013 conference for emergency dispatchers. “Responding to them, on the other hand, requires all the coordination, support, funding, and planning emergency services agencies can muster.”

Musterling for the Salt Lake Valley drill was every police, fire, and medical emergency services agency from the state’s four most populated counties, which are home to nearly two million residents. Two emergency transport helicopters from the two main trauma centers were involved as well as the Utah Air and Utah National Guard.

Reality suspended
The 8 a.m. start was an obviously non-crowded theater time of day, but the group of 60 or so volunteers, some profusely bleeding red poster paint from their wounds, managed to give off a three-star performance during triage. Some died at the scene, passing away from their injuries as other victims tried in vain to help. Others simply just got in the way while some did their best to act out a situation they hope they never go through for real.

A half hour earlier, a team of five dispatchers picked to handle drill communications started going over the scenario and discussing routine channel assignments, and possible communication problems that could come up as the drill got into full gear.

What wasn’t routine was their location—some 100 yards away outside in the theater’s parking lot. Their console was a mobile unit mounted in the back of an SUV.

The handling of communications from the scene was to get the calltakers out of their comfort zone.
“Standing out here in the cold, we’re already there even before we start,” joked Beth Todd, the most experienced dispatcher in the group.

Having the dispatchers at the scene was Meersman’s idea. “Dispatchers are rarely, if ever, at the scene of any emergency,” he said. “We thought it might be an instructive way to broaden their perspectives and show them what first responders are actually dealing with at a scene they just sent them to.”

At 8:10, things got earnest. Dispatcher Jennifer Davidson coded the shots fired as a 135-D-2, according to the Police Priority Dispatch System™ used at Davidson’s home call center, Valley Emergency Communications Center (VECC).

Davidson and Lori Hintz, a dispatcher at Salt Lake International Airport, are experienced dispatchers, but Hintz is the first from the city’s airport staff to be part of handling a multi-injury incident, real or staged.

Updates of position and location of vehicles were handed off seamlessly as dozens of vehicles came and went. Although the communications between police, fire, and medical was practically nonstop during the 90-minute rehearsal, things were almost too quiet at the dispatch station. “There was a glitch or two, such as some channel jumping,” Meersman said. That’s when someone breaks into a radio channel not dedicated to his or her specific agency.

“Things can get really hairy in a few seconds if people start jumping, he said. “Communications channels must be established up front and must stay as assigned, if at all possible,” he said, adding that there are dozens of examples in real-life MCIs where dispatchers maintaining control over the radio channels prevented more injuries to victims and even serious harm to rescuers than had they not done so.

As teams headed to “hot wash” meetings to discuss how the drill went, the dispatchers said the drill succeeded in giving them a new perspective. “I’m getting a new appreciation for what people in the field are dealing with,” Lori Hintz said, who is a dispatcher at Salt Lake International Airport. “We have an idea of these things just like everybody else who watches the news. But it’s good to get an actual picture first-hand.”

They all agreed, however, that being able to watch events would be a distraction to dispatching, not a help, in a real event, saying they wouldn’t be able to concentrate as well on what callers were telling them.

Davidson said she remains in favor of the ears-only dispatching. “It does help to watch how something like this would play out, but if we’re watching as well as listening in a real event, we’d no doubt be less effective,” she said. “Still, I’d recommend any dispatcher do one of these. It gives a new mental picture of what’s going on when there is a real MCI.”

Todd said that the correct number and type of vehicles were dispatched efficiently and people quickly got to where they needed to be first. That isn’t likely in an actual incident because emotions start to run high in an MCI, she said.

VECC dispatcher Angela Wiggins said lessons from every drill she’s participated in carry over into the routine run of calls. “Training is training, and the more you get, the better you’ll get through any incident,” she said. “There’s no better confidence boost than telling folks, ‘It’s just like what we did in training.’”
On Track

Age Factors
Older population more susceptible to falls

Brett Patterson

It was an unlikely accident, and the only indication that something had gone wrong was a triggered medical alarm inside the home.

The subscriber registered to the Rescue Alert alarm system was a woman over age 65 and living alone, according to her profile. But EMS found the home empty despite the personal alarm the woman had activated from that same location. The Rescue Alert calltaker was unable to get any information because no one answered at the home. “Responders moved the search outdoors,” explained Michael Bangerter, response center director for Utah-based Rescue Alert. “It was a no-contact situation
and, just like a PSAP, we don’t give up until the situation is resolved.”

Minutes later, responders found the woman at the bottom of a deep window well where, they later learned, she had fallen while reaching for a gardening tool. Responders pulled her out, the personal help button still in her possession. She more-or-less dusted herself off with the tool in hand to continue gardening. Her injuries did not require transport.

It ended well but that’s not always the case.

Falling is the leading cause of both fatal and nonfatal injuries among the senior population, age 65 and older. In fact, according to the Centers for Disease Control and Prevention (CDC), one in every three senior adults falls each year. In 2010, 2.3 million nonfatal fall injuries among older adults were treated in emergency departments and more than 662,000 of these patients were hospitalized.1

Reasons vary as to why the older generation is more susceptible to falls. It could be an indoor environment—even a familiar setting—where furniture becomes an obstacle course because of poor sight, gait, or balance disorder. Slippery floors, uneven and cracked sidewalks, and dim lighting may pose hazards in public places. Dizziness, confusion, and a sudden drop in blood pressure are also common causes.

Statistics show that more women than men fall during their later years. This is in part due to the likelihood of outliving a male spouse, although biological differences also contribute to greater risk. For instance, women’s muscle mass declines faster than that of men, especially in the immediate few years after menopause.2 However, men are more likely than women to actually die from a fall.

What outcomes are linked to falls?

According to the CDC:

- Twenty to 30% of people who fall suffer moderate to severe injuries, such as lacerations, hip fractures, or head traumas
- Falling is the most common cause of traumatic brain injuries (TBI)
- Falling is the most common cause of fractures among older adults and include fractures of the spine, hip, forearm, leg, ankle, pelvis, upper arm, and hand3

The period of time spent immobile while recovering from a fall injury often affects health outcome. Muscle cell breakdown due to prolonged compression starts to occur within 30-60 minutes of the fall when the patient remains on the floor or ground. Dehydration, pressure sores, hypothermia, and pneumonia are other complications that may result due to immobility during recovery after the fall.4

When to call 9-1-1

A quick and appropriate response to a fall can minimize pain, confusion, and complications. However, that’s easier said than done; most falls among the elderly go unreported. An injury related to the fall might seem minor, but internal injuries may be present without outward symptoms. Another factor for the older population is embarrassment from a perceived “loss of control.” Despite a common fear of falling, some feel it is no reason to seek help when it does happen. They may have the thought, “Older people fall all the time without injury, so why should it be any different for me?”

Bystanders are more likely to call 9-1-1 when a person—stranger, neighbor, client, or loved one—falls. The patient may be unconscious, having difficulty regaining consciousness, or conscious but unable to seek assistance independently.

It could be the outcome of the fall warranting concern, such as a spinal injury, obvious fracture, or signs of an acute medical problem, such as stroke. Serious pain is also a common reason for seeking help.

Protocol and falls

The issue of falls in older age has been a neglected public health problem. Many health providers are unprepared to manage falls in older individuals because they lack sufficient knowledge of the conditions that might have predisposed a fall. Without considering underlying health conditions, triage teams and first responders may underesti-
these distances need rapid transport to the nearest hospital where they can be tested for internal injuries and where surgeons are available to properly address such problems. 

The second Key Question on Protocol 17 determines the cause of the fall: accidental/unknown, dizziness with fall (ground level), electrocution/lightning, fainted or nearly fainted (ground level), or jumped (suicide attempt). The EMD should follow the appropriate shunts as directed. Ground-level falls are the most common, and they may be caused by a simple slip, trip, or a medical problem that caused fainting, near fainting, or unconsciousness. A ground-level fall includes falling from a standing position or from a height in which the feet can touch the floor, i.e., from a bed or chair. The Rules and Axioms in the Additional Information assist in defining the cause and provide valuable information in determining the appropriate response.

Rule 1 tells the calltaker to “Always consider that the patient's fall may be the result of a medical problem (fainting, heart arrhythmia, stroke, etc.).” In the vast majority of ground-level falls caused by a medical problem, the medical issue will initially take priority over any injuries sustained from the relatively low mechanism of injury associated with a fall from ground level. This is why Protocol 17 shunts to Protocol 31 if it is learned that a ground-level fall was caused by fainting or near fainting. In fact, many calls coded as “fall and unconscious (cause unknown)” are actually cardiac arrest cases. It's the “chicken or the egg” type situation:

```plaintext
The caller recognized the fall, but not the cause of the fall.

According to Axiom 1, “Ground-level falls in elderly patients commonly result in hip fractures, which are not prehospital emergencies.” A caller may recognize the possibility of a hip fracture from the appearance of the patient's leg—which is often shortened slightly and rotated inward—and the inability to bear weight on the leg; pain can be moderate to severe and present anywhere from the pelvis to the knee.

Axiom 1 has proven to be a sticking point, and it is sometimes taken out of context. While hip fractures can be very painful and debilitating, and in some cases even cause death, they are not pre-arrival or even prehospital emergencies in the sense that a few minutes shaved from the response time would not make a difference in the outcome. In fact, these patients actually need slow, methodical, and gentle transport, rather than speed, which is often associated with rough handling and a rough ride to the hospital that is painful and can even aggravate the injury.

A hip fracture might be an urgent situation requiring ambulance transport, but it doesn’t make it an emergent situation, depending on other factors involved (such as slipping on ice and getting the individual out of the cold). In dry and warm (comfortable) situations, the patient can receive adequate support from a pillow or blanket roll, and that’s usually all they need until BLS arrives.

Some people disagree, but it has been the Academy’s view that an isolated injury without priority symptoms, from a low mechanism of injury, does not justify the risks associated with a lights and siren response, and such a response is very unlikely to make a difference in outcome anyway. The injury may be painful, but the serious risks are generally associated with recovery and are not minute critical.

A fall associated with alteration of consciousness, however, is potentially critical even at ground level because of the potential for airway obstruction and even cardiac arrest. Trauma patients described as not alert with ineffective breathing require an airway maneuver, and the EMD should protect life over limb and open the airway (Rule 3). If breathing is effective and Pre-Arrival Instructions are not necessary, it is prudent to encourage the rescuer to use his/her hands to stabilize the patient’s head and neck in the position found if a spinal injury is suspected (Rule 5).

Care for the ground-level fall of a patient should include showing support and compassion, while monitoring for any changes and encouraging the patient not to move unless absolutely necessary. DLS Links direct the EMD to instructions for airway maneuver (ABC-1) if the patient is in arrest or has ineffective breathing and is not alert. Links to specific panels on Case Exit are also available to address scene safety or to direct the caller to handle bleeding or an avulsed tooth, if necessary. In most cases, however, gentle and careful transport to the hospital for further evaluation and treatment is the priority.

Sources
3 See note 1
Answers to the CDE quiz are found in the article “Age Factors,” which starts on page 30. Take this quiz for 1.0 CDE unit.

1. _____________ is the leading cause of both fatal and nonfatal injuries among the senior population, age 65 and older.
   a. cardiac arrest
   b. traffic accidents
   c. falling
   d. inclement weather

2. Statistics show that more women than men fall during their later years.
   a. true
   b. false

3. The period of time spent immobile while recovering from a fall injury does not affect health outcome.
   a. true
   b. false

4. If the caller reports “She fainted,” the EMD should use which of the following Chief Complaint Protocols?
   a. Protocol 17: Falls
   b. Protocol 28: Stroke (CVA)/Transient Ischemic Attack (TIA)
   c. Protocol 31: Unconscious/Fainting (Near)
   d. Protocol 32: Unknown Problem (Person Down)

5. The first Key Question on Protocol 17 determines:
   a. if the person is alert.
   b. whether there is serious bleeding.
   c. how far the person fell.
   d. the part of the body injured.

6. The second Key Question on Protocol 17 determines:
   a. the distance to the ground.
   b. whether this is common for the patient.
   c. how many people are involved.
   d. the cause of the fall.

7. Rule 1 in Protocol 17 tells the calltaker to:
   a. “always consider that the patient’s fall may be the result of a medical problem.”
   b. “protect life over limb and open the airway.”
   c. “encourage the patient not to move.”

8. A caller may recognize the possibility of a hip fracture based on:
   a. an oddly positioned or twisted neck.
   b. the appearance of the patient’s leg—which is often shortened slightly and rotated inward—and the inability to bear weight on the leg.
   c. nasal congestion and watery eyes.
   d. bumps, blisters, or open sores.

9. Ground-level falls in elderly patients commonly result in hip fractures, which are not considered prehospital emergencies in the MPDS in the sense that:
   a. there is generally very little pain involved.
   b. it’s faster to call for a taxi.
   c. the patient would be put at the end of the triage in the ER.
   d. a few minutes shaved from the response time would not make a difference in the outcome.

10. Care for the ground-level-fall patient should include:
    a. showing support and compassion.
    b. monitoring for any changes.
    c. encouraging the patient not to move unless absolutely necessary.
    d. all of the above
A guy in a 1968 Buick Le Sabre backs out of his parking space at a snow-packed lot at a large discount grocery store when the vehicle suddenly stalls and refuses to go, despite the driver gunning the engine repeatedly.

Without looking back and apparently without hearing the atonal roar of car horns directing him to do otherwise, the driver angrily slams the gearshift into drive, causing the long, heavy automobile to jump like a deer back to where his exit began. He pulls the shifter into reverse again and floors it. The tires kick up rooster tails of snow and ice, but the vehicle moves about five feet and stops exactly where it did before. Clearly upset, the guy puts the car in park, opens the door, and climbs out to find out what the heck is wrong with his car.

What’s wrong with his car is another car—a brand new SUV with dealer plates—is right square in his way. It had become stuck behind four other cars inching their way into parking spaces and precisely in the path of the Le Sabre’s exit. No one was hurt in the event, but the SUV’s freshly clear-coated exterior was temporarily scarred.

The impact of low-impact
Such fender-benders happen everywhere all day long. In fact, a review of almost any police call center data will show that 70–75% of auto accidents called into 9-1-1 are low-impact, minor or non-injury incidents. Despite the lack of severity or need of a DELTA response, the run-of-the-mill crash is a remarkably time-consuming call for dispatchers.

Version 4.2 of the Police Priority Dispatch System™ (PPDS®) released in mid-November addresses that fact in a major update of Protocol 131: Traffic/Transportation Incident (Crash). The number of Key Questions has been significantly reduced by categorizing incidents into either LOW MECHANISM or HIGH MECHANISM and tailoring the interrogation to match either situation.

“Too many questions nonsensical or not relevant to the matter at hand can hinder a calltaker’s accurate and timely processing of information,” said Dave Warner, a police consultant for Priority Dispatch Corp.™ who has been closely involved in drafting and beta testing v4.2. As Warner pointed out, callers are also quick to become angry if they think...
questions are irrelevant or if they start to think the calltaker isn’t listening.

“Several elements in Protocol 131 have been refined and more terms defined, all in an effort to get to the relevant details with far fewer questions,” Warner said.

In version 4.2, LOW MECHANISM is defined as “A situation in which there is evidence to suggest minor or unknown injuries,” like the winter parking lot incident described earlier. HIGH MECHANISM is defined as “A situation in which there is evidence to suggest serious injuries as a result of the mechanism of injury. Situations may include, but are not limited to, all-terrain/snowmobile, high-speed collision, possible death at scene, rollover, vehicle off bridge/height, and vehicle vs. pedestrian/bicycle/motorcycle.”

“This might sound more difficult and somehow too arcane, but the changes actually make the calltaker’s life easier by eliminating general questions and being incident-specific,” Warner said. “In short, what we’ve done is provide a Key Question sequence that better addresses the majority of traffic accidents in communication centers where police have a primary response over the need for EMS or rescue personnel.”

One of the Key Questions that has been eliminated from Protocol 131 is “Has anyone involved been using alcohol or drugs?”

Also pared from the previous version are all but one of the 10 Determinant Suffixes included in v4.1. The suffix “B=blocking or slowing traffic” remains below new suffixes “H=HAZMAT” and “R=Rescue.” Calltakers may still only select one of the three suffixes, choosing the highest on the list if more than one of the conditions is reported.

**Fewer questions**

The changes to Protocol 113: Disturbance/Nuisance also reflect the goal of eliminating unnecessary caller interrogation and arranging Key Questions in a more coherent manner. Specific Key Question pathways are now tailored to the types of calls handled on this protocol.

Where safety at the scene for callers and responding police remains the top priority of EPD, the first question under “Disturbance” is, “Were weapons involved or mentioned?”

This question has a Pre-Question Qualifier of (Appropriate) for calls involving a nuisance, and has been removed altogether on other call types, such as complaints of a loud stereo or television.

Calltakers would do well to memorize the new definitions of “NUISANCE” and “TOO MANY QUESTIONS NONSENSICAL OR NOT RELEVANT TO THE MATTER AT HAND CAN HINDER A CALLTAKER’S ACCURATE AND TIMELY PROCESSING OF INFORMATION.”

— Dave Warner

“Disturbance”, Warner added. “There are important changes made that will help clarify both when making Determinant Code classifications.”

NUISANCE is defined as, “A minor disturbance, such as begging (panhandling), skateboarding complaints, or other activities causing annoyance or bother to others.” Disturbance is “Any act causing disquiet, agitation, or interruption of the peace and quiet. This includes mutual combat fights or situations where a physical altercation is imminent.”

Significant changes

Of all the v4.2 revisions, Protocol 105: Animal is the most significantly changed with a dozen or so refinements.

As with the other retooled protocols, “Every call type now has its own Key Question pathway,” Warner said. “Again, the changes are designed to prompt more appropriate Key Questions based on the sub-Chief Complaint or call type selected and to speed up call processing.”

Among these changes, a new 105-C-3 Determinant Code, “CONFINED DANGEROUS animal” has been added to Protocol 105. The new classification allows the calltaker to indicate when an animal does not currently pose a threat to others as explained in the new definition of “CONFINED Animal.” It also includes the use of the newly revised definition for “DANGEROUS Animal.”

“This [revision] is significant because the term ‘DANGEROUS Animal’ is no longer defined by the local jurisdiction,” Warner said. “Before the update, calltakers were directed to follow whatever definition their individual center used to define ‘dangerous.’ A universal definition simplifies the process for everyone involved.”

A DANGEROUS animal is now clearly defined as “Any animal that, by type or behavior, poses a threat of death or serious injury to people, livestock, or domestic animals.”

An example would be a bobcat or mountain lion in someone’s backyard. A CONFINED DANGEROUS Animal, then, could be an alligator stuck in a Florida resident’s irrigation canal within a fenced yard or a cougar that somehow got trapped in a garage. In such cases, the correct code is 105-C-3.

Whether weapons are involved remains the top Key Question on Protocol 105. Warner explained that there is a high correlation between a dangerous animal situation and the presence of guns. “If the neighbor’s dog has attacked a child, for example, you may want to grab a shotgun and end any chance of the dog hurting anyone again.”

Animal cruelty can also give rise to weapons showing up, although many cases involve someone who simply fails to properly care for an animal in which case a PQP of (Appropriate) was added. The weapons questions will not be prompted for calls involving stray animals, barking dog complaints, or minor bites. A new Post-Dispatch Instruction d has also been added to Protocol 105 in case the situation of a barking dog resolves on its own: “(Barking dog) Call us back if the barking stops.”

**New subquestions**

Last but not least, on Protocol 135: Weapons/Firearms, Key Question 3b “(Gun) Have shots been fired?” has been revised with the addition of two new subquestions designed to gather more information if the caller has heard shots but didn’t see who fired them.

Key Questions 3bi reads, “(No) What direction were the shots coming from?” and Key Question 3bii reads, “(No) Did you see or hear anything else?”

The two Rules in Protocol 135 remain the same in v4.2 and should be kept in mind when handling any weapons or firearms calls, Warner said. Rule 1 states, “All SHOTS FIRED calls should be considered authentic until proven otherwise,” and Rule 2 reminds the caller that “SHOTS FIRED that are heard only (not observed visually) should be coded 135-C-1.”
Answers to the CDE quiz are found in the article “Less Is More,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. In v4.2, LOW MECHANISM is defined as:
   a. A situation in which there is evidence to suggest minor or unknown injuries.
   b. A situation in which there is evidence to suggest serious injuries as a result of the mechanism of injury.
2. Which of the following is a Key Question that has been eliminated from Protocol 131?
   a. Is there anything blocking or slowing the flow of traffic?
   b. Has anyone involved been using alcohol or drugs?
   c. Has the vehicle fallen off a bridge?
   d. Is anyone injured?
3. On Protocol 131, which of the 10 Determinant Suffixes included in v4.1 remains in v4.2?
   a. B = Blocking or slowing traffic
   b. I = Impaired
   c. D = Amount of damage
   d. P = Damage to government property
4. Of all the v4.2 revisions, ____________ is the most significantly changed with a dozen or so refinements.
   a. Protocol 131
   b. Protocol 113
   c. Protocol 105
   d. Protocol 135
5. What new Determinant Code has been added to Protocol 105 in v4.2?
   a. 105-D-3, TRAPPED DANGEROUS animal
   b. 105-C-3, CONFINED DANGEROUS animal
   c. 105-B-2, LOOSE DANGEROUS animal
6. Which of the following is among the refinements to Protocol 105 in v4.2?
   a. The new CONFINED Animal definition has been added to Protocol 105.
   b. The DANGEROUS Animal definition has been revised and is no longer defined by local jurisdiction.
   c. The DANGEROUS Animal definition includes an animal that poses a threat of death or serious injury to livestock.
   d. all of the above
7. If a homeowner calls to report that a cougar is trapped in his garage, the correct code is:
   a. 105-A-1.
   b. 105-B-2.
   c. 105-D-1.
   d. 105-C-3.
8. There is a high correlation between dangerous animal situations and the presence of guns.
   a. true
   b. false
9. A new Post-Dispatch Instruction d has also been added to ____________ in case the situation of a barking dog resolves on its own: “(Barking dog) Call us back if the barking stops.”
   a. Protocol 131
   b. Protocol 113
   c. Protocol 105
   d. Protocol 135
10. On Protocol 135, which of the following has been added as a subquestion to Key Question 3b?
    a. Where’s the suspect/person responsible now?
9-1-1 Plot Points

Below are some highlights of the first-ever nationwide self-assessment of call centers connected to the 9-1-1 emergency network around the U.S. Although the data was collected in 2011, and fewer than half the centers (27 states) responded, the partial results are important mile markers as centers plot their paths toward the Next Generation 9-1-1 era. The full report, Review of Nationwide 9-1-1 Data Collection, can be obtained at 911.gov.

9 of 27 states reported having only a state-level 9-1-1 authority and no sub-state 9-1-1 authorities.
26 states reported having a total of 2,480 primary PSAPs and 538 secondary PSAPs.
8 states reported that costs of operating 9-1-1 exceeded revenues for the fiscal year.
15 states reported having a dedicated 9-1-1 surcharge.
11 states reported that 9-1-1 authorities have defined NG9-1-1 plans, with 4 states implementing totally digital 9-1-1 statewide.
14 states reported having no plans for implementing NG9-1-1.
3 states indicated they can process and interpret IP location and caller information within their states (12.7%).

71% of all 9-1-1 calls were from cellphones.

173,958,226 Total calls to 9-1-1 in 2011 of the 19 states reporting data, with responses ranging from 197,000 calls per state to 89,605,140 calls per state.

99% of all states have implemented E9-1-1, Phase II.
At age six, most children can barely tie their shoes let alone recite their home address or write in cursive.

But that didn’t stop a 6-year-old Maryland boy from dialing 9-1-1 on Aug. 28, 2013, when his mother suffered a seizure while preparing a family meal. Kenny Watson’s quick thinking helped him connect with EMD Roberto Ramirez, a calltaker with Prince George’s County (Md.) Public Safety Communications who directed first responders to the boy’s unconscious mother.

“Most of the time, the young callers we get are pranksters,” said Ramirez, Watson’s lifeline to assistance. “But I just heard in his voice that he wasn’t joking. I thought ‘He’s for real.’”

Though Kenny couldn’t recall his home phone number, he knew his address, which he relayed to Ramirez. Meanwhile, Ramirez asked him Case Entry questions while simultaneously reassuring Kenny that he would stay on the line with him and that help was on the way.

“I looked at the prior calls and saw that Kenny had called 9-1-1 twice before,” Ramirez said. “He was good and calm the whole time. He was like, ‘Yeah, I got this.’”

Ramirez had Kenny confirm that his mother wasn’t having multiple seizures, that she was breathing, and that she was lying in a comfortable position. He also provided instructions should Watson’s mother regain consciousness.

During the call, Ramirez told Kenny, “You’re doing a good job at this,” and “You’re a pro,” to which the boy responded, “I know. I do this all the time.”

Fire and emergency medical responders arrived at the home within minutes, evaluated Kenny’s 30-year-old mother, and transported her to nearby Fort Washington Hospital for further care.

Ramirez, formerly a volunteer firefighter in New Jersey, has only been a calltaker with the Prince George’s center for 2 ½ years. But it’s calls like Kenny’s, he says, that remind him why he started a career in emergency dispatch.

“I look back, and this is why I do my job and why I love it,” Ramirez said.

The call was unusual enough that it has attracted attention from the local news media, including at least one TV news station. When teased about Kenny’s call making him something of a celebrity in the community, Ramirez shrugged it off as falling back on his training.

“I’m just excited to meet Kenny and tell him he did a good job and that he’ll be able to take care of his mom in the future,” Ramirez said. “I felt pretty good.”

Prince George’s County Public Safety Communications covers a service area of more than 870,000 residents. In 2012, it responded to more than 1.4 million calls for service.
72 Hours
New Orleans mourns the deaths of two dispatchers

Within three days in September 2013 in New Orleans, La., two New Orleans Police Department (NOPD) 9-1-1 center employees lost their lives in two separate incidences.

Paulette Brown, 51, a 32-year veteran radio dispatcher with the police department’s 9-1-1 center (which takes the area’s medical, fire, and police calls), was on her way to work on Interstate 10 the night of Sept. 8 when her car was struck by a suspected drunk driver traveling in the wrong direction. Brown died at a local hospital from her injuries within days of the incident.

“Paulette was always talking about her family, was friendly, and got along with everyone,” said Stephen Gordon, executive director of Orleans Parish Communication District (OPCD, the administrative organization for the parish’s 9-1-1 call center) and previously a captain of the NOPD 9-1-1 center and Brown’s supervisor.

Then, on Sept. 11, Christine George, 39, a calltaker and co-worker of Brown’s at the NOPD communication center, was gunned down near her Gentilly, La., home along with her two adult children, 20-year-old daughter Trisa George and 18-year-old son Leonard George. All three victims sustained multiple gunshot wounds. Investigators questioned and released Shawn Peterson shortly after the crime, and arrested him days later on three counts of first-degree murder.

“For her [center] to get a 9-1-1 call on her, I couldn’t even imagine what [her colleagues] felt, and I’m pretty sure it knocked them on the floor,” George’s brother, Patrick Preston, told WVUE-TV News in New Orleans.

June Wilder, a chaplain for the NOPD, knew George and couldn’t initially process the deaths of both women.

“The word ‘overwhelming’ comes to mind, and ‘total shock,’” Wilder said. “That was the first time I attended a triple funeral,” referring to the funeral for George and her two adult children.

Gordon confirmed that not only had Brown’s and George’s colleagues at the NOPD comm. center answered the 9-1-1 calls for each calamity, but also that off-duty members of the center went to the scene of the George family shooting.

“After Hurricane Katrina, this would have to be the worst tragedy” that NOPD’s call center had faced, Gordon said. “I was worried about the families but also worried about the 9-1-1 operations.”

The center’s dispatchers and calltakers mourned their co-workers and met with NOPD chaplains and grief counselors, while neighboring Jefferson Parish Sheriff’s Office dispatchers pitched in their own time to cover calls at the New Orleans center. The center’s employees were also deeply moved by the hundreds of sympathy cards and gift baskets that poured in from 9-1-1 centers across the country, Gordon and Wilder said.

“It was amazing, the outpouring of support,” Wilder said. “It let these [dispatchers and calltakers] know that they’re not alone.”

“Nine-1-1 is a community, and when we received that support from across the country, we knew that we were a nation,” Ausettua AmorAmenkum, education coordinator and public information officer for OPCD, said the tsunami of cards and well wishes from 9-1-1 centers around the country in the wake of the deaths had a significant impact on center employees’ healing process.

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“I tried to encourage them to allow themselves to grieve, to talk about it, to cry, but to not keep it bottled up inside,” Wilder said.

To express their support for Brown, George, and their families, the center’s co-workers assisted with funeral arrangements and created memorial shirts in tribute to their fallen friends. At each funeral, the two women and their families were honored with a NOPD motorcade and a police honor guard at the graveside services.

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“Nine-1-1 is a community, and when we received that support from across the country, we knew that we were a nation,” AmorAmenkum said.
Life’s a Wonderful Thing
Three-year-old wraps hearts around her finger

Three-year-old Ireland Nugent is a national media celebrity.

Upon first glance at her photo, you might think it’s the curly blond hair and big blue eyes or the pretty-in-a-pink-tutu ballerina pose skyrocketing her to fame.

Or maybe it’s because of the picture taken at her third birthday party of Ireland looking every part the princess dressed in a yellow taffeta gown and pink and yellow tiara.

Most likely, however, it’s all of that and more tossed in with the wonder and fascination shining through the eyes of a little girl who on the evening of April 11, 2013, suffered serious leg and hand injuries in a tragic lawn mower accident at her home in Palm Harbor, Fla.

“She’s (Ireland) phenomenal,” said EMD Alexis Frymoyer, the Pinellas County (Fla.) dispatcher who answered the frantic 9-1-1 call from a neighbor who responded to the accident. Jerry and Nicole Nugent, her six brothers and sisters, a neighbor who provided first aid at the scene of the accident, and the 9-1-1 caller. Sunstar Paramedics responds to all medical emergencies in Pinellas County.

Nicole Nugent said the visit was something that she and her husband had wanted to arrange once Ireland was physically able, although it was hard to predict how the toddler might react when introduced to the responders that had provided emergency support.

“We didn’t know what it would mean,” Nicole Nugent said. “She’s been so tough and happy throughout this, and, at the same time, we thought it would be nice to thank everyone who had a hand in saving her life.”

Frymoyer was among nearly a dozen first responders gathered at Sunstar Paramedics headquarters in Largo, Fla., on May 22, 2013, to meet Ireland, her parents, Jerry and Nicole Nugent, her six brothers and sisters, a neighbor who provided first aid at the scene of the accident, and the 9-1-1 caller. Sunstar Paramedics responds to all medical emergencies in Pinellas County.

Nicole Nugent said the visit was something that she and her husband had wanted to arrange once Ireland was physically able, although it was hard to predict how the toddler might react when introduced to the responders that had provided emergency support.

“We didn’t know what it would mean,” Nicole Nugent said. “She’s been so tough and happy throughout this, and, at the same time, we thought it would be nice to thank everyone who had a hand in saving her life.”

Ireland arrived in her mother’s arms dressed in a red-and-white striped, blue-starred two-piece jumper. The red ribbon holding curly bangs in place above her forehead gave the toddler an unrestricted view of the responders taking turns to sign the pink cast covering her left forearm. She clutched a white teddy bear a Bayflite paramedic gave her when the family arrived.

Not content to stay still, Ireland squirmed to join the play of her siblings. Once on the floor and on her own, she scuttled around the room on her knees while her parents talked about her recovery since losing her lower legs and feet in the accident; she had not yet been fitted with the prosthetics she would decorate with Dora the Explorer stickers.

Later during the meet, and in her dad’s arms, she looked inside the Bayflite medical chopper that had ferried her to Tampa General Hospital after the accident, and watched a miniature remote-controlled ambulance follow the family along a hallway of Sunstar offices. She shied away only slightly from the sight of the many uniforms.

“Since the accident, people in uniforms tend to make her nervous,” Nicole Nugent
said during an interview with Tampa Bay Times staff filming the reunion.

Frymoyer said it was incredible experience meeting Ireland.

“She moved around the room like nothing had happened,” she said. “She took the Band-Aids out of the goody bag Sunstar gave her and put them on the end of her legs. She was like every other two-year-old.” (Ireland was two years old at the time of the visit.)

As far as Ireland’s take on the afternoon, her mother said it’s hard to say.

“I don’t know if she understood any of it,” Nicole Nugent said, according to a story in the Tampa Bay Times. “She was happy to meet new friends because she’s two and that’s what they like to do [at that age]. For me, it brought some closure.”

Frymoyer had answered the phone call coming in early that evening in April and, initially, had difficulty understanding what had happened.

“The caller was on a landline, and there was a lot of static,” she said. “I could hear screaming in the background about an accident involving a lawn mower. After asking Case Entry questions, I began to understand the significance of the injury.”

Aly Smith, a nurse who lives next door to the Nugents, was home at the time of the accident, and hearing the commotion, ran over to offer help. Smith applied direct pressure to stop the bleeding while Frymoyer relayed instructions from Panel 6 (Amputation) of the Medical Priority Dispatch System™ (MPDS®) Case Exit Protocol. A sheriff’s deputy on scene stepped in to control the chaos while waiting for response to arrive. The call ended when EMS arrived.

Smith was amazed at Ireland’s composure while awaiting emergency crews. The girl was conscious and breathing, and talked about her puppies and sisters.

“It was very hard to see her like this, but she wasn’t having a hard time and that made it a lot easier,” Smith said.

The reunion, held three weeks after Ireland’s release from the hospital, underscored why Frymoyer chose the profession.

She graduated from Eckerd College in 2010 with a degree in biology and gravitated toward the profession while volunteering for the Eckerd College Search and Rescue team. She likes “helping people in the moment” without the expectation for resolution.

“We don’t usually get the experience of meeting the family,” Frymoyer said. “It was great seeing her progress and comforting to see how well the family had made it through a very hard time. It reassures me that what we do makes a difference.”

In the seven months (as of Nov. 11, 2013) since the accident, Nicole Nugent said the community and national outpouring has been tremendous. Donations from all over the country have helped cover medical expenses. Steve Chamberlin, a former professional wrestler, has helped cover the payment of her prosthetics through his charity 50 Legs, started after he lost a leg in a motorcycle accident.

Nicole Nugent said her daughter is doing remarkably well despite pain attributed to fitting each new set of prosthetics to accommodate her growth spurts. Ireland dreams of becoming a ballerina, and her mother plans to enroll her in classes as her stability on her prosthetics and gait training progresses.

“She’s a fun-loving little girl who loves to be with her brothers and sisters,” Nicole Nugent said. “Everyone spoils her. She’s well loved, that’s for sure.”

Follow Ireland’s recovery on the Nugent’s website irelandnugent.com/home.html and on Twitter @IrelandNugent
At 19:13 hours on Sunday, Nov. 24, 1940, a small gas tank exploded at Marksbury Road, Bedminster, in the city of Bristol (or Brüder, the German code word for the city in southwestern England).

Within 30 minutes, 897 part-time personnel from the Bristol Auxiliary Fire Service (AFS) reported for duty, spending the rest of that night and into the next day dodging collapsing masonry and shattered glass in their battle against fires fueled by Luftwaffe (German air force) bombers dropping incendiary devices and high-explosive bombs.

Firefighters, stretched to the limit, heroically attempted to douse flames at the perimeters despite being incapable of saving individual buildings blown apart, blast by blast. Winds fueled fires that burned like a blowtorch deep into structures.

For the Germans, it had been a successful night. The 12,500 bombs dropped during the six-hour blitz destroyed major wartime supply lines, from the port city to the Midlands and southern England. A quarter mile of the city, including a shopping area known today as Castle Park, was nearly leveled to rubble and ash. Two hundred Bristolians were killed and another 689 were injured while only two German aircraft and their crews failed to return.

Bristol firefighters had most of the fires under control by late morning, although 26 were still smoldering and being attended to some 36 hours later.

And that was only the beginning of the Nazi Blitz on Bristol. Between Nov. 24, 1940, and April 11, 1941, there were six major bombing raids over Bristol, killing 1,299 people and damaging nearly 90,000 businesses and homes.

Like Germany’s attack plan for London—an all-out aerial bombardment by the Luftwaffe on the city’s infrastructure and people—Bristol was also meant for a similar fate. A population shattered of confi-
dence and without the services required for their survival would be left with only one option: surrender.

But Bristol wasn’t going to give in. Firefighting was a main line of defense, and it meant rushing into the carnage with hoses and trucks, often on foot, while bombs continued to fall and explode. Water mains would break, forcing firefighters to pump water from the harbor.

Bombs weren’t the only devices that could maim and kill the firefighters. Products of Bristol’s commerce—gun and instrument parts, ball bearings, springs, and wire—were unintended weapons propelled by a blast at a factory or warehouse.

Firefighters’ helmets provided some protection. Hard enough to withstand some of the impact from falling materials, with a low-slung back allowing water to run off their coats, the helmet could also be used to shield the eyes and skin from stinging particles and sparks from the blistering intense heat.

But they’d be nothing on the heads of the timid. Bristol was the fifth most heavily-bombed British city during World War II.

“Firefighters ran in each time, facing the most unpredictable dangers,” said Louise Ganley, PDC™ clinical support officer in the U.K. “It wasn’t a question for them. They went in while others ran for shelter.”

Ganley has firsthand stories from the Blitz. Her maternal grandfather, George Shatcott Lloyd, volunteered for service in the Bristol Volunteer Fire Brigade when a heart murmur detected before the war in Europe pre-empted active service in the military.

“He did the next best thing he figured he could do,” Ganley said. “He lived down the street from the station, and through the war, he either walked or rode his bike there in the event of an air raid.”

Lloyd was second in Ganley’s family line of public service or, at least, for the period she has thus far researched since catching the genealogy bug in 2006. A great-grandfather on her father’s side, Albert Weston, was a firefighter at the turn of the 20th century for the Calne Fire Brigade in Wiltshire. Calne is about 82 miles (132 km) due east of London.

Weston was part of the original crew that traveled to fires on a wagon pulled by horses borrowed from the local bus company. A smaller engine—a hand-pumped engine pulled by a single horse—was called out on days the borrowed horses were scheduled to pull the bus.

Ganley knows little else about Weston except that at age 2, he lost his father in a shipbuilding accident. Watson’s father suffered the “breaking of every bone in his body” from a long and lethal fall in which he was slammed against a ship’s hull, according to the coroner’s report.

Ganley’s search has also turned up a few notable names and black sheep.

Her great-great-great-grandfather, John Todd, was a brother of Mary Todd, the beleaguered wife of Abraham Lincoln, the U.S. president during the Civil War.

Ancestors of a more criminal persuasion lived at least part of their lives banished to Australian penal colonies established by the British government.

“It’s all been very fascinating,” Ganley said. “Sometimes, I come up blank but then I just get back to it from another line of the family.”

Sources