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NG9-1-1
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Baby Stories
Babies might not watch the clock but they certainly know when the time has come as shown in these stories highlighting arrivals in places far from where mom and dad intended.
BRETT PATTERSON
Brett is an Academics & Standards associate and Medical Council of Standards chair for the IAED. His role involves training, curriculum, protocol standards, quality improvement, and research. He is a member of the IAED College of Fellows and Rules Committee.

Brett began a career in EMS communications in 1987. Prior to accepting a position with the IAED, he spent 10 years working in Pinellas County, Fla.

COLLEEN CONRAD
Colleen is an administrative supervisor for Salt Lake City 9-1-1, with current duties involving the consolidation of fire and police dispatch offices and assisting in the near-future move to a new Public Safety Building, which will include a new phone system and new radio system. She was the project manager for the recent implementation of the PPDS®. Colleen has worked for Salt Lake City for 31 years.

SHAWN MESSINGER
Shawn is a police consultant and Emergency Police Dispatch instructor for Priority Dispatch Corp.®. He is a former chief deputy for the Okanogan County Sheriff’s Office where he was the director of a combined 9-1-1 communication center. During this time he oversaw the deployment of a new CAD and countywide RMS system, a VoIP 9-1-1 phone system, and the deployments of ProDA® in EMD and EPD. Shawn was also commander of a multi-jurisdictional SWAT team.

Tracey joined the IAED™ after spending nine years with the ambulance service as a paramedic, EMD, dispatcher, and education manager. While Tracey still teaches EMD, the majority of her time is spent working with European agencies on research projects using the Priority Dispatch System™.

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Go A’Wandering
But carry the essentials along

Audrey Fraizer, Managing Editor

couple dozen “20-something” yoga enthusiasts schlepped mats, music CDs, and water bottles a mile up a strenuous trail in the east bench of the Wasatch Mountains in north-central Utah. Not far behind them was a barefoot hiker hopping from rock to rock while apparently leading a group of teenagers, each in a pair of slick-soled sandals that were causing them to slide one foot back for every three feet they advanced on the scree.

Next came the moms and dads straddling babies in carriers on their backs and tugging the hands of two- and three-year-olds noticeably perturbed by parental expectations, young women lug- ging purses, and a dog off leash despite watershed restrictions.

It was your fairly typical Memorial Day weekend crowd on the popular Bell Canyon trail—a steep climb (about 900 ft. elevation gain/mile) to two waterfalls at distances of about two and three miles, respectively. I was in a group coming down the trail, and another group coming up the trail, and three miles, respectively. I was in a group coming down the trail, and the ones entertaining the weird looks no doubt attributed to our packs, light hiker boots, trekking poles, and CamelBaks. We had hiked an additional mile past the waterfalls to a high alpine meadow still covered by snow despite warming weather.

Even without planning to hike the extra distance, no one from our group would have left home without what we call the 10 essentials. Some of the items might seem more bother than practical, especially for a traditional holiday hike; however, as stated by The Mountaineers out of Seattle, Wash., the “ten Es” originators: “You won’t use every one of these items on every trip, but they can be lifesavers in an emergency, insurance against the unexpected.”

We’re not stodgy hikers. Rather, we prefer erring on the side of caution and carry the essentials to compensate for unpredictable weather conditions, accidents, and falling off the trail. Nine times out of ten, none of us will pull out a map or compass, but on the 10th time, getting on the right path will save us from turning on the flashlight to find our way out in the dark.

Bell Canyon is an “up and back” hike, which makes it tempting to lighten the pack by removing the navigational stuff. We don’t. It’s also a misnomer to think that a trail labeled as a “day hike” means throwing caution aside. Numerous people have been injured and killed in Bell Canyon because of slip-soled shoes or misjudging ability. Three years ago, a preschool teacher lost her footing while traversing a creek several feet above the falls. Her body was found wedged on the bench of the Wasatch Mountains despite the essentials to compensate for unpredictable weather conditions, accidents, and falling off the trail. Nine times out of ten, none of us will pull out a map or compass, but on the 10th time, getting on the right path will save us from turning on the flashlight to find our way out in the dark.

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No one can control how someone else approaches the outdoors, and no one—despite what the pack holds—is guaranteed a protected trip. The unexpected does happen. That’s the reason for 9-1-1. Not that three numbers give us the “right” to flaunt precaution, but when bad things happen, it’s good to know you’re out there with the essentials to help.
Keeping It Confidential
Does the public always have the right to know?

Scott Freitag, IAED President

T he Maine Legislature’s Judiciary Committee in May recommended against passing a bill to alter the state’s law as it applies to the confidentiality of information in 9-1-1 emergency call transcripts.

The bill, sponsored by Sen. David Burns, a retired state trooper, expands current law to include restrictions on “information or records that relate to a pending law enforcement investigation or a pending criminal prosecution.” Illegal disclosure would result in a Class E misdemeanor.

The legislative debate coincided with a judge’s March ruling to withhold transcripts of emergency calls relating to the murder of two teenagers on Dec. 29, 2012. The judge ruled that there was a “reasonable possibility” public disclosure could influence potential witnesses and, consequently, prejudice the case. The judge’s ruling on the confidentiality issue is on appeal.

A central question was the right of silencing transcripts by making them exclusive property of law enforcement. The Judiciary Committee more or less decided, by its vote of 8–3, to hold off until the case is decided; they took a wait-and-see attitude expressed by one member of Maine’s Judiciary Committee, who said, “Until we know what they’re doing, I just don’t want to make a wrong move.”

We’ve had a similar case in Utah that, because the case was closed, forbid the disclosure of various police reports, maps, interview transcripts, and 9-1-1 tapes.

Until now.

Does the name Susan Powell ring a bell? She disappeared from her home in West Valley City, Utah, in 2009. Her body has never been found. No charges were ever filed. Her husband Josh was long suspected in her disappearance. Last year, Josh killed himself and the couple’s two young sons in a house fire in Washington State. Josh’s brother Michael, who police now believe helped Josh dispose of Susan’s body, committed suicide in February. There are no other direct suspects left.

The 9-1-1 call placed on Dec. 7, 2009, and released May 20, 2013, is haunting, at least for those of us familiar with the case. The caller—Josh’s mother Terri Powell—asks the calltaker for a welfare check at the home of her son, daughter-in-law, and their two children. Terri is on her way to the house following reports from the daycare provider that no one answers her knocks on the door. No one is picking up the phone. Despite snowfall overnight, there are no tire tracks on the driveway. The calltaker tells her response is on their way, and that ends the 4-minute, 20-second call. Later that evening Josh and the two boys return from a supposed camping trip; there is no sign of Susan.

My point is not the specific reason the call was restricted from public access. But, rather, I am questioning the authority to hold 9-1-1 calls confidential. The issue is not handled the same in each state, and, according to the National Conference of State Legislatures (NCSL), six states keep 9-1-1 calls confidential and six states place restrictions on the release of 9-1-1 calls or the information contained in them.

All states follow federal laws contained in the Health Insurance Portability and Accountability Act (HIPAA) in relation to health records and other privacy laws.

What are the options?

A policy without restriction on 9-1-1 public access, except those protected under federal law, does compel a greater sense of accountability, at least according to one side of the debate. For example, Freedom of Information Act advocates claim restrictions make it harder to track response times, and without the restrictions, the public and media maintain a 9-1-1 watchdog position.

In addition, and this is a plus for EMS response, telling the “whole story” could dispel a “mistake” media “exposes” or a judgment made by people without knowledge about how 9-1-1 operates.

On the other hand, responders have sat in favor of restrictions necessary to law enforcement investigations and to protect people from reprisal when making a 9-1-1 call that could jeopardize their security. Victim rights advocates promote restrictions to protect victims of domestic violence.

A second issue involves the ability to maintain confidentiality.

Current E9-1-1 systems are closed, single purpose systems, contrary to the multiple entities capable of sharing NG9-1-1 systems. As the National Emergency Number Association (NENA) points out in its NG9-1-1 Transition Policy Brief #6, Next Generation 9-1-1 will be part of a larger system shared with general government, private sector entities, and other public safety services/ agencies. The amount and types of information available will easily exceed current systems.

This is not a one-size-fits-all decision. Each state must decide the confidentiality requirements that work for the good of the public and the good of response. Would the call from Terri Powell put us any closer to the truth if it had been released to the public at the time her daughter-in-law disappeared?

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**Each state must decide the confidentiality requirements that work for the good of the public and the good of response.**

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**Sources**

**Horizontal Vs. Vertical Dispatch**
Responsibilities between calltaking and dispatching functions

**Jeff Clawson, M.D.**

**Question**
I recently came across an article that has raised some concern regarding horizontal versus vertical dispatching. I was hoping you could clarify some questions. In the article it states the following: Team approach is referred to as “horizontal” dispatching. The interrogator (calltaker) follows the entry and key question protocols while the radio dispatcher listens and, at predetermined points during the questioning, dispatches the appropriate response as indicated by the information.

**Answer**
This was an early chapter I wrote in 1994 about Emergency Medical Dispatching within the American College of Emergency Physicians (ACEP) EMS Textbook.

Below I have attempted to address each of your questions with answers shown in a blue font.

Does the dispatcher listen in on conversation over another phone?

Basically, the listening part is simply not done anymore – this particular method is very outdated, and essentially predates computerized dispatch protocol systems. Twenty years later, the various points at which a dispatch code-based “send” occurs are now well defined in the protocol and automatically done in the ProQA® software where the call is pended to the radio dispatch position. ProQA dispatches (sends code to CAD) at different points depending on the level of acuity and urgency determined.

Does the dispatcher stand over the shoulder of the calltaker and listen?

No, never.

If the calltaker is on one side of the room and the dispatcher is on the other side where they cannot hear the calltaker and, information is sent through a CAD system, is this still referred to as horizontal dispatching?

Yes, what you have just described above is the correct definition of a “horizontal” set-up. Horizontal simply means that the “interrogator/coder/instruction-giver” is a different person than the “radio dispatcher/unit allocator/queue handler.”

How would this be considered faster and better than vertical dispatching?

It is only faster, or more efficient, in that two people are performing some different functions in parallel. In this regard, it is obvious that some time can be saved and the caller is not left with any pregnant gaps while the vertical (single) calltaker/dispatcher sends the call and interacts with responders. For example, while the radio dispatcher is sending the response and interacting with them as they come on radio, the interrogator is giving Post-Diag Dispatch Instructions or Pre-Arrival Instructions and Case Exit instructions. Of course, if calls remain in the queue for any length of time, part of this time saving is lost.

The article goes on to say: “Vertical” dispatching makes each dispatcher responsible for a geographical area and requires that individual to handle all calls from start to finish. This dispatch configuration is less effective for EMDs using priority dispatch protocols.

Today this would be worded differently, as most centers with more than one person on the floor, don’t just do different “areas”.

Does this mean that your protocols are not as efficient for a single dispatcher center to use? Or does this mean that doing EMD as a single dispatcher regardless of what protocols are used is less effective?

The latter is correct. The type or brand of protocols is irrelevant to this issue. I was referring to any dispatch protocols generically in this regard.

This horizontal versus vertical dispatch configurations aspect has raised issues regarding whose software to purchase being a single dispatcher center.

Dispatch center configuration isn’t an issue in selecting software per se. The Academy protocols are used in many single dispatcher centers around the world. The issue of protocol/software brand should be based on the completeness and robustness of the content, sophistication of the protocol software navigation, and its CAD interface preciseness to name a few. A greater issue is that with the MPDS®/FPDS®/PPDS®, you are not just buying products; you are really obtaining the IAED™ system that created them, maintains them, and perpetually evolves them to be on the cutting edge of the standard of care, practice, and public service. With now just over 3,600 center users of these, the feedback alone, provides the Academy with an endless supply of cases, experience, and input unlike any other.
FAST is key to effective stroke identification and treatment.

FAST is the acronym for warning signs, and FAST is the speed of action required to improve the chances of patient survival.

FAST is also the outcome reached in research assessing the effectiveness of EMD use of the telephone-administered Stroke Diagnostic Tool (SDxT) in emergency calls.

**FAST—the acronym**
A stroke occurs when one of the arteries to the brain is blocked (ischemic) or bursts (hemorrhagic). When that happens, the area of the brain affected starts to die. The damage can cause problems with walking, speaking, seeing, or feeling.1

Stroke and cerebrovascular disease are the second largest cause of death in the world.2 A stroke can occur at any age; risk of a stroke more than doubles each decade after age 55.

The U.S. National Stroke Association presents the acronym FAST to remember the warning signs of a stroke:3

- **F**—is for **Face**: Ask the person to smile. Does one side of the face droop?
- **A**—is for **Arms**: Ask the person to raise both arms. Does one arm drift downward?
- **S**—is for **Speech**: Ask the person to repeat a simple phrase. Is his or her speech slurred or strange?
- **T**—is for **Time**: If you observe any of these signs, call 9-1-1 immediately.

The Medical Priority Dispatch System™ (MPDS) Stroke Diagnostic Tool (SDxT) involves a quick, three-item diagnostic test—asking the patient to smile (to check for facial drooping), asking the patient to raise both arms above his/her head (to check for weakness or paralysis on one side of the body), and asking the patient to repeat “The early bird catches the worm” (to identify any speech abnormalities). Each question is scored, according to the patient’s response. The higher the score, the higher the likelihood of evidence of a stroke.

**FAST—speed of action**
When a person suffers a stroke, prompt treatment can mean the difference between permanent neurological damage and an almost-full recovery; treatment is most effective when administered as soon as possible after onset.1 When a stroke is suspected, a call for emergency medical help is paramount.

Protocol 28: Stroke (CVA)/Transient Ischemic Attack (TIA) in the MPDS is selected for the conscious and breathing patient when the caller initially reports “stroke” or one or more of the symptoms listed in the STROKE Symptoms list on Protocol 28. Since it is impossible in a prehospital environment to tell whether symptoms are from a TIA—a temporary disruption in the blood supply to part of the brain—or an acute stroke, EMDs should assume that all stroke-like symptoms signal an emergency and need prompt evaluation.

**SDxT—methods**
The University of North Carolina, School of Medicine, Department of Emergency Medicine, published a study4 to assess the effect of introducing telephone-administered SDxT into stroke-related 9-1-1 calls to the Raleigh-Wake County (N.C.) communication center. Dispatchers were trained in using the SDxT and administered the tool when using Protocol 28.

Study participants were divided into two groups: callers identified by 9-1-1 dispatchers as reporting stroke-like symptoms (forward-identified), and stroke patients transported by Wake County EMS and discharged from the hospital with a diagnosis of stroke (considered true strokes) (reverse-identified).

Data was collected from calls received from May 1, 2007, to June 30, 2008—divided into “before” (n=41,088) and “after” (n=34,627) use of the SDxT.

Dispatcher accuracy (after—during the period they were using the SDxT) was compared to the accuracy that would have been obtained had the SDxT been used as the screening instrument for sensitivity and specificity (before—during the period prior to using the SDxT), based on the caller complaints leading to protocol selection.

**SDxT—results**
The percent of true stroke patients identified increased by 5% after the SDxT was used, compared to pre-implementation. The sensitivity and specificity of stroke identification before and after SDxT implementation was similar, however the accuracy by which patients with stroke-like symptoms were dispatched increased by almost 5%.

The most common non-stroke dispatch categories among reverse-identified patients—those the EMD did not categorize as stroke patients before or after the tool was introduced—included unconscious, sick person, and fall. This finding was one of the most relevant in the evolution of the SDxT.

These results raise the possibility of integrating the SDxT into these additional Chief Complaints in the MPDS. In fact, the SDxT is currently being added to Protocol 18: Headache in v13.0 of the MPDS.

Placement of the SDxT in protocols relevant to possible stroke—for example, Protocol 17: Falls, Protocol 18: Headache, and Protocol 26: Sick Person—would give EMDs a tool for faster identification of possible stroke patients and, consequently, a rapid deployment of EMS assistance.

**Sources**
5 Brici, J., et al. STAT 911: Stroke Assessment Tool for 9-1-1 Dispatchers
Passing The Ball
It takes a team to score a goal

Shawn Messinger

I prefer team sports more than individual sports for the same reasons I enjoy working as part of an emergency services team. Success on the court and in the field hinges on a group’s ability—each member’s contribution—to work together for the benefit of the team. Yes, there will always be the team’s star performer but for a team’s overall success, the responsibility is shared no matter where the spotlight falls.

Maybe it’s a part of getting older but watching Super Bowl XLVII took me back to my football career, beginning in junior high and continuing through high school, college, and post-college semi-pro ball. Despite the cuts, bruises, and two-times-a-day practices sweating out the heat, I enjoyed every minute of it, or at least I do in retrospect. I was no superstar. Like so many playing a team sport like football, I was just big enough, and just quick enough to play alongside the stars. I took pride knowing that my efforts, and the efforts of others like me, made it possible for the stars to be stars.

This is not unlike working as part of the emergency services team, where the police officers, paramedics, and firefighters tend to appropriate most of the public’s attention. The spotlight rarely shifts to the thousands of dedicated 9-1-1 telecommunicators; although the irony is the scrutiny media tend to place on 9-1-1 and it’s not performative. The spotlight falls. The ability to provide immediate lifesaving Pre-Arrival Instructions to arrive. The ability to provide this assistance is well worth the seconds added to the dispatch process. They thought about that for a minute and then nodded in agreement; no one in the group had looked at it that way.

Commonly used expressions come to mind in making this point: “There is no ‘I’ in team,” or “We’re only as strong as our weakest link.” Some might roll their eyes and call these sayings cliché, but anyone who has played on or worked for a “team” with members in the “game” solely for personal glory knows the reality. They are based in truth.

Telecommunicators have the protocol, certification, and training bringing their profession to the same level demanded of others in the chain of response. They are an essential link in the critical care provided to the public. Similar to the generations of offensive and defensive linemen, blocking backs, punters, and long snappers, telecommunicators do their part to support the team. They kick off the chain resulting in the really big plays.
The Long Run
Still going strong after all these years

Colleen Conrad

I decided to take on the challenge of writing a regular column for The Journal because I want to be that voice: the one of the calltaker, the one of the dispatcher, and the one of the supervisor. I have been and still am the person who has worked on the telephones taking the calls, the calm voice reaching out to the officers and firefighters through the radio, and the supervisor who hopes she’s been the support that her dispatchers have needed.

I have been in this business a long time. Often I tease that I started in this line of business before dirt was invented. There are times when the reality of those years slaps me in the face. To be honest, when I first started we were working on the department’s very first CAD and it had not been long since they had been working on a manual card protocol system. We are now on the fourth CAD of my career.

When I started working as a records clerk for the Salt Lake City Police Department, I had an eight-month-old infant. That infant has grown into one of the most wonderful women I know and she has given me two grandchildren—both of whom are older than she was when I started. I had two more just-as-awesome children besides that full-grown infant and am now on my third husband. Makes me think of a bad Jeff Foxworthy joke … You know you work in public safety when you’ve had more spouses than you have pairs of jeans.

As we get ready to move Salt Lake City 9-1-1 into its new palatial home in the city’s brand new Public Safety Building in August, I reflect on things that I have seen, things that I have done, and things that I have experienced over the last 31 years. When I started my job it was big hair, leg warmers, and bang bracelets. Now it’s all iPhones, iPads, and straight hair.

This is the second move I have seen. Our original home was a condemned high-rise that stood above the county’s jail. More than once we would turn to see a cockroach scurrying across the floor or a mouse in the kitchen. Our statewide 9-1-1 office was in the basement of the building, along with the sheriff’s office dispatch. The 9-1-1 operators would answer all of the incoming 9-1-1 calls throughout the state. They would prioritize the call and then connect that call to the correct agency. They were literally like switchboard operators you would see in an old movie—or anyone over 40 years old would remember Lily Tomlin’s one ringy dingy. Their office had 2 x 4 planks across the floor over the little streams of water that would leak in the basement. You would cross them like a balance beam in order to avoid walking in the puddles of water.

We even dealt with prisoners escaping from their holding cells through the false ceilings to adjoining rooms and walking out of their confines. Sometimes, below our floors, angry jail prisoners would start clanging and banging around their cells and the floor would rumble from their antics.

In 1988, we moved to a converted office building that had been vacant for a few years. It was never meant to be a home for what it’s being used for. Water leaks in our evidence room have ruined property. A rainstorm through a leaky roof in our electronics room completely fried our electronics, taking out our computers, our phones, and a lot of our lights. We couldn’t receive 9-1-1 calls. We couldn’t do much of anything. One weekend day, a fire alarm went off. Upon inspection, one of the supervisors found wires had fried and an electrical fire had started up the wall. My favorite day (insert sarcasm) was the day the water fountains backed up with some type of sewage and black sludge came spewing and oozing out of the fountain heads that we would get our drinking water from. Many dispatchers have been late for work because they have been stuck in the elevator.

You can now see why I am looking forward to the move to our new building. To me, it’s not just a building—it’s a palace. A palace where we won’t trip and fall over each other, where there are beautiful mountain views, and a place of happily ever after. Okay, I know it’s a dispatch office and happily ever after is a bunch of crazy talk—but a princess can dream, can’t she?
Security heightens following Boston tragedy

Bombs detonated at the Boston Marathon finish line killing three people and injuring hundreds didn’t put the brakes on the thousands of bicyclists, runners, and walkers hitting the pavements since April 15.

The bombers and their bombs couldn’t even stop a pig from flying.

“In light of what happened, we made sure we had extra security in place,” said Lisa Knapp, assistant manager, Cincinnati (Ohio) Emergency Communications.

Knapp works in the city known for one of the most famous marathons in the United States. Making its debut in 1999 and held on the first Sunday in May, the Flying Pig Marathon, or the “Pig” for short, attracts huge crowds—and in 2013, a record 33,000 runners from all 50 states and 16 countries and probably double the number of spectators came out. Fans are called “squealers,” and volunteers called “grunts” do everything from working the race to dressing in pink pig costumes.

Knapp and Dispatch Supervisor Larry Arnold were in Salt Lake City, Utah, attending NAVIGATOR in April when contacted by the center’s training supervisor.

“The police department wanted a rep from the communication center to attend a meeting about marathon security,” Knapp said. “Everyone’s on alert.”

While security has always been high, this year’s Pig showed increases in police visibility and the placement of extra surveillance cameras monitored from the Emergency Operations Center (EOC). Highly-trained bomb dogs worked the entire route, their snouts to the ground sniffing for the explosives they’re trained to detect. Backpacks were subject to police search, and at the start line race participants put items for transport in clear plastic bags for pick up at the finish.

Arnold, who’s a runner, had two daughters entered in the marathon.

“If you don’t run, they win,” he said.

In the single incident reported, Cincinnati police arrested a man accused of carrying a concealed weapon to the race and making threats about terrorism.

In other parts of the country:

The April 20 date of the Salt Lake City Marathon had organizers scrambling to discuss what they knew about the Boston bombings and readjusting response to maintain safety. On the positive side, Salt Lake City police had the experience of the 2002 Winter Olympics although not the luxury of time for a race set to run five days after the tragedy in Boston.

By the day of the race, the city had more than 500 officers stationed throughout the course, a helicopter deployed, and the presence of FBI and Utah National Guard personnel. Bomb-sniffing dogs were seen along the route and on the TRAX light rail lines taking runners and spectators to the starting line at the University of Utah. The 6,000 registered runners held a moment of silence before the marathon in honor of the lives lost in Boston.

IAED™ President Scott Freitag was selected director of the newly formed Salt Lake City 9-1-1 Communications Bureau. The appointment coincides with the near completion of the city’s new $125-million public safety complex that features a state-of-the-art consolidated (police, fire, and ambulance) emergency communications/operations center.

The bureau combines previously independent city dispatch units into a combined agency that will handle calls for police, fire, and emergency medical services. More than 70 employees are staffing the new center on a 24-hour, seven-days-a-week, 365-days-a-year schedule and handle the approximately 550,000 9-1-1 calls anticipated during the first year of consolidated operations.

Freitag will direct the new department following 16 years of service in the Salt Lake City Fire Department, working in a variety of capacities including communication director and public information officer.
According to local news, the 9-1-1 center had a dedicated radio channel, and suspicious activity could be reported anonymously by texting keywords TIPS SLCPD and MARATHON. Information could be sent to police by texting the word CRIMES.

Organizers of the Rite Aid Cleveland (Ohio) Marathon removed bags left unattended and took similar safety precautions as the Pig, according to the Cleveland Plain Dealer. A moment of silence was held before the Rite Aid Cleveland Marathon on Sunday, May 19, and some runners wore "Boston Strong" shirts.

The Columbus Marathon, which has several months to prepare for its Oct. 20 race, will likely include additional road closures leading up to the event, according to Columbus Business First.

Robert Lanoue, Sunstar system status controller for the State of Florida/9-1-1 public safety telecommunicator, received the 911 Public Safety Telecommunicator Award for 2013 from the Florida Department of Health.

Lanoue has worked in EMS as a pre-hospital care provider since 1987 and joined the Sunstar Communications Team in 1994. In 2000, Lanoue went back to Sunstar operations as a field paramedic, and then returned to Communications in 2006 where he now holds the position of a communication training officer (CTO).

During working hours, Lanoue spends most of his time training new system status controllers in the art of channel operations and IAED™ EMD calltaking.

According to Sunstar Paramedics Communications Training Coordinator Ronald R. Shiner, who oversees the Sunstar Communications Training Dept., Lanoue has handled more trainees during the past year than any other communication center training officer or preceptor. He spends countless hours as a CTO performing Channel QA/QI and also EMD QA/QI to further assist his peers in keeping the center’s already exceptional standards to IAED ACE levels. In 2012, the 123 emergency calls Shiner evaluated from Lanoue’s total number tallied an overall EMD score of 99.44%.

During his ‘off’ time, Lanoue reserves his Saturdays for teaching CPR classes to the citizens of Pinellas County in-line with the Florida Department of Health Strategic Plan Objective 31 to provide injury prevention programs to the public.

The 23rd Annual Excellence in EMS Awards ceremony was held July 17 in Orlando, Fla.

**Job ranking puts dispatchers at the top of low pay scale**

Stress and the importance of 9-1-1 combine to make dispatching and calltaking among the lowest paid professions.

The analysis, conducted by U.S. News using data provided by compensation experts PayScale, ranks jobs offering far less than median pay and because of factors such as work demands and significance in relation to pay makes the jobs lowest on the reimbursement scale. The pay data is based on median mid-career earnings, although the ranking reflects pay in combination with the other factors cited.

Police, fire, and ambulance dispatchers (at a median mid-career salary of $39,300) rank third on the most underpaid job list. The job is described as ‘one of the most stressful jobs you can have while sitting at a desk. Pay is well below the median, as it is for some firefighters and police officers’.

First and second place went to assisted-living coordinators ($36,900) and day-care directors ($32,100), respectively. Occupations descending from third-place dispatchers are: office nurse ($42,700), medical insurance coordinator ($34,600), lead pharmacy technician ($34,900), veterinary technician ($32,800), social worker ($42,300), emergency medical technician/paramedic ($39,600), and artistic director ($48,200).

**Program gives early alert**

Family information that can be accessed before an emergency adds to the lifesaving potential of dispatchers and other responders in San Juan County, N.M.

The program, called Smart911, lets residents go online to log family Safety Profiles and pictures into a database displayed to the 9-1-1 calltaker providing additional information that can be used to facilitate the proper response to the location. The San Juan County Communications Authority purchased the system from money collected through a tax funding EMS. The service is provided at no cost to residents while the PSAP pays the developer an annual amount per position and an installation fee.

A Smart911 Safety Profile can include data about all family members, including medical conditions or disabilities, addresses associated with all phone numbers, and household details including utilities, emergency contacts, vehicles, and even pets. It is currently available in at least 28 states.

**Celebrity SWAT**

Some celebrity big names in the movie and television business are the latest victims of hoax 9-1-1 calls reporting fake crimes, with one of the more recent “swatting” calls begging the question “Do you feel lucky, punk?” At the very least, it didn’t make the Los Angeles Police Department’s day when dispatched on a call reporting men with assault weapons at the Bel Air home of the Dirty Harry actor Clint Eastwood. Officers quickly determined no one was in danger at the home—Eastwood wasn’t home at the time of their arrival—avoiding the full-scale tactical response. Victims in recent months
Don’t hang up on that call

Hang up calls are probably among the top nuisance calls in emergency communications and, in many cases, centers are fighting back to curb abuse and unintentional misdiaising.

And age is no barrier.

A 21-year-old mother of a baby dialing the emergency line seven times in six minutes faces a misdemeanor charge of misusing 9-1-1 that could lead to a fine of up to $6,000 and a year in jail. Citations were given to eight people in the same area in (Astoria, Ore.) 2012 for similar incidents. Five people have been cited already this year.

The center in Astoria reportedly receives nearly 3,000 mistake calls or hang ups every year of which an estimated 25% are attributed to children playing with phones.

A 35-year-old man made his first appearance at the Henderson Justice Court (Nevada) following his arrest on 59 counts of unlawful use of 9-1-1 for allegedly repeatedly calling Henderson 9-1-1 and hanging up. The number of counts, however, falls far short of the 3,600 actual calls he is accused of making. Police arrested the suspect that same month after detectives watched him make some of the calls. He faces two counts of unlawful use of 9-1-1 and was being held at the Henderson Detention Center on $2,000 bail.

Sometimes the problem is careless dialing, such as the case in Raleigh-Wake County (N.C.) with callers mistakenly dialing 9-1-1 rather than the 919 area code. Realizing the mistake, callers hang up, and when that happens, the calltaker has to call back. If no one answers, an officer is dispatched to the address associated with the call.

Raleigh-Wake police officers were dispatched to 3,501 hang up calls to 9-1-1, or an average of 113 calls a day in January and, according to the Raleigh-Wake County Emergency Center, it’s a trend on the rise much to the dismay of law enforcement agencies and 9-1-1 centers.

In some cases, the address can’t be traced.

According to the most recent data available, from Sept. 1, 2011, to Oct. 1, 2012, Valley Emergency Communications Center in West Valley City, Utah, received 301,730 calls to 9-1-1 of which 245,000—or more than 80% of those calls—were made from cell phones. Of those cell phone calls, 116,243 came in as hang up calls. The majority—95,752—were calls that either an officer responded to that turned out to be a false alarm or the caller had a phone that did not allow dispatchers to pinpoint a location. Approximately 430 were calls made on deactivated cell phones that dispatchers could not call back or trace.

Florida schools beef up police dispatch

The police department serving Pinellas County Schools, Fla., increased its standards for police dispatchers to include certification as a 9-1-1 Public Safety Telecommunicator.

The new description requires an extensive background investigation and within six months of hire certification through the Florida Dept. of Law Enforcement using the Florida Crime Information Center, National Crime Information Center, and the International Public Safety Network and telecommunicator certification. The “preferred candidate” must have a “strong background and experience in customer service/related stressful situations.”

The Pinellas County Schools Police Department consists of 26 sworn law enforcement officers and 10 civilian support personnel. The department provides law enforcement services that include school resource officers, internal criminal investigations, and a K-9 utilized for drug sniffs. The department’s emergency communication center provides 24-hour coverage as the first point of contact for the district throughout the year, as well as the monitoring of all intrusion alarms for the district’s 150 schools and support facilities.

St. Louis emergency communications was the inspiration for Twitter, at least according to the social networking service’s innovator Jack Dorsey.

According to a story on 60 Minutes, as a kid Dorsey was intrigued by conversations relayed in short bursts of sound he heard coming over his home scanner, which picked up transmissions from the St. Louis center. Although actual development depended on innovations such as text messaging, Dorsey’s idea combined short burst messaging (140 characters maximum per tweet) with the “in the moment” venture and feelings the tweeter can make available to the entire world. As a teenager, Dorsey created software tracking the movement of emergency vehicles on a map.
Cellphones defy decline of middle age

Nothing like the sweet talk of victory, and in this case the talk that was sweet to one but not the other happened over the phone between wireless rivals Motorola and Bell Labs.

According to cellphone lore, Martin Cooper, then Motorola president and division manager, placed the first call from a cellular phone 40 years ago—on April 3, 1973—to the head of research at Bell Labs, effectively claiming the coveted spot in history. The phone Cooper used—called a DynaTAC—was for talk only without any of the browsers, applications, and texting capabilities now bundled into the mobile device.

But it took another 10 years before Motorola brought the first cellphone to the market, a nearly two-pound DynaTAC selling for $3,995, and another 10 years after that for today’s popular features to be part of the same mobile device. Some of the highlights in order of appearance: 1993—Simon device that included a pager, e-mail, a complete keypad, and a calendar; 2002—the first phones with built-in cameras; 2003—BlackBerry’s Quark series offering e-mail, texting, and a Web browser; and in 2007, Apple launched its first iPhone (a combined mobile phone, an iPod, and a wireless communication device). Apple’s App Store opened for business in 2008.

Research shows that smartphone users spend less time talking on the phone than they do accessing the mobile Web, sending text messages, taking photos, and listening to music. The most common use for all mobile devices such as sleep apnea, drivers who use sedating medications, and drivers who do not get adequate sleep (less than seven or eight hours of sleep a day for adults and nine or 10 hours for adolescents).

According to the National Sleep Foundation’s 2005 Sleep in America poll, 14% of Americans perform shift work. Compared to their day shift counterparts, shift workers are more likely to suffer from insomnia as well as excessive daytime sleepiness (61% vs. 47% and 30% vs. 18%, respectively). The International Classifications of Sleep Disorders reports that shift workers are at increased risk for a variety of chronic illnesses such as cardiovascular and gastrointestinal diseases.

Fireworks 9-1-1 checklist might come in handy next time around

Every year, communication centers are flooded with calls regarding fireworks. The majority of these calls are not an emergency, but the call ties up the 9-1-1 system, potentially delaying an emergency call from getting through. To keep the public safe while also keeping the lines as free as possible, the Washington State Fire Marshal set up the following chart, with input from emergency dispatchers, for residents to use as a guide about when to call 9-1-1 regarding fireworks. The chart is used by permission from the Washington State Fire Marshal.

<table>
<thead>
<tr>
<th>Firework-related incident?</th>
<th>Call 9-1-1?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fireworks making noise in your area?</td>
<td>Yes</td>
</tr>
<tr>
<td>Time of use (after 9:00 p.m.)</td>
<td>Yes</td>
</tr>
<tr>
<td>Have a firework-related injury?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you seen a firework-related injury?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your area?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your county?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your state?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your country?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your city?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your town?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your neighborhood?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your school?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your church?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your bar?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your restaurant?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your hotel?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your office?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your home?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your car?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your truck?</td>
<td>Yes</td>
</tr>
<tr>
<td>Fireworks displays are legal in your SUV?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your jeep?</td>
<td>Yes</td>
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<tr>
<td>Fireworks displays are legal in your jeep?</td>
<td>Yes</td>
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<td>Fireworks displays are legal in your jeep?</td>
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<tr>
<td>Fireworks displays are legal in your jeep?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
INTERNATIONAL NEWS

Twitter shows LAS control room in action

A unique application of Twitter not only showed the public the range of 9-9-9 emergency calls answered by the London Ambulance Service (LAS) control room but, also, provided a public teaching forum.

The control room tweetathon, as it was called, broadcast on Twitter the work of two calltakers during two separate shifts (12 p.m. to 6 p.m., and 6 p.m. to 12 a.m.). Their combined 88 emergency phone calls over the 12 hours demonstrated the distressing situations routinely encountered over the phone, and the situations better handled by other healthcare professionals or agencies.

The two calltakers also answered questions the tweetathon generated regarding the control room. The top five, according to the LAS story:

1. How many calls did we take yesterday? We took just over 4,700 emergency calls yesterday. Frontline staff attended 2,976 incidents.

2. What’s the difference between a calltaker and a dispatcher? A calltaker answers 9-9-9 calls and finds out the severity of the patient’s condition. A dispatcher allocates appropriate frontline resources, such as ambulances or fast response cars, to the patient. Both calltakers and dispatchers are known as Emergency Medical Dispatchers.

3. How many calltakers are there per shift? On a normal day we can have as many as 36 staff taking 9-9-9 calls. Between 70 and 80 staff are working in the control room at any time.

4. Are we planning any future tweetathons in other parts of the Service? Yes. We’d like to tweet live with one of our ambulance crews or single responders.

5. Are there any vacancies in the control room? See our current vacancies page (http://www.londonambulance.nhs.uk/working_for_us/current_vacancies.aspx) to find out if we’re looking for more Emergency Medical Dispatchers to work in our control room.

Elephant sets the beat for CPR

The elephant in the room may be the one to save your life during a cardiac arrest or, at least, that’s the finding of a study published in the British journal BMJ (2009; 339:b4707).

The study had investigators evaluating the song “Nellie the Elephant” as effective background music for administering CPR. According to the results, Nellie’s beat increased the number of people getting the right rate of compressions on a mannequin, although there was a drop in those hitting the correct depth.

Nellie is among several beat-makers tested for application to CPR.

A second study, published in the Emergency Medical Journal in 2012, found that the proportion of paramedics who maintained compressions within the optimal range of 100 to 120 a minute was significantly higher when listening to “Disco Science” by Mirwais (82%) than when listening to “Achy Breaky Heart” by Billy Ray Cyrus (64%) or no music at all (65%). But over a third of compressions were still too shallow, irrespective of the music used. “Achy Breaky Heart” was found to be harmful because it made people compress too fast, so the heart didn’t have a chance to fill properly.

They did not investigate “Stayin’ Alive,” by the Bee Gees, which the British Heart Foundation used in its 2012 “Hard and Fast” CPR ad campaign.

No matter the music selected, teaching bystander CPR to the general public offers the greatest potential for survival in out-of-hospital cardiac arrests in Europe, as reported at the main session on Resuscitation Science at the European Society of Cardiology’s EuroHeartCare Congress, held March 22–23 in Glasgow, Scotland.

The European Resuscitation Council estimates that around 500,000 people suffer a sudden cardiac arrest every year in Europe. While bystander CPR increases survival rates by two to three times, it is only delivered in one in five out-of-hospital cardiac arrests. Optimizing this rate, the European Resuscitation Council has estimated, could save 100,000 lives in Europe each year.

Studies have also suggested that formal CPR increases survival chances. For example, statistics from the American Heart Association (AHA) show survival rates around 30% in cities with widespread training, such as Seattle, while the survival rate averages 1–2% in cities offering fewer opportunities to learn CPR, such as in New York City.

A campaign in Southern Ireland trained 65,000 people in bystander CPR and use of an automated external defibrillator (AED) was correlated to increasing the number of people surviving out-of-hospital cardiac arrest from 1% in 2005 to 6.5% in 2012. The program, sponsored by the Irish Heart Foundation (IHF), Pre-Hospital Emergency Care Council (PHECC), and National Ambulance Service (NAS), also introduced CPR training into the school curriculum resulting in 76% of students saying they would be likely to give CPR if they were present when a person collapses; 90% felt more confident to perform CPR after training; and 68% said they would show their family and friends how to perform CPR.

Sources


The ABCs of Gen. XYZ
The kids are different but they’re all right

By James Thalman

If the generational divide between the 20-something baggy-britches and the 50-something fanny-packers is untethering your communications team, don’t come whining to Kevin Willett. As far as the veteran public safety consultant is concerned, the last professionals who should be judging each other based on age or appearance are first, first responders.

“The looks and age of a fellow calltaker have as much to do with the course of a 9-1-1 call as the looks and age of the caller,” Willett told The Journal after leading another packed-in audience through his popular “Bridging the Generational Divide” workshop. Although he clearly and often told those 30 and younger in the audience at NAVIGATOR ‘13 in Salt Lake City this past April that “you don’t get a trophy just for showing up anymore,” most of his verbal improvised explosive devices were meant for the biases of Baby Boomers. The over-50 set tends to be way too quick to judge and too slow to mentor younger folks coming up, he said.

The first Boomers notion to go ka-boom was the old chestnut that because someone is older, they’re better. “You’ve lived longer and you know more—at least you should know more—but you don’t know it all,” Willett had earlier and unashamedly announced to the class. “And just because mid-20s staffers expect to take vacations when they’re scheduled and don’t seem all that eager to give the center total control of their lives doesn’t mean they don’t know what loyalty is or what real work feels like.”

Willett, who is part stand-up comedian and part dispatch evangelist, exhorted veteran workers to ponder a question too few dispatchers and too few people in all walks of life never seem to stumble across: Am I the problem?

“What we need to finally get to is the fact that the problem with ‘them’ is most often a problem with ‘us’ believing that different is bad or worse or weird when different, as it always was and always will be, is just different,” he said.

Grouping up into our like-looking, like-minded, same-age cliques is easy, and maybe just human nature, Willett said. In this day and age of instant communication and social networking coolness zipping at light speed, people categorizing and often simply dismissing or taunting someone because they’re different has become the new American pastime.

The best rule of thumb: Appearances can be deceiving. Get that, and you’ve got the thing in hand, he said. On the other hand, a person’s accouterment can be very revealing and accurate: If you have something called a pen or two or three in your shirt or jacket pocket or have read an actual ink-on-paper publication within the past two or three years, you’re a Boomer. Time to start getting out of the way.

If you think wristwatches are heirlooms or that libraries with actual printed books are museums, or you’ve never worn a pair of shiny shoes, or you’ve never worn a pair of shiny shoes, you’re generation X, Y, or Z and are probably regarded most for being the main reason this country is going straight to H-E-double hockey sticks.

What folks born after World War II and before 1966 should be doing is getting ready to stand aside. Start reacting to episodes that appear a younger person might not know what he/she’s doing, and that might very well be the case. “You can’t know something you’ve never been taught,” he said. “Before getting all high and mighty, ask yourself if maybe the kid just doesn’t know.”

“By the way, if the kids today don’t measure up, it might be your fault,” he told the group. “Maybe you parents were more interested in being your kids’ buddy than their parent. You’re the ones who hovered like helicopters patrolling the risks out in the real world and giving them trophies because everyone’s a champion for trying when in fact you knew all along that’s not the way the world works. You taught your kids that they deserve a trophy for just showing up.”

So, why blame younger coworkers for being that way? “They kind of want to be recognized for showing up, for doing their jobs just because they do them, not just when they do them exceptionally well,” Willett said. “Saying so didn’t bother you back then, so would it kill you to say so now?”

It’s as natural as liver spots for older folks to go around proclaiming how off track the course of public safety is and how the world in general will face great peril once “these kids” get their hands on things.

“Guess what?” he said. “The old-timers when you were that age made the same dang prediction. How’d things turn out?”

And, what’s with all the tattoos these days? “Younger folks don’t have a problem with it, why do you?” Willett asked. “Ask them about

THE OVER-50 SET TENDS TO BE WAY TOO QUICK TO JUDGE AND TOO SLOW TO MENTOR YOUNGER FOLKS COMING UP.
Willett gave two personal examples: A young applicant for a dispatching job had a tattoo of red lips on her wrist. Instead of saying how weird the image was, not to mention its right-out-there-in-public location, Willett said, “Tell me about that tattoo.” The young woman turned out to be a young mom, and the tattoo turned out to be an exact replica in size, color, and location of the best kiss she said she will ever receive: a spontaneous smooch from her 4-year-old daughter to brighten up one of those bad days young, single, working mothers encounter on a regular basis.

“It was a beautiful reminder and a beautiful story,” Willett said. “I couldn’t tell you (the story) today if I had just raised my eyebrow and said nothing.”

The other example involved a young staffer at his office—Public Safety Training Consultants in Redwood City, Calif. Her fiancé had stopped by to pick her up for a formal occasion but before heading out, the young man took Willett aside and asked if he knew how to knot a standard business-type necktie.

“Now, I could have made a huge deal about how had he lived to the ripe old age of 24 years having not learned how to tie a tie,” Willett said. “But I didn’t. I stopped myself and said, ‘Sure.’ I walked him into the men’s room so I could show him in a mirror that’s how you learn to tie a Windsor. If anyone had come in they might have wondered what I was doing with my arms around this kid, but I wouldn’t have cared. I showed him how, he did it himself a couple times, and we walked out of there both proud of ourselves and with an experience that will connect us for good.”

In short, he said, recognizing differences isn’t the problem; not finding ways to fold those differences into the mix is the problem. You can’t just wave your hand and make everyone get along, but that doesn’t mean supervisors and team leaders shouldn’t try. For starters, he said, consider trying the following approaches:

- Younger workers have had parents cheering them on since they first swung and missed at T-ball. Veteran dispatchers and center supervisors can create the team they want by cheering new dispatchers on by giving them as much as they received early on.
- Accept that the younger ones will turn up for a major emergency event, but they won’t be working a lot of overtime.
- Half of the call center workforce will retire in the next five years. If you want to pass along any wisdom to posterity, better get to it now.
- Older folks are about competition; younger ones are about collaboration.
- Older folks will work their heads off and consider any lesser effort to be goofing off.
- Working class heroics don’t mean diddlysquat to younger workers. They’ve been through the Great Recession and saw with their own eyes that long hours and loyalty by their parents didn’t mean diddlysquat to their employers.
- A tattoo is no longer a sign of a poor decision.
- More money isn’t the motivator it used to be. Younger people like to work but they like to play more. Recognize that they are a lot better at keeping their lives in balance than you workaholics out there.
- Make a fuss welcoming newbies. If nothing else, print business cards with their name and the agency on it. No title is necessary. They’ll feel they are part of something. You’d be surprised how many younger dispatchers say having a business card made them “a real person.”
- Make a fuss about dispatching as a career, not just a job. Show and tell them that no other profession does more to make the world a better place. Remind them that dispatching is the golden thread that holds emergency response together.
- Sure, there’s Google and Facebook and Instagram and a thousand other way-cooler places younger I-tech-soaked people could work. But Larry Page, Mark Zuckerberg, and Kevin Systrom all know 9-1-1 by heart, and it’s the first number they call when things go haywire in the real world. You are part of that network, and it’s something to be proud of.
Push Of A Button
OnStar is first non-emergency ACE

By Audrey Fraizer

A bite that pinched like a bee sting put a quick end to an otherwise good day in the desert for Gene Schutzler, his wife, son, brother-in-law, and their involuntary guest.

The Schutzlers were in Oregon’s high desert in October 2010 when a bite on Gene’s lower leg caught his immediate attention. Lifting his pant leg, he not only noticed a fresh set of puncture marks on his inner calf, but also a well camouflaged reptile slithering out of his way.

Gene had his answer in the first and last glimpse he saw of the reclusive spotted rattlesnake, no doubt sulking from the unplanned point of contact.

Gene radioed his wife Ginny, whose first reaction was to hit a red button in their General Motors (GM) truck. She was dubious about a reply; after all, there was no reception for cell phones in this wilderness so why should it be any different for a button pushed to alert an OnStar advisor hundreds of miles away at an OnStar call center?

That was the second surprise for the Schutzlers that afternoon.

OnStar Emergency Advisor Lynn Piper immediately answered their alert, used GPS coordinates to pinpoint their location, contacted police, and patched them into emergency medical care.

A second OnStar Emergency Advisor, Lee-Ann Troughton, gave Pre-Arrival Instructions (PAIs) from Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites), telling him to remain as calm as possible, to keep the wound below the heart, and to avoid movement that would increase the heart rate and, consequently, hasten the speed of venom moving through the bloodstream.

Piper called the PSAP and assisted a medical helicopter service with locating the scene while Troughton stayed on line with the Schutzlers the whole time until Gene was loaded into the helicopter and rushed to a trauma center in Boise, Idaho. He survived.

Safe to say the Schutzlers will never leave home without OnStar.

“Serious things happen all the time to people away from home and without...
about 10% are calls for medical problems like chest pain, breathing problems, unconscious person, seizures, and heart problems.

Two OnStar advisors are on every EMD call: the advisor answering the call contacts first responders and provides continuous updates about people involved; the second advisor asks the MPDS series of questions and provides help until the first responders arrive on scene.

Prior to MPDS, OnStar advisors conferenced medical calls into PSAPs (Public Safety Answering Points) in the respective geographic area, which might or might not use the MPDS. Regardless of the tools in place, the process to transfer the calls took time away from helping the victim. It also was a burden they had the potential to lift from the incredibly busy PSAPs, Shiemke said.

“It was something we could do by going with the MPDS,” Shiemke said. “We wanted to provide a more complete service and, at the same time, fill in the gap of time during any emergency situation.”

Shiemke credits OnStar Global Emergency Services Leader Ann Maher with the initiative to implement EMD. Maher credits Shiemke for following through on the 20 Points and ACE application.

“This is very serious business, and ACE shows we are doing our absolute best to help in a crisis,” Maher said. “We have the best tools our advisors can use.”

Shiemke said awaiting word from Page was very exciting when she called and said they had made it.

“We wanted to provide a more complete service and, at the same time, fill in the gap of time during any emergency situation.”

— Amy Shiemke

The snakebite rescue is a single emergency medical call on a list that keeps on growing. Similar to PSAPs, OnStar advisors give instructions to control bleeding, deliver babies, give CPR, and dislodge food causing a person to choke. And their experiences are similar to EMDs working inside a PSAP.

In January 2012, Heather Irwin was the OnStar emergency second advisor on an EMD call from a mother, frantic about her three-month-old baby’s breathing trouble. The situation grew even more tenuous when the baby stopped breathing, necessitating infant CPR PAIs that Irwin relayed to the mother and the mother relayed to a passenger now outside of the car. A quick thank-you from the mom once the ambulance arrived was the last Irwin heard of the incident.

“We don’t get any follow-up after a call so I don’t know what happened to the baby,” Irwin said. “But that’s part of the job. There’s always another call, another person who needs our help.”

OnStar emergency advisors also assist their fair share of Good Samaritans, as shown in the following two stories available from the OnStar site.

Tyler Andrews couldn’t miss seeing the SUV stopped in the middle of an entrance ramp he had taken to merge onto a tollway in the spring of 2012. He pulled over, saw the panicked looks of a woman and three children, and noticed the unconscious driver slumped over the steering wheel.

Andrews pushed his red emergency button and explained the situation to the OnStar emergency advisor, who immediately alerted first responders. A second EMD-certified advisor provided first-aid instructions, first to Andrews and then to the wife of the driver. The husband survived and Andrews received the OnStar 2012 Good Samaritan of Year award in recognition of stopping to help.

Rennie and Sara Muzii were on their way to a family outing in June 2012 with their three children when they saw a woman on the side of the highway pulling a man out of a vehicle and laying him on the ground. Sara pushed the OnStar button while Rennie exited the car to find out the problem. The OnStar advisor provided instructions for helping the man prior to ambulance arrival.

Sources
Order In The Protocol

Process configured to dispatch appropriately

By Brett Patterson

Editor’s Note: The following two FAQs were originally published in the July/August 2009 and 2010 issues of The Journal, respectively. We are running them again in interest to our readers.

Question:
My higher ups would prefer to change the order of EMD questions and dispatch, rather than keep the order the way it is. This is what they suggest we follow:
1. Begin the EMD process by asking the Case Entry Questions
2. Dispatch EMS using that information
3. Go back to caller for Key Questions after dispatching EMS
4. When the EMS call is en route, advise them of level of priority
They heard some agencies already do this and refer to it as the “step up process.” Have you heard of this, but most importantly is it allowed?

Answer:
You are correct in that some agencies dispatch routinely at Case Entry, then code, and potentially downgrade later. This is sometimes called pre-alerting and the rationale given most often is to save response time in the interest of saving lives. While this approach may save a few seconds, there are reasons for keeping the order as is: pre-alerting is often counterproductive, it is not safe, and it is inconsistent with the protocol’s design.
The ECHO determinant allows for immediate dispatch when the potentially time-critical patient is in need of the closest available trained responder and scene safety concerns are not present. This covers the patient care concerns about response time often cited by proponents of the pre-alert. Unfortunately, political concerns about response time are often the underlying fear when response time is paramount. Remember, most experts agree that less than 5% of EMS calls are actually seconds-critical and current ECHO response practice addresses those calls.

It has been our experience that pre-alerting crews to respond at Case Entry is self-defeating because crews learn very quickly to expect the downgrade and become less assertive with regard to initial response to the bell. In other words, just like the EMD, the crew members do not yet have enough information to make a responsible decision regarding response, and they trust that the EMD will make that decision in a moment or two, so they wait.

Additionally, the immediate HOT response to all calls exponentially increases the chance of an emergency medical vehicle collision by increasing the time spent running lights-and-siren.

The MPDS® was designed to identify and address time-critical events and dispatch appropriately. When time allows, which includes the vast majority of EMS calls, the MPDS takes a minute or so to determine what is needed and prompt a responsible and appropriate response to the call.

In summary, the Academy does not mandate any particular response policy; these decisions are best made locally because resources vary. However, the Academy recommends using the MPDS to assign varied, responsible, and safe responses using the multiple Determinant Descriptor codes provided at the dispatch points recommended by the protocol. A blanket, immediate response for all calls is, in our opinion, unsafe and unproductive.

I hope that helps.

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

Question:
Would a CHARLIE-level call be a COLD response when no first responder is sent to the scene? I realize that the service makes the policy but I would like your opinion. If you have a first responder going on the call then the ALS unit runs COLD, but if there is no first responder sent, then the ALS unit should run HOT. As a dispatcher and para-

Answer:
The CHARLIE level designates an ALS need. This may warrant a HOT or COLD response, depending on patient condition, i.e., cerebrovascular accident (CVA) not alert, HOT vs. CVA alert and breathing normally, COLD. The decision to send a first responder is decided locally and is usually related to the patient’s immediate need and the location and availability of ALS resources. In the example of the CVA patient, if the patient is alert and breathing normally, and first responders are not transport capable, there is little value in sending one, even if the ALS unit is sent COLD.

However, if the patient has the potential need for airway management or a defibrillation, the non-transport first responder may have value.

The HOT and COLD question has more to do with time saved which, in most systems, is only a matter of a few minutes or less that, in the majority of cases, is not significant in relation to patient outcome. The question that must be considered with assignment to each code is pre-arrival need, i.e., manpower, potential life-saving intervention, ALS monitoring, etc. In the case of the CHARLIE tier, the need is normally ALS monitoring only, and a COLD, ALS-only unit is sufficient, unless the patient is neither alert nor breathing normally. In the latter case either a HOT ALS response or the addition of a closer first response unit may be prudent, but rarely both as opposed to a DELTA response. Please note that the not alert condition is most often coded DELTA when the Chief Complaint associates it with a general cerebral perfusion issue, as opposed to a glucose or local perfusion issue (Diabetic Problem or Stroke).

Hope this helps.

Brett A. Patterson
IAED Academics & Standards Associate Medical Council of Standards Chair
A Long And Winding Road

NG9-1-1 is a journey, not a destination

James Thalman
The first official 9-1-1 call made in Haleyville, Ala., on Feb. 16, 1968, wasn’t much of a leap in telephone technology. Alabama Speaker of the House Rankin Fite’s call to state Rep. Tom Bevill at City Hall could have been handled with a couple tin cans and a taught string. Bevill’s “hello” wasn’t much of a quote for an occasion that would mark the advent of modern emergency communications in North America. Observers at the time were more impressed that the call came without an intervening Alabama Telephone Company operator to make the connection, and that it could be seen coming in as the switchboard tapped out the ordinals “9-1-1.”

The great idea of connecting every home telephone across the United States to a single emergency services network that had been in the research and development phase for more than 10 years was becoming a reality. The set of numbers were first adopted by Nome, Alaska, as its three-digit emergency network access code a week later. By the end of the 20th century, 96% of the geographic United States and Canada is connected to some type of emergency response system that is connected to 9-1-1.

As far as anyone staffing communication centers or most anyone who has ever had the occasion to call 9-1-1 can attest, the network is an unmitigated success. Those who built the network accurately predicted that 9-1-1 would ultimately settle fully into the American psyche, that is if emergency services providers and the government oversight boards would recognize that existing emergency reporting methods were inadequate, especially in the face of an ever growing, evermore mobile population.

Some 45 years and an Information Age later, the 9-1-1 network remains everything it was cracked up to be. Even as the busy signal and the home telephone itself have become nearly extinct as the digital technology boom has unmoored communications from copper wire landlines and kicked them up to light speed and into virtually everyone’s hands, those three digits remain the quickest way to get real help to real emergencies today.
While no one can say the 9-1-1 system has become less reliable, the old argument that it is inadequate, especially as life is done at the speed of light with devices people carry with them all the time, is resurfacing. Dispatchers, their supervisors, and dispatch industry trade associations and vendors aren’t saying 9-1-1 isn’t good, they’re saying it’s just not good enough. The summer of 2013 sees the industry caught in the undertow created by the natural forces of digital communication innovation and the apparent infinite consumer demand for more, better, faster devices and applications. Interviews by The Journal with a cross-section of call centers show that the urge to purge the landlines and upgrade to a true next generation 9-1-1 full-broadband digital system ranges from an open-armed embrace, to general acquiescence, to its inevitability.

“Getting 9-1-1 up and running took about four decades, but it was a pretty short, well-charted trip,” William Harry, director of Valley Emergency Communications Center (VECC) in West Valley City, Utah, told The Journal in May. “Everybody knows how we got here. So, everybody’s got a compass but exactly where we’re headed has been tough to plot.”

Centers feel themselves aging at an alarming rate. Dispatchers and supervisors say that the public believes that call centers are as technologically sophisticated as they are. Several attending the International Academies of Emergency Dispatch (IAED) NAVIGATOR conference in Salt Lake City in April used the recorded music industry as a template for what dispatch is going through: While people can create, display, and stay in touch via the Internet all by themselves, call centers are a team, must be available 24/7, and are still trying to figure out how to get from cassette tapes to compact discs. Dispatchers interviewed for this article say a 9-1-1 call still comes down to a voice-only conversation, and no matter how much extra digital data needs to be managed, in the real world the exchange of information will remain the core job of dispatch, no matter how sophisticated technology becomes.

Mignon Clyburn, acting chairwoman and point person for the Federal Communications Commission’s (FCC) NG9-1-1 plans, reaffirmed that notion this past June when announcing that telephone service providers must, no later than Sept. 30, 2013, provide bounce-back alerts to people who are trying to text 9-1-1 to a comm. center that is not yet capable of handling text messages.

She stated unequivocally that any such digitized advancement in communications was to “complement the voice telephone call, not replace it. No virtual communication can take the place of a one-on-one phone call in an emergency.”

Call centers are working toward implementing text message handling, but many front-line dispatchers and their supervisors aren’t sure that plugging into the wide open streams of digital data won’t add static to what has been a straightforward and proven communication network.

The trail from that day in Alabama wasn’t a short hike but it was well-marked, Curtis James, a veteran dispatcher in upstate New York told The Journal. “Me and everyone I know embrace it and dread it. It’s inevitable, I suppose, but the truth is we have a hard time taking seriously what amounts to a nifty way for people to virtually socialize. If you’re in trouble, and if you’re able, call us.”

In the past 10 years, however, that notion that digital technology enhancements will enhance the 9-1-1 network is an idea that has been turbocharged by the rapid and unceasing development of the latest digital communications devices that make the good, old reliable voice-only network look like an Edsel next to a DeLorean.

It’s not that we don’t see the benefits of a “network of networks” that proponents of NG9-1-1 predict it will be, James said. “It’s the next smart, right step. It’s just that a true next generation 9-1-1 is just trickier and complicated by a factor of four. Not the least of the problems facing a center is the market is never going to be finished making technology new and improved. Once you buy into an information/data management system, you’re obsolete anyway.”

Other center managers equate modernizing their shops with going from using a hi-fi by plugging in a set of headphones to building and setting up a bi-amped, seven-speaker, subwoofer-enhanced home theater system. The basic conundrum is the headphones still work really well, but wouldn’t it be great if we had surround sound?

A tough act to follow

With great success comes great expectations. Even though the public 9-1-1 serves is using digital devices that weren’t even imagined 10 years ago, they have gotten used to 9-1-1 being there when they need it no matter what. That’s a tough act to follow. And centers feel as likely to catch up as Wile E. Coyote is to catch the Warner Brothers’ Road Runner. NG9-1-1, a multi-agency, carefully organized effort to fully digitize 9-1-1, is already 10 years old, and full adoption of all the data necessary to bring comm. centers fully into the 21st century is at least 10 years away.

A handful of stouthearted and financially flush emergency communication agencies are out in front scouting the way. Those centers are or are about to be at the text messaging stage.

In an age when consumers can collect and share loads of digital data as fast as a dispatcher can say, “OK, tell me exactly what happened,” the traditional circuit-switched 9-1-1 networks are telegraphs by comparison.

NG9-1-1 has inertia to the third power. Some public safety veterans say there hasn’t been this much anticipation in the industry since the original 9-1-1 network powered up.

“That’s no exaggeration; that’s the magnitude of change we’re talking about here,” Trey Forgety, National Emergency Number Association’s (NENA) government affairs director, told The Journal in a telephone interview from NENA’s Alexandria, Va., headquarters.

PSAPs, trauma centers, poison control centers, the U.S. Coast Guard, disaster management center, “you name it, can create partnerships as easy as making friends on Facebook,” he said. “We can’t not do this. Helping people in their hour of need remains Job 1. A fully realized NG9-1-1 just helps us do that better.”

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**“THE PUBLIC’S CAPACITY FOR INFORMATION ACCESS AND SHARING HAS TRANSCENDED THE LANDLINE, STATIC DEVICES OF EMERGENCY CALL CENTERS.”**

– Thomas Ginter
From here to there

NG9-1-1 might well be the definitive example of "easier said than done." A lot has been said, and said again. White papers have been put out by the FCC, NENA, and the U.S. Department of Transportation, to mention the Big 3 trying to chart the here-to-there for the broadband era of emergency dispatch.

The FCC has reported that state and local governments will spend up to $1.2 billion over the next 10 years for 9-1-1 upgrades, with an additional $1.5 billion spent on recurring connectivity, hosting and operations, and maintenance. (See the 2012 July/August edition of The Journal, "Left Out in the Cold" for more details on call center funding.)

Getting there is more journey than destination and in more ways than one, Thomas Ginter, vice president for product management at Telecommunication Systems (TCS), told The Journal. His company's bread and butter is solving the E-9-1-1, NG9-1-1, text message, and wireless communications challenges in general. Last summer, TCS purchased microDAA GIS Inc., a provider of NG9-1-1 systems for $37 million. The company is also spearheading a new SMS (Short Message Service) to-9-1-1 initiative to help PSAPs be part of the texting generation, which sends more than 2 trillion messages a day.

It's clear that the company sees NG9-1-1 as a growth industry, Ginter said.

"It's more than that," he noted. "The public's capacity for information access and sharing has transcended the landline, static devices of emergency call centers. Catching up and keeping up is an imperative of our times. Communication centers can't be waiting for the arrival of NG9-1-1, it's already here. There are new applications and vehicles for digital data-sharing becoming available every day."

Ginter said he understands and his company has researched the urge for dispatchers to want to hang on to what they know—the ears-only processing of calls. To make the notion sit better with the dispatchers who are in the driver's seat of every call, Ginter's favorite analogy is comparing the car his family had when he was a kid to one his kids have now.

"Let's take the 1969 Pontiac Parisienne," he said. "In its day, it was Pontiac's most popular of all the so-called Wide-Track cars. It was big, powerful, and its interior had all the bells and whistles. Take the fellow back in '69 who is driving that car and teleport him forward into a Cadillac Escalade. He'll know what to do with the steering wheel, the gas pedal, the brakes, the turn signals."

He'll feel sure he can drive the Escalade, Ginter said, noting that if the anachronistic guy at the wheel looks closer at his "Space Age" dashboard, he'll regard the number and array of buttons as something transplanted from an Apollo mission control console. "He'll see buttons where cranks used to be, and he won't have the first idea what half of them do or even what the terminology in the electronics section of the owner's manual even means. He'll see what looks like a radio, but when he flips it on, he'll be lost in the hundreds of options to select. And what does 'AUX' mean and 'DVD'?"

Our fellow caught in the time warp will still be able to drive the car off the showroom floor without any trouble, Ginter said. At first, all that new technology designed to make him a better, safer driver will look like a mess of distractions. But, through a process of trial and error—and perhaps even resorting to carefully reading the owner's manual—he soon starts to see his '69 Pontiac as dear but not nearly the sweet ride he thought it was.

"The point is dispatchers tend to see NG9-1-1 upgrades in their centers as distractions right now, and I don't blame them," Ginter said. "The voice-only network has worked better than fine up to now. But, once they get used to the advantages of the ways a fully IP-based system can help call processing, dispatchers will be just like the public is with the Internet and ePads—impossible to get along without them."

The one thing dispatchers want to do—quick, safe, accurate delivery of help where it’s needed—will still be job No. 1, they’ll just be able to do it better and better. We’re just getting started with what is nothing short of an incredible digital age of dispatching.

The medium is the message

The fact is that the message for as long as there have been emergencies and human beings has remained the same: Get help to the scene now.

"The only dynamic part of the emergency services equation anywhere today is the technology," said Steve Proctor, executive
A voice on the other end

No matter how finely attuned PSAPs become to the brave new world of digital emergency communications, technology will never replace the most important point of contact in a 9-1-1 call—the human voice.

So say several first-generation dispatchers when asked their opinions of Next Generation 9-1-1. If and when the capacity to seamlessly handle the demands of broadband exists—even to the point that nascent voice command programs such as Siri become the norm—veteran dispatchers believe no app will ever replace the sense of security and contact in a crisis that comes exclusively with the human voice.

People are taking the move into all things digital as a kind of manifest destiny, Steve Proctor, executive director of the Utah Communications Agency Network (UCAN), told The Journal recently. “People might be overlooking how important the sound of a caring, calm voice is to anyone involved in a serious accident or any kind of emergency situation.”

Proctor said as his own agency observes the succeeding generation of 9-1-1, he often catches himself thinking about his first years as a state Department of Transportation dispatcher. He would handle snowplow deployment as well as man the public contact point for road condition updates.

“Several times, especially late night or early morning hours during bad storms, I’d start getting calls for road conditions by people who would keep calling every 20 minutes or so,” Proctor said. “It bothered me at first. But then I realized those folks weren’t weather nuts tracking a snowstorm, and they weren’t in any real danger, they just wanted to hear a voice on the other end telling them what was going on out there and that things were probably OK.”

They were minor points in the scheme of emergency dispatching over the years and the evolution of UCAN. “But I’ve thought about those folks a lot over the years, and especially these days I keep them in mind as we move ahead with NG9-1-1,” he said. “That kind of trust and public sense that we’ll be there no matter what needs to remain the centerpiece of whatever upgrades we implement. That’s what it’s all about and I suspect always will be, no matter how fast or how much data we can handle.”

director of the Utah Communications Agency Network (UCAN) and a 42-year veteran of the radio side of emergency communications, told The Journal in May. The information age is having its way with “the other side of every 9-1-1 call. Technology is having its way with everybody and is adding to an abiding sinking feeling that despite their own best efforts to stay ahead of the digital curve, they are falling behind.”

No matter how well their system is working, many have reached a point of diminishing returns when getting by with obsolete and sometimes nearly extinct equipment simply won’t do, he said.

UCAN has been modernized once before. The 100-tower radio system was updated and retooled as a world-class network to handle all two-way communications during the 2002 Winter Olympic Games held in Salt Lake City. More than 10 million calls came through the hub during the Olympics and Paralympics without a hitch, Proctor said.

“If we had tried to handle that kind of traffic without upgrading our system, we would have failed miserably,” Proctor said. “But today, given the significant increase in population in the state and the accompanying increase in emergency communications, that system is maxed out. Plus, it’s now 10 years old and getting more obsolete every day. Radios break down; replacement parts stop being made. And broadband is just another way of saying we’re getting obsolete.”

Proctor mentions the past decade in part to remind folks that the 2002 Olympic Games came off incident-free, despite being less than five months after the Sept. 11, 2001, terrorist attacks in New York City. “We felt a lot like the poster child for public safety, and the world was watching.”

He also mentions Olympics as a lens through which other emergency communicators might view the current push to retool for NG9-1-1. If steps, particularly funding streams and territorial boundaries, aren’t set and agreed upon, Proctor said, “a lot of PSAPs could be headed toward a calamity UCAN averted because we didn’t have time for turf wars and fooling around in 2002. We had to be up and running—no excuses—by Feb. 8.”

That clarity of purpose might not be coming through in the nascent NG9-1-1 era, Proctor said. And, the proportion and scale of individual call centers might be much smaller, “but the goal of protecting the public’s safety and well-being looms just as large.”
Seriously injured patients rely on you to give the best medical attention and care. To do that, you need knowledge, experience and the proper tools. That's why the Centers for Disease Control and Prevention (CDC) has released the widely endorsed Field Triage Decision Scheme: The National Trauma Triage Protocol to help EMTs and paramedics choose the best transport destination for trauma patients. Designed in partnership with other leading organizations and experts in injury care, the Decision Scheme has been published in the prestigious MMWR Report & Recommendations. It's a valuable tool that can help your EMS system save lives.

Get a free copy of the Field Triage Decision Scheme: The National Trauma Triage Protocol, the MMWR and other free resources at www.cdc.gov/FieldTriage
Baby Stories

Unpredictability is the only sure bet

Audrey Fraizer
Childbirth is a priority situation, same as a baby in any sort of medical emergency, and often in the same category as cardiac arrest and choking, which explains why Pre-Arrival Instructions (PAIs) for delivering a baby and assisting a baby in respiratory distress have been part of the Medical Priority Dispatch System™ (MPDS®) from the start.

But there is one major and potentially frustrating difference. The EMD isn’t driving the event. Childbirth is patient driven. The patient dictates the speed and progress through the PAIs, not the EMD; no one can accurately gauge what will happen during delivery or the outcome.

That’s why Protocol F: Childbirth–Delivery continues to evolve.

So, how likely is it that you will be the emergency dispatch support person for an unexpected arrival? There are few statistics available, although the chances appear to be minimal. But if it does happen, more than anything else, the caller—the mother or person assisting—requires guidance and reassurance, and for the EMD sounding calm and confident, it says you’re right there with them.
The day I gave my daughter CPR will be forever in my mind.

It was like I was outside of myself watching, calmer than I think would be possible in that situation for anyone who hasn’t been on the other end of a 9-1-1 call. I knew her breathing was agonal the second I saw and heard it. I’d been watching her breathing religiously for months, and there was very obviously no air moving. Her 20-second apnea alarm had never gone off that there was still oxygen in her blood. That meant I had to act because there were minutes left, and the paramedics would be too late if I didn’t do something. I started with compressions first. I remember thinking how she seemed so much like one of those plastic dolls I’ve practiced on over the years, just as limp but heavier.

I told my mother to call 9-1-1 and put it on speaker, double verifying my address and phone number, stating “baby not breathing,” answering the EMD questions, and telling the calltaker to go to MPDS’ Protocol 9: Cardiac or Respiratory Arrest/Death and Pre-Arrival Instruction A: Airway/Arrest/Choking (Unconscious)-Infant < 1 yr.

I was careful to speak slowly and clearly despite the urgency of the situation. The calltaker was a bit startled, but recovered quickly and coached me through the rest and converted to ventilations and compressions. I was grateful she was there for me, and promised myself if we made it through this I would thank her personally and introduce her to my daughter.

I made sure my daughter’s head was tilted back, covered her mouth and nose with my mouth, and blew the two puffs of air in and saw her chest rise and deflate. I made sure I didn’t waste time switching back and forth between compressions and ventilations. I made sure to press down far enough and come all the way up between pumps. I told the calltaker to use the compressions monitor, but I was already singing the “Staying Alive” song in my head so I already knew I was going fast enough.

I knew even in the moment that I was doing everything right, but I also knew that in 12 years I’ve never had a documented life save that we knew of because so often CPR is not enough. I remember having the “it’s not working” reaction, but continued CPR telling myself, “this is helping her even if I don’t see a response.”

The truth is, I really thought it was the end. Five to seven minutes into the call, paramedics arrived and laid her on the bed; she had a pulse of 120. She had a chance after all. The first few hours looked grim, but then the most talented doctor I’ve ever met threw a Hail Mary treatment at her and it began to work. For the week after that, she clung to life on a ventilator in one of the best NICU’s in the country.

I thought we could lose her any day. Three months later, she had recovered. Within a year, health problems related to her premature birth leading to her cardiac arrest resolved completely.

The calltaker answering that call has no idea that my daughter survived, just like Jenn Schifelbein may have saved a guy having his second heart attack in a week a little while before that. There is another piece of that story that they’ll never know, so we all just move on and will never realize the true impact we have each had on so many lives.

The one time I’ve had a known life save ... it’s my own daughter. It’s like every 9-1-1 call I’ve ever taken was a rehearsal for the most important and terrifying moment of my life. The paramedics played a critical role, as did the responding officers and of course, all the hospital staff. But 9-1-1 is the true first responder that all the rest of them depend on.

This job is like no other. What we do is important and changes and saves lives. It is interesting, scary, fun, exciting, boring, and annoying all at the same time. But I’m only going to leave you one bit of advice.

Nothing we do is more life critical than being an Emergency Medical Dispatcher. So even if you don’t always like that part of your job, keep your skills up and be a damn good one.

I hope to never be a stranger. You can always find me on Facebook or on my blog www.10MilesUphillintheSnow.blogspot.com.
angry to get the show on the road, unless it meant being in the car on the road leading to the hospital.

“He sounded scared,” she said. “He said there was a lot of blood. They live 25 minutes from their hospital. She [Stacey] didn’t think they would be able to make it.”

Lunt instructed the caller to persuade Stacey to stop pacing, get towels, and have her lie down so that he could check the delivery status. Johnston saw the infant’s head.

“That really made me nervous,” Lunt said. “Uh oh, I thought, we’re doing this whether the ambulance gets there in the next few minutes or not.”

Lunt helped Sprague through her contractions, while keeping Johnston focused and calm during the silent moments in between. Twelve minutes later, mom was holding her nearly six-pound Abigaille, and dad was thanking Lunt for her fabulous help at a time he thought a doctor would be present. Unity Ambulance was at their door.

While Johnston was admittedly nervous during the call, in retrospect he said the experience might be worth repeating on one condition.

WCRCC is the county’s communication and dispatch center for all law, fire, and EMS agencies within the county. It also acts as the county’s E-9-1-1 PSAP. WCRCC came on-line Aug. 15, 2001, with the merger of the dispatching facilities and personnel from the City of Belfast and the County of Waldo Sheriff’s Office.

New Kid On The CAD
EMD in training answers call of a lifetime

Jeff Poff was on day 18 of training with Waukesha County (Wis.) Communications when he answered the call everybody wants—as long as it goes well.

“My wife is in labor,” Mukwonago resident Bobby Larson said.

“Great,” Poff thought. “I’ll get an ambulance over there. No problem.”

The reason for the call just after 9:30 a.m. on March 16 had no intention of waiting. In the seconds it took Poff to transfer the call to Mukwonago EMS dispatch, dad said his hands were touching the baby’s head. Poff’s trainer Holly Dischler, who was also on the call, sat back, poised to jump in if necessary.

“I started to sweat,” Poff said. “And once the baby was out, dad tells me, ‘Oh my God. He’s not breathing. Tell me what to do.’”

Referring to Pre-Arrival Instructions, Poff told Larson to turn the baby over and briskly rub his back to stimulate breathing.
No Time For Modesty
Baby delivered on side of road during rush hour

Maybe it was all for the better that no one stopped to ask why the Lincoln Navigator was parked on the side of the road during rush hour at the gates of Fort Bragg military base on Feb. 6, or that no one bothered to call 9-1-1 to report a guy who was leaning suspiciously over his front-seat passenger.

Maybe it was lucky that the SUV did not attract undue attention, with a line of cars stacked along the road with curious onlookers peering into the windows.

It was bad enough that this was a first for the driver, and his attention most carefully focused on the modesty—or perhaps the discomfort—of his wife’s pending situation. He didn’t need anyone else complicating his second child’s birth, it was already complicated enough.

“The first thing we heard (when answering the 9-1-1 call) was a guy saying, ‘I don’t think my wife’s going to make it,’” said EMD Kerrie Ruppert, Fayetteville (N.C.) 911 Communication Center. “No way did we think it was going to be a baby delivery.”

But a baby almost on board it was.

Although the caller was hesitant to take the necessary first step of checking the delivery’s status—which is where the discomfort part comes in particular—he relented, following a fervent apology to his wife.

“I see the hair, the head is out,” he told Ruppert.

As Ruppert said, she swept into “baby mode,” taking over the call from her trainee of two days, switching to the ProQA® baby delivery Pre-Arrival Instructions (PAIs), and getting the baby on board at about the same time firefighters arrived on scene in rush hour traffic.

Despite fleeting reservations, the delivery went very well, maybe better than anticipated if there had been time to anticipate anything at all. Mom wasn’t saying much—at least nothing Ruppert could understand—and dad, a civilian contractor at the base, was calmly and responsively following Ruppert’s every instruction. Their other child was sitting buckled into a carrier in the backseat, crying on pitch to her mother’s clear expression of pain.

Ruppert kept her cool.

“I must have said ‘okay’ to the dad a thousand times,” Ruppert said, based on the audio of the call she listened to later. “But that’s okay because it was reassuring to him. It made it so we walked through everything easily.”

Eight minutes later on Tuesday afternoon, Feb. 6, mom and baby were on board the ambulance and on their way to the hospital, and none too soon according to a dad apprehensive of delivery steps beyond tying off the umbilical cord with his shoelace. He heard the sirens approaching and that was the end of the call. Their infant daughter was wrapped in a sweater that as a probable keepsake will never make the donation boxes.

The call made the day for the Fayetteville communication center.

“’We were all excited, especially when we heard the baby take her first breath,” Ruppert said, referring to the team of four dispatchers and four calltakers on the 3 p.m. to 11 p.m. shift. “This was the first time in my years at the center that we’ve used ProQA to deliver a baby. We are a team. We did this together.”

Ruppert started in dispatch 13 years ago when a robbery at the gas station where she was working convinced her to pursue other career options. Since both her parents have career military backgrounds, and her mom is a crime prevention specialist in the Fayetteville Police Department, they convinced their only daughter to submit an application for an opening in emergency communications.

For Ruppert, there’s no going back.

“I love this,” she said. “We’re truly the first ones there giving help, and if sometimes it’s just people wanting someone to talk to because they’re scared, I’m okay with that too.”

As far as another baby delivery? Ruppert said she’s okay if that doesn’t happen for awhile, although her introductory call to baby delivery is one that she doesn’t hesitate to talk about.

“This was awesome,” she said, “I’m really proud of what we did.”

The Fayetteville 911 Communication Center is responsible for dispatching police and fire within the city’s limits and the Cumberland County Emergency Operations Center is responsible for dispatching for the sheriff’s office, as well as Hope Mills and Spring Lake police, ambulance service, and volunteer fire departments. The center has been using MPDS® since June 1, 2011.
**Triple Crown**

Babies have her number

It was a boy and a girl born almost exactly 24 hours apart for EMD Linley-Marie Cummings. And then another girl.

“This was crazy,” said Cummings, of MD Communications in Saskatoon, Saskatchewan, Canada. “People have been here for years and haven’t had one baby. I was lucky enough to have two.”

Four weeks later Cummings assisted on a third delivery, which can only mean that babies have her number. She was extra lucky to have three.

“I didn’t think this was going to ever happen again after the first two,” she said. “I was so surprised.”

Cummings wasn’t the only one flabbergasted by the events. After all, the MD Communications stork doesn’t dispense all that many babies each year prior to the arrival of first responders. In 2010, the center recorded four; followed by three in 2011, five in 2012, and five so far in 2013. Fellow EMD Jessica Rempel assisted in the delivery of a baby on April 4.

“I’ve never heard of anything like this in the 28 years I’ve worked at MD Communications,” said Director LeeAnn Osler. “It is truly amazing.”

The first two babies the MD Communications dispatcher helped coach into the world arrived on a Friday and Saturday (March 29 and March 30, 2013), and both during the early morning hours, before 5 a.m.; the babies will probably continue to wake up their parents in the months to come.

The third baby, who arrived shortly after midnight on Saturday, April 27, made her debut inside a car pulled over to the side of Highway 16 just outside the tiny rural village of Elstow (population 89 in 2011).

**March babies**

Not only was it unusual for one dispatcher to answer both calls in March one day apart when she was one of four dispatchers on duty, but the deliveries also beat the odds of an ambulance getting there prior to the completion of MPDS’ Pre-Arrival Instructions (PAIs). Neither call came from rural areas. The boy and girl were delivered in homes in the city of Saskatoon, Saskatchewan, Canada.

“Our responders get there so quickly, and that made it even crazier about these calls,” Cummings said.

Before Cummings was able to make it through Key Questions—she was on KQ5 each time—dads on both calls said the disconcerting, “Oh my, I can see the baby’s head.”

“They happened so fast,” she said.

Cummings said the births were intense from her side of the phone, with the baby girl arriving on Saturday adding a little extra stress to her coaching. She wasn’t immediately breathing, but that was remedied within seconds with instructions that dad rub the baby’s back.

“What a relief when the baby cried,” she said.

**April baby**

The baby girl delivered in April on the side of Highway 16 was born five minutes before first responders made it to the scene and 15 minutes prior to the arrival of ambulances. The actual delivery, however, went quickly, Cummings said.

“I tried keeping them calm,” she said. “Then all of a sudden he sees the baby’s head. From there it went fast.”

Although the umbilical cord was wrapped around the baby’s neck, Cummings did not flinch. She gave instructions to “Slide your finder under the cord,” and had the dad stretch the cord carefully over the baby’s head (away from the baby’s body).

A towel they had packed “just in case” kept the baby—named Willow—warm, while the shoelace from dad’s boots was used to tie off the umbilical cord.

“Then all of a sudden he sees the baby’s head. From there it went fast.”

**The right place**

Maybe it was the alignment of the planets putting Cummings at the right place at the right time. After all, she said the experience “put her over the moon” and this is the place she wanted to dispatch 9-1-1 after graduating from a one-year Public Safety Communications program offered at the Cloverdale Campus of the Kwantlen Polytechnic University in British Columbia. MD Communications hired her in February 2012, and she is EMD certified.

“This is what I wanted to do, and I wanted to work at MD Communications,” she said. “I like to help people and I’ve always respected the type of job we do.”

And now that she has three births under her headset.

“I feel relaxed about taking these calls,” she said. “Although, I’ve been told my chair’s being pushed out of the way the next time this happens.”

MD Communications employs 38 EMDs, all of whom are also EFDs. The center is the only Accredited Center of Excellence (ACE) in Saskatchewan, having earned its initial ACE in 2000. They process and dispatch medical emergency and inter-hospital transfer calls for 38 ambulance companies, 22 rural fire departments, 150 rural first responder groups, Saskatchewan Air Ambulance, and Corman Park Police Service (after hours).

**Editor’s Note** Cummings assisted in the delivery of a fourth baby in June, born to a mom who is friends with the mom giving birth in April, and both on Highway 16.

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**Linley-Marie Cummings Dispatcher is magnet for baby deliveries.**

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**THE JOURNAL | July/August 2013**
Yellowhead Highway will always signify more than the busy road through Saskatoon, Saskatchewan, Canada, for a couple anticipating the birth of a second child.

And, most likely, a similar route they would prefer to bypass in the future if given a similar situation.

The couple was about 50 kilometers (30 miles) away from their intended medical center destination in Saskatoon on Thursday, April 4, when shortly after 7 a.m. the soon-to-be-dad and driver called 9-1-1.

“He was on speakerphone and said his wife was having a baby,” said MD Communications EMD Jessica Rempel. “I advised that he immediately pull over to the side of the road and turn on his four ways.”

Dad pulled to the side, activated the emergency flashers, and Rempel was about midway through MPDS® Key Questions (KQ) at the time mom said she could feel the baby’s head. A 9-1-1 supervisor following the call relayed information to an ambulance while a second dispatcher called first responders in Clavet, a village about 15 kilometers (9 miles) outside of Saskatoon.

Although help would be coming from two directions, it was certainly not the reassuring situation any parent would hope for. Yellowhead Highway (or Highway 16) is the major east-west route through Saskatchewan province in western Canada. Traffic was heavy and mom was hesitant, Rempel said.

“Can you blame her?” Rempel said. “They were on the side of the road on a main highway during morning rush hour. I felt really bad for her.”

Feelings aside, Rempel jumped into Pre-Arrival Instructions for childbirth and delivery. Eighteen minutes into the call and Rempel heard the baby’s first cries and seconds later the blare of sirens from the ambulance arriving on scene. Rempel congratulated the couple, told them she would be disconnecting, and turned the call over to Clavet responders.

The ability to help people is the stuff Rempel lives for and this was not the first time she found herself on the imminent side of childbirth. Turn the calendar back to Nov. 3, 2011, and Rempel, who was new on the job, was giving the same instructions to those at a Saskatoon massage clinic. The mother-to-be had booked a prenatal massage on the date the baby was due, and just as she was getting dressed to leave, the baby got ready too.

“Her husband called 9-1-1 and their doula (labor coach),” Rempel said. “I gave him instructions over the phone and the baby arrived before the ambulance.”

The massage clinic—ironically with the business title Inside Out Therapies—was undoubtedly the preferred birthing venue, if either of the couples Rempel had assisted in baby deliveries had been handed the opportunity to choose. Clinic staff provided warm towels, linens, and warm pillows to make mom more comfortable. Fortunately, the couple forced into the April 2013 roadside delivery had packed along clean towels “just in case.”

“The babies were fine, and that’s the main thing,” Rempel said.

Rempel took a 180-degree turn in her career choice two years ago, leaving an accounting job for calltaking and dispatch at MD Communications, and it might just be the best decision she ever made.

“I plan to stay with this,” she said. “This is my career. At the end of each day, I feel like I’m accomplishing something by helping someone.”
Practice Makes Perfect
Dispatcher wants to be ready for anything

Sara Schallert believes in the idiom practice makes perfect or, at least, how it applies to the Medical Priority Dispatch System™ (MPDS™).

“I practice all the time,” she said. “The more I study the calmer I am and the more I am able to calm the caller.”

The study habits worked out precisely to Schallert’s advantage on Dec. 15, 2012, when the Waukesha County (Wis.) Communications (WCC) Center EMD was presented the ultimate 9-1-1 challenge: comforting not only the individual at the center of their emergency.

“The caller said her sister was in labor,” said Schallert, who worked for a heavy-duty truck dealer before finding her “dream” job in communications. “I heard the mom screaming in the background, so I said to myself ‘ProQA® here we go.’”

This was Sarah Young’s third baby, but despite her past two deliveries, the baby arriving that day defied her expectations.

“She didn’t have the time she thought she had,” Schallert said. “She called her husband at work and said he’d better come home, ‘We’re having a baby here.’”

Fewer than eight minutes into the call, baby Isabelle Young announced her presence. County paramedics arrived moments later, which was about the same time the three adults in the room—aside from mom—were checking out each other’s shoes for a lace to tie the umbilical cord.

The baby’s cry was music to Schallert’s ears and, presumably, to the ears of everyone else at the Young home and in the dispatch center shortly after 6 a.m.

“It was such a good feeling that everything went well,” Schallert said.

Sarah’s sister Megan had made the call, while the sisters’ mother helped deliver the baby by following the Pre-Arrival Instructions (PAIs) Schallert relayed from her ProQA screen. Dad was close at hand, although his hands were certainly full trying to keep their other two children occupied.

The communication center cheered.

“Everyone was super excited for me,” Schallert said. “We were in the 11th hour of a 12-hour shift and the call really pumped everybody up. There was lots of energy in the room.”

The baby story doesn’t end there.

One month later to the exact date, Sarah took Isabelle on a special trip to the communication center to meet the individuals involved in her unexpected morning delivery. But not only did center Director Sherri Stigler introduce her to Schallert and her coworkers, but, also, to the paramedics who had arrived on scene.

Schallert was thrilled to hold the baby, just as mom was thrilled to meet the people who helped bring Isabelle into the world.

“We all got to hold the baby,” Schallert said. “She was adorable. Mom and baby were both adorables. It was also great for the paramedics. Everyone saw a bit of the center and how it works.”

And, yes, Schallert truly does study the card set to be better prepared over the phone when using ProQA. She has reviewed every protocol several times and is well aware of the protocols and PAIs still on her “not yet required for a caller” list.

“I can now check off the one for child-birth,” she said.

WCC is a 9-1-1 public safety answering point (PSAP) and dispatch center for 29 communities within Waukesha County. The center is staffed with 40 telecommunicators divided into three functions: calltakers, police dispatchers, and fire dispatchers.
On Track

Foodborne Illness
Summertime and the bacteria is lurking
Audrey Fraizer

Picnics, outdoor festivals, state fairs, and barbecues are just part of the fun that makes summer a highly favored season.

But along with the good comes the bad.
The events many Americans longingly anticipate during those cold and dark winter months spent indoors are also the desired stomping grounds of some of the deadliest critters around: foodborne bacteria.

Foodborne illness is the most commonly reported communicable or infectious disease. The Centers for Disease Control and Prevention (CDC) estimates that each year roughly 1 in 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die from foodborne diseases.\(^1\)

The potential for foodborne illness increases during the summer due to temperature and handling. Foodborne bacteria grow fastest at temperatures from 90 to 110 degrees Fahrenheit and the moisture (humidity) only allows them to flourish. Cooking and eating in the great outdoors without the safety valves of refrigeration, thermostat-controlled cooking, and kitchen sinks can make a picnic more enjoyable for the bacteria than for the people partaking.\(^2\)

The raw details

The time frame measured from that first bite of potato salad left out too long until the first signs or symptoms appear (often abdominal cramps, nausea, vomiting, or diarrhea) is called an “incubation period.” Incubation may last hours or days, depending on a patient’s immune response. The speed of onset usually depends on the amount of contaminated food that is swallowed, and the symptoms vary depending on the infectious agent.\(^3\)

There are more than 250 pathogens and toxins known to cause foodborne disease, but only seven of these pathogens are to blame for 90% of the agonizing illnesses, hospitalizations, and deaths: *Salmonella*, norovirus, *Campylobacter*, *Toxoplasma*, *E. coli* O157:H7, *Listeria monocytogenes*, and *Clostridium perfringens*.\(^4\)

Of these, *Listeria* is the least common but considered the most deadly—especially for the elderly, people with compromised immune systems, or for pregnant women who can unwittingly pass on the pathogen to an unborn baby.\(^5\)

*Listeria* doesn’t usually cause typical food poisoning symptoms such as stomach cramps, diarrhea, and nausea, which grants the bacteria a longer incubation until it develops into something more serious, such as meningitis or sepsisemia.\(^6\)

Surprisingly, all of this may be lingering around waiting for the right mixture of temperature, cooking, and eating to induce foodborne illness.

A SAFEGUARD AGAINST FOODBORNE ILLNESS IS KILLING THE BACTERIA THROUGH COOKING AND PASTEURIZATION.

But perhaps the most common cause of food poisoning in the United States is *Clostridium perfringens*, which resides in beef, poultry, and gravies. Initially cooking the meat kills the growing bacteria but not the spores that grow into new cells, which is why prompt refrigeration is necessary. This explains why outbreaks often occur in large institutions or events where large quantities of food are kept warm long before serving.\(^7\)

Home-canned fruits and vegetables can also be a great treat in the summer heat, but the consumer should be aware that home-canned preserves can sometimes contain *Clostridium botulinum*, a naturally occurring bacteria in soil that becomes a potently toxic protein when sealed off from air. If exposed to foodborne botulism, a person may suffer effects on the nervous system, which may become fatal.

In adults, symptoms of botulism poisoning include double or blurred vision, drooping eyelids, slurred speech, difficulty swallowing, dry mouth, and muscle weakness; while infants (often exposed to botulism through an introduction to honey before 12 months) may experience lethargy, weakness, poor feeding, constipation, poor head control, poor gag and sucking reflexes, etc.\(^8\) Even early symptoms of botulism indicate a true medical emergency and should be addressed immediately. In severe cases and with prolonged time, respiratory muscles may become paralyzed, creating difficulty breathing or respiratory failure.

Observing and reporting outbreaks

The U.S. Food and Drug Administration (FDA) Coordinated Outbreak Response and Evaluation (CORE) Network, established in 2011, works with the CDC, the U.S. Department of Agriculture (USDA), and state public health and agriculture agencies in the prevention of and response to human and animal foodborne illness outbreaks.

The potential for a food poisoning outbreak is investigated when two or more people have similar symptoms after consuming the same foods. Health officials can identify a suspected outbreak of food poisoning as they would identify a flu outbreak, by researching data clusters of sick people having a common exposure, or same source, of the same illness.

Surveillance networks, such as PulseNet and FirstWatch systems, can detect patterns of illness over defined geographical areas, provide notification, and monitor outbreaks. PulseNet, coordinated by the CDC, is a national laboratory-based surveillance system that uses DNA patterns submitted electronically by state and local health departments to...
identify the genetic make-up of the sample bacteria affecting a population. This information can be used to determine the potential source of infection in what may otherwise look like unrelated illnesses.\(^4\)

In 2011, PulseNet recognized over 280 clusters of foodborne pathogens and played a crucial role in identifying the scope of the Listeria monocytogenes outbreak associated with cantaloupe from Colorado.

As another resource in outbreak detection (not solely foodborne illnesses), FirstWatch is a non-database specific analysis tool providing real-time data surveillance for identification of emerging patterns, trends, or geographic clusters of potentially concerning incidents. For MPDS\(^*,\) PPDS\(^*,\) and FPDS\(^*\) users, FirstWatch data surveillance selection criteria can be based upon any combination of Determinate (sub-Determinate) and/or the Chief Complaint/Nature Problem Code selected within CAD related to the reason that someone calls 9-1-1 or goes to the hospital (such as syndromic surveillance).

When the system detects a potentially concerning trend or pattern in the data, an alert automatically goes out to authorized users. (Alerts can contain summary reports, charts, graphs, maps, or other critical information.) FirstWatch can be configured to monitor 9-1-1 communication call center data for police, fire, or EMS.

Agencies using the medical, fire, and police protocols select the codes they want monitored and the thresholds for notification of an alarm. A sudden increase in calls coded with Chief Complaint 26: Sick Person (Specific Diagnosis) could trigger an automated FirstWatch alert notification, if that code was selected for real-time surveillance.

**Response**

Foodborne illness does not always require a call to 9-1-1 or immediate medical treatment. A period of “watchful waiting” during which the patient and doctor observe symptoms may be appropriate for diarrhea (neither persistent nor severe) and mild stomach cramps. These types of symptoms arising from bacterial food poisoning, similar to gastroenteritis, may eventually resolve without medical treatment.

However, a call to 9-1-1 is advised if:

- Signs of severe dehydration are present (little or no urine; sunken eyes, no tears, and a dry mouth and tongue; fast breathing and heartbeat; dizziness; and not acting alert).
- Bacterial food poisoning is associated with home-cooked food and the patient’s complaints are symptomatic of botulism (blurred or double vision, trouble swallowing or breathing, and muscle weakness, etc.)\(^3\)
- The food causes a severe allergic reaction.

Response also depends on any co-morbid conditions, the patient’s age, and length of time since onset. These considerations may warrant greater vigilance, especially for those with compromised immune systems, young children, and the elderly.

**Protocol**

The MPDS provides a complete interrogation to obtain the patient’s symptoms for correct prioritization. The EMD should be suspicious of foodborne illness when handling complaints of abdominal pain. However, the EMD should not automatically assume that abdominal pain complaints are due to foodborne illness. Abdominal pain above the navel may actually be a heart attack, and women within child-bearing years may report abdominal pain in the case of an ectopic pregnancy (especially if fainting or near fainting is also a symptom).

Except in unusual cases, true abdominal pain is not considered a prehospital emergency, and the severity of the pain is not related to the seriousness of the problem (Protocol 1, Rules 1 and 2). For example, gastroenteritis, as a symptom of foodborne illness, can create mild to severe cramping pain accompanied by nausea, diarrhea, and vomiting. There is no medical cure, and it usually self-limiting in duration. The greatest concern in these cases is dehydration from the failure to replace body fluids, especially among infants.

Chief Complaint 26: Sick Person (Specific Diagnosis) is used for a patient with a non-categorizable Chief Complaint who does not have an identifiable priority symptom (abnormal breathing, chest pain, decreased level of consciousness, or SERIOUS hemorrhage). After Key Question interrogation, if no higher-level Determinant Descriptors apply, the EMD may use the ALPHA-level or OMEGA-level NON-PRIORITY Complaints to address symptoms such as nausea, vomiting, defecation/diarrhea, etc.

The EMD should never minimize the patient’s problems and should encourage the caller, “If s/he gets worse in any way, call us back immediately for further instructions,” (Case Exit instructions). Uncertainty or inability to rule-out priority problems may require a higher-level response to further assess the situation (26-B-1, “Unknown status/Other codes not applicable”).

In some communication centers, a caller with OMEGA-level NON-PRIORITY Complaints could be referred to an Emergency Communication Nurse (ECN) in a center using the Emergency Communication Nurse System™ (ECNS™). ECNS is intended for use alongside MPDS and interfaces with the ProQA\(^®\) software.

Using the ECNS software, the nurse asks a series of questions to determine a level of care consistent with the patient’s complaints. There are 22 Recommended Levels of Care built into the system, including a visit to an urgent care center the day of the call, scheduling an office visit with the primary care provider, or contacting poison control.

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**Sources**


CDE-Quiz  +  Medical

Answers to the CDE quiz are found in the article “Foodborne Illness,” which starts on page 36.
Take this quiz for 1.0 CDE unit.

1. What are the two reasons foodborne illness tends to increase in the summer season?
   a. eating in a hurry and sharing bites from the same burger
   b. purchasing snacks from an outdoor vendor and eating the food at a public pavilion table that is
      not sanitized after each use
   c. higher outdoor temperatures and improper handling
   d. hotdogs and baseball games

2. The incubation period of food poisoning means:
   a. the time it takes the bacteria to form on the food.
   b. the time it takes for the individual eating to notice the food tastes “funny.”
   c. the time frame measured from that first bite of tainted food until the first signs or symptoms appear.
   d. the time frame between feeling the first symptoms until the sickness has passed.

3. Favorable homes for the prevalent bacteria Salmonella include:
   a. maple syrup and pancake batter
   b. home-canned green beans
   c. dogs and cats
   d. baby chicks, turtles, lizards, and other reptiles

4. The most common cause of food poisoning in the United States is:
   a. Escherichia coli.
   b. Clostridium perfringens.
   c. Listeria.
   d. Clostridium botulinum.

5. The potential for a food poisoning outbreak is investigated when:
   a. four or more people have similar symptoms after consuming the same foods.
   b. one person has severe symptoms.
   c. everyone attending the same event complains of abdominal pain.
   d. two or more people have similar symptoms after consuming the same foods.

6. PulseNet is a national laboratory-based surveillance system using:
   a. fecal samples only to help identify foodborne outbreaks.
   b. DNA pattern technology to help identify foodborne outbreaks.
   c. food samples suspected of containing the infectious agent.
   d. Aspartate Aminotransferase (AST) Test.

7. Foodborne illness always requires a call to 9-1-1 or immediate medical treatment.
   a. true
   b. false

8. Chief Complaint 26: Sick Person (Specific Diagnosis):
   a. is reserved for critical problems requiring immediate transport.
   b. assumes a co-morbid condition exacerbating the present complaint.
   c. is used when the patient has several priority symptoms.
   d. is reserved for a patient with a non-categorical Chief Complaint who does not have an
      identifiable priority symptom.

9. Uncertainty or inability to rule-out priority problems may require a lower-level response.
   a. true
   b. false

10. The Emergency Communication Nurse System may receive transferred cases coded in the following
    Determinant level:
    a. ECHO
    b. CHARLIE
    c. DELTA
    d. OMEGA

To be considered for CDE credit, this answer sheet must be received no later than 08/31/14. A passing score is worth 1.0 CDE unit toward fulfillment of
the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive
credit. Please retain your CDE acknowledgement for future reference.

CDE Quiz Mail-In Answer Sheet
Answer the test questions on this form. A photocopied answer
sheet is acceptable, but your answers must be original. WE WILL NOT PROCESS ALTERED SIZES.
A CDE acknowledgement will be sent to you. (You must answer 8
of the 10 questions correctly to receive credit.)
Clip and mail your completed answer sheet along with
the $5 USD (must be U.S. currency) NON-REFUNDABLE processing fee to:
The International Academies of Emergency Dispatch
110 South Regent Street, Suite 800
Salt Lake City, UT 84111 USA
Attn: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.
Please return your CDE acknowledgement
for future reference.
Name ____________________________________________
Organization ______________________________________
Address __________________________________________
City ___________________________ St./Prov. ____________
Country _____________ ZIP ______________
Academy Cert. # ________________________________
Daytime Phone ( ) _______________________________
E-mail __________________________________________

PRIMARY FUNCTION
☐ Public Safety Dispatcher (check all that apply)
□ Medical ○ Fire ○ Police
☐ Paramedic/EMT/Firefighter
☐ Comm. Center Supervisor/Manager
☐ Training/QI Coordinator
☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other

ANSWER SHEET  +  MEDICAL
July/August 2013 Journal “Foodborne Illness”
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
8. □ A □ B □ C □ D
9. □ A □ B
10. □ A □ B □ C □ D

Expires 08/31/14
Someone once described emergency medical dispatch as 25% boredom, 75% stress, and 90% sheer terror.

“That’s pretty much 100% correct,” said Brian Dale, a paramedic, veteran emergency medical dispatch instructor, and Accreditation Board chair for the International Academies of Emergency Dispatch® (IAED™), as another class of 16 dispatchers-in-training gave nearly an agonal sigh when told that only one remaining task lay between them and their weekend—a test.

“Oh, please,” Dale said in answer to the group murmur. “You knew there’d be a test. Plus, we’ve gone through a lot of material; we need to see how much of it stuck.” Remember, he advised, reviews of performance are the rule in dispatching, not the exception. “Get used to it.”

“Feeling overwhelmed is bad, but it’s good,” said Chris Bradford, a long-time instructor recently named National Q manager for Priority Dispatch Corp.™, in an interview at the 2013 NAVIGATOR conference hosted by the IAED. “That means they’re paying attention. Anyone who doesn’t feel like they’re in over their heads at the end of...
their first course is kidding himself. Just wait until they start finding out all the things we didn’t teach them.”

The initial EMD/EFD/EPD course is in effect a long first introduction. The real learning comes at the console, Dale said. “We can teach you about the protocols and the academic of dispatching in class, but there are concepts and realities of the work that you don’t learn until you have the headset on.”

**Unpredictable by nature**

From the time the phone rings to the dispatching of responders, there are between 80–100 million variations an emergency call can take, excluding the hairpin turns that can come up during Pre-Arrival Instructions. Without clear control of the call, things can suddenly go off the hook or even over a cliff if the caller is highly emotional or becomes agitated. Dispatchers can feel like they have just grabbed hold of an electric fence, wondering if they have hold of it or if it has hold of them.

However, as taught in the EMD/EFD/EPD course, the responsibility of the emergency dispatcher is to build upon the predictable elements among the unpredictability. Equipped with training, experience, and the decision-making aids of prompts, rules, axioms, and shunts embedded in the MPDS®, PPDS®, and PPDS®, the emergency dispatcher can make light work of maintaining order.

One of the beauties of the protocol is that it diminishes the likelihood of being whipped completely off course by gathering the most critical information at the start. They most common criticism young dispatchers express is the feeling that repeating the protocol verbatim seems too scripted or mechanical, as if they are robots instead of human beings.

“If you think about it—and only experience handling calls can teach this—the protocols actually make way for a person’s higher decision-making abilities to come into play in those overheated situations,” Scott said, noting the “I feel like a robot” claim ironically has more to do with the individual dispatcher being too rigid than the protocol being too scripted.

Scott likes to illustrate this point by comparing dispatchers to airline pilots. The pilot’s overriding goal while flying hundreds of people in a metal tube through the sky at hundreds of miles per hour is undoubtedly safety first. With few exceptions, the airline industry has become one of the safest industries in the country because pilots and flight crews have become absolutely committed to following a set of pre-flight and inflight protocols.

“Prior to takeoff,” Scott said, “does a pilot sit in the cockpit mentally checking the aircraft’s ability to fly and then taxi to the runway based on his feeling that the plane is in good working order? No. Never. The pilot and flight crew go through a long pre-flight list including every gauge and indicator, ensuring that every function involved in the safe operation of that aircraft has been checked first.”

Everything from the most arcane backup battery to the fuel tanks comes under review, Scott explained. Doing so may be a routine task but isn’t a mechanical process because knowing those systems have been thoroughly checked enables the pilot to use higher skills in case of an emergency.

“By making sure the routine parts of the trip are checked before leaving the gate, the pilot’s judgment during an exceptional situation during the flight isn’t impaired,” Scott said. “The protocol is like a pre-flight check list. Ensuring that basic information is gathered during Case Entry is essentially the same duty as a pilot making those pre-flight checks.”

Likewise, this process is essential for the safety of those involved whether passengers—or callers—become anxious, impatient, or agitated. Experts say the main reason the airline industry has become an excellent example of safety is that the standard pre-flight rundown that pilots could argue makes them feel “like a robot” is continuously refined and because following it to the letter has been taken even more seriously.

The caller needs you to manage the call, not the other way around, Dale told the students earlier. “Don’t forget that. No matter how much you want to veer off into reassurance or give signs that you are empathetic, you’re just setting the spring on a land mine that could easily blow up the call.”

**The uneasy chair**

There are all kinds of external pressures weighing on the person in that ergonomically correct but ultimately uneasy chair in front of the dispatch console. One of these stressors is summed up in the popular but ultimately incorrect saying, “Seconds save lives.”

Logic might dictate that the faster responders are on the scene, the better the outcome, Dale said. “Reducing the time out the door might make an agency’s bottom line look better, but it doesn’t inherently translate into a patient actually receiving the most appropriate, injury-mitigating treatment.”

From its inception, the dispatch profession has been the subject of discussion and outright criticism by those who have deeply held memes, or misconceptions, about a dispatcher’s duty. These erroneous ideas still ripple through agencies, despite the dispatching profession becoming a fully recognized industry during the past 35 years. “Seconds save lives,” for example, is a reconstituted version of earlier attitudes about the role of dispatching in a medical emergency.

Whether evolution, revolution, or renaissance, the rise of the dispatching industry’s profile in emergency medicine has not wholly displaced a host of misconceptions.
as these situations address immediate dangers. Before the situation on Case Entry is a good place to start their ability to confidently calm the caller must not breathe it in.

A dispatcher who can command and reassure with confidence—with a tone of voice that s/he believes it, too—is gold in this situation. As Bradford said, any command to calm down must be immediately followed up with a reason, as in, “Sir, please calm down and listen to me carefully so that we’re sure to do it right.” Reassurance can also work wonders: “You’re doing great,” “I am here with you,” or “That’s very good.”

A dispatcher who can command and reassure with confidence—with a tone of voice that s/he believes it, too—is gold in this situation, Dale said. “If the dispatcher wholeheartedly believes it, and says so without the slightest hint of hesitation or doubt, emotion immediately dissipates, and the dispatcher really is coming to the rescue. There’s nothing more human than that.”

As Aspirating exasperation

No other emergency can distress a dispatcher faster than a mother’s anguished screams that she discovered her toddler prone, not breathing, and cyanotic. The natural but incorrect response in these situations is to succumb to the parent/caller hysteria, which can infect the dispatcher instantly. Handling a call with a child in a life-or-death situation goes right to the heart, especially for dispatchers who have their own kids. You must not breathe it in.

Instead, dispatchers must cling to the lifeline of the protocol, which directs them to collect the right information, dictates the right help to send, and provides the right instructions to help the patient until responders arrive. This reliance on the protocol grants reassurance to dispatchers that “know what to do,” which affects their ability to confidently calm the caller and provide real assistance in an otherwise frightening situation.

Though this is a lesson that can’t be truly taught in class, it can be a point of preparation until it comes live through the headset.

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As Bradford said, any command to calm down must be immediately followed up with a reason, as in, “Sir, please calm down and listen to me carefully so that we’re sure to do it right.” Reassurance can also work wonders: “You’re doing great,” “I am here with you,” or “That’s very good.”

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As
CDE Quiz Mail-In Answer Sheet

Answer the test questions on this form. (A photocopied answer sheet is acceptable, but your answers must be original.)

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July/August 2013 Journal “Cool, Calm, Collected”
Please mark your answers in the appropriate box below.

1. [ ] A [ ] B [ ] C [ ] D

2. [ ] A [ ] B

3. [ ] A [ ] B [ ] C

4. [ ] A [ ] B

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6. [ ] A [ ] B

7. [ ] A [ ] B

8. [ ] A [ ] B [ ] C

9. [ ] A [ ] B

10. [ ] A [ ] B [ ] C [ ] D

To be considered for CDE credit, this answer sheet must be received no later than 08/31/14. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.

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Going The Extra Mile

Determination and ingenuity tracks down depressed teen

He was 16 years old and lonely. His family had recently moved to Atlanta, Ga., from a smaller town in Georgia where he had spent most of his young years. As a “new kid” he was not altogether “successful,” by his standards, in finding his place among hundreds of strangers at the large inner-city high school.

His friends back home in Jackson were worried. They knew he was unhappy, depressed. One friend in particular who had stayed in contact did not want to take lightly the text messages he had been receiving for the past two weeks. He feared his friend had followed through with his threats that evening.

“The friend said he wanted to commit suicide,” said Chris Curley, a dispatcher for Grady EMS in Atlanta, Ga.

The friend apparently told his parent, who called 9-1-1 at about 10:30 p.m. on March 17, 2013. The caller said her child’s friend had told him he had taken an unknown amount of medication. He was depressed about the move.

Curley called the boy’s cell phone number provided by the caller’s son. He answered. Although his voice was slurred from the effects of the drugs, she was able to find out a few facts: his family was living in apartment E; and the complex was near a lake. The pills had made him groggy, and he was unable to get up out of his bed. Curley convinced him to kick his bedroom door to alert his parents.

“I kept on talking to him, reassuring him that things would get better,” Curley said. “I was not letting this one go.”

He hung up.

Curley was determined to find him. If he wasn’t going to help her find him, she was going to try any means possible to make sure she did. EMD Terrell Journey jumped in. He looked up the address of the home associated with the cell phone. The address jived with his story; it was where the family had lived before moving to Atlanta. They called the real estate agent who had sold the home; perhaps she would know the new address. No answer.

Curley and Journey called his cell phone numerous times and searched the Internet for more family information. Curley “pinged” the cell phone to find out the cell tower grid the phone was in, and that would tell them within a certain range where he could be. She mapped every apartment complex within the grid and narrowed down the choices to a complex by a lake with lettered apartments.

She called the courtesy officer on duty and explained the situation.

The story ends well, Curley said. The teen’s kicking woke up his mother, and he was rushed to the hospital. He made a full recovery and was in counseling to help him adjust to his new situation.

“They had no idea how hard it had been on him,” Curley said. “But I had gone through the same situation at his age. My family moved to Tampa [Fla.] and I had to start over again. I knew it was hard. I could understand how he felt. Parents don’t always see that.”

Journey said this is the kind of story that needs to be told about 9-1-1.

“We will go the extra mile to help even if it seems impossible,” Journey said. “Chris could not rest until she found location. I was compelled to assist her in every way I could. We worked a long time on this call and in the end we may have very well saved a life.”
EMD Mari Gallegos knew what she had heard.

The caller told her there were “bodies” all over the place. How many bodies, she asked. She needed him to elaborate.

“He told me two,” said Gallegos, a dispatcher for Grady EMS in Atlanta, Ga. “His father and his girlfriend. He was looking for them because he had been the only one still in the car after the crash.”

The hour was late—past midnight—and the weather seasonably wet and cold on the date, Feb. 21, when the driver hit an embankment and the car tumbled down a hill and into a ditch. The driver didn’t know exactly where they were, except somewhere in the vicinity of Marietta, a city outside the Grady EMS jurisdiction, and darkness without side lighting obscured the point of impact.

“You could hear the distress in his voice,” Gallegos said. “We had to figure out exactly where he was.”

Supervisor Shanaque Jackson remembers hearing Gallegos having difficulty confirming an address. Based on the ALI, the caller was somewhere near I-285 and Bolton Road, and dispatch sent the closest unit in the direction of the call. Jackson broke into the call to assist, and once confirming location, EMD Chris Curley called surrounding jurisdictions to have them en route since this was outside Grady EMS territory.

Gallegos stayed on the line with the driver. He had found his father, his passenger in the backseat, but not his girlfriend, who had been sitting in the front passenger seat. Both had been thrown from the vehicle.

“He was clearly distressed,” Gallegos said. “He was determined to find her.”

Gallegos’ hopeful words, “We’re going to do this,” comprised the last contact she had with him. Over the radio she heard responders tell dispatcher Shanta Hutchins two patients were in transport. They were leaving the scene.

“That wasn’t right,” Gallegos thought. The driver had said three. She asked Hutchins about the third patient and asked the crew to call the communication center. She explained to the crew that there had to be another person. The caller, she said, had been frantically looking for someone, aside from his father, for about six minutes before passing out.

“The six-minute delay was critical information,” Jackson said. With the time element, “the crew was able to backtrack the caller’s route and determine the initial impact of the wreck.”

Forty minutes after the initial call, a paramedic tells Gallegos that he hears someone moaning. Arriving at the source, he finds the “missing” passenger under a bridge 1.7 miles away from the scene of the crash. Her body had been ejected at impact and propelled in a diagonal direction while the car continued to roll down the hill. Although conscious, she had suffered severe facial injuries. Her leg was bleeding from an open femur fracture.

The call was the last of Gallegos’ shift. She left not knowing the woman’s chances of survival; the father had died en route to the hospital. The call had been extremely emotional for other reasons, as well. The caller had told Gallegos personal details about his life. He had lost his mother a month earlier and, since he was driving when the accident occurred, he felt responsible for the outcome of the accident.

“He was telling her things that would have been difficult to hear even for a seasoned dispatcher,” Jackson said. “I can’t imagine anyone else receiving this call and displaying the type of compassion and concern that Mari displayed this night.”

The incident and Gallegos’ determination showed everyone the importance of actually listening to the caller, Jackson said.

Gallegos was grateful for everyone’s help in staying with the call and finding the second passenger.

“I was told you could hardly see any evidence of the car from the road,” she said. “She could have died out there if no one had found her that night.”

Gallegos worked as an EMT in California prior to moving into dispatch two years ago at Grady EMS. She said the ability to help someone during a crisis and the occasional signs of gratitude reinforce her decision.

“Every once in a while you get that thank-you making it all worthwhile,” she said. “And that’s what happened this time. Everybody had heard about it.”
Dr. Henry Heimlich coached Rescue 911 Host William Shatner in the Heimlich maneuver at the first-ever EMD conference held in 1989 while the producer of the popular CBS show—Arnold Shapiro—looked on.

Dr. Heimlich, a featured speaker at the event, warned his audience to be prepared for rejection and ridicule when advancing on a new project. Criticism should be expected, he said, and sometimes it can even work out in the inventor’s favor. “Some useful criticism serves to identify flaws and contributes to eventual perfection of the idea,” he said. “If your peers initially understand and accept your idea, it’s not really very new or creative.”

Dr. Heimlich was preaching to the choir, a choir that has grown into the thousands since the conference 24 years ago. He was also preaching to relatively new although thoroughly convinced converts to the Medical Priority Dispatch System™ (MPDS®): Shatner and Shapiro.

Rescue 911 was an early example of reality TV with its recordings of actual calls to 9-1-1 and interviews taken at the time the re-enactments were filmed in any of the predominant locations in California, Idaho, and Utah. The show ran for seven years (April 18, 1989–August 27, 1996), outliving many similar programs because of its happy endings.

The following three stories featured are “success stories” incorporating the MPDS. In each of the episodes, the emergency medical dispatchers can be seen and heard using the protocol’s Pre-Arrival Instructions (PAIs).

**Episode 215: Choking Granny; Jan. 16, 1990**

A piece of a home baked roll fresh from the oven is lodged in 79-year-old Luella Patterson’s “windpipe” and the four-to six-minute window of survival is shutting to a close. A call to 9-1-1 from her frantic granddaughter, who finds Patterson leaning over the kitchen sink next to the chair where she had been sitting and eating the roll, is answered at Clark Regional Emergency Services Agency (CRESA, Vancouver, Wash.).

“Do something,” the caller pleads.

The dispatcher verifies location and assures the caller help is on the way. He hands responsibility to EMD Larry Cummings, quickly explaining to him that the victim is choking. A total obstruction of the upper airway is preventing her from talking and breathing. She is now unresponsive and swings in the arms of her grandson-in-law like a ragdoll when he catches her fall.

Cummings launches into PAIs, relying word-for-word on a printed cardset for the instructions he conveys to the caller who relays them to a third person in the room. The caller is, at times, hysterical and when she can no longer watch, leaves the room to summon help from a houseguest.

Patterson is fading. The Heimlich maneuver does not dislodge the bread, and after three attempts, Cummings tells the caller (now the houseguest) to position Patterson face up, straddle her hips with his legs, place his hands, one on top of the other above her belly button, and push. The granddaughter, hearing sirens, rushes to the front door. She waves arriving EMTs to the house, and less than a minute later, paramedics rush through the door carrying gear to pull the obstruction out from her throat. Patterson survives.

**Episode 406: Toddler Glass Save; Oct. 18, 1991**

Four-year-old Brittany Tanner is eating lunch, sitting in a booster seat propped on a chair at the dining table. Her younger sister is kitty-corner, looking in wonder as big sister swings her legs faster and faster to rock the grown-up chair back and forth between the table and the sliding glass doors behind her. Their mother, Susan, who is eight months pregnant, has just left the room to call her husband Stan at his office. She is well within listening distance of their two children.

Brittany keeps rocking, like a child on a swing set pumping her legs to go higher in the imagined dynamism to have her toes touch the sky. There is a crash. Susan looks. She screams. She hangs up the phone, but not before telling Stan that she must call 9-1-1.

Sensing an emergency, Stan takes off in the direction of their home in suburban Fresno, Calif. Susan is at Brittany’s side, begging for
Lynn runs out the front door only to find her husband collapsed on the driveway. He does ever, since the dogs are barking to go out, Lynn credits for saving their marriage.

Two weeks later, Brittany is home from the hospital. She refuses to sit in the simulated rocking chair, and her parents have replaced every window in the house with safety glass. They celebrate Brittany's survival at a picnic attended by doctors, paramedics, and the 9-1-1 dispatcher who provided the life-saving instructions.

**Episode 502: Lightning Husband; Sept. 5, 1991**

John and Lynn Endicott are getting ready for dinner on the first night they are home from a camping trip, a romantic get-away Lynn credits for saving their marriage. A storm is building outside their home on Sleepy Creek Road in Lakeland, Calif; however, since the dogs are barking to go out, John figures he has the time for a short walk while Lynn makes dinner.

Thunder cracks, and the sound is so close, Lynn runs out the front door only to find her husband collapsed on the driveway. He does not respond to his wife's pleas.

Heartland Communications Facility Dispatcher Scott Cullen answers her call to 9-1-1. It is his first call as a certified EMD, having finished the course the day before. He knows the problem is serious from the tone of Lynn's voice and tells her to bring John close to the phone. Cell phones do not exist.

Lynn drags John to the landline next to the porch and proceeds to provide CPR following the PAIs Cullen reads from his cardset. Giving her the instructions, he said during a later *Rescue 911* interview, was a moral imperative. “If I didn’t tell her what to do, he was going to die. No doubt about it.”

John does not respond. She continues giving mouth-to-mouth resuscitation. “There was nothing there,” she later said. A Lakeland Fire Department truck arrives 12 minutes into the call and Scott Culk, who is on his first call as a paramedic, quickly loads John into the ambulance and hooks him up to the machines. John was a flat line on the monitor. He was clinically dead. The base physician tells Culk to administer sodium bicarbonate, a remedy for lightning strike victims he had only recently heard about. John’s pulse returns.

Despite a 1% chance of regaining any function, Lynn refuses to give him up. Two weeks into her daily visits to the hospital ICU, she recognizes a change in his condition when she leans down to kiss him. He kisses her back. Three weeks after that, John is released from the hospital and is able to return to his job following 20 months of intense speech, physical, and occupational therapy.

“My husband is alive because of a decision he [Cullen] made to give CPR,” said Lynn, during an interview as part of the *Rescue 911* re-enactment. “I could never thank him enough.”

Cullen, a dispatcher for nine years, credits the ability to give the life-saving instructions. “The sad fact is that most fire departments don’t allow dispatchers to give instructions for CPR,” he said. “And nothing makes us feel so helpless as when someone calls up and they need help, and all you can do is sit there and say ‘I can’t tell you what to do because the agency is worried about being sued.’”

In July 2013, Cullen marked his 29th anniversary with the Heartland Communications Facility and, of course, he remembers Lynn’s call on that weekend in early September 1991. He was in his ninth year of emergency dispatching, not counting the four years he handled fire dispatch part time while in the U.S. Air Force. Communication staff had just completed the EMD certification course but had been given instructions to hold off on using the protocol until that Monday.

The call came in Saturday evening, around dinnertime. The caller was obviously upset and described briefly what had just happened. More than anything, Cullen recalls Lynn’s determination to keep her husband John alive. John had been struck by lightning and was not responding to her verbal commands or nudging. She insisted Cullen do something.

“I needed to give her the CPR instructions,” Cullen said. “This lady was not going to be denied.”

The *Rescue 911* re-enactment stays true to the incident, with a few minor exceptions. Rain towers were brought to the Endicott home to create the rainstorm. The Endicott’s two dogs, however, would have nothing to do with getting wet when it wasn’t actually raining.

“They kept going to where it was dry just a few feet away,” Cullen said.

Stunt dogs from LA stood in. Cullen had the opportunity to meet the Endicotts and has talked to them at various times over the years. Lynn manages a frame shop not far from the fire department, and John retired from the phone company, where he worked before and after the medical emergency.

“He has short-term memory loss, but last time I heard, he was doing very well,” Cullen said.

The call and Cullen’s PAIs for CPR represented a triple first for Heartland: the first time protocol was used in answering calls, the first CPR bystander PAIs provided from that center, and the first CPR save of a person struck by lightning.

Cullen downplays the star part. He did not meet Shatner. He said more important than star power are the changes that have taken place since 1984 when he started in emergency communications.

“I used to feel so helpless when I couldn’t tell people how to do CPR or give any other instructions,” he said. “I think of how many other lives may have been saved over the years if we had had the standards and practices we do now.”

Shortly after the incident, Cullen testified in favor of a dispatcher immunity bill (contingent upon following the protocols) before the California State Senate. In 1992, the state Senate passed a bill to allow 9-1-1 operators and other emergency dispatchers to give life-and-death medical advice over the telephone. Currently, limited liability protection is available to dispatchers under the state’s Health and Safety Code.

Cullen has never second-guessed his commitment to the profession.

“I wouldn’t want to do anything else,” he said. “I work at something I love that helps people. I don’t like being out there in the front, but I thought the story gave a good image of what dispatch does.”

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