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FEA TURED  

SLIPPERY SLOPE  
Winter is an ideal time for lovers of the outdoors to enjoy fresh mountain air and popular activities such as skiing. But it’s also a time to be aware of dangerous avalanches.

SAN BERNARDINO MASS SHOOTING  
The Dec. 2 mass shooting in San Bernardino, Calif., shocked the nation and tested the composure and skill of local dispatchers and emergency responders.
Sonja is an independent marketing communication consultant specializing in health care and community health. Sonja is currently working with North Memorial Health Care, based in Robbinsdale, Minn. In addition to her duties there, she also supports a variety of social marketing initiatives, medical associations, clinics, and physician groups.

Art is a software instructor and IAED™-certified ED-Q™ instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 18 years and works at Union County Regional Communications in Westfield, N.J. Art has been involved in 911 telecommunicator training and medical quality assurance since 1999.

Sherri is the training and operations manager for Waukesha County Communications, Wis., a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at stigler@waukeshacounty.gov.

MAIL CALL
We’d love to hear from you! Has something outstanding happened in your comm. center recently? Or are you a budding columnist? Should your center be in the running to be our next Your Dispatch story in Your Space? Do you have a suggestion for The Journal? Email editor@emergencydispatch.org with your thoughts.
Salt Lake Tribune columnist Robert Kirby wanted to become a firetruck. At least he did at age 3 when anything in the universe seemed possible. The world was his unaltered adventure.

Kirby eventually reached the age of reason—that time in life when reality smacks us in the head. No matter how hard he applied his talents and experience, he would never make it as a firetruck. He could not race lights and siren unless he was the person behind the switches.

Kirby was forced to rethink his goal. Eventually, he pursued a career as a police officer and, later to his astonishment, a career every bit as unlikely as his dreams as a 3-year-old:

I certainly never considered the possibility of becoming a newspaper columnist. Neither did anyone else who knew me. We would have laughed out loud at the very idea, as if I had suddenly announced an interest in becoming the pope.

Kirby’s point: Most of us spend a lifetime looking for the career that defines who we are, and most of us never find it. The dreams we held as a child become lost in the fray of life or are impossible to achieve. Somewhere along the way, most of us fall into a profession that suits temperament, requires skills and talents we never knew we had, or, simply accommodates lives outside of work. Jobs happen.

I have talked to many dispatchers and calltakers about their profession, particularly during conversations related to a call subsequently highlighted in The Journal. Why did you become a dispatcher? Was this something you always wanted to do? What keeps you at this highly stressful, demanding, and often thankless job?

I don’t recall anyone saying that a career in the 911 center was the stuff of childhood desires. In some cases, the individual had grown up wanting to become a firefighter, police officer, or EMT/paramedic and followed that dream, later moving from working in the field to sending others into the field.

Most often, I hear that a classified ad or job board led the individual to apply. An interview request is accepted, and following the interview and testing process, an offer is made. The person is trained, certified, and begins the job of helping complete strangers through some of the most harrowing experiences imaginable.

The people who do stay tell me about the satisfaction gained from helping others and the confidence that comes from the ability to provide instructions that can save a life or bring a life into the world.

No one I’ve talked to regrets the path selected, no matter how accidental or unintentional, and those who stay find they have received more than they ever dreamed could happen.
MPDS DOESN’T SKIP A BEAT
AHA guidelines go to the heart of EMD

Scott Freitag, IAED President

A review of the 2015 American Heart Association (AHA) guidelines for CPR proves the visionary work of the Academy and its Medical Priority Dispatch System™ (MPDS®). The recommendations, which the AHA updates for release every five years, include greater recognition of an EMD’s vital role with initiating CPR and, also, the importance of information an EMD collects and provides to EMS crews arriving on scene. The role is one the Academy has long advocated. The EMD’s role in giving lifesaving instructions to the caller and gathering information for use in response is the essence of protocol.

The “2015 AHA Guidelines Update” marks 49 years since the first set of guidelines were published in 1966 and focuses on topics with significant new science. For example, “Part 4: Systems of Care and Continuous Quality Improvement” is new to 2015, with its concentration on integrated processes necessary to create systems of care for both in-hospital and out-of-hospital resuscitation. This section is especially relevant to emergency dispatch in its separation of the AHA adult chain of survival into two chains—one for in-hospital and one for out-of-hospital care systems.

AHA’s credit to dispatch is implicit in updated section 4.5. However, not only do the guidelines address the importance of bystander instructions but, also, the significance of educating dispatchers to “identify unconsciousness with abnormal and agonal gasps across a range of clinical presentations and descriptions.”

Evidence supporting the recommendation points to the MPDS process:

“In systems that currently have protocols to aid dispatchers in the recognition of cardiac arrest, the sensitivity when using protocols ranged from 38 percent to 96.9 percent, with a specificity exceeding 99 percent. Use of these scripted protocols has been shown to increase the rate of dispatcher-guided CPR. The identification of abnormal breathing or agonal gasps is particularly important in the recognition of cardiac arrest by emergency dispatchers.”

The MPDS EMD certification course has long taught emergency dispatchers to recognize agonal breathing (gasping), and the Agonal Breathing Diagnostic Tool provides real-time EMD support. Changes to the airway and breathing panels in MPDS v12.2 further enhanced compliance to de-emphasizing the breathing check and removing the old “Look, Listen, and Feel” method from the BLS algorithm.

The AHA also cited research (section 4.6.1) showing an absolute survival benefit of 2.45 with the use of dispatcher instructions for continuous compressions over traditional CPR. These recommendations are incorporated into the MPDS (and have been since 2004), with a caveat allowing for eventual ventilations in cases of extended response times. Beginning with version 11.2, a Compressions 1st pathway was introduced to facilitate rapid delivery of compressions.

The Academy stays far ahead of the curve ball because, again consistent with AHA 2015 guidelines, the Academy relies on a system of care approach for developing consistent, clear goals aimed at decreasing incidence of and improving survival from cardiac arrest” based on “high-quality data measurement, feedback, and comparison.”

Members can look forward to a much more detailed and dispatch-specific article in a later issue of the Journal, integrating discussion from the Emergency Cardiovascular Care Update (ECCU) 2015 Conference held in December. The ECCU meeting—The New Resuscitation Guidelines: Translating Science into Survival—detailed the new guidelines, which were presented by the actual researchers, and, in addition, elaborated on how the guidelines should be applied.

Brett Patterson, IAED™ Medical Council of Standards Chair, attended the annual meeting in the interest of evolving the MPDS. At the 2015 conference, he presented the IAED’s abstract: “Dispatcher-assisted bystander cardiopulmonary resuscitation increases when using the Medical Priority Dispatch System’s standardized Pre-Arrival Instructions: Kaunas City experience.”

Stay tuned.
I have a question involving multiple patients when using MPDS Protocol 31: Unconscious/Fainting (Near). If I select multiple patients for this protocol, it fast tracks and fills in the unknown information and doesn’t code the call as an ECHO if the patient is unconscious or not breathing. In the same protocol, with a single patient, it does code the call as an ECHO. Why?

John Halatchik
Professional Development Coordinator
Tompkins County 911 Department
of Emergency Response
Ithaca, NY, USA

John:

Thank you for reaching out to the Academy for clarification of this very important question. The issue of the unexpected finding of multiple unconscious patients has been previously submitted and formally discussed and addressed by the Council of Standards. As you can see in the Additional Information section of Protocol 31, we added the EMD’s Third Law of Safety: One patient down, trouble around? Two patients down, coincidence found? Three patients down, danger abounds!

The issue of multiple unconscious patients should always be viewed as a scene/caller safety issue from the outset. As per other protocols, when multiple patients are initially reported, information on each individual patient is not solicited. The fast track feature, common to other protocols, fits well here as it moves quickly forward to dispatch. Overall, ECHO is not used when safety issues are involved as it could dispatch a non-traditional responder, not trained or equipped to quickly assess and address the scene, rather than simply focus on the patient.

Scene safety and prompt dispatch are the primary concerns when dealing with multiple patients. On a more practical note, obtaining individual patient details and providing individual instructions for multiple patients is problematic from a protocol perspective. On protocols where multiple patients are likely, and on protocols where scene or mechanism of injury evaluation takes precedence over individual patient evaluation, i.e., Protocol 29: Traffic/Transportation Incidents, note that the protocol is actually designed to assess the scene, and more generally, rather than specifically, patient injuries. When multiple patients requiring Post-Discussion or Pre-Arrival instructions are encountered, and scene safety issues are ruled out or not present, it is recommended that, when possible, additional incidents be created to be handled by additional emergency dispatchers. If this is not possible, the EMD may, after dispatch, provide PDIs/PAlS for individual patients based on perceived priority. While not optimal, it is really the best we can do with only one emergency dispatcher and multiple patients. The delivery of twins or triplets comes to mind. While it has not been possible or practical to this point to develop a protocol that simultaneously provides individual patient care instructions for multiple patients via a single emergency dispatcher, it is possible, when scene and staffing circumstances allow, to create additional calls and, in essence, add resources to the incident.

I hope this response has been helpful.

Jeff Clawson, M.D.
Brett Patterson, Medical Council of Standards Chair
TAPPING INTERNATIONAL DATA AND EXPERTISE

UKE and EUG MPDS users are essential to research

Tracey Barron

In 2009, the clinical backbone of the International Academies of Emergency Dispatch (IAED) grew even stronger with the addition of the UKE Clinical Focus group to evaluate the clinical and operational value of the Medical Priority Dispatch System (MPDS). The group, which is made up of representatives of each U.K. ambulance service using the MPDS, decided early to promote conversation involving an MPDS topic rather than simply sending each member a prearranged questionnaire asking what they thought might contribute to the research process. The group agreed that joint fact-finding was a major part of their undertaking, and that included collecting data from the multiple communication centers for applied use in research projects and the Academy’s Proposals for Change (PFCs) to further validate and improve the protocol system and dispatch process.

The initial group and its emphasis on the UKE version of the MPDS soon attracted followers, leading to a consistent 20 members that meet regularly to discuss protocol and potential research projects incorporating data from the various centers, as mentioned. I am the chair, and for more than six years our group has grown to include members from Ireland, the Isle of Man, and the Channel Islands. A corollary EUG Clinical Focus group was organized in early 2015 to represent German-speaking users, chaired by Gernot Vergeiner, a member of the IAED College of Fellows. The EUG focus group met for the first time in summer 2015.

The UKE Clinical Focus group has established a solid reputation among its IAED clinical research team members in the U.S. and the international research community overall. We have developed and submitted several PFCs to the Academy, including a comprehensive PFC to modify Protocol 12: Convulsions/Seizures, resulting in core updates in MPDS version 12.2 to better detect seizures caused by pre-existing conditions other than epilepsy and atypical seizures through Key Questioning and EMD monitoring of the patient.

The UKE Clinical Focus group also works jointly—and over long distances—to draft and submit its completed research for publication in journals dedicated to prehospital and in-hospital emergency care. In 2013, the international peer-reviewed Emergency Medical Journal published the group’s manuscript, “Aspirin administration by emergency medical dispatchers using a protocol-driven aspirin diagnostic and instruction tool.” The study analyzed EMD data collected between September 2008 and June 2010 from several international centers and included all calls recorded under MPDS Chief Complaint Protocol 10: Chest Pain (Non-Traumatic), and Protocol 19: Heart Problems/Automated Internal Cardiac Defibrillator. Results were based on the number of times the Aspirin Diagnostic Tool was used, the number of times it was successfully completed, the number of times aspirin administration was advised, and the percentage of patients who took aspirin when advised.

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

No protocol escapes our attention and, considering the expertise and experience of the people in our group, individual suggestions seldom go unchallenged. We certainly don’t promote adversity within our ranks. We respect what each member brings to the table. During discussions, we make sure the point raised relates to the point in question, and we allow responses to any point made.

The UKE and EUG groups work voluntarily to contribute to the knowledge bank necessary to further the research and understanding of effective dispatch through data collection, and they create compelling cases for meaningful change to the MPDS.
I was excited to see the story in The Journal highlighting the art of motivation (Nov/Dec 2015). Let’s face it, there are lots of mornings, afternoons, and nights when we wake up and wonder why we do what we do. The crazy schedules; the overtime; the horrific calls we take; the sometimes-ungrateful agency personnel we encounter; the bosses who really don’t seem to get it. A dispatcher’s world is vast and busy, and it’s tough to muster motivation in this environment. It’s a jungle in there.

Truth be told, when you accepted the job, you agreed to become part of this jungle community. And while you can bemoan that nobody really prepared you for what lies ahead lurking alongside the path of this profession, you’re here now. Time to develop your survival strategy and set out to discover where your own motivation is hiding.

How do we find motivation in these primitive surroundings? Where do we begin to look for it, especially when we are so distracted by those big elephants stomping all over the dispatch room? By that I mean huge issues that never seem to go away, despite the number of times you poke at them. This is the stuff that you absolutely find to be demotivating—ordered overtime, difficult co-workers, management inconsistencies, technology that keeps changing, callers screaming at you, growing expectations of your position, and seemingly unending scrutiny over how calls are handled. Man, this is a noisy jungle! Who has the map that shows the “X” where my motivation is buried? Ask the questions and consider the challenges:

- Will I find motivation when those co-workers I have trouble with move off my shift? After all, some are lazy, some are constantly picking at me, and others are just plain crazy.
- Will I find motivation when I find the buried treasure? Nobody gets into this profession to get rich, but it sure would be nice to earn more, have more benefits, better insurance, and a sweeter schedule with more days off.
- Will I find motivation when our “King of the Jungle” (director/manager) decides to leave? After all, I don’t like the leadership style.
- Will I find motivation when supervisors stop looking over my shoulder and stop correcting me on every move I make? After all, I know what I’m doing, and I don’t need them to remind me. I’m an adult; I don’t need supervision.
- Will I find motivation when all of the assorted bugs, flies, mosquitoes, and gnats (callers) stop biting at my skin? Rude callers, insolent cops, and fire personnel who have absolutely NO idea what a dispatcher has to go through are constant sources of irritation.

Respectfully, dear travelers, the answers to all of those questions are an easy and undeniable “no.” You won’t find motivation if those things happen because there will always be new monkeys, new lions, new giraffes, and more bugs. Hidden treasures are meant to stay hidden. Remember, jungles have a way of proliferating, which is why they’ve been around for centuries. But never fear—all is not lost. There is one place in the jungle where you will find the answer, where you will find motivation.

I’ll suggest the answer lies in the very center of the jungle hidden among the thickets of the deep green forest. It is on the shores of the still and glistening watering hole. If you make your way up to the banks, lean over, and stare deeply into the calm, clear water, you will discover the source of every motivation you’ll ever need peering right back at you. Motivation can never come from other people. It can never come from accolades, money, or power. Motivation must come from someplace deep inside you and only you.
RAGING AGAINST THE PROTOCOLS
Controlling caller frustration during the interrogation sequence

Art Braunschweiger

Recently, I taught several training classes at an agency that had been using the Medical Protocol in card set form and was now switching to ProQA®. At one point, a dispatcher said, “The software’s great, but the people around here don’t let us get through all these questions. They just want us to send the ambulance, and that’s it.” The other dispatchers in the room nodded their heads in agreement. My response to this was the same as it always is: “OK, what are you doing about it?”

Let’s talk about why callers resist questioning. Imagine you’re at an airport, walking to your designated gate with no time to spare. An airline representative stops you and starts asking you questions about your destination, your seat, and a few other things. I’d be willing to bet that you would politely (or maybe not so politely) tell that person to get out of your way because you have a flight to catch. But what if you knew those questions would somehow get you on the plane faster and get your preferred beverage in your hand sooner?

Put very bluntly, 911 callers resist interrogation because they can’t see what’s in it for them. Nearly all of them will be smart enough to realize the advantages of cooperating if they understand why that’s to their advantage. If you give them this understanding up front on every call, it will become an automatic part of your routine.

**Step one:** Deliver immediate reassurance. The moment your caller states his or her emergency, even if it’s only to say “I need an ambulance,” say “I’m going to help you, sir/ma’am,” and then lead right into your next question. That’s important even if you haven’t gotten to what happened yet, because it immediately tells callers that you’re going to give them what they want.

**Step two:** As soon as you’ve asked awake and breathing, explain what’s going to happen next and why. “The ambulance is being dispatched while we’re talking. I’m going to ask you some questions so we can help him until they get there.” There are many variants of this that work equally well. Some dispatchers in my agency add “but these questions are not delaying help.” The key is to make sure your callers are told why they need to cooperate. Saying, “I have some questions I need to ask” is not enough.

Consider discussing this statement at a staff meeting and coming up with a “best practice” that everyone can adopt. You can then teach it to new hires as they begin to take calls. Caller management is a skill to be learned like any other.

Prep your callers early, every time, before you get pushback to your questions. Repeat or reinforce what you’ve told them whenever you sense impatience coming to the surface. It takes a consistent effort from you and your staff, and a willingness to believe it will work. Don’t admit defeat before you’ve even answered the phone. Instead, make it a challenge to turn around your most difficult group of callers, and see if your own expectations of them don’t change.
What could be more important than protecting our children?

Announcing 9-1-1 COMMUNICATION CENTER BEST PRACTICES IN CASES OF MISSING CHILDREN

A missing child is a critically important and high profile event that can rip the fabric of your agency and community if not handled correctly. In terms of urgency, use of resources and potential impact on the community, a missing child requires a level of readiness akin to a disaster. This joint initiative of NAED, APCO, NENA, National AMBER Alert and the National Center For Missing & Exploited Children (NCMEC) was created to:

- Promote awareness of the critical role of the 9-1-1 communication center in handling missing and exploited children calls
- Develop and endorse best practices
- Develop tools for handling incidents of missing and abducted children

Helping to PROTECT OUR CHILDREN is as easy as 1-2-3!

2. Request a copy of the Public Safety Telecommunicator Checklist for Missing Children.
3. Apply to attend NCMEC’s CEO Overview Course in Alexandria, Virginia.

CEO Overview Course

9-1-1 Communication Center Managers and Directors are invited to apply to attend the two-day overview course held at the National Headquarters of NCMEC in Alexandria, VA. Courses are conducted approximately every six weeks at no cost to participants.

For more information, visit www.missingkids.com/911 or email 911@ncmec.org
Dr. Clawson inducted into Utah APCO Hall of Fame

Dr. Jeff Clawson, creator of the Priority Dispatch System™ (PDS™) protocol and co-founder of the International Academies of Emergency Dispatch™ (IAED™), was inducted into the Utah Association of Public-Safety Communications Officials’ (APCO) Hall of Fame on Oct. 7, 2015, during the organization’s annual conference on Salt Lake Community College’s Miller Campus in Sandy, Utah.

“The APCO Hall of Fame is an award reserved for those individuals who have made significant lifelong contributions to the enhancement of public safety communications in our state,” said Utah APCO President Karl J. Kuehn. “The chapter appreciates your vision of emergency dispatch and the many efforts you’ve taken to enhance our profession through both Priority Dispatch™ and the Academy.”

Kuehn said a little more than 20 people have been inducted into Utah APCO’s Hall of Fame, which is located at Valley Emergency Communications Center in West Valley City, Utah.

Mark your calendars for NAVIGATOR 2016

NAVIGATOR is almost upon us, and this year, registration will take you to the nation’s capital for three days of the best educational sessions, entertainment, and networking opportunities available on the planet (the same goes for international NAVIGATOR offerings) for police, fire, and medical emergency communication personnel. The International Academies of Emergency Dispatch™ (IAED™)-sponsored communication fest features awards, top-notch speakers, research poster exhibits (and new this year—stage presentation of the winning poster), an exhibit hall, and more than 100 educational sessions that provide those coveted CDE credits.

So, mark your calendars and make your reservations for three days of instruction, motivation, and inspiration at the Gaylord National Resort, National Harbor, Md., from April 27–29.

Dates for international NAVIGATOR 2016 conferences have been scheduled as follows:

- Middle East NAVIGATOR at the JW Marriott Dubai, United Arab Emirates (UAE), Feb. 2–4
- Asia NAVIGATOR at the JW Marriott Kuala Lumpur, Malaysia, March 1–3
- EURO NAVIGATOR at the Crowne Plaza Salzburg, Austria, Sept. 14–16
- UK NAVIGATOR at the Bristol Marriott City Centre, England, Sept. 20–22

Stay tuned for the yet-to-be-announced dates for China NAVIGATOR, Australasia NAVIGATOR, and Ireland NAVIGATOR.

9-1-1 Magazine pays tribute to dispatcher lost on 9/11

For the past 13 years, since Sept. 11, 2002, 9-1-1 Magazine Editor Randall Larson has consistently paid tribute to the “men and women, responders and civilians, Americans and foreigners, who came to aid the injured, the displaced, and the heartbroken in the days and the decade since that awful Tuesday morning” (Sept. 11, 2001).

And 2015 was no different with a tribute to Jersey City Fire Department (JCFD) dispatcher/EMT/canteen volunteer Joseph Lovero, who responded from off-duty to support JCFD’s crews that were assigned to support operations at the World Trade Center. According to a tribute to him on the memorial page at www.firehouse.com, “Joe was assisting a FDNY battalion chief when the second tower came down. They ran for cover, the battalion chief survived, Joe was seriously injured, and the battalion chief found him in the rubble when the smoke cleared and had him transported to St. Vincent’s hospital where he died.”

The Jersey City Fire Department named a new fireboat the Joseph Lovero in his honor.

Virtual research conference raises wellness awareness

Leading behavioral science researchers and mental health specialists provided insight into the stress-related health issues of dispatch at the inaugural 911 Wellness Foundation (911WF) virtual research conference.

911WF Director of Research Lora Reed, associate professor, Forbes School of Business, Ashford University, California, and Alan Swank, assistant professor, Forbes School of Business, presented “The Servant-Led PSAP: Creating a Climate for Optimal Employee Wellness,” emphasizing leadership’s responsibility in creating healthy work environments for employees.

Michelle Lilly, associate professor, Northern Illinois University, presented “Recent Evidence for Stress-related Health Problems in 911 Telecommunicators.” Her research examines stress-related and trauma-related health in high-risk populations.

Phoenix Chi Wang, a Ph.D. candidate in the Department of Sociology, Harvard University, Cambridge, Mass., presented “Between Everyday Life and Bureaucracy: The Emotional Cost of 911 Dispatch.” Her current academic work focuses on 911 dispatchers, emergency communication systems, CAD coding processes, and federal-to-local 911 policy structure.

Sara Gilman, Chief Mental Health Officer, 911WF, presented “Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Evidence Based Mental Health Treatment for the 911 Telecommunicator.” EMDR is a form of stress-related recovery psychotherapy.

The conference concluded with a roundtable discussion led by Capt. Simon Hargrove, New Orleans Police Department, La.

“By strategically advancing wellness research to identify stress-related health challenges among these highly valuable professionals we can boost their resilience, performance, and retention,” said Jim Marshall, Founder and Chairman, 911WF.
The National 911 Program, housed within the National Highway Traffic Safety Administration (NHTSA), is developing a report to assess the costs, service requirements, and specifications needed for Next Generation 911 (NG911). The National 911 Program will work with Mission Critical Partners, a public safety and emergency communications consulting firm, and its subcontractor Booz Allen Hamilton, a technology consulting and engineering services firm, to gather feedback from 911 stakeholders to address the focal areas of the report, including:

- Geographic breakdown of costs among PSAPs, broadband service providers, and third-party providers of NG911 services
- Assessment of NG911 service readiness among PSAPs
- Differences in PSAP access to broadband that affect costs
- Technical analysis and cost study of singular delivery platforms, such as wire line, wireless, and satellite
- Analysis of NG911 service requirements for people with disabilities

The report will be completed within the next two years. Congress requested the report in Section 6508 of the Middle Class Tax Relief and Job Creation Act of 2012 "to serve as a resource ... as [Congress] considers creating a coordinated, long-term, funding mechanism for the deployment and operation, accessibility, application development, equipment procurement, and training of personnel for Next Generation 911 services."

The National 911 Program, 9-1-1

Federal communication programs cover PSAPs in emergencies

Two tools—emergency alerts and the Public Safety Support Center (PSSC)—can help public safety communicators in an emergency. The Integrated Public Alert and Warning System, or IPAWS, maintained by the Federal Emergency Management Agency (FEMA), is an integrated gateway through which authorized public safety entities, including PSAPs, can alert the public to emergencies such as a wildfire or an AMBER alert for a missing child. Authorized IPAWS users can send alerts through the Emergency Alert System (EAS), which delivers the information via radio, television, and other media, and/or Wireless Emergency Alerts (WEA) delivered to consumers’ cellphones. Email IPAWS@fema.dhs.gov for more information.

A Web-based, one-stop portal to enable PSAPs to request support or information from the Public Safety and Homeland Security Bureau (PSHSB) and to notify the bureau of problems affecting emergency services is now accessible at www.fcc.gov/public-safety-support-center.

The PSSC handles notifications of service outages, complaints related to E911 location accuracy, fraud/non-service initialized 911 calls, tower lighting outages, and text-to-911 service. The PSSC also answers questions regarding PSAP or public safety operations, or FCC rules and regulations. PSHSB staff directly review requests made to the PSSC, viewed directly by PSHSB staff.

Companies fined for failure to handle 911 calls for those with hearing loss

Three companies received fines totaling $1.4 million for failure to handle 911 calls for people with partial hearing loss over periods varying from five weeks to 10 months through applications used by callers who are hard of hearing. In addition, the companies were unaware of this issue until a Federal Communications Commission (FCC) investigation uncovered the problem.

Sprint will pay $1,175,000, Hamilton will pay $235,000, and InnoCaption will pay $25,000. Each company will file detailed compliance reports with the FCC Enforcement Bureau and implement risk management processes.

Individuals who can speak but have difficulty hearing often rely on the Telephone Relay Service (TRS) Internet Protocol Captioned Telephone Service (IP CTS). Consumers are not charged for the service, and the companies providing the service are eligible for compensation from the federally mandated TRS fund, provided they comply with FCC TRS rules and orders.

Test calls made in 2014 by the FCC’s Enforcement Bureau and Consumer and Government Affairs Bureau not only revealed the companies were unable to accept and handle 911 emergency calls made using IP CTS applications but, also, submitted inaccurate requests to the TRS fund administrator for compensation during the period they were found out of compliance.
The word’s out—Australasia NAVIGATOR packs in the numbers

After three years in the profession, Emergency Medical Calltaker (EMCT) Alex Shulamith is making her mark in emergency dispatch with her selection as the 2015 Australasia NAVIGATOR Dispatcher of the year.

“Alex guides and supports new EMCTs to a place where they are competent to continue in their practice alone,” said Wellington Free Ambulance Service, Central Communications Center Delivery Manager Katy Wilkinson, who lauded Shulamith for commitment to teamwork, compliance to protocol, and the ability to function well under stress. “Alex has progressed into a passionate and inspiring EMCT mentor.”

The award surprised Shulamith.

“I was really happy just to be nominated, and I definitely wasn’t expecting to win,” she said in an interview posted on the Wellington Free Ambulance Service website. “I found out a month prior to the conference, so it was very hard work keeping it quiet. I just had to tell my mum, who almost burst with the news, too.”

The Dispatcher of the Year Award was a big occasion but definitely not the only highlight at Australasia NAVIGATOR, held Nov. 3–6, in Melbourne, Victoria, Australia. Emergency Services Telecommunications Authority (ESTA) was formally recognized as a medical ACE, having been notified one month earlier of the center’s accreditation. In 2013, ESTA took more than 24 million calls—an average of one call every 13 seconds—and dispatched to more than 19 million events.

Australasia NAVIGATOR also welcomed the largest audience in the history of the IAED™ conference, attracting 106 people—double the number attending the 2014 conference—predominantly from Australia and New Zealand.

China NAVIGATOR 2015

The International Academies of Emergency Dispatch’ (IAED™) presented China NAVIGATOR 2015, Oct. 11–12, in Qingdao at the Shangri-La Hotel. In all, 226 members and representatives of various emergency communications agencies in China participated.

Hulunbuir 120 Medical Emergency Command Center, Hulunbuir City, Hailar District, Inner Mongolia, China, achieved medical Accredited Center of Excellence (ACE) status in September, and was honored during China NAVIGATOR 2015 for the tremendous accomplishment. Hulunbuir is the seventh public safety agency in China since April 2013 to achieve ACE status in Emergency Medical Dispatch. The other ACEs include: Yunnan Province Emergency Center; Hangzhou Ambulance Center; Huizhou City Health and Family Planning Bureau; Qinghai Province Medical Emergency Center; Suzhou Emergency Center; and Wuxi Emergency Medical Center.

Zhang Li of China’s Wuxi Emergency Medical Center received China NAVIGATOR 2015 Dispatcher of the Year honors. Priority Dispatch Corp.™ (PDC™) presented a special award to Huludao Emergency Medical Center in China for the agency’s contributions to Emergency Medical Dispatch.
Three Decades on the Fly
North Memorial Air Care continues to soar

Sonja J. Carlson

Paramedic Scott Anderson worked the first North Memorial Air Care (Minnesota) shift inside a Jet Ranger helicopter without wheels, moved outside the hangar atop a flatbed wagon pulled by a tractor-trailer. The space inside was cramped, to say the least, with the nurse and Anderson sitting side-by-side next to the patient in transport.

“We had to do as much as we could at the hospital before leaving and primarily managed the patient’s airway en route,” Anderson said.

There was no Global Positioning System (GPS), and dispatch estimated the helicopter’s location between point A and point B on the flight plan. The pilot would use time and distance estimates. Dispatch pulled out maps directing pilots to fly, for example, five miles northeast of a particular town or provide intersection of roadways.

“Our onboard medical crew would get out the atlas and try to pinpoint the scene,” said Steven Brinkman, a pilot with North Memorial Air Care for 30 years.

Anderson said pilots learned to navigate and find the destination “on the fly,” before the advent of GPS.

“I’ll never forget a Memorial Day flight where we were landing in Des Moines (Iowa) and didn’t know where the hospital was,” he said. “Dispatch had to use landmarks to direct us to the hospital.”

Once arriving at the hospital, before heliports were more the norm, staff on ground identified an open area for the helicopter to land.

Anderson, who has been with the company since 1985, said the process involved innovative, on-the-spur-of-the-moment thinking.

“I remember a flight where the best place to land was a ballfield, and we were told that we shouldn’t have any trouble finding it because it was so well lit,” Anderson said. “They had all the ballfield lights on and the local ambulance at the ready. It felt like we were on display.”

These days, hospital safe-landing zones are predefined. With the advent of GPS, pilots are armed with a satellite system that can determine the user’s position and display it on the unit’s electronic map. They can enter the GPS coordinates into the navigation unit, and autopilot will fly the crew directly to the scene.

GPS does not diminish the importance of dispatch. Atmospheric interference, satellite positioning, and tuning inaccuracies can interfere with accuracy. Flights absent of predefined safe-landing zones must take into account obstacles like trees, towers, and wires. The dispatcher must coordinate a temporary landing zone to include latitude/longitude coordinates, a ground contact, and special radio frequency, and, at the same time, (if applicable) Pre-Arrival Instructions (PAIs) for the patient.

A statewide radio communications systems introduced 14 years ago en-
hances ground-to-air contact. Pilots and dispatchers can talk back and forth regardless of location or altitude, either from systems built in the aircraft or by using handheld radios.

“There were many times we did not have communications,” Brinkman said. “Because, prior to that, we could talk only if we were in the air at a certain minimum altitude.”

Instead of carrying minimal supplies to ease the patient’s pain, at best, EMS helicopters are equipped with medications, ventilators, cardiac monitors, CPR equipment, surgical devices, and blood/fluid resuscitation products vital to keeping the patient alive en route prior to arriving at the hospital.

The care required starts with information gathered at dispatch.

“Our customers can be 911 callers, ground resources [police, fire, EMS], or other hospital personnel,” said Jan Althoff, EMD/Quality Assurance at North Memorial Air Care. “Triaging and providing Pre-Arrival Instructions can differ slightly depending on the customer.”

The helicopter EMS industry has expanded rapidly, particularly over the past 15 years, and with popularity and prevalence comes scrutiny and regulation.

The Federal Aviation Administration (FAA) published a final rule affecting all helicopter providers—not solely air medical helicopters. The portion of the regulation applying to helicopter air ambulance requires helicopter instrument rating for all air ambulance pilots, preflight planning to identify and document the highest obstacles along their planned routes, and a risk analysis considering all aspects of the route and weather.

The tractor-trailer is no more, and ballparks are left to the hometown team. GPS saved dispatch from location estimation.

During the 30 years since its founding, North Memorial Air Care has evolved from a single aircraft and two pilots to nine Agusta 109 helicopters—reaching speeds of up to 180 mph—flown from six bases in Minnesota and Wisconsin. More than 100 pilots, paramedics, and flight nurses provide response throughout Minnesota and areas of Wisconsin, Iowa, and the Dakotas. They respond to more than 4,500 service requests each year.

North Memorial Air Care Communications Center is accredited by the Commission on Accreditation of Medical Transportation Systems and by the Commission on Accreditation of Ambulance Services.

I remember a flight where the best place to land was a ballfield, and we were told that we shouldn’t have any trouble finding it because it was so well lit. It felt like we were on display.

— Scott Anderson

1985 Air Care team:
The original North Memorial Air Care team in 1985 that has grown to a team of more than 100 pilots, paramedics, and flight nurses today, serving Minnesota and western Wisconsin with nine aircraft and six bases.

1985 helicopter:
North Memorial Air Care launched in 1985 with a single helicopter that often had to land in fields due to the lack of heliports.

1985 team aircraft:
The team that started North Memorial Air Care in 1985 and helped it grow into one of the longest-running air ambulance services in the upper Midwest.

1985 team helicopter:
With no ground crew back in 1985, the North Memorial Air Care medical team would tow the helicopter out of the hangar themselves.

Current team Agusta:
Today, North Memorial Air Care has transported nearly 50,000 patients and flown more than 80,000 hours safely.

2015 dispatch:
North Memorial Air Care Emergency Medical Dispatcher Steve Carlson monitors flights from its six bases to more than 150 communities across Minnesota and western Wisconsin.

2015 Agusta:
The latest addition to North Memorial Air Care’s fleet of nine Agusta 109 twin-engine helicopters.
Before the movie was out on the big screen and the reviews in, the Madison County Communication Center and Laurel Volunteer Fire Department on the west tip of North Carolina were prepared for a possible influx of hikers on the now even more famous Appalachian Trail (AT).

The recent movie—“A Walk in the Woods,” starring Robert Redford and Nick Nolte—is based on the book of the same name and chronicles writer Bill Bryson’s venture to hike the 2,144-mile trail. The characters are out for adventure, and much like AT hikers in real life, they get much more than they bargained for.

“That’s why we walk the trail,” said Franklin Emerson, Chief, Laurel Volunteer Fire Department. “It’s much easier to find someone if you can see in your mind where things are and the best way to get there.”

Emerson routinely walks sections of the 35-mile stretch of the AT in his jurisdiction, and he regularly recruits about a dozen other public safety volunteers to join him. Emerson and his crew don’t stick to the main footpath since that’s not the likely place to locate people lost or missing on the AT. Hikers are more likely to get turned around on the main trail and go off trail or accidentally take a side trail winding deeply into the densely wooded Pisgah National Forest.

A hiker might become disoriented, especially as darkness seeps through the canopy of leaves shrouding the trail, making it nearly impossible to navigate which direction leads out. Most hikers carry cellphones, although not as the end-all safety device or as a replacement for essential gear. Cellphones are an additional tool and do come in handy in case of an emergency, depending on reception.

Overall reception on the AT is best on the ridges and in towns, and hikers have reported getting a bar or two even in remote locations. A “lost hiker” in Madison County calling 911 is in good hands. A 120-foot cellphone tower on top of Rich Mountain in Pisgah National Forest in Madison County went into service in 2006, enabling reception in the community and along the highways and AT.

A Madison County dispatcher can use a hiker’s cellphone to determine coordinates through cellphone tower signals; a hiker able to provide a voice or camera shot description of surroundings—think landmarks—further aids in rescue.

Emerson said the hiker might be directed to the nearest hut along the well-marked trail and told to stay put until response arrives. If an injury pre-empts the ability to walk out, Laurel firefighters—who are either EMT or medical responder certified—provide first aid and transport their patient out of the woods on a big wheel equipped with a transport litter. Deaths from accidents and murder are relatively rare, considering the millions of people hiking the trail each year.
Sometimes, a missing hiker report involves search and rescue. Maybe the hiker failed to contact a friend or family member at a time specified or suffered an injury complicating a call for help. Emerson rallies his volunteers and, depending on the situation, enlists the aid of other local agencies. Madison County dispatchers gladly pitch in to coordinate radio communications during a subsequent ground or air (helicopter) search.

Six years ago, Madison County communication center Director Teresa Ogle was the radio contact on scene when two hikers went missing.

Ogle said it’s an experience she’ll remember for a long time.

“They got turned around,” she said. “It got dark. The trail isn’t wide, and the family called. We couldn’t get a plot on them because they hadn’t tried to contact us.”

A helicopter search located the two men, who were dehydrated and out of food and decidedly ready to give a second try another time.

Emerson said the two men were their own worst enemies.

“They kept moving on us,” Emerson said. “We couldn’t get a fix on them. They thought they could hike out.”

Not too long ago, a 15-year-old boy was found after a three-day search that had crews hunting the forked trails and walking a mile of ridge.

“He got lost, and we found him in Tennessee,” Emerson said. “He was good and thirsty, but besides that, OK. We were all relieved after that one.”

Emerson has lived in the county all of his life. He is a founding member of the Laurel Volunteer Fire Department and has been chief for the past eight years. The sections he has hiked as part of his commitment to search and rescue might add up to the 2,149 miles of trails, but he’s not interested in hiking the distance incrementally or through one long trek at the average of seven months on the trail.

“I hike in sections,” he said. “I get out and walk. I observe stuff. I take mental note. It saves a lot of time knowing what to expect. I’m not interested in hiking the whole trail and never have been.”

County Manager Forrest Gilliam is also a section hiker, in his own way. He spends a lot of time on the road away from the county’s government seat in Marshall visiting the county’s two other more populous cities—Mars Hill and Hot Springs. The trail runs down the center of Hot Springs so, in essence, walking on Main Street is the same as hiking that section.

“That’s about the extent of my hiking,” he said.

The same goes for Ogle.

“We have four seasons, and they’re all beautiful,” she said. “I go on vacation and am glad to come home to the mountains.”

How about hiking the Appalachian Trail?

“Not me,” she said. “I wouldn’t want to live anywhere else, but that doesn’t mean I want to hike the Appalachians.”

In Madison County, dispatchers can use a hiker’s cellphone to pinpoint coordinates through cellphone tower signals. When a hiker can provide a description of surroundings, rescue is even more likely.
There’s a lot to be said for working in public service at a place where you can point to a home—no matter where it is on your town’s map—and know the names of the people who live there.

It’s not that Teresa Ogle would do her job to a lesser standard if she had taken her career to a PSAP other than Madison County Emergency Operations Center (EOC) in Marshall, N.C.

“I love what I do,” she said.

And don’t think for a second it would make a difference anywhere else.

A small, close-knit community, however, can make the call more personal.

In Madison County, with a population of 21,000, the call could easily come from a family member, neighbor, or someone who graduated from the same high school class or frequents the same diner.

“You never know what’s going to happen with the next call,” said Ogle, who grew up in rural Spring Creek in Madison County and now lives in Marshall within sight of the 911 center. “You always have to be prepared. We’re family here.”

**It’s home**

A majority of the residents (55 percent) work outside the county, driving to Tennessee or any of the three counties at Madison’s borders, according to County Manager Forrest Gilliam, who has lived there most of his life. The county’s largest cities—Mars Hill, Marshall, and Hot Springs—provide industrial and commercial employment; however, most jobs are either in government or with the schools.

Most people like Gilliam tend to stay in the area.

“It’s home,” Gilliam said. “It’s a good place to live. I love the way you know just about everybody and how we take care of one another.”

Madison County’s rural setting draws tourists to experience the outdoors or, at least, admire the colorful bouquet of leaves from a passing car in the fall.

The Appalachian Trail winds through Pisgah National Forest, which makes up a quarter of Madison County’s 450 square miles of land, and the French Broad River beckons to white-water rafters. Natural mineral water baths in the town of Hot Springs are the ideal venue after a hard day hiking, boating, biking, or horseback riding in the Blue Ridge Mountains.

As beautiful as the area might be, it is not the setting for the fictional “The Bridges of Madison County,” which was also originally a Robert Redford project.

“We get calls from people asking if we are,” Gilliam said. “There are at least 12 Madison counties in the country, and it’s not us.”

**Idyllic setting**

During any season, views of the rugged and heavily forested terrain from any angle are stunning, and Ogle and her staff had an unobstructed and solitary venue for the sights.
“All I had to do was step outside the door of the double-wide (trailer) where we had our 911 center,” Ogle said. “We were at the top of a hill—beautiful.”

In 2012, the views came down from the top of a hill. The county completed a civic center accommodating the sheriff’s office, jail, and start-of-art EOC. The trailer was gutted for storage. Communication equipment complementing current and anticipated 911 demands gave Ogle the confidence to give the Medical Priority Dispatch System™ (MPDS™) another, harder thought.

“We talked about the Medical Protocols for years, and I was never aboard,” she said. “We’re a small center, and we had only one person on at a time. In my mind, I couldn’t see how one person could handle CPR, baby delivery, or any instruction while at the same time be responsible for answering the other calls coming in and dispatching response. Couldn’t be done.”

Ogle checked around to find out if that truly was the case.

“It wasn’t,” she said. “We could do this, and it was time to move forward.”

They took the MPDS plunge in 2013, and, in retrospect, she said, “We should have done this a lot sooner.”

**Strong initiative**

Madison County EMS Medical Director Stace Horine, M.D., said Ogle assumed a “huge performance” initiative that has improved EMS for the public, and though he resists any recognition for the effort, he was “certainly supportive” of her goal.

“I know cultural change was a big part of the challenge, and she was able to accomplish this seamlessly,” he said. “It was hard since there is always a tendency to go back to old habits in the rush of an emergency.”

Horine credits the successful transition to the paramedics’ general familiarity with the MPDS (they had heard about it from other agencies), diligence, and Ogle’s willingness to be part of the process.

Ogle certified as an EMD and EMD-Q®, answered 911 calls, and presented the audiotapes for training purposes. She let the dispatchers listen and critique her performance. The hands-on involvement, she said, enhanced her perspective and demonstrated the emotions certain calls could provoke.

For example, Ogle was “scared to death” about taking a CPR call but instantly started PAIs for a young man his mother found unconscious and not breathing. Six minutes into chest compressions from the mother following Ogle’s instructions, he started breathing.

“I know how my people feel when answering CPR calls,” she said. “We train to do CPR, and we’re prepared, but we don’t train to start the person breathing. We train to keep doing the CPR until help arrives.”

The one-seat dispatch center in the trailer changed to a two-seat operation after the move, with full coverage during the 12-hour shifts. The double transition—protocol and partnering up—was further complicated by the zeal to achieve ACE status.

“Learning to Q was overwhelming,” she said. “That was my biggest obstacle. I had lots of questions.”

Ivan Whitaker, Priority Dispatch System™ Program Administrator—Medical, quickly became part of the Madison County EOC extended family. He was the No. 1 supporter and go-to guy. When she said “We can’t do this,” he insisted they could.

Soon enough they were “rockin’ the calls,” as they like to say at the center.

“We were making 100 percent compliance,” Ogle said.

On Sept. 8, 2015, Ogle received a call from International Academies of Emergency Dispatch™ (IAED™) Associate Director Carlynn Page.

“I was so excited when she said we were an ACE,” Ogle said. “I immediately texted my employees. They needed to know first. They are the ones who have done this, not me. It is their accomplishment.”

Ogle had a space on the wall to highlight the ACE plaque. It will be visible to anyone coming to the center, including newer residents reporting their addresses for 911 service purposes. Her staff guides them on a tour of the EOC.

“What we do is so important,” she said. “And I want them to know that we give the best service possible.”

The achievement, however, won’t slow down Ogle’s generally 10- to 12-hour day. Ogle will still wear multiple hats as EOC manager, director, finance officer, and stand-in dispatcher. She can’t say for how long she will stay.

“I never wanted to put in time to retirement,” she said. “I want to make a difference, and the day I stop thinking about what we do for people of this county, is the day I step down.”

Gilliam, who was elected county manager in 2014, is a big proponent of the job Ogle does and the center’s value to the community. He certainly doesn’t want any business about Ogle’s stepping down while he’s in charge.

“I trust her to do a great job, and that’s what she does,” he said. “She’s very dedicated. We have a great partnership and work as a team.”

Ogle found her niche when she answered a classified job ad and subsequently was hired as a dispatcher 20 years ago. She advanced to management after eight years, and although in the lead position, she relishes time away from administrative tasks to answer calls and dispatch response.

“You actually get to help someone,” Ogle said.

The center provides services to nine fire departments, three EMS units, and emergency management (EM). Of the nearly 6,400 calls made to 911 in 2014, more than half (3,710) were related to EMS, followed by fire (2,676), and, finally, EM (42).

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*I never wanted to put in time to retirement. I want to make a difference, and the day I stop thinking that way and stop getting excited ... is the day I step down.*  

— Teresa Ogle
CALLER REPORTS TIGHTNESS IN CHEST
Should calltaker use chest pain or breathing problems protocol?

Brett Patterson

Brett:
The caller reports tightness in his or her chest, but denies it is heart related. The caller also reports difficulty breathing and a history of COPD and, in addition, tells the calltaker that he (or she) hasn’t used the breathing machine that day. Would this be considered chest pain due to the tightness in the chest, or a breathing problem? Or could the calltaker have chosen either protocol?

Thanks!
Lt. Audrey V. Boyd, RPL
Communications Coordinator
Greenville County EMS
Greenville, SC, USA

Audrey:
Chest “tightness” is a common expression used to describe wheezing, especially in asthatic or COPD patients. However, it is also listed in the Heart Attack Symptoms list. The patient you describe is most likely correct to place his or her problem in the lungs; however, it cannot be left to the EMD to diagnose the etiology of the sign/symptom. Fortunately, the protocol addresses this.

“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. (≥ 16, alert, no reported STROKE symptoms) Use the Aspirin Diagnostic & Instruction Tool on either protocol as appropriate.”

So, the simple answer to your question is use Protocol 6: Breathing Problems (patient’s foremost complaint), tell the patient to use his or her inhaler or nebulizer, and then use the Aspirin Diagnostic & Instruction Tool.

Brett A. Patterson
Academics & Standards Associate
Medical Council of Standards Chair

9. 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. (≥ 16, alert, no reported STROKE symptoms) Use the Aspirin Diagnostic & Instruction Tool on either protocol as appropriate.
Karlea Brown preferred to stay in the background to escape attention. She skipped meals, scrimped on calories, found reasons to avoid exercise, and always found herself back where she had started or—even more distressing—past the point of initial departure.

Brown was the victim of accumulated bad habits and falling self-confidence. She wanted out, and to stay out she knew it would take a major shift in her lifestyle.

“I had to get out of my comfort zone,” she said. “I had to make changes.”

Brown did but, wisely, not overnight. After all, she would always be just steps away from “Dispatching Disease,” a term she borrowed from Paul Bagley, a retired New Hampshire police officer and 911 dispatcher, who wrote the column Dispatching Disease published in 911 Magazine.

According to Bagley, four symptoms characterize the disease:

Obesity is among the natural, predictable results that come from dispatching. [While] the three most-common medical complaints among emergency telecommunications are (in no particular order): diabetes, heart disease, and depression.

The disease, as Brown could tell you, is the nature of the 911 beast. It’s a sedentary, stressful job, packed with overtime, shift work, high-calorie snacks, food and drinks gulped at the workstation in anticipation of the next call, and the tendency to find comfort in fast foods that are easy to grab.

Brown had no intention of giving up her dispatch career—she’s a supervisor at Frederick County, Md., Emergency Communications.

So, she did what Bagley recommended. Having recognized the problem, Brown developed a plan. She would work out daily and eat sensibly. She would quit sugar-thick soft drinks and juices and switch to water. She also realized a complete 360-degree turn was unrealistic.

“That’s a sure way to fall back into old habits,” she said.

Brown modified favorites, such as coffee with low-fat milk and sugar substitute instead of cream and real sugar, and Greek yogurt in recipes calling for sour cream. She reads labels at the grocery store and never leaves home without a water bottle. Brown didn’t do everything at once or begin an exercise routine at an impossible level.

And she created the 80:20 rule to keep on track for the rest of her life.

“Eighty percent of the time I eat healthy,” she said. “Twenty percent of the time I allow myself normalcy.”

Brown brings fruit to work. She devotes 30 minutes a day to exercise, which she can accomplish at work through simple calisthenics (office chair crunch and left lifts and swings) or at a gym. She doesn’t like to push others, although she does encourage healthier lifestyles among co-workers. Brown organized a biggest loser contest and developed a workout chart based on call type (Alarm = 10 jumping jacks).

She has stuck to the plan—now truly a lifestyle—going on nine years, and the difference is remarkable, she said. Brown has lost more than 100 pounds, and she feels great.

“I’m no longer tired and miserable all the time,” Brown said. “I’m no longer sick about how I look or what others might say about how I look.”

Brown has also gained back her confidence. Two years ago, she asked Kevin Willett if he would welcome another speaker, and she is now an instructor for Public Safety Training Consultants (PSTC). Brown and Willett presented the session, “Work Station Workouts, Night Shift Nutrition, and More …” at NAVIGATOR 2015.

The new association prompted Willett to improve his own lifestyle.

“I used to drink one Coke every two hours,” said the noticeably lighter-on-his-feet Willett. “Now I stick to water.”

Sources

Slippery Slope

Winter brings awareness of powerful, deadly avalanches

Josh McFadden

For the winter sports enthusiast, there isn’t a more exciting place to be than on a snow-covered mountain slope or powder-filled trail enjoying the thrilling rush of skiing, snowboarding, or snowmobiling.

Avid outdoors lovers can also be found during the colder, snowier months snowshoeing, cross-country skiing, or even taking in the fresh (albeit chilly) air for a winter’s hike.

Ordinarily, these outings provide exhilarating experiences, picturesque settings, and gorgeous photographic opportunities.

But there’s always the potential for disaster coming in the form of one frightening, powerful force: an avalanche.

Whether you’re a novice at one of these activities, participating on neatly marked courses, runs, or roads, or whether you are an adventurous expert or daredevil venturing into the backcountry, these winter alpine activities should be done with caution and with the realization that avalanches are a reality.

Since 2005, a total of 271 people have been killed in U.S. avalanches.¹

The causes and mechanisms

Avalanches occur when the packed snow cannot support its own weight. When an outside influence comes into contact with this condition, avalanches are triggered; factors can include rapid wind speed, temperature changes, and human involvement.² Contrary to common belief and folklore, loud noises can’t start an avalanche. So the next time you’re on the slopes with family or friends, feel free to yell your lungs out; you’re in no danger of causing snow to slide down the mountain.

In most instances, avalanches start within weak snow layers, which develop inside the snowpack or form on top of the snow and become buried. Eventually these weak layers can no longer sustain the weight of the snow on top, and they will give way, forcing the snow above them to release and slide downhill.³

Similar to a landslide—a dangerous phenomenon when earth slips and slides away due to instability and forces of gravity—an avalanche can be classified as any amount of snow sliding down a mountain.⁴ As the sliding snow comes closer to the bottom of the slope, it increases in speed, intensity, and force. Therefore, even slides that begin small and with little speed can develop into tremendously powerful forces of nature, capable of creating disaster and devastation.

Avalanches are capable of reaching speeds of 80 mph within a few seconds.⁵

Consider what would happen if you were to roll up a small snowball in your hands, place it on a steep, snowy slope, and then gently push it. Gradually, the softball-size snowball will transform into an uncontrollable mass careening down the mountain, crushing anything in its path. Avalanches are similar in nature, only much worse.

Avalanches are most likely to occur 24 hours after a snowstorm of 12 or more inches.

Avalanches can be classified into two groups: surface avalanches and full-depth avalanches. A surface avalanche will take place when a layer of snow with different properties, such as dry, loosely packed snow, slides over a separate layer of snow, such as one that is wet and more densely packed. Conversely, a full-depth avalanche is one in which an entire cover of snow slides over the ground down a slope.⁶

As avalanches move downward, they can have the appearance of slabs—snow cut out in sections or blocks—and can also be characterized by wet or powder snow.

Where they happen

If you find yourself in particularly steep environments with snow present, be advised that these are the most common physical conditions for avalanches to start. Most of these avalanches—as many as 90 percent—take place on slopes with angles between 30 and 45 degrees.⁷ On steep terrain, less force is required to generate an avalanche’s power. As one would expect, more momentum is gained and speed produced on steeper hills and mountainsides.

In the United States, Colorado, Alaska, Washington, Utah, and Montana are the top five states for avalanches. Idaho, California, Oregon, Nevada, New Mexico, and even Arizona experience them...
Artillery fire from Italian and Austrian troops triggered massive avalanches that killed between 20,000 and 40,000 soldiers. Some of the bodies were not found until the following spring.

The dangers and effects

When death results from being caught in an avalanche, there are normally one of three causes. Three-quarters of victims die from suffocation, having been buried beneath the snow.

Sometimes the suffocation occurs because the airway becomes clogged with snow. In other cases, though, the airway is open and usable; however, as the person breathes, exhaled carbon dioxide builds up around the face and melts the surrounding snow. When the snow refreezes, the carbon dioxide has a diminished ability to diffuse away, and oxygen cannot diffuse inward as effectively. Gradually, the person breathes a higher concentration of carbon dioxide and less oxygen. This leads to disorientation and unconsciousness, and eventually death.9

About 24 percent of avalanche deaths are a result of blunt trauma. The sheer power and swiftness of the moving snow can toss the victim mercilessly onto ice, rocks, and trees, or even over cliffs. These collisions can cause internal bleeding in vital organs such as the liver and spleen. Victims of blunt trauma also suffer fractures to legs, arms, and the skull.10

A very small percentage (1 percent or less) of victims die due to exposure and the effects of frostbite or hypothermia. Revival is possible if the victim is sufficiently warmed.

Lareida said these statistics are typical of the calls his center receives.

“Most of the deaths are from suffocation,” he said. “The other smaller part die from heavy injuries received during the ascent inside the avalanche. The ones that survive an avalanche are mostly not fully buried once the avalanche comes to a stop. These people are commonly only under shock or have minor injuries.”

Avalanches can affect varying numbers of people depending on when and where they happen. For instance, Lareida said his center has responded to avalanche calls where one person has been buried. In 2001, for example, the center responded to call where 11 people were buried in an avalanche. Five of the 11 people were killed.

Rescue response: Time is of the essence

When it comes to recovering an avalanche victim, every second is precious.

Unless the person has perished from blunt trauma, as previously detailed, there is a high probability of saving the person’s life if he or she is reached quickly. Statistics vary, but the consensus is that victims who are dug out of the snow within 15 minutes of being buried by an avalanche have a 90 percent survival rate. On the other hand, victims who are trapped underneath the snow for 45 minutes or more have only a 20 percent chance of avoiding death.11

Diego Lareida, manager of the Kantonal Walliser Rettungsorganisation 144 call center in Wallis, Switzerland, said his center regularly deals with avalanches and avalanche-related calls. During the winter season of 2014–15, there were 29 avalanche-related accidents in the 144 call center’s area of responsibility.

The most deadly avalanches in recorded history occurred in the Italian Alps during World War I in December 1916.
Once pulled out from the snow, rescuers face a number of possible challenges, not the least of which is transporting the person to safety. Depending on the location and severity of the avalanche, this could be a difficult prospect.

Lareida said no two avalanches result in the same exact types of rescue efforts or responses. But in any case, a host of resources get to work without delay.

“Every rescue mission is different, especially in terms of stress for our center,” he said. “Almost simultaneously, rescue helicopters, mountain guides, and avalanche rescue dogs are called into action.”

In any avalanche call or rescue scenario, Lareida said it’s imperative that all parties are communicating effectively. Survival increases when dispatchers and rescuers are on the same page and can act swiftly and effectively. This communication also helps prevent further injuries to additional people.

“The biggest part for our response center is coordinating all of these assets in an efficient manner,” he said. “The rescuers and the avalanche dogs are always on call and have to be within a close distance to the helicopter base for a quick reaction.”

Lareida also said it’s important to restrict public access to avalanche-affected areas immediately after the incident.

Avalanche survivors will likely have suffered exposure to the cold conditions. Two possible cold-related injuries are frostbite and hypothermia. With frostbite, “body levels actually freeze and crystallize at the cellular level. Frostbite generally occurs in places that receive the most cold-affected blood flow: toes, fingers, ears, nose, and cheeks. It ranges in severity from temporary numbness and waxy-looking skin, to completely frozen tissue that is as hard as an ice cube.”

Meanwhile, hypothermia is a body’s response to the cold where it can no longer keep a normal functioning temperature. The victim of an avalanche may display hypothermic symptoms such as sluggish behavior, pale or gray- or blue-tinged skin, and skin that is cool or cold. Level of consciousness is also an important sign for rescuers to recognize.

As pointed out in Axiom 4 of Protocol 20: Heat/Cold Exposure, dispatchers are trained to recognize that “Hypothermic patients can appear dead, even to trained rescuers. A person isn’t considered actually dead unless they are ‘warm and dead.’”

The more quickly rescuers can move the hypothermia victim to a warm, protected shelter the better. Dispatchers are also told to instruct rescuers to “remove (the victim’s) wet clothing and apply external sources of heat.” Rescuers should start CPR if the victim has no vital signs.

Safety precautions

The best way to survive an avalanche is to not be in one. When recreating in the mountains when snow is still on the ground, take the following precautions:

- Avoid areas of fresh accumulation of snow.
- Evaluate avalanche conditions.
- Travel with a partner or group.
- Avoid steep areas, especially those near ridges.
- Wear an avalanche rescue beacon.
- Practice using rescue equipment. Of course, even the most cautious person could be vulnerable to avalanches. If you are caught in one of these powerful forces, there are measures you can take to increase your chances of survival. Some of these include:
  - Try “swimming” to the surface.
  - Discard equipment (skiis, snowboard, etc.).
  - Do not scream or open mouth while in an avalanche; you could choke on snow and other debris.
  - As you are coming to a stop, put your hands in front of your face to make an air space.

Sources

3. See note 2.
4. See note 2.
8. See note 2.
10. See note 9.
11. See note 5.
13. See note 12.
San Bernardino Mass Shooting
Dispatchers provide command performance

Audrey Fraizer

Fire and police dispatchers share a floor in the San Bernardino public safety center, and on Dec. 2, despite different agencies they answer to, they were handling the identical intensity of 911 calls coming in from the Inland Regional Center where employees from the city’s health department had gathered for a training event and Christmas party.

Dispatchers from both city agencies took calls and maintained radio contact from the time the shooting started at 10:59 a.m. and again, four hours later, during the gun battle less than a mile away between police and shooting suspects Syed Farook, a 28-year-old county health inspector, and his wife, Tashfeen Malik, 29.

The first call EMD Kathy McRaven answered, at approximately 10:58 a.m. PST, was from an alarm company reporting a sprinkler system going off in a building at the same address as reported over a police radio, 1365 S. Waterman Ave. The second call McRaven answered, forcing her to switch from the first, came from a woman in a restroom inside the building frantic to help another woman who had been shot.

McRaven, San Bernardino Fire Department Dispatch Supervisor, launched into Medical Priority Dispatch System™ (MPDS®) Pre-Arrival Instructions (PAIs) to help control bleeding when a third call came in, this time involving a victim shot in the abdomen.

“I was doing everything at that moment,” McRaven said. “I was answering calls, talking on the radio, and within moments I had dispatched every fire department medical vehicle available, plus two battalion chiefs.”

The callers were still on the line with McRaven; she asked the woman on the second call if she could barricade the room, and she responded that she couldn’t.

“Even though I was the only fire dispatcher at that moment, I didn’t want to get off the phone,” she said.

Seconds later, McRaven’s partner, Stormy Medley, who had gone on break prior to when the shooting started, was back at the console. She jumped on the radio to handle tactical and command frequencies. There were now two dispatchers handling the situation from the fire department.
Dispatcher Marisa Harvins, City of San Bernardino Fire Department
“We wiped out everything we have to cover the city,” McRaven said. “We called AMR [American Medical Response] to send over 15 ambulances after we heard multiple victims had been shot. Then we had to worry about covering our own city for any other calls that came in not related to the shooting.”

On the other side of the center, police dispatchers were answering 911 calls and directing the police arriving on scene.

“Units, just now shots fired,” said San Bernardino Dispatch Supervisor Annie Teall, who has been in dispatch for 27 years. “1-Ida-10 with 1-Sam-8 can start down that way, Inland Regional Center, 1305 South Waterman. Call number 6127.”

Multiple calls to 911 followed, and within minutes, dispatchers knew it was an active shooter incident.

The first two officers on scene included San Bernardino Police Department Lt. Mike Madden, who manages the 911 center. He was on lunch break and less than a mile away from the center when he heard Teall’s voice come across the radio.

Instantly, Madden, who has been with the department since 1993, knew something was wrong by the intensive tone of Teall’s voice. He jumped in his squad car and rushed to the scene.

A third officer arrived, and they entered the building, without cover and armed with only their sidearms. They pushed through the smoke from the discharged weapons to the conference room where the first shots fired had been reported. The room was loud. Shooting victims were pleading for help. Fire alarms going off and blaring, and water spraying from fire sprinklers added to the chaos.

“We’ve got multiple victims, multiple victims. We have at least 20 victims. I need all available personnel,” Madden said over the radio.

Teall and Marisa Havins were two of four police dispatchers on duty in the communication center at the start of the incident, but within a “very short time,” three more had arrived to assist, Madden said.

Early information coming over the radio was sketchy. People at the scene could only relay what they had witnessed during an attack that took less than four minutes: Unknown race; subject male; all-black clothing with black mask.

“Shooter in parking lot. No better description on that location,” reported Havins, who had been through “Active Shooter Training” in Arkansas before moving to California.

Minutes after the shooting had stopped, multiple police squads were arriving on scene. With revolvers drawn, a line of police ran along a road at the perimeter of the parking lot, as shown in a 32-second video taken by a bystander inside the building. The woman capturing the police with the camera on her phone suggested to co-workers that police were participating in a training drill, as in fact they had been. The San Bernardino SWAT team, conducting a training exercise a few miles from the scene, arrived quickly, already dressed in protective gear.

“See if the SWAT team are on the air and if they copied the circs,” one officer said.

“Lincoln 6, we copied. What are the circs?” SWAT Commander Lieutenant Travis Walker responded. “Six, we’ll be in route.”

“We do have victims down. Fire is staging.”

On the dedicated fire dispatch side, Judy Croteau, a fire prevention officer and part-time dispatcher, soon joined McRaven and Medley. No more than 15 minutes later, Brian Acosta, manager of the nearby County Communication Center, along with County Fire Division Chief John Chamberlain, came in to offer assistance.

“Brian coordinated incoming resources, taking that burden off us,” McRaven said. “He covered our fire stations and coordinated with other companies to send ambulances to the scene. It was a real collaborative effort.”

Police dispatchers also spoke to unharmed callers and shooting victims as they waited for EMS to arrive.

“We deal with shootings all the time, so this isn’t my first shooting victim,” Police Dispatcher Joe Goff said. “But this is the first one who I couldn’t get help to, and I didn’t like hanging up on him.” Goff, a 10-year veteran of dispatching, said the man to whom he was talking had been shot in the stomach and leg. “I had hoped he was safe because officers were there,” he said. “But I have no idea what happened to him or who he was. And that’s the rough part.”
Another police dispatcher, 28-year-old Loreal Davidson, had only been on the job for four months. “I spoke to some victims in different buildings. One had been shot and just wanted to be assured help was on the way,” she said. 9

McRaven went back to the call involving the woman shot in the abdomen.

“That’s when the police entered and calls stopped coming in,” she said. “To this day, I have no idea of what happened to either of the women, and it’s probably better that I don’t.”

Police passed the dead and wounded in a decision not to render help until they were sure the shooters had left the premises. In a back hall, police encountered nearly 50 people huddled for protection, refusing to budge, and raising the concern among law enforcement that a shooter was holding them hostage.

“We said come to us, come to us,” Madden said at a news conference on Dec. 3, the day after the incident. “Eventually they did, and the first motions they made opened the floodgates. Everybody wanted to come forward and get out as quickly as possible.”

There was eeriness in the smoke and confusion and carnage. A Christmas tree had been set up, and dining tables were decorated in a festive holiday tradition.

“It was surreal,” Madden said. “You train for it and your job is dealing with reality, and we did the job we are supposed to do. We bring some sort of calm to the chaos.”

McRaven also called the situation “surreal” from the dispatch perspective.

“We had participated in drills, and we’ve certainly talked to people who have been shot,” she said. “But we were not accustomed to an event like this that takes so many city and county resources. You can get nervous, and I admit that I was nervous during the time I was the only one in the room. You tell yourself I know what to do. I do this every day. I do my job very well, so just do it.”

Madden praised dispatchers.

“Just listen to the YouTube recording,” he said. “That says it all.”

The recording of the first 11 minutes features the voices of Teall and Havins.

Madden had put Teall in charge during his brief absence for lunch.

“They were extraordinary,” Madden said. “But they couldn’t have done their job without the support they had. Everyone was cool, calm, and professional.”

He also praised police, firefighter, and EMS responders for keeping their emotions in check while performing the jobs they were trained to do.

The tough part for responders comes later, Madden said.

“There is so much tragedy left behind by a senseless act of violence,” he said.

“There are families entering the holidays without loved ones. That’s the stuff making this hard to deal with.”

Debriefings were open to police and fire dispatchers that same evening, and McRaven elected to go home instead.

“We were there 12 hours, and we were tired,” said McRaven, who has been with San Bernardino Fire Dispatch for 20 years. “I just wanted to go home to talk to my kids. We don’t talk about the details; we just talk.”

Sources

2. See note 1.
3. See note 1.
5. See note 1.
7. See note 1.
10. “It was Unspeakable, the Carnage,’ Officer Describes Being First on Scene of San Bernardino Shooting.” KTLA 5. 2015; Dec. 3 http://ktla.com/2015/12/03/it-was-unspeakable-the-carnage-officer-describes-being-first-on-scene-of-san-bernardino-shooting/ (accessed Dec. 11, 2015).
Fast reaction and appropriate response to an emergency is what American Medical Response (AMR) does for more than 2,100 communities in 40 states and the District of Columbia. But that’s not all.

The medical transport organization continues to prosper because it’s also proactive. It’s ready to send basic and advanced life support air and ground crews that are better prepared for the emergency because of a generation of EMDs providing information gathered through use of the Medical Priority Dispatch System™ (MPDS®).

“AMR has a very positive relationship with the Academy,” said Stephen L’Heureux, Director, AMR Communication Center Learning Network. “We’ve created a strong bond over the many years AMR has been using the protocol systems.”

The “strong bond” and knowing the Academy has dispatch’s back in medical, fire, and police emergencies recently prompted an AMR system-wide deployment of the Police Priority Dispatch System™ (PPDS®) Protocol 136: Active Assailant (Shooter).

Implementation was scheduled for Jan. 9 and will be managed locally within the municipal contracts and health care partners under the incident management system.

“This will be mandatory in all our centers, even if the center handles only transport for home health care,” L’Heureux said.

The project took off Dec. 6, less than one week after the mass shooting in San Bernardino claimed the lives of 14 people and injured 22 more, the AMR mandated a system-wide implementation of PPDS Protocol 36: Active Assailant.

Less than a week after a mass shooting in San Bernardino claimed the lives of 14 people and injured 22 more, the AMR mandated a system-wide implementation of PPDS Protocol 36: Active Assailant.

The literature and documents off the PDC website and make it available on the AMR portal? L’Heureux said. “We’ll train all AMR dispatchers on the protocol and get the word out that this is the action we’re taking.”

Hinckley welcomed the project.

“The Academy made the protocol available for everyone to use as part of our goal to protect responders and the people at these situations when they happen,” he said. “I said, ‘Hey, why not? This is great.”

With that said and done, L’Heureux went one more giant step forward. He asked Robert Pastula, Priority Dispatch Corp. Police Protocol consultant and former Chief of Police at the University of North Alabama in Florence, Ala., to co-host an AMR dispatch training webinar about the protocol.

Pastula is a frequent NAVIGATOR speaker in the police education track, and within days he and L’Heureux had a two-prong presentation providing the crux of Protocol 136—Key Questions, Evacuation, and Lockdown—and three scenarios to demonstrate how the protocol works in a rapidly developing active shooter incident.

The webinars reached more than 100 dispatchers at 23 AMR communication centers in 48 hours, L’Heureux said. Additional webinars were held in January.

“In 10 days, we had accomplished our goal,” he said. “And the day after, my office was already receiving emails thanking us for doing what we could to keep people safe.”

Police Protocol 136 addresses random attacks initiated by active and often unknown assailants at places offering unrestricted access to potentially large numbers of victims, such as movie theaters, shopping malls, and school campuses.

The protocol was developed by the International Academies of Emergency Dispatch® (IAED™) with the assistance of the National Tactical Officers Association and in association with PPDS users from California; Colorado; New York; Maryland; Florida; North Carolina; Washington, D.C.; Canada; and the United Kingdom.

Protocol 136 can be used by all communication centers at no charge, whether or not they are licensed PPDS, FPDS®, or MPDS users. AMR operates nearly three-dozen communication centers and has been using the MPDS for more than 20 years; seven of the AMR-affiliated dispatch centers are medical Accredited Centers of Excellence (ACE).

For more information about the Active Assailant (Shooter) Protocol, visit the IAED website at www.emergencydispatch.org and click on the link inside the box at the top of the page, highlighting the Protocol 136 Update. Complete instructions are available on the page dedicated to Protocol 136 and the IAED response.
LOOKING AHEAD

What do swatting and pocket dialing have in common? Both are topics featured in the March/April Journal of Emergency Dispatch distributed at NAVIGATOR 2016 in Washington, D.C., and, as always, delivered to emergency communication centers. Readers can also look forward to continuing dispatch education (CDE) articles, words of wisdom from Dr. Jeff Clawson, Brett Patterson’s ever-popular FAQ dedicated to answering questions focused on protocol and compliance, and an emergency dispatch perspective based on experience and found in columns by Art Braunschweiger and Sherri Stigler. In addition, our research writer Tracey Barron provides a description of the type of investigative study that interests the IAED and doesn’t require a large investment of your time or money.
El Niño’s fingerprints appear to be entrenched in the outlook for winter 2016. According to National Oceanic and Atmospheric Administration (NOAA) forecasters, El Niño could become one of the strongest on record and is expected to influence weather and climate patterns this winter by impacting the position of the Pacific jet stream.

Even with El Niño lurking in the shadows of the jet stream, the Farmers’ Almanac calls for a repeat of last winter—at least in terms of temperatures with unseasonably cold conditions over the Atlantic Seaboard; eastern portions of the Great Lakes and the lower peninsula of Michigan; Ohio, Kentucky, most of the Tennessee and Mississippi Valley; as well as much of the Gulf Coast. New Englanders will once again experience a very frigid (shivery) winter (deja vu).

Bad weather woes
Blizzards are snow events with sustained winds of at least 35 mph. In addition to the hazards from accumulating snow and drifts, blowing snow decreases visibility. The snow can damage utility poles—causing power outages—and disrupt highway travel. The weight of the snow increases the structural load on roofs, leading to potential structural collapse.

There are also hazards associated with human error, including the potential of carbon monoxide poisoning from using portable stoves for heating small spaces, and entrapment in a vehicle overturned from the driver hitting black ice on the highway. Driving too fast for weather conditions and the time it takes to adjust to winter changes in road conditions play a major role in traffic fatalities. According to the University of California–Berkeley weather center, fatal crashes are more likely to occur on the first snowy day of the season compared with subsequent ones (14 percent higher chance).

Freezing temperatures and heavy snowfall are also two of the most damaging causes of equipment freeze-ups and building collapses. The Blizzard of 2015 was a heavy hitter in central and eastern Long Island (NY) and all the way through southern and eastern New England. IHS Global Insights estimated a $1 billion hit across the Northeast, including a $265 million loss in Massachusetts, where residents on the eastern side of the state dug themselves out of 3 feet of snow.

Winter determinants
The Fire Priority Dispatch System™ (FPDS™) does not designate a special Chief Complaint Protocol to handle severe winter weather. Instead, the Chief Complaint Protocols address the emergency or problem caused by the winter storm or condition, as shown in the chart below.

Burst pipes
Winter weather poses a threat to pipes, particularly overnight when temperatures plummet and water demand is
minimal. Water has a maximum density just above freezing, but once the temperature hits around 37 degrees Fahrenheit (2.8 degrees Celsius), it reverses course and expands. The pressure of water freezing and expanding (2,000 pounds per square inch) attempts to enlarge the pipe, pushing against its sides as well as its nearby valves, seams, and faucets. The water doesn’t have to actually freeze to cause a problem; the pressure alone can eventually force a crack to rupture.

Frozen pipes feeding boilers and heating units can render the equipment inoperable. Broken pipes in sprinkler systems can send showers of water throughout a building, damaging areas far from the original problem. If pipes freeze and burst and the building is unoccupied at the time, the damage can go undetected, spilling several hundred gallons of water per hour.

A water flow alarm is designed to detect water movement from a broken pipe and alert the building’s contracted alarm company. These calls, handled on Protocol 52: Alarms, most often receive a CHARLIE-level response.

A private caller’s report of a water problem could also generate an ALPHA response on Protocol 53: Citizen Assist/Service Call. A “CITIZEN ASSIST” is defined as: “Providing a service to citizens in incidents that may not be an emergency, but, due to unusual circumstance, cannot be resolved without intervention and, if left unattended, may become an emergency.”

A simple water problem can become a serious hazard, however, when combined with an electrical hazard, which is indicated as a CHARLIE-level response. Wet electrical connections can short circuit, which may lead to fire or electrocution.

**Carbon monoxide poisoning**

Another common report in the winter months is a sounding carbon monoxide detector. This is due largely to the use of carbon monoxide (CO) in combustion fumes, such as those produced by stoves, lanterns, burning charcoal and wood, gas ranges, and heating systems.

Poor ventilation systems and blocked ducts can trap the deadly gas, creating a danger that is imperceptible without a CO detector. Some cities and towns require the installation of carbon monoxide detectors. The Lebanon, Pa., City Council passed an ordinance that went into effect Jan. 1, 2016, requiring rental property owners, owners occupying row houses, hotel and motel owners, and rooming houses to purchase CO detectors.

These alarms are handled on Protocol 52, which includes a “C” suffix for carbon monoxide, Key Questions to address sick individuals, and the Post-Dispatch Instruction (PDI) “Do not use any open flame or anything that could cause a spark. Leave the building/area immediately (and leave the door open).”

Carbon monoxide poisoning can be difficult to diagnose. The colorless, odorless gas can cause symptoms similar to the flu including headaches, fatigue, nausea, dizzy spells, confusion, and irritability. Later stages can cause vomiting, loss of consciousness, and eventually brain damage or death.

If carbon monoxide poisoning is suspected and people are sick, the situation is urgent and the calltaker must notify EMS immediately. MPDS’ Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/ CBRN also provides instructions for caring for these patients.

**Wires down**

One inch of ice on a single span of power line weighs as much as 1,250 pounds, and that weight on the lines can bring down utility poles. According to Protocol 55: Electrical Hazard, Axiom 1, the wires attached from pole to pole are of higher voltage than wires attached from pole to house.

Callers should be advised against going outside to investigate downed or hanging electrical wires, because snowdrifts, tree branches, and debris can hide...
the potentially live wire underneath. Touching a live wire or simply getting close to the hazard can be fatal. As stated in Rule 1 of Protocol 55: All electrocution patients are assumed to be in cardiac arrest until breathing is verified.

The caller’s responses to the Key Questions on Protocol 55 guide the calltaker in selecting appropriate PDIs to address electrical hazards. For instance, KQ 3 “Is water involved with or near the hazard?” and KQ 6 “Is anyone near or in contact with the electrical hazard?” directly relate to PDI-c “Beware of electrical risks and electrified water,” and PDI-d “Do not touch any unconscious people or anything touching the electrical hazard.”

Snow-covered roofs

Problems don’t stop when the snowstorm ends. Rising temperatures melt the snow and make the weight of the snow heavier on the roof. Though the mass of the snow stays the same, the volume, due to melting and compacting, decreases and in turn causes a rise in density. Heavy, wet snow can weigh more than 10 pounds per square foot. Two feet of snow on an average size roof can be the equivalent of 38,000 pounds, or 19 tons.

Those attempting to remove the snow from a roof should only do so if the building is determined to be structurally safe by an authority familiar with the snow conditions of the region and the design capacities according to local building code.

If snow is not removed from the roof, snowmelt during the day freezes when the sun goes down, creating sheets of ice and freezing drains. “Ice dams” are formed when the melting snow runs down a roof and later refreezes at the edge of the roof. The refreezing gradually forms a heap of ice that blocks the path of the melted snow.

On a flat roof or a roof with a low slope, it doesn’t take long for the ice dam to cause water backup, leakage, and eventually roof collapse. The potential of a roof collapsing not only endangers the people inside, but also threatens responders entering these hazardous spaces, some with roofs pre-dating fire code. Leaking chemicals and other toxins intensify the danger.

Other signs of an impending structure collapse include cracking beams, walls buckling, doors popping open, lowered sprinkler heads, jammed doors, stuck windows, and deformed steel members. Many survivors report having only seconds to decide whether to leave the building.

The Key Questions on Protocol 54: Confined Space/Structure Collapse help determine the severity of the problem, whether anyone is known to be trapped, and whether hazardous materials are involved. The Key Questions also provide identifying information for responders, including the type of building/space/structure, the location of trapped individuals, the warning placard numbers (chemical ID) of leaking hazardous materials, etc.

A structural collapse and entrapment (confirmed) involving hazardous materials requires a DELTA-level response, while a structural collapse and entrapment (unconfirmed) involving hazardous materials is generally a CHARLIE-level response.

Smoke investigation vs. structure fire

A caller’s report of smoke outside could be from homeowners firing up their fireplaces for the first time of the season or during the cold winter nights. Or it could be the result of an exhaust dryer vent operating off the side of a house; the appearance of smoke could be the hot dryer air mixing with the cold air outside.

Reports of outside smoke are typically handled on Protocol 68: Smoke Investigation (Outside). However, Chief Complaint Selection Rule 6 in Case Entry states: “If smoke is smelled inside a building, use Protocol 69.” Calls reporting smoke coming from a building could lead to the Structure Fire Protocol, as the smoke’s origin would be within the building.

Winter is not immune to structure fires, as the chill and the holidays bring on their own ignition sources: candles, torches, and portable heating units. During severe cold weather, homeowners have even been known to use blowtorch devices to attempt to thaw frozen pipes, often resulting in the need for Protocol 69: Structure Fire.

Mutual aid

During snowstorms and ice storms, communication centers become swamped with calls reporting tree limbs and power lines down, structure collapse, water problems, and other weather-related emergencies.

Protocol 65: Mutual Aid/Assist Outside Agency addresses a agency’s reliance on “MUTUAL AID,” defined as “an agreement between communities (agencies) that allows for the exchange of equipment for use during an emergency. Also, a request for specialized apparatus or equipment to the scene of an emergency, or a request for station coverage due to unfilled normal assignments or unusual activity levels.”

Reliance on standard mutual aid, however, may not be possible. Blizzards and ice storms may cause regional impacts, across jurisdictional boundaries, and transcend state boundaries. Planning personnel should consider what other, more distant fire departments could be tapped for help and whether neighboring departments are looking for the same backup assistance. State and federal government disaster assistance can be requested during severe weather emergencies when local resources are exhausted or require additional support.

In addition, FEMA recommends standard operating procedures for the following:

- building collapse
- dispatch and response in high (over 39 mph) winds; go/no-go policies
- water distribution system problems due to prolonged power failures
- street, bridge, and tunnel closures/access limitations

Sources

YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “El Niño Lurks,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. Fatal crashes are more likely to occur on the first:
   a. full moon.
   b. snowy day of the season.
   c. holiday of the new year.
   d. Monday of the month.

2. Chief Complaint Protocols address the emergency or problem caused by the winter storm or condition.
   a. true
   b. false

3. Winter-related alarms, including carbon monoxide (CO) alarms, are addressed in which FPDS Protocol?
   a. Protocol 52: Alarms
   b. Protocol 57: Explosion
   c. Protocol 60: Gas Leak/Gas Odor (Natural and LP Gases)
   d. Protocol 61: HAZMAT

4. At what temperature does water reverse its course and begin to expand?
   a. Zero degrees Fahrenheit (minus 17.8 degrees Celsius)
   b. 10 degrees Fahrenheit (minus 12.2 degrees Celsius)
   c. 37 degrees Fahrenheit (2.8 degrees Celsius)
   d. 72 degrees Fahrenheit (22.2 degrees Celsius)

5. A water problem combined with an electrical hazard would indicate which level of response?
   a. DELTA-level response
   b. CHARLIE-level response
   c. BRAVO-level response
   d. ALPHA-level response

6. All electrocution patients are assumed to be in cardiac arrest until breathing is verified.
   a. true
   b. false

7. Two feet of snow on an average size roof can be the equivalent of:
   a. 2,000 pounds, or 1 ton.
   b. 19,000 pounds, or 9.5 tons.
   c. 24,000 pounds, or 12 tons.
   d. 38,000 pounds, or 19 tons.

8. If smoke is smelled inside a building, use:

9. An agreement between communities (agencies) that allows for the exchange of equipment for use during an emergency is known as:
   a. Writ of Consent.
   b. MUTUAL AID.
   c. Intermunicipal cost-sharing agreement.
   d. Memorandum of Understanding.

10. State and federal government disaster assistance can be requested during severe weather emergencies:
    a. in advance of the actual weather emergency.
    b. at the first indication the storm has started.
    c. when local resources are exhausted or require additional support.
    d. following the first major incident as a result of the storm.

To be considered for CDE credit, this answer sheet must be received no later than 02/28/17. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
BABY’S IN CHARGE
Protocol 24 revised for sake of delivery

Audrey Fraizer

Editor’s Note: The following CDE is based on “The Birds and the Bees of Childbirth,” presented by Cassie Stavros and Sharon McCool at NAVIGATOR 2015, and revisions to the Medical Priority Dispatch System™ (MPDS®) version 13.0.

My wife is having a baby,” the caller tells EMD Cassie Stavros, Lead Communication Specialist, Central Lane Communications, Eugene, Ore.

She turns to Protocol 24: Pregnancy/Childbirth/Miscarriage, and when she asks Case Entry Question 1—How many weeks (or months) pregnant is she?—the father is quick to reply, “She’s giving birth. That’s how far along. You need to get me an ambulance.”

Stavros has been through this before during her two years in calltaking prior to transferring to dispatch and working as lead specialist at the center in Eugene. She’s on the line with an anxious father, a mom in audible pain and fear, and a baby who’s not waiting for a drive to the hospital. This call, however, adds dimensions, testing Stavros on other levels becoming more apparent during each stage of the delivery.

The mother is on the “totie,” which Stavros doesn’t recognize as his word for the “toilet.” She repeatedly tells dad to calm down. He is apprehensive, mom’s voice is growing more pitched, and the baby doesn’t seem to budge past its head, even after three contractions.

Stavros moves to Panel 16 of Protocol F: Childbirth-Delivery and instructs the father to lay her flat. He’s hesitant.

“She can’t lay on the ground,” the father said. “There’s not enough space [in the bathroom] to lay her down.”

Stavros repeats directives to “calm down.”

“Take her to another room,” Stavros recommends. “Have her lie down in the hallway if you have to.” Stavros continues, providing instructions to place two pillows under his wife’s bottom; the mother is to grab her knees, pull them to her chest, and then push hard to get the baby out.

Mom follows the instructions relayed by her husband. Stavros provides instructions for her to push twice. Mom does and, again, the baby does not emerge beyond its head. Stavros goes to Panel 17 and tells dad to position his hand just above her pubic bone. He does. She moves to Panel 18 and dad follows instructions to push down and hold for three seconds.

“The shoulders are out,” the dad exclaims. “The baby’s out.”

A weak cry alerts Stavros to a possible breathing problem. She tells the dad to rub the baby’s back with a towel.

Paramedics arrive at the door.

Stavros critiqued the call almost immediately after she disconnected the line. She had assumed mom was on the floor and had misunderstood his use of the word “totie.” She faulted herself for repeatedly telling him to calm down.

“I never say that anymore; ‘calm down,’” she said. “It doesn’t help. I now say, ‘Take a deep breath’ and I’m here with you.’”
There were also good things, such as the lifesaving recognition that comes from experience and training and the advancing nature of Protocol 24 and its increasing number of PAIs added to help EMDs direct the caller and patient through potential complications of childbirth and delivery.

“It was a good call,” Stavros said.

And it was a call helped by her military background in delivering instructions and keeping her emotions in check.

“I was able to focus and get into the zone,” she said.

Protocol 24: Pregnancy/Childbirth/ Miscarriage

Protocol 24 is the most evolving protocol in the MPDS, according to Brett Patterson, IAED™ Academics & Standards Associate and Medical Council of Standards Chair.

“We started with instructions for a normal delivery and over the years have added instructions to cover more and more complications,” Patterson said. “Some are highly unlikely to happen but, according to our obstetrics council, even though they may seem a bit invasive, the consequences of not providing them are potentially fatal, so it’s better to include them for the rare chance they do.”

MPDS v13.0 continues the protocol’s progression with multiple modifications to Protocol 24 and the PAIs in Protocol F, including the addition of another possible delivery complication ‘cervical cerclage (stitch),’ a new Key Question (KQ) 4 (“<6 months/24 weeks) Does she have abdominal pain?” and coordinating 24-C-3 Determinant Code “Abdominal pain/cramping (<6 months/24 weeks and no fetus or tissue),” and new Axioms, definitions, and DLS Links. PAIs for miscarriage are also now provided on a new Protocol G (Panels 1–9).

New and assumed complications

Cervical cerclage (stitch) is a surgical procedure involving a strong suture that prevents dilation of the cervix and, therefore, premature labor. It is a high-risk complication that involves positioning and encouragement not to push since the stitch must be removed before birth (Axiom 3). For this reason, the EMD is directed to the breech positioning pathway. This pathway is also used when the caller reports presentation of the cord, hands, feet, or buttocks.

With the addition of cervical cerclage, the number of complications addressed in Protocol 24 has reached nearly a dozen, and this is without considering complications related to one anomaly.

first, which is a dire prehospital emergency that often must be handled at the hospital for the survival of the baby (Axiom 2).

The addition of cervical cerclage brings the number of potential childbirth complications addressed in the protocol to almost 12, without taking into account different complications related to one anomaly. For example, the failure to progress during end-stage labor could be due to shoulder dystocia or the size of the baby’s head obstructing passage through the mother’s pelvis.

During the call highlighted earlier in the article, Stavros realized that the baby’s inability to emerge beyond its head might be a sign of complication in the baby’s positioning.

That should send an alarm to the EMD, said Sharon McCool, EMD-Q®, Central Lane Medical Educator and EMD Regional Instructor. “After the head comes out, the rest of the baby should come flying out,” she said. “If that doesn’t happen, the dispatcher must do all she or he can do to get mom to deliver that baby.”

In this case, shoulder dystocia was causing the delay. After delivery of the fetal head, the baby’s anterior shoulder gets stuck behind the mother’s pubic bone. The head emerges and seemingly gets sucked back into the birthing canal at the end of a contraction when the pelvic muscles relax.

“Basically, the baby is bone to bone,” McCool said. “It’s something more likely to happen for post-term babies or tiny moms giving birth to large babies.”

Shoulder dystocia is relatively uncommon—occurring in about 20,000 U.S. births each year—but poses serious harm to the baby and mom if birth is unduly delayed. Shoulder dystocia is not scripted as a potential complication in the MPDS, but it is a type of complication assumed when the baby fails to deliver following three contractions in the final stages of active labor, Patterson said. If the same occurs in the hospital setting, the mother will be instructed to change positions, similar to the position described in Protocol F: Panel 16.

“If that doesn’t work in the hospital, and the baby is still not out after several more pushes, the doctor will reach in and break the clavicle in an effort to fold the shoulder,” Patterson said. “That’s obviously nothing we’re going to advise in the EMD setting.”

McCool emphasized the importance of checking on the baby’s breathing status once the shoulder is released and the baby delivers.

“This has been a long, hard birth for the baby,” McCool said. “The baby is going to be sluggish, and you’ve got to focus on whether that baby is breathing.”

New Key Question

A second call played during the presentation highlights a surprise birth—mom didn’t know she was pregnant—compounded by breech presentation. EMD Daniel Wegscheider of Leitstelle Tirol, Austria, was the calltaker that was featured when named Euro NAVIGATOR Dispatcher of the Year 2013.

According to the call, abdominal pain that morning was the first indication that mom might be pregnant; the pains progressed, and, by the time she made the 112 call, the baby was on its way but in a legs-first breech position. Although mom was alone, she was able to follow Wegscheider’s instructions, including preparing a spot that was clean and soft for the baby to land.

“Abdominal pains are contractions until proven differently, even if the mother doesn’t recognize the contractions as labor,” McCool said.
24 PREGNANCY / CHILDBIRTH / MISCARRIAGE

KEY QUESTIONS

1. How many weeks (or months) pregnant is she? (1st Party Only)
2. (≥6 months/24 weeks) Can you see (feel or touch) any part of the baby now? (You go check and tell me what you find.)
   • BREACH or CORD
   • Head visible/out
   • Baby born (complications with baby)
   • Baby born (complications with mother)
   • Baby born (no complications)
3. (≥6 months/24 weeks) Is she having contractions (labor pains)?
   a. (Yes) Is this her first delivery?
   b. (Yes) How many minutes apart are the contractions (labor pains)?
4. (<6 months/24 weeks) Does she have abdominal pain?
5. Is there any SERIOUS bleeding (spurting or pouring)?
6. Does she have any HIGH RISK complications?

Finding a towel or similar item in which to wrap the baby is essential to keeping the baby warm and, when indicated, to stimulate breathing. The addition of KQ 4 on Protocol 24 identifies abdominal pain and cramping, which at any time during pregnancy “should be considered contractions until proven otherwise” (Rule 2). The new KQ 4 also complements changes to the Pre-Question Qualifiers on KQs 2 and 3 from “(≥5 months/20 weeks)” to “(≥6 months/24 weeks).”

Patterson said the ranges were adjusted based on the likelihood of fetal survival outside the womb in the prehospital setting. A mother alone also raises other issues, McCool said.

“It’s very unsettling for the mom, forcing the EMD to prioritize,” McCool said. “You have to make decisions based on what this mom can do. You don’t want that mom getting up and walking around looking for a pin, shoe lace, or string. The towel, however, is essential, she said.

Patterson said the towel—or comparable item for wrapping the baby—is necessary for warmth and, when indicated, to stimulate breathing. New language and formatting added to Protocol F, Panel 8 directs the EMD to confirm each action to make sure each is done before moving to the next.

“The baby is wet and without much of a fat layer; it’s going to lose body temperature rapidly,” he said. “Hypothermia is a strong possibility, so it’s important to wrap up the baby as soon as possible.”

According to widespread recommendations, the instructions for tying off the umbilical cord in Panel F.9 have been modified to first wait three minutes to monitor the baby, unless complications arise with the mother or baby. This delay is associated with neonatal benefits when the infant is placed at the level of the placenta.1

Patterson said the issue of a delay in tying off the cord, potentially allowing a final transfusion of blood to the newborn, has been pushed in the U.K., but less so in the U.S. While the Academy has now embraced the three-minute delay in protocol, a new Rule 6 on Protocol 24 provides an exception: “The umbilical cord should be tied immediately (F.9) if the mother or baby develops complications after delivery.”

That’s not all

Protocol 24 and Protocol F include several other modifications, a few of which include the following:

• The new suffix “M = Multiple birth” allows for more specific data collection and differentiation of local response.
• The patient conditions “Placenta abruption” and “Placenta previa” have been added to the “HIGH RISK Complications” list and can be defined and authorized by local medical control; Axioms 4 and 5 provide EMDs with information to better understand these conditions.
• A new Protocol G, in conjunction with Protocol F, handles MISCARRIAGE situations. (This Protocol appears as a pullout behind Protocol 24 in the card set.) These Panels include instructions to “Evaluate MISCARRIAGE,” “Wrap Fetus (and Afterbirth),” “Suprapubic Pressure,” “Fundal Massage,” and “Wait and Monitor.”

POSTPARTUM Hemorrhage has been defined (“Vaginal bleeding ≤8 weeks after delivery”) for clarification and, by Rule, should be handled on Protocol 21 when delivery of the baby and the placenta is complete and bleeding is the only complaint. New protocol additions specifically address this condition.

McCool and Stavros emphasized the importance of training with the Childbirth, Delivery, and Miscarriage Protocols. “It’s a different kind of call to handle,” McCool said. “We’re not going to wait until help arrives. We’re here to help mom. The baby’s in charge.”

Source

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ANSWER SHEET MEDICAL

Jan/Feb 2016 Journal “Baby’s in Charge”

Please mark your answers in the appropriate box below.

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D
9. A B C D
10. A B C D

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NO MOUNTAIN HIGH ENOUGH
Protocols bridge the distance in an emergency

Jeff Clawson, M.D.

Heath, Montana, is a town most tourists and even most Montanans never see. Lying in the central and remote part of the state in the Judith Mountains, Heath is quite a distance from any big city and any major medical facility. Thirty years ago, when Lewistown Police Department EMD Don McCoy wrote the accompanying letter, it would take an ambulance at least 30 minutes one way in good weather to reach Heath from Lewistown, the closest ambulance service available in the area. The 20 miles over a mountain pass separating the two towns heightened the drama of McCoy’s 911 call involving a 7-year-old girl who was not breathing and a mother who needed help NOW.

McCoy may have answered calls like this in the past, but this time he had the Medical Priority Dispatch System™ (MPDS®) and his new EMD certification on his side. The EMD training he had received gave him the tools and assurance that he could and did provide the best possible over-the-phone care in a trying situation. His telling of the experience provides a clear reminder of why the Academy’s protocol system is a vital link in the chain of survival especially for extended EMS responses, to the benefit of communication centers and the communities they serve.
MY FIRST EXPERIENCE WITH EMERGENCY MEDICAL DISPATCH

I received the call on 911 number at approximately 0255. The victim was a 7 year old girl. The girl’s mother is the one who called. She told me “my little girl has stopped breathing”. I immediately paged the ambulance, while trying to calm the mother. At this time I radioed Bob Hawley, who was working with me and had him return to the station. I asked the mother to not hang up the phone, and if there was anybody else there with her. She told me that her husband was with the girl. I established that the girl was not choking because she had been sleeping for a few hours. The mother told me that the girl couldn’t breathe at all, and was starting to turn blue. I asked if anyone there knew how to do mouth-to-mouth resuscitation or CPR, and she responded “no”. I told her to relay instructions to her husband, because he would have to breathe for her. He then started to breathe for her, but couldn’t get a pulse.

About this time the ambulance crew left the station. The house is in the community of Heath, about 20 miles in the mountains. I began relaying directions to the house to them, and informed them of what was happening.

After the ambulance left, Hawley came into the dispatch room. I told him what we had. He then talked with the mother. Hawley was teaching an EMT Class and one of the people in the class is a neighbor to these people. Hawley had the lady hang up and call this neighbor. Hawley also told her to call us back after she contacted Gregory. When she called back, Hawley began talking them through CPR. After a few minutes Gregory arrived and began doing CPR. This entire time span since beginning to this point was about 4 to 5 minutes.

Gregory and the girl’s father continued doing the CPR until the ambulance arrived, which was just about 30 minutes after I first received the call.

As the ambulance got there the girl still had no pulse and was not breathing. Her pupils were fixed and dilated also. The ambulance continued the CPR until they arrived at the hospital. The girl was pronounced dead on arrival.

Even though the girl died, the training I had received through the Dispatch RT school on Emergency Medical Dispatch was invaluable. I was able to control my own emotions and also control the mother’s emotions. We learned in the school to keep the party on the phone and relay instructions to another person. The procedure worked exactly as it is planned. It is amazing how effectively it worked.

I only wish the parents had called us quicker. The mother said that it had been 10-15 minutes since the girl had quit breathing before we were called. Maybe we could have helped to save the girl’s life if she had called sooner.

The girl’s name was Jennifer Lawson.

Don McCoy
Lewistown P.D.
Merchants Guild Cafe is a trendy little cafe in East Bentleigh, Australia, known for its rather esoteric menu, collaborative seating, and diners who are eager to come back for the doughnut French toast, slow-cooked pulled lamb, eggs panzanella, and coffee brewed from locally roasted beans.

It’s also known for great customer service. Just ask Ryan McFarlane.

“If it had happened anywhere else, I don’t know if I’d be here at all,” said McFarlane, a father of two, who was having a meal out at the cafe with his wife, Samantha (“Sam”), when the seemingly impossible happened.

“The last thing I remember was slumping to the table,” McFarlane said. McFarlane, a triathlete, had passed out for no apparent reason. His wife later said they were at a loss of what to do.

Luckily, waiter Ryan Winston was able to get things started.

“I looked over, and there he was face-down at the table,” Winston said. “I called triple zero [the emergency number in Australia].”

Vanessa Waters, EMD, Emergency Services Telecommunications Authority (ESTA), answered the call, and within seconds, she was giving CPR instructions to Michelle Yore, who had rushed to the table to offer assistance. Yore gave chest compressions according to PAIs Waters was providing to Winston over the phone.

ESTA provides emergency and non-emergency calltaking and dispatch for all police, fire, ambulance, and Victoria State Emergency Services in the state of Victoria.

McFarlane survived the sudden cardiac arrest, and the trio he acknowledges for extending his stay on Earth met at the same cafe for a reunion following his recovery.

Yore and Winston said they were glad to help.

“I can’t imagine what it would be like to stand by and not be able to help,” Yore said. “We’d be watching someone die.”

Waters said giving PAIs is part of the job and a part she is grateful to provide for callers experiencing a life-threatening emergency.

“It’s great to be able to help out and make a difference in someone’s life,” she said.

The sudden attack was brought on by an irregular heartbeat that will now be kept in check through an S-ICD arrhythmia device implanted by a MonashHeart cardiology team in Melbourne. McFarlane is one of a handful of Australians to have been treated with this lifesaving technology that offers protection from sudden cardiac arrest.
150 people are killed by avalanches worldwide each year.

Most are snowmobilers, skiers, and snowboarders.

Statistics show that 93 percent of avalanche victims survive if dug out within 15 minutes. Then the survival rates drop fast. After 45 minutes, only 20 to 30 percent of victims are alive. After two hours, very few people survive.

An estimated 40,000–80,000 men lost their lives during WWI in the Tyrolean Alps, with avalanches triggered by gunfire.

A total of 18,000 Austrian and Italian troops were reported to have been lost in the Dolomite valleys of northern Italy on December 13, 1916, in more than 100 snow avalanches.

On May 31, 1970, 18,000 people perished when an avalanche hit the village of Yungay, Huascaran, Peru.
WORKPLACE PERSPECTIVE
The three generations don’t always agree

Audrey Fraizer

Workers do not stay at their jobs like they used to, and reasons have more to do with the sign of the times than simply job dissatisfaction. Baby boomers, Generation Xers, and millennials carry generational traits that, disregarding personal idiosyncrasies, define approaches to the work environment. The generations simply do not compete on the career longevity timeline. The generation retiring from the workforce (boomers) through the generation entering the workforce (millennials) do not share perspectives regarding career expectations, work and life balance, and, overall, the meaning of work in the scheme of life.

There is overlay, and, of course, no definition fits every individual in the respective generation; however, the period during which someone is raised does influence the traits brought to the workplace.

And it’s not only the age of the individual designating the level of expertise. For example, because many boomers are postponing retirement and, instead, taking on a second career, the new kid at the CAD may actually be older than the millennial and Generation X new hires.

Effectively mixing the three goes a long way in explaining NAVIGATOR’s prevalence of talks relating to retaining good employees, career progression, and bridging the generation gap.

Statistics
Generations on either side of a U.S. Bureau of Labor Statistics (BLS)
report would probably shake their heads when reviewing the contrasting generations’ career longevity.

The average person born during the baby boom (1943–1961) held 11.7 jobs from age 18 to age 48. Nearly half of these jobs were held from ages 18 to 24, and longevity increased the longer the boomer was in the labor force, with 10.4 years the median tenure of workers ages 55 to 64. Since boomers tend to stay long term with the same organization, as they grow older, it’s not unusual for a boomer to log 15 to 20 years with a company.

Those entering the labor force or in it for just a short time, however, do not fare so well on the longevity chart.

Gen Xers (1961–1982) worked an average of 3.2 jobs in the first 12 years of their career. They do not plan to stay with one company or along one job path during their working years, especially if it means sacrificing family and friends.

The upper age tier of millennials (1982–2002) expect to stay in the job for three years or less and to continue that path throughout the progression of their working life. The short tenure adds up to 15 to 20 jobs over the course of a career.

Not at face value

Although still relative newcomers to the workforce—and in the absence of the boomers’ longer track record—millennials appear to seek personal fulfillment over achievements in careers. They favor flexible schedules, the opportunity to acquire new skills, developing “work families,” and rationale for the work they’ve been asked to do and the value it adds. Work does not define them, but if they don’t get what they want—time allocation, relationships, and job security—they will go elsewhere. They value individuality.

Generation X was sandwiched between the generation that believed in the American dream (boomers) and the generation receiving awards for attempting—and sometimes not even finishing—a competition. Generation X was not coddled and learned independence at an early age (the first generation of latch-key kids), and, consequently, they look for the same on the job: autonomy and productivity on their own terms. They don’t buck authority, but they are indifferent to titles. They value self-reliance in the face of the changing American dream, and because of that they adapt much more easily to change in the workplace than the boomers.

Boomers are notorious for long hours on the job. Work and life balance takes a back seat to “face time” at the office. They don’t want time off. They want to be seen. They are less likely to offer recognition since career development has been based on seniority (rather than skill and expertise). Work establishes self-worth, identity, and fulfillment. They value success.

Blending

As mentioned, NAVIGATOR provides a full menu of “how to” accommodate generations, whether it’s recognizing the strengths each generation contributes to the workplace—and combining the strengths to create an effective team—or advice about “how to” provide greater job satisfaction among members of each generation.

For example, “How to be a Cheer/Leader for Your Center” (speakers Todd Allen and Michelle Allen) might apply more to millennials since it’s the generation that relies on positive feedback and that discipline can actually be a positive thing.

Many of the sessions that address the generational issue do so in an indirect way, such as “Mentoring—Key Role in Training” (speakers Berenise Rodriguez and Adriana Guillen) that could appeal to each generation because of the interchange required between trainee and mentor. “An Alternative Schedule That Works for Staff and Administration” (speakers Cullen Peltier and Lauri Maki) provides the planning that went into an employee-friendly schedule, which is a must for Gen Xers and millennials, who put a high value on personal life.

The session “Appreciating the Generations” (speaker Karlea Brown) goes to the heart of the topic: multiple generations are in the workforce together.

Learn about each generation, their workplace characteristics, and their strengths and differences.

Because a large number of baby boomers are putting off retirement in favor of entering a second career, it is not uncommon to see three generations of people working side by side. Effectively mixing this trio of generations provides challenges and opportunities in the workplace, including in communication centers.

Understanding the backgrounds of those with whom you work will make you a more well-rounded co-worker and supervisor.

Sources:


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