All for One or One for All?

Is consolidation the unified answer?

Where There’s Dust
There could be serious hazard

Coming to the Rescue
Ambulance triage and PAIs drive lifesaving protocols

Doggone Frightening
Bite can be worse than canine’s bark

The International Academies of Emergency Dispatch

July | August 2014

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The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,858,366; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,018,035; 7,421,301; 7,445,234. The PPDS is protected by U.S. patent 7,436,937. FPDS patents are pending. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the NAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.
Lisa has worked with the 9-1-1 system in Charleston County, S.C., for 28 years, the past five of which have been with the Consolidated 9-1-1 Center. As the center’s public educator, Lisa teaches children and adults what to do when they call 9-1-1. She is also the center’s photographer/videographer filming and producing videos to educate the public about the 9-1-1 system.
T he Journal depends on many willing to enhance the publication.

In addition to compelling content from three staff members (Michael Rigert, Heather Darata, and me), we look to the outside contributions of our editorial board and readers.

As the managing editor, I couldn’t ask for better associates. Mike has an extensive editorial background and, similar to Heather—copy editor par excellence—is tenacious in his approach to editorial style. Heather and Mike enjoy long talks about proper grammar, punctuation, and the Associated Press Stylebook. The AP Stylebook is the reference guide for the mass media industry.

Mike has also taken on the tasks of tracking deadlines and notifying us when the calendar changes due to competing assignments or projects that demand quick turnaround. Mike’s a master at that and maintains his cool despite the juggling of his many job demands.

As mentioned, Heather is perfection in copy editing. She cares deeply about presentation and accuracy. When her schedule permits—which is limited since she edits a variety of things—she writes the occasional Your Space story. She’s very good. I don’t question her expertise.

Heather, Mike, and I aren’t alone in carrying The Journal, IAED™ newsletters (ACE and QTips), and the recently added social media component. Lauren Packer masters Twitter, Facebook, blogging, and the LinkedIn dimensions required in today’s fast-access news environment. Lauren’s NAVIGATOR blog features 28 interviews she records while at NAVIGATOR; she tweets at least once daily.

Our indispensable editorial board consists of the experts in emergency communications (easily more than 100 years of combined experience in the comm. center). Board members provide feedback on how we’re doing, what we could be doing better, recommendations for articles, and reliable sources for us to contact. They write columns, feature stories, and continuing dispatch education articles. They are frequently called upon to check technical accuracy.

There are others in the mix such as Cynthia Murray, assistant editor and Research & Standards proofreader, who gives our CDEs a thorough review and, of course, our graphical design team who makes The Journal eye-catching and appealing to our job demands.

Finally, and most importantly, we have the contributions of our readers. We are always in the market for your insight and perspective to sweeten the pot of our publications. Top on our list—at this time, anyway—is finding an EMD, EFD, or EPD willing to write a regular column for The Journal. If you want more information about the column or if you have suggestions for stories, contact us at editor@emergencydispatch.org.

We look forward to hearing from you.
Sign of Accreditation
Badge identified standout accomplishment

Scott Freitag, IAED President

Anyone at NAVIGATOR surely noticed the purple lanyards worn by attendees from IAED’s Accredited Centers of Excellence (ACEs).

And if you did, I thank those of you who approached those wearing them to extend a handshake, knuckle bump, or high-five.

Academy Associate Director Carlyn Page said the lanyards provided visual acknowledgement to every agency that has been through the process—and not only those receiving onstage acknowledgement at this year’s conference—and opened a door to non-ACE members interested in learning more about becoming an ACE.

The lanyard designed with the ACE logo also came in handy for providing quick introductions; the lanyard branded a potential mentor. People wearing the lanyard were available to offer advice about their ACE experiences, recommend contacts (mentors), or extend a congratulations. Anyone seeking information and advice about achieving ACE status can go to Page or Brian Dale, the Academy’s Accreditation Board chair.

As many of you know, ACE signifies a top position in emergency dispatch communications. Accreditation requires documenting completion of the “Twenty Points” maintained by the Academy’s Accreditation Board and upholding those same standards for the three-year period before the reaccreditation deadline rolls around.

No one has ever said the process is without challenges. Some might describe the ACE achievement as similar to steps taken one at a time to reach a mountain’s summit—you might be breathless from the climb but once there, the view is worth every step.

The Salt Lake City 911 Communications Bureau is tri-accredited (accredited in the fire, police, and medical protocol systems), and that results in answering lots of “how-to” questions from other agencies interested in single, double, or triple accreditation. While each agency is unique, here are my recommendations.

1. Calculate your readiness to begin the process
   Self-assessment will provide you with a simple overview of how you currently fare against the Twenty Points of Accreditation.

2. Find a mentor
   The accreditation standards are detailed, and the learning curve can be rather steep. Recruit an organization or individual willing to review their process and critique elements of your documentation. You can ask about the ideal composition of the in-house ACE committee and tips for motivating dispatchers to keep the momentum going.

3. Attend the Academy’s ACE Workshop (always a pre-conference session at NAVIGATOR)
   The generally four-hour session, held pre-conference, reviews the Twenty Points and provides tips for making it through the list without becoming overwhelmed.

4. Elicit staff buy in from the start and enlist their assistance
   No one can do this alone and without staff support; I was grateful to have the people willing to run with the project. Laurie Wilson-Bell, who was at NAVIGATOR, held the reins of accreditation for us at Salt Lake City. It’s a process we repeated after a consolidation that brought police/fire/medical dispatch into the same room. Our newer staff had minimal exposure to ACE except, perhaps, what they had heard from others. We had to bridge their perceptions of communications to the logic for accreditation. We needed to provide relevance and meaning to the new information, motivating them to buy in to the ACE perspective.

5. Be ready to make tough decisions
   We didn’t put a choice on the table. ACE confirmed our dedication to using critically evaluated, high-quality processes, and those unwilling to recognize the benefit did not fit into our vision.

6. Track progress
   Documenting accomplishments motivates everyone involved and you can make it simple by creating spreadsheets and forms that require minimal effort to fill in once the activity is completed.

7. GET INTO IT
   The accreditation process improves nearly every aspect of your comm. center. When staff members are better trained, they begin to get used to the idea of following specific processes, quality of care improves, processes improve, and the public notices. Centers willing to make the most of the process will reap the benefits far into the future.

The lanyards at NAVIGATOR celebrated the vision Dr. Jeff Clawson, IAED co-founder, had many years ago in the advancement of emergency communications. If you had the chance to give a pat on the back or a handshake, thank you. If you are from an ACE, and the recipient of a high-five, thanks for helping to spread the word.
A Most Compelling Read
EMD demonstrates power of dispatch

Tracey Barron

A captivating article in the most recent issue of the *Annals of Emergency Dispatch & Response (AEDR)* chronicles an amazing call between an Emergency Medical Dispatcher (EMD) and a mother to-be (who we’ll call Ann) caught short in getting to the hospital in time for delivery.

This is a phone call that should be mandatory in EMD classes since it clearly demonstrates the power of dispatch and our ability to influence so many lives.

Read on.

She’s having a baby—alone

Ann’s mother (who we’ll call Sue) makes the call and reports that she and Ann are in places separated by at least an hour drive; this is Ann’s first child and the baby has an undiagnosed true footling breech presentation.

Ann, who is in active labor, lives in an isolated, rural area, and she is alone. The estimated time of arrival of the nearest ambulance is about 20 minutes, and the same goes for a nurse—the woman’s cousin—reported to be en route.

Breech births are riskier than the birth of a head-down baby and just how risky they are depends on the baby’s positioning. Perinatal mortality is increased two- to four-fold with breech presentation, regardless of the delivery mode. Footling breech (one or both hips and knees extended, feet presenting) comprises 10 to 30 percent of all breech births.

The breech presentation was the call-taker’s first in six years of emergency communications, with the experience of recently becoming a first-time father. The birth of his child provided levels of confidence and empathy he might not have had otherwise.

Sequence of events

The EMD codes the call 24-D-1 (Pregnancy/Childbirth/Miscarriage – DELTA – Breech or Cord) and immediately sends the code to dispatch. Response is a single Advanced Life Support (ALS) crew sent lights-and-siren (“HOT”). The EMD tells Sue that it’s time they hang up so he can call Ann. The EMD instantly changes his directive to having Sue stay on the line and he will conference the call.

According to the article, the situation at Sue’s home reminded the EMD of the emotional strain of seeing his wife in labor and the delivery of their child in a hospital with midwifery guidance.

“I couldn’t imagine how scared this patient would be, so conferencing the call was the right choice,” he states.

The call is connected and the EMD goes straight into Pre-Arrival Instructions (PAIs). Ann is sitting on the toilet. He orders her off the toilet and reaches the sequence for beginning the actual BREECH delivery instructions (and modifies them slightly from the second-party script since Ann is on her own).

In between Ann’s pains, the EMD inquires about access into the house, gives words of reassurance to both parties, gives Ann instructions for pushing, and—this part is most remarkable—lets Sue coach her daughter.

Eighteen minutes into the call, the nurse arrives to find a healthy baby girl wrapped in a blanket. Paramedics enter the home moments later.

Just doing my job

I don’t want to spoil the whole story. You will have to open your issue of the *AEDR* and turn to page 9 to read the exciting conclusion. However, I do want to emphasize the key learning points this call clearly illustrates:

• Follow the protocol—full compliance to protocol is key.
• Be prepared to think laterally.
• We should never think we have heard it all before; in this business there will always be a call that will surprise us.
• We all have, or will have at some stage, taken a call that will leave a lasting impact on someone’s life, whether it be a successful resuscitation, a baby delivery, or just someone vomiting or an individual who has fallen and injured a hip.

We must never sell ourselves short and disregard the lasting impression our able voices and actions behind the scene imprint on callers. Our profession—EMDs, Emergency Fire Dispatchers (EFDs), and Emergency Police Dispatchers (EPDs)—casts a powerful first step into the sequence of events in any emergency situation, starting with the caller who might be trying to survive or help someone else survive the worst possible moments of their lives.

This is no easy task. Nothing about what we do is routine. We are the link that determines the strength of response.

Source

Developing as a Leader
It takes more than climbing the rungs

Ivan Whitaker

What is your leadership style? How did you obtain your leadership style? How do you know if you’re a good leader?

A mentor told me that a great leader could spend a lifetime seeking the answers to these questions, in turn increasing the individual’s ability to lead.

To answer these questions, we must overcome a few barriers.

1. You must believe you are a leader.
2. You must have a desire to learn about leadership.
3. You must have a desire to know how others view you as a leader.

You must believe you are a leader

“I do not evaluate a leader until I see who that person’s followers are. Who is listening to the individual? Who respects the individual?”—Kenneth Chenault, CEO and chairman of American Express

In my opinion, numerous flawed definitions of leadership have blurred the ability of many to recognize the real leaders in their organizations. In the workplace, many interchange the words “leader” and “leadership” with a particular job title. I believe this is a tainted perception. Job titles are often closer to the word “management” than leadership. Some managers are also leaders; however, the two do not always go hand in hand. In fact, some leaders can drive the success of entire organizations without a definitive span of control.

Leaders tend to know when it is appropriate to rise to the occasion and motivate others to follow their lead. This usually occurs naturally and is not based on a position title. At times, it happens so naturally that the leader does not realize this is taking place. Due to flawed representations of the meaning, individuals may not recognize their role in nurturing and developing their leadership skills.

My first recognizable memory of witnessing this was at age 11. While playing an organized basketball game at a neighborhood YMCA, a boy on my team looked in my eyes and said “You will make the shot.” It would be the deciding shot of the game. He exuded confidence. He dribbled the ball down the court, made a shifty move, and passed me the ball. Without hesitation, I shot the ball, and “swoosh” the ball went in the net. Without celebration, the boy got on his bicycle and pedaled away.

The boy who knew I could make the shot, Daunte Culpepper, grew up to be a Pro Bowl quarterback for the NFL’s Minnesota Vikings.

You must have a desire to learn about leadership

“Leadership and learning are indispensable to each other.”—John F. Kennedy

Over the years, I have observed that many have not recognized the need to obtain information regarding differences in leadership styles.

When individuals sincerely focus on developing and nurturing their leadership skills, they also learn more about the characteristics of those they intend to lead. I first began my quest for leadership knowledge at the age of 19. During my first managerial position, I read about a CEO that was a transformational leader who successfully turned around several major corporations.

He wrote, “With all my success, it wasn’t until my later years in life that I truly began to understand leadership” (Ray Kroc, founder of McDonald’s).

You must have a desire to know how others view you as a leader

“A good leader wants to get it done. Executive Quotient (EQ) is the most important thing—to have the focus and influence to get whatever the job at hand is completed.”—Kenneth Chenault

Never base your performance as a leader on a performance evaluation. Take a strong look at your ability to influence, motivate, and lead individuals toward common goals.

Does your leadership style include a high level of EQ?

EQ is the ability to focus on the job at hand and complete tasks. In leadership, this extends to the ability to get others to do the same. Great leaders can do so without sacrificing quality. While intelligence quotient (IQ) and emotional intelligence (EI) are very important in leadership, EQ is particularly important because it is a tangible representation of your influence as a leader.

For those in management positions, consider conducting 360-degree evaluations. This can be valuable information moving forward. Make the evaluations anonymous. Take an objective look at the details of the evaluation and adjust accordingly.

Look to others for your future development. For those not in management positions, ask peers if you are viewed as a leader in the organization. Gain insight on their views of a good leader and build from there.
Have you ever seen a “Q”? Based on the whisperings of dispatchers, this mythical creature is a faceless force of negativity whose only function is to tell everyone what they are doing wrong. They lurk in the shadows of emergency communication centers and exist only to listen to the dispatchers’ calls and then nitpick their performance and point out all of their faults. Fueled by caffeine and versed in a language of performance standards and protocol rules, these odd creatures exist only to suck the morale and confidence from the staff.

While there may be a quality assurance dispatcher (or “Q”) out there that meets this description, most of the quality assurance personnel that work with us are kind, positive, and objective professionals. The anonymity of “Q” allows for easy demonization and placement of blame, but in most cases, that description is misplaced and unfair.

Certified EPD-Qs™, EFD-Qs™, and EMD-Qs® are trained to apply written standards to case review, provide objective and unbiased feedback, and identify areas for improvement so that dispatchers can apply the data obtained through the auditing process and increase their confidence, competence, and eventually, their compliance. So why is this negative perception of QA so prevalent?

For most of us, these behaviors are learned early in our youth and have been frequently reinforced throughout our lives. “Feedback” has come to represent an evaluation of all we have done wrong. Even when critical feedback is combined with positive reinforcement, we tend to overfocus on the negative and cling to our emotional reactions. And emotional reactions can be contagious. Over time, negativity can become the prevailing culture of any given group (or center). It then becomes acceptable to subscribe to this way of thinking. An individual’s perceptions and reactions then begin to shift so that they are consistent with the overall atmosphere maintained by the majority. New employees simply propagate the myth that the “Q” is the troll beneath the bridge.

Watching the Winter Olympic Games revealed a very different culture. A noticeable pattern of behavior was demonstrated by all of the athletes regardless of which sport they competed in and which country they represented. As soon as they had completed their performance they immediately looked up to the scoreboard. What were they looking for? Feedback. Olympians covet feedback. Whether positive or critical, this information, this data, was essential to their future performance.

Consider the multiple qualifying rounds for some of the Olympic sports. If a speed-skater or snowboarder did not perform to standard, or he or she made an error, that athlete wanted the feedback so that he or she could apply it and have an opportunity to improve in subsequent performances. These athletes are conditioned from a young age to value feedback. To them, QA is an essential and positive part of their growth and development. Their desire to be the best, to win a medal, provides them with a very different perception of feedback—and the person providing it.

How can we develop this same way of thinking? Can we create an atmosphere where we immediately request our “scores” at the completion of a call? Can we develop a culture where everyone wants more case evaluation so that they can apply the data and improve on subsequent calls? Is it possible to consider the “Q” as a coach—a trainer that wants us to succeed?

It starts with each one of us. We should have pride in our performance and want to be the best at what we do. Just as athletes continually train, we should continually seek and complete Continuing Dispatch Education. As even the most conditioned Olympian can make an error or have an “off day,” we too should understand and accept that we are fallible. This shift of culture should start on Day One. Review your new-hire curriculum or dispatcher academy. Is understanding QA data or applying feedback included in the initial instruction? This is a great opportunity to reinforce the benefits of performance evaluation before the first Case Evaluation Record is even received.

Don’t wait for someone else to initiate positive change. Remember and reference the Olympics. Applying them as a model for excellence, we can begin conditioning ourselves to view performance evaluations as part of our development and success. The path to the podium is accepting, and applying, QA feedback. Working with our “Q,” we can “go for gold” and strive to be the best at what we do.
Hi Brett:
While checking the ProQA® Paramount logic sequences for the Unconscious Choking CPR pathway, I noticed that the protocol instructs a rescuer to do a round of compressions, then start mouth-to-mouth. However, if mouth-to-mouth is unsuccessful due to the absence of air movement in Panel C-5 (the rescuer did not feel the air going in or out), the EMD is directed to go to Panel C-9 and provide instructions for the combination of 2 breaths then 30 chest pumps. Why do we instruct the rescuer to keep attempting mouth-to-mouth instead of doing chest compressions only?

Thanks,
Irena M. Weight
Director of Translation, Standards, and Logic Design
Priority Dispatch Corp.™

Hi Irena:
The rationale is to compress first to try and dislodge the object, which is why we reversed the ventilations/compressions sequence for the Unconscious Choking (UC) pathway in v12.2. If air does not go in when we first try to ventilate, we keep trying to ventilate after each compressions sequence, checking the mouth for an object in between attempts, with the hope of dislodging or, in desperation (for a lack of a better term), pushing the object into the right, main-stem bronchus, which would allow lifesaving ventilation of the left lung. This may happen because the right, main-stem bronchus is wider, more vertical, and has a straighter alignment to the trachea than the left bronchus. If the object can be “pushed” into the right bronchus, it can then be removed later with a bronchoscope.

Thanks,
Brett A. Patterson
IAED™ Academics, Standards, & Research Medical Council of Standards Chair
Hi Brett:

An EMD asked me a couple of questions about Protocol 12: Convulsions/Seizures and thought it would be great to add your insights to my answers in the reply.

1. Why was the question “Is he epileptic or ever had a seizure before?” changed to “Is he an epileptic (diagnosed with a seizure disorder)?” I think that the way the question was changed will exclude patients who may have had one febrile seizure as an infant and, since then, no other occurrence. The question is now very specific and there are some patients not diagnosed with a disorder, but who do have seizures. Are we missing these patients with this question?

2. Can you explain why a 12-B-1 is a BRAVO? If breathing cannot be verified, shouldn’t the Determinant Descriptor be at a higher level? For example, a 12-C-4 is at a higher level and we know that patient is breathing on this one. I realize that a 12-C-4 is no seizure history (confirmed no seizure disorder), and that the unknown is lower because we don’t know; the C-4 is a CHARLIE because we know that the patient doesn’t have a seizure disorder and, therefore, is at a higher likelihood of cardiac arrest. Do you have words of wisdom regarding why unknown issues are BRAVO?

Thanks friend!
Kim Rigden-Briscall
Master ED-Q™ Instructor / EMD Instructor / BOA Reviewer

Hi Kim:

The Key Question you refer to [in the first question] was changed because of undertriage. There were several Proposals For Change (PFCs) and other anecdotal evidence alerting us to the fact that patients who had experienced a recent seizure, but had not been diagnosed with a seizure disorder, were being included in this group when the intention was to include only diagnosed patients, who have been shown to be at lesser risk of hypoxic seizure (about 75 percent less risk, in fact).

The question differentiates patients with a “diagnosed” history, and this group should not include patients who have had a previous seizure or two and have not had more serious causes ruled out. Your point about excluding patients with a history of a febrile seizure is true; but these patients are intentionally not included in the “diagnosed with a seizure disorder” group because a history of a febrile seizure is likely not related to a current seizure, or does not lessen the odds of the current seizure being more serious than a common grand mal seizure.

Your second question involves statistical probability. When the caller is not with the patient and breathing cannot be verified, the probability of cardiac arrest is greater in the patients of cardiac age range; the probability that the problem is a standard, grand mal seizure is greater in the patient under cardiac age range. If the patient’s current status of breathing is not known, it is less likely that the patient’s history of seizures is known. The “E” suffix is available if the history of seizures is known. Therefore, an agency may elect to send a different resource based on the suffix. In the absence of information other than the complaint of seizure, the BRAVO response “recommendation” is relatively standard in the MPDS as a method of sending someone to assess.

It is important to remember that an agency can send what it deems appropriate to any code, and the response may well be the same as the 12-C-4 code you point out. As a reference for acuity, consider the following London Ambulance Service data (v12.1.2):

<table>
<thead>
<tr>
<th>Code</th>
<th>Cases / Arrests</th>
<th>CAQ*</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-B-1</td>
<td>1762 / 4</td>
<td>0.20%</td>
</tr>
<tr>
<td>12-B-1E</td>
<td>1262 / 0</td>
<td>0.00%</td>
</tr>
<tr>
<td>12-D-4</td>
<td>2677 / 29</td>
<td>1.00%</td>
</tr>
<tr>
<td>12-D-4E</td>
<td>1570 / 1</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

As you can see, there is a decreased risk for both patients under cardiac age range and patients with a history of epilepsy. Unfortunately, because the 12-C-4 code was added in v12.2, we do not yet have the CAQ data to compare. My guess is that the results will be somewhere between the above BRAVO and DELTA levels (without “E” suffix), and likely closer to the BRAVO level because breathing has been verified.

Thanks,
Brett

* CAQ = Cardiac Arrest Quotient (percentage of cases with a Cardiac Arrest outcome)
Warning system is free for the taking

The New Hampshire Bureau of Emergency Communications wants to make something perfectly clear: The state system set up to send emergency messages to any phone number in the 9-1-1 database is free to any municipality.

But despite multiple contacts made by the bureau, only 25 percent of the municipalities had signed up at the time of this writing.

The targeted notifications warn residents of serious incidents in the neighborhood, including warnings about inclement weather—tornadoes or snowstorms, for example—missing children, and dangerous suspects in the area. There are strict rules for the type of information that can be relayed.

Residents in municipalities that have activated the system can easily access the warning system by registering cellphone numbers and email addresses.

Reasons for resistance include alternative systems already available and the cost and time to maintain the system; however, the bureau has reported that many municipalities have expressed interest in taking the state up on the deal.

Life EMS Ambulance EMT receives Star of Life Award

GRAND RAPIDS, Mich.—James Hadley, an Emergency Medical Technician (EMT) for Life EMS Ambulance, was recently among EMS caregivers representing the U.S., Canada, and the Virgin Islands to receive the American Ambulance Association’s 2014 Star of Life Award.

Hadley was nominated for his dedication to EMS and support of Life EMS Ambulance, including going beyond his assigned duties to help coordinate Life EMS Ambulance’s presence at major community events such as Grand Rapids’ marathon and Festival of the Arts.

Hadley began his career with Life EMS Ambulance in 1997 and has held positions ranging from mobility associate with the wheelchair division, to personal response system installation, to full-time EMT.

“My goal is to leave a positive impact on everyone I come in contact with, whether I’m in a planning meeting or caring for a patient,” Hadley said. “Meeting the other Star of Life recipients at the conference really brings home that what we do as EMS providers is special.”

Life EMS Ambulance responds to medical emergencies over 3,600 square miles of western Michigan, including Grand Rapids/Kent, Portage/Kalamazoo, Ottawa, Ionia, Newaygo, Lake, Mason, Allegan, and Van Buren counties. The Life EMS Ambulance communication center is an Accredited Center of Excellence (ACE).

9-1-1 Magazine celebrates 25 years in business

The 9-1-1 Magazine celebrated an anniversary that transcends the generations.

Truly.

The publication reached the quarter century mark this past year never straying from its original and lasting purpose to “educate, inform, and inspire the emergency communications community [and] to find solutions to 9-1-1 and dispatch center management through authoritative, timely, and independent reporting and analysis.”

A notable change, however, was the “somewhat reluctant” decision to abandon the magazine’s printed origins in “favor of the light of modern electronically pixilated e-publishing on the World Wide Web,” according to editor Randall D. Larson.

Larson also had reason to celebrate. He joined the magazine’s editorial staff in 1995 and for the past 19 years has covered the rapidly changing and now technology-driven profession.

One component, however, has remained steadfast, Larson states in an editorial about the magazine’s anniversary:

“There’s still a person piloting that console, adding professionalism and intuition and human experience, something no machine can deliver,” he said.

Jim Voelkl, 9-1-1 Magazine’s founding publisher, introduced the publication in the winter of 1988–1989 with a 36-page issue highlighting the unique role dispatch plays in making holidays safe.

Larson, who entered the dispatch profession in October 1984, was fourth in the succession of managing editors and, according to his own count, “supplied the content and imagery for 103 issues.”

“To coin a phrase, it’s certainly been a long, strange trip,” Voelkl said.

Residents in states prone to hazardous weather can seek shelter from places funded through two sources of Federal Emergency Management Agency (FEMA) supplied mitigation grants: the Hazard Mitigation

Federal agency funding places to stay safe from the weather

Residents in states prone to hazardous weather can seek shelter from places funded through two sources of Federal Emergency Management Agency (FEMA) supplied mitigation grants: the Hazard Mitigation
FEMA’s HMGP assists states and local communities in implementing long-term hazard mitigation measures following a major disaster declaration. As of Nov. 1, 2004, all communities must have an approved hazard mitigation plan in place to remain eligible for HMGP funding. Eligible projects include residential and community shelters in tornado-prone areas.

FEMA will fund up to 75 percent of the eligible costs of each project.

According to FEMA criteria: A safe room is a hardened structure specifically designed to “near-absolute protection” in extreme weather events, including tornadoes and hurricanes. The level of protection provided by a safe room is a function of its design parameters, specifically the design wind speed and resulting wind pressure and the windborne debris load resistance.

They can be built of concrete or other reinforcing material in a basement or an interior first-floor room, or buried in the yard. Since it is a rebate program, the shelter has to be installed before the resident applies for the rebate administered by state energy management departments.

Cautionary notes: Grant programs are limited and competitive, which means that just because a city or county applies does not mean its application will be selected and funded. Make sure the companies hired to build the safe rooms are following FEMA regulations. Guidelines are specified in FEMA 320, Taking Shelter from the Storm: Building a Safe Room for Your Home or Small Business and FEMA 361, Design and Construction Guidance for Community Safe Rooms.

**Alaska prepares for the next big one**

When the Great Alaskan Earthquake struck the south central region of the state on March 27, 1964, the energy released by the upheaval was **LIFE** magazine reported, “400 times the total [energy] of all nuclear bombs ever exploded” until that time. When all was said and done, the 9.2-magnitude quake—which struck around 5:30 in the evening on Good Friday—and its many aftershocks caused hundreds of millions of dollars in damage, killed more than 130 people (including more than a dozen tsunami-related deaths in Oregon and California), and, in ways literal and figurative, forever altered the Alaskan landscape in places like Anchorage, Seward, and Valdez.

An EOC using a mobile application at Jonah Bay in Prince William Sound practiced on software that can send photos and damage descriptions to operations centers in real time to start planning for response. A mobile system also tested at the EOC would allow collection of critical damage assessment data necessary for agencies to coordinate and deploy resources.

Several communities practiced tsunami drills that included sounding tsunami warning sirens and sending messages on TV or radio stations.

The state drill, which started at 1:36 p.m. on Thursday, March 27, also drew 103,597 participants (totals as of March 31) from every region to practice the Drop, Cover, and Hold On technique.

**Daylight saving time bad for the heart, study says**

Switching over to daylight saving time in the spring, and losing one hour of sleep, raises the risk of having a heart attack the following Monday by 25 percent, compared to other Mondays during the year, according to a U.S. study released in March.

By contrast, heart attack risk fell 21 percent later in the year, on the Monday after the clock was returned to standard time, and people got an extra hour's sleep.

The impact of moving the clock forward and backward was seen in a comparison of hospital admissions from a database of non-federal Michigan hospitals. It examined admissions before the start of daylight saving time and the Monday immediately after, for four consecutive years.

The most dangerous times for heart attack (and for all kinds of cardiovascular emergencies—including sudden cardiac death, rupture or aneurysm of the aorta, pulmonary embolism, and stroke) are the morning and during the last phase of sleep. A group from Harvard estimated this risk and evaluated that, on average, the extra risk of having a myocardial infarction (heart attack) between 6 a.m. and noon is about 40 percent.

Research findings particularly relevant to shift work highlight interruptions in the circadian clock, according to a member of the research team, Martin Young, an associate professor with the University of Alabama, Birmingham’s Division of Cardiovascular Disease.

“Every cell in the body has its own clock that allows it to anticipate when something is going to happen and prepare for it,” Young said. “When there is a shift in one's environment, such as springing forward, it takes awhile for the cells to re-adjust. It's comparable to knowing that you have a meeting at 2 p.m. and...
having time to prepare your presentation instead of being told at the last minute and not being able to prepare. The internal clocks in each cell can prepare it for stress or a stimulus. When time moves forward, cell clocks are anticipating another hour to sleep that they won’t get, and the negative impact of the stress worsens; it has a much more detrimental effect on the body.

**Source**


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**Bystanders hesitate to call 9-1-1 in overdose emergency**

Studies consistently show that although bystanders are usually aware of the victim’s circumstances, people hesitate to call 9-1-1 when witnessing an overdose, and too often the call is never made.

The odds of calling 9-1-1, however, do increase in the presence of a female bystander. According to one study, 70.6 percent of women called for medical help, while 66.7 percent of males called. Another study suggested that people between the ages of 35 and 44 were most likely to witness an overdose, followed by those 25 to 34. Yet, the 35- to 44-age range was not the most likely to have made a 9-1-1 call—25- to 34-year olds were. In other words, people who were more likely to witness an overdose were not the most likely to call 9-1-1.

According to other findings,

If a bystander had previously personally overdosed, the person is less likely to call 9-1-1 when witnessing an overdose in the future. However, if bystanders were taken to the hospital during their last overdose, they are more likely to call in comparison to people who had not been taken to the hospital. The more overdoses people witness, the less likely they are to have called 9-1-1 at the last overdose. There is also evidence that “individuals who had witnessed more overdoses were more likely to report potentially dangerous or counterproductive actions, such as injecting the victim with water, salt, speed [amphetamines], or bleach.”

For participants who witnessed 11 or more overdoses and delayed or did not call 9-1-1, the main reason for not calling was the belief that the victim could be helped without medical assistance.

The most prevalent reasons for not calling 9-1-1 are fear of police involvement and subsequent arrest, as well as having inaccurate information, such as believing they are in control of the situation and can revive the individual. Another barrier to calling 9-1-1 is the illegality of certain substances. Community members are also concerned that they will be labeled a “drug user,” suggesting that stigma can make people less willing to call 9-1-1.

Other common reasons for not calling 9-1-1 are: a bystander may not have access to a phone or the person had regained consciousness before seeking medical assistance.

During an overdose, which is a medical emergency, time is of the essence, and any delay in treatment can put a person at risk of death or brain damage. For example, a San Francisco-based study found overdose victims who received emergency medical care while they still had a pulse and blood pressure have survival rates greater than 90 percent. But most overdose cases resulting in death (101 of 117) were reported only after the victim had advanced signs of death.

**Source**


**Emergency management license plates bring attention to response**

New York has issued designated license plates to state and local emergency response vehicles. The plates, which have a white background and a red banner and feature the letters “EM,” were designed to make it easier to recognize emergency response vehicles during storms or other emergency situations.

According to the New York State Department of Motor Vehicles, the vehicle must be owned or controlled and registered in the name of the state agency or locality to be eligible for the red license plate. The New York State Department of Homeland Security and Emergency Services will determine how many red license plates will be available to the various agencies and localities. There is no charge for the plates.

Illinois enacted similar legislation; however, registration is by personal application with the funds collected distributed to state programs. Applicants must show appropriate documentation to qualify and, if approved, must pay a $20 fee for the original issuance in addition to the appropriate registration fee.

The $20 fee is divided between the Emergency Management Fund to cover training and education programs, and the state’s special license plate fund to defray administrative processing costs.

**U.S. Fire Admin. puts focus on vehicular arson**

During the 2014 observation of Arson Awareness Week in May, the U.S. Fire Administration (USFA) focused full attention on vehicle arson. According to statistics:

- From 2008–2010, 14 percent of all fires were vehicle fires. Of these fires, seven percent were intentionally set. Source: USFA

- From 2004–2006, an estimated 27,900 intentionally set vehicle fires occurred each year in the U.S. These intentionally set fires resulted in an average of approximately 40 deaths, 75 injuries, and $169 million in property loss each year. Source: USFA

- During 2007–2011, local fire departments responded to an average of 20,400 intentionally set vehicle fires, accounting for seven percent of intentionally set fires and resulting in an average of 32 civilian deaths, 67 civilian injuries, and $176 million in direct property damage. Source: National Fire Protection Association

- Two-thirds of intentionally set vehicle fires occur under the cloak of darkness (9 p.m. to 6 a.m.). Source: National Fire Protection Association

- Over the last 10 years (2003–2012), there has been an average of 14,737 vehicle arsons reported, accounting for 26.5 percent of total arsons annually. Source: FBI
Vehicle helps flow of communication during major disaster

Communication problems between public safety and law enforcement during a major disaster in Australia might be an issue of the past with the introduction of a mobile command unit.

The Emergency Services Integrated Communications (ESIC) vehicle, built by Australia’s National Safety Agency (NSA), packs IT technology in the 14.8-meter (48-foot, 6-inch) trailer. It has a satellite and can also connect to 4G LTE and 3G wireless networks from any carrier in Australia.

Other features include wall-to-wall interior displays showing camera feeds, 3-D disaster simulations, relevant Twitter chatter, and other information useful to incident response. During response, a central controller can connect to police, firefighters, and other agencies and patch the communications devices together.

NSA—an Australian not-for-profit research and development organization for emergency management—spent nine months building the vehicle, which was rolled out for operations in Victoria in March 2014. More ESIC vehicles are planned for future distribution around the country.

USA not alone in hoax emergency calls

The European Union (EU) and the USA share a common problem when it comes to hoax/false emergency calls and, also, the development of strategies to curb the abuse (accidental and intentional).

Between these two extremes: Cyprus (8 percent), Romania (14.57 percent), Austria (30 percent), Bulgaria (38 percent), Spain (56.26 percent), Belgium (46 percent), Slovakia (68 percent), Ireland (60 percent), Czech Republic (75 percent), Portugal (77 percent), Hungary (90–95 percent), and Norway (80 percent in Oslo and 90 percent in the rest of the country).

The ratio of hoax/false calls to the total number of calls varies considerably: from a low of 3 to 5 percent in Germany (however, varying by region and season) to a high of 99.35 percent in Greece.

The measures to reduce the number of hoax/false calls indicated by member states fall into two main groups.

• Technical and organizational measures: These include prioritizing of calls and filters. Finland has plans to direct the SIM-less 1-1-2 calls first to an announcement and then to the emergency center if the caller continues the call after hearing the announcement. Finland also plans to open a separate number for inquiry calls that are not considered emergency calls.

• Technical and legal measures: These include blacklisting and penalties. Spain and the Czech Republic are considering a plan to put those making repeated calls on a temporary “blacklist.” In Belgium, SIM cards from which 1-1-2 is repeatedly abused may be temporarily blocked. The Netherlands operates automatic warning messages and issues warning calls. Germany, Finland, the U.K., Slovakia, the Netherlands, the Czech Republic, and Ireland are developing plans to penalize the caller. In Estonia, punitive action is possible only in case of dispatching resources when action has been taken. Bulgaria and Slovakia have indicated that fines may be imposed. In Denmark, the Copenhagen Fire Brigade is considering blacklisting repeat offenders.
Planning to a Tee

PGA Championship starts months before play begins

There are some things that response just won't do, no matter who calls the shots.

For example, would you send one of your responders into a marsh to retrieve a microphone on the green that an alligator decided was a "must-have" item in its nest?

The answer depends on your perspective, according to Don Lundy, director, Charleston County EMS, S.C.

If you're the technician concerned about losing a $1,400 piece of equipment or a spectator worrying about a close encounter of the wildlife kind, maybe.

If you're the person in charge of handling emergency medical services for the six days the PGA is in town, not necessarily. Your priorities might not be on par with event hosts'.

"We knew the gators were there," Lundy said. "But we weren't going to get the microphone just because the technician wanted it back."

Lundy was in charge of EMS operations during the 94th PGA Championship held on Ocean Course, Kiawah Island, in South Carolina. Reasons that PGA officials chose Kiawah Island are much the same reasons the island's a popular destination for thousands of visitors: golf courses, natural beauty, and protected natural habitat for viewing wildlife; gazing at the 600 to 700 gators on the island from a respectable distance is spectacular.

While Charleston County EMS is no stranger to large-scale events, the PGA is unique wherever it's held because of the way the game is played and the PGA rules. Charleston County officials were told to anticipate 35,000 tourists daily plus the media and golfers. PGA rules restrict portable toilets and water stations to areas outside of where camera crews film.

Unlike a foot race or national political convention, play is going on at several locations at the same time, with crowds following players of their choosing.

"Staging units for response time [without a major event] is a hair-pulling experience," Lundy said. "I can't say we expected a nightmare, but we knew it was going to be a challenge."

Never without a new challenge

The 13.5-square-mile Kiawah Island is a private, exclusive resort and residential area. It is considered one of the East Coast's premier golf destinations. The island has

Audrey Fraizer
They borrowed XL radios from state police and brought in maps of the Ocean Course and surrounding area in the event the Geographic Information System (GIS) went down. They planned on extensive use of FirstWatch, a software surveillance system that allowed them to analyze the clustering of calls.

“FirstWatch kept us ahead of the curve to allocate resources,” he said.

There was also the matter of staff convenience.

“We brought dispatchers in early in the process,” he said. “Personal comfort was important.”

The communication center was set up a fair distance from parking lots, which meant dispatchers, working 10-hour shifts, had to walk more than a mile in hot and humid weather. Shifts were arranged to avoid peak traffic times. Food was purchased from the clubhouse at lower prices compared to meals sold to spectators, and dispatchers were advised to bring in ample water for drinking. Upon request, the PGA brought in a 47-inch TV for a visual tracking of the players.

The PGA covered all overtime costs.

As the time clock clicked, bleachers were going up along with luxury boxes; a 32,000-square-foot golf shop was built in just three days and a 40,000-square-foot tent was dubbed the largest-ever PGA sports bar.

During the event, temperatures were in the high 80s, with humidity values above 60 percent, exacerbating concerns of dehydration. Spectator water rules were modified to allow entrance with one sealed water bottle.

Police officers were posted at key intersections along the routes. Charleston County Sheriff’s Office air support and motorcycle units monitored the single route continuously. Parking was monitored to maintain corridors for emergency transport. Ambulances were given the right-of-way even when the noise might interfere with the concentration of a golfer in play.

“They understood that,” Lundy said. “Once someone gets in the back of the truck, we’re the player.”

There are some things, however, that happen outside the control of the best-laid plans.

Cars broke down on the way in and buses broke down on the way out. The number of sports broadcasters arriving from around the world for the last two days of the championship interrupted emergency radio systems. These “microwave wars’ overrode signals at the receiver and blocked emergency radio transmissions.

“Be forewarned,” Lundy said. “On the last day, we had nothing but digital.”

Lundy said the two “burn downs” to discuss what went right and wrong revealed the success of the event.

“We never had a bad day because we respected each other’s mission,” he said. “The PGA said they’d love to come back, although I’m not sure the islanders would say the same.”

Lundy also offered the following recommendations:

• Preplanning is key—get everybody around the table as soon as possible.
• Set up a predeployment plan—Charleston County EMS established two for the PGA and the other for a 20-mile radius of the island.
• Come prepared—don’t assume residents will welcome you.
• Make friends with key people—how else do you buy meals at reduced costs?
• Plan for the unplanned—no matter how ridiculous someone’s suggestion might be, it could turn out to be a game changer.
• Maintain perspective—it’s not the place for people with short tempers.
• Flexibility is key—not everything goes exactly as planned.

Facts and figures from the 94th PGA Championship

• Medical staff treated 180 attendees, with the common medical problems being abrasions, lacerations, abdominal pains, and heat-related symptoms such as dizziness and chest pain.
• Only three patients required transport to the hospital; all other patients were treated on-site at the numerous medical stations staged throughout the Ocean Course.
• Figures from the Charleston Convention and Visitors Bureau show that hotel occupancy in Charleston County was about 86 percent.
• More than 91,000 room nights were booked in the county and the average daily rate was almost $149.
• College of Charleston researchers earlier projected that the championship at the Ocean Course would mean about $92 million in direct tourism impact.
Hi Brett:

Here are several questions that have been asked by the EMDs here time and time again. Can you please answer these questions so that they can see the response from the Academy? I would greatly appreciate it.

Thank you for your time,

Liz Garcia
Sergeant, Performance Improvement & Training
Cleveland Emergency Medical Service
Cleveland, Ohio, USA

1. Are anxiety and panic attacks processed through Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt? If so, do you send an ambulance if the caller mentions symptoms during the call but not necessarily at Case Entry (short of breath, hyperventilating, rapid heart rate, etc.) or do you send only a police response?

A complaint of “anxiety attack” or “panic attack” is essentially a caller’s diagnosis of the problem, not a sign or symptom that can be processed using the Medical Priority Dispatch System™ (MPDS™). It is only different from a complaint of “toxoplasmosis” in that EMDs are more familiar with the diagnosis and can guess at which protocol might be appropriate. Similar to complaints like “drunk” or “heart attack,” the EMD should not guess at a symptom or protocol but rather repeat “Tell me exactly what happened?” in an effort to get a Chief Complaint description that can be triaged appropriately.

2. The caller complains of chest pain (no trauma involved) during Key Questions (after Case Entry). Do you switch to Protocol 10: Chest Pain (Non-Traumatic) if that isn’t the protocol selected or do you stay with the protocol selected if there is no shunt? And, if not, do you administer aspirin?

This depends on the Chief Complaint. Other priority symptoms, such as breathing problems or heart problems can be handled on their specific protocol and the Aspirin Diagnostic (Dx) and Instructions Tool can be utilized from there, as appropriate. Note that Critical EMD Information on the Aspirin Dx reads: Utilize the Aspirin Diagnostic & Instructions Tool – if authorized by local Medical Control and the chest pain (Heart Attack Symptoms) patient is alert and >16 years old.

There is also a new Rule that addresses the most common dual complaint, chest pain with difficulty breathing. It reads: (>16) When the complaint description involves both NON-TRAUMATIC Chest Pain/Heart Attack Symptoms and Breathing Problems, choose the protocol that best fits the patient’s foremost symptom, with ECHO-level conditions taking precedence. Use the Aspirin Diagnostic and Instructions Tool on either protocol, as appropriate. However, if the complaint is not an obvious priority symptom, and chest pain is “discovered,” the EMD should move to the Chest Pain Protocol. This is relatively rare because most people understand the significance of chest pain. It is more likely discovered when another priority symptom like difficulty breathing is the “foremost” concern.

3. Caller states that he was in a car accident or fall (traumatic event) a few days ago or even yesterday and is now complaining of pain (arm/leg pain). Do you go to Protocol 30: Traumatic Injuries (Specific) or do you go to Protocol 26: Sick Person (Specific Diagnosis) to address the pain? Do you always go to Protocol 30 when there is trauma involved no matter the time the event occurred?
When it is clear that the complaint is related to the NON-RECENT trauma, the EMD should use the protocol that is specific to the mechanism of injury. If the mechanism of injury is not specifically addressed by protocol, Protocol 30 is appropriate. The exception to this is Traffic/Transportation Incidents (Protocol 29) because this protocol is designed to handle the scene rather than specific injuries. When a patient calls after a motor vehicle accident and is not on the scene, the Chief Complaint is almost always an injury, not the accident itself. Protocol 30 will address this sort of complaint.

4. A patient calls in with leg or back pain due to a fall that occurred a few days ago or the day before. Do you always go to Protocol 17: Falls Accident itself. Protocol 29 is designed to handle the scene rather than specific injuries. When a patient calls after a motor vehicle accident and is not on the scene, the Chief Complaint is almost always an injury, not the accident itself. Protocol 30 will address this sort of complaint. Protocol 29 is designed to handle the traffic incident scene, rather than specific injuries.

5. Is “side pain” addressed on Protocol 1: Abdominal Pain/Problems or Protocol 26: Sick Person (Specific Diagnosis)?

- Non-traumatic “side” pain should be addressed on either Protocol 1 or Protocol 5: Back Pain (Non-Traumatic or Non-Recent Trauma), depending on the location of the pain.

6. A person has been involved in a car accident, but has made it home without being seen by paramedics or doctors. The person now calls 9-1-1 for an ambulance. Do you go to Protocol 30: Traumatic Injuries (Specific) or Protocol 29: Traffic/Transportation Incidents since the patient is no longer at an accident scene?

When a patient calls after a motor vehicle accident and is not on the scene, the Chief Complaint is almost always an injury, not the accident itself. Protocol 30 will address this sort of complaint. Protocol 29 is designed to handle the traffic incident scene, rather than specific injuries.

7. On Protocol 26: Sick Person (Specific Diagnosis), you can shunt only to Protocol 10: Chest Pain (Non-Traumatic) or Protocol 21: Hemorrhage/Lacerations. Can you go to Protocol 12: Convulsions/Seizures or Protocol 28: Stroke (CVA) Transient Ischemic Attack (TIA) if symptoms suggest it during the call, not Case Entry?

Yes, but beware of “card surfing.” Usually, priority complaints are part of the initial complaint. We have found that signs or symptoms “discovered” while on another Chief Complaint Protocol do not have the same acuity (not as serious an outcome) as when that sign or symptom is part of the initial Chief Complaint. This is why we have limited shunting from Protocol 26 to chest pain. However, when it is clear that you should be somewhere else, i.e., the patient provides symptoms clearly defined on another protocol (HEART ATTACK Symptoms, STROKE Symptoms, Seizure), you should move to that more appropriate protocol. This generally happens when a better historian (caller) comes to the phone and provides a more defined or descriptive Chief Complaint.

8. Do you go to Protocol 23: Overdose/Poisoning (Ingestion) when the caller states that the patient had been drinking alcohol and is now unconscious or not alert?

No. “Drunk” is a caller diagnosis. They are calling because they cannot wake the patient. Use Protocol 31: Unconscious/Fainting (Near) for this complaint. An article explaining the Academy’s position involving an “intoxicated person” protocol reads in part: Why can’t we deal with drunks as drunks? Why don’t we create and use an “intoxicated person” protocol for these patients and stop wasting valuable resources responding to and transporting them? The answer is really quite simple; it’s possible to be both sick and drunk. In reality, the complaint of “drunk person” is essentially a diagnosis made by Chief Complaint alone. The practice of diagnosis by complaint alone, especially in the non-visual, hands-off environment of dispatch, is inherently dangerous in all but a few, very exceptional and reliable circumstances. When this is done, we rely exclusively on the opinion of an untrained caller who, in the case of the intoxicated person, is often quite biased.

9. For full arrest due to overdose, do you go to Protocol 23: Overdose/Poisoning (Ingestion) first or do you send a 9-E-1 (Protocol 9: Cardiac or Respiratory Arrest/Death-ECHO-1) and go to medical arrest instructions out of Case Entry?

Code as 9-E-1 and handle as a medical arrest. The Standards Council is considering adding “Arrest” to Protocol 23 but this has not happened as of yet.

10. Do you stay on the line with the caller or disconnect when there is a second-party caller on the line who can call back if anything changes or gets worse even though the protocol (Critical EMD Information or Case Exit) advises the EMD to stay on the line with unstable patients?

There are many variables to consider when deciding to stay on the line or not. Patient condition should be the first consideration. Caller competency, caller emotion, how busy calltakers are in the communication center, and response time are also important. Because there are so many variables, it has not been possible to provide EMDs with a definitive “list” of stay-on-the-line situations. I believe this will always be a judgment call. The EMD should always have the best interest of the patient in mind when making this decision.
Norman Rivera shys away from questions focusing on his “contributions” to dispatch, although they must be significant considering the 2014 Communicator of the Year Award he received for his efforts.

“I was hesitant when directed to do this,” said Rivera, EMD, Toronto Emergency Medical Services (TEMS), in Ontario, Canada. “I’d rather stay in the shadows.”

The peer-nominated award acknowledges Rivera’s confidence—and reserve—as it translates into the position of respect he holds in the comm. center and among field responders. He dispatches ambulances, trains new calltakers, and dispatchers on the floor.

“People look up to me in the center,” he said. “The medics on the road know my voice. When I’m on the radio, they know they’re in good hands.”

The same goes for his co-dispatcher, Rory Donahue. At TEMS for eight years, Donahue said staff support adds to the positive experience. He also credits the Medical Priority Dispatch System™ (MPDS®), a part of TEMS’ chain of emergency response since 1992.

“MPDS is consistent and a system we can depend on to assess individual needs,” said Donahue, a Toronto parks and recreation employee prior to joining TEMS. “I’ve used it from the start, and to me, it’s great.”

TEMS is about team

TEMS Central Ambulance Communications Center (CACC) Cmdr. Leo Tsang said teamwork is essential to the organization.

“We truly believe that everyone needs to be integrated into the team,” Tsang said. “We couldn’t achieve what we have without the team approach.”

By any standards, the size of TEMS with respect to its personnel, coverage area, call volume, and response volume, complicates the team concept.

Toronto EMS is the largest municipal paramedic service in Canada, covering 641 square kilometers (247 square miles) and a daytime population of 3.5 million people (resident population is 2.8 million). TEMS processes 420,000 emergency calls per year, with requests for service resulting in transporting 200,337 patients per year or an average of 550 transports per day, according to 2013 figures. TEMS operates a fleet of 241 vehicles, which includes ambulances and bus-sized emergency support vehicles for transporting up to 20 patients at a time in case of a mass casualty incident.

The 172-member comm. center staff includes calltakers and dispatchers, a destination coordinator for paramedics, an out-of-town response coordinator, information technology, and supervisory personnel. The comm. center is supported by the Education and Quality Improvement Unit (EDQIU) that has six certified EMD-Qs®.

Kim Rigden-Briscall compared TEMS to a gigantic machine, albeit a well-oiled one.

“TEMS is incredibly big and at the same time, incredibly dedicated,” said Rigden, commander, CACC Education and Quality Improvement Unit. “This is a very hardworking group of people. They really understand the Academy’s expectations.”

ACE outlook

In 2000, TEMS mandated EMD certification for dispatchers and calltakers. In 2006, it
Twenty Points of Accreditation.

The process renewed the emphasis on strict MPDS compliance according to Academy standards. The EDQUIU began auditing calls and providing one-on-one feedback to EMDs. By the end of December 2007, the ACE application was in the mail.

Donahue recalls how everyone pitched in from all levels within the organization.

“It required the effort of dispatchers and management,” he said. “We each had a responsibility. We all had to meet the same high standard.”

Carlynn Page, IAED associate director, delivered the eagerly anticipated news via a congratulatory phone call on April 8, 2008.

TEMS representatives were present at NAVIGATOR 2008, held in Baltimore, Md., to accept the ACE award. However, in keeping with the TEMS team spirit, IAED President Scott Freitag made a second presentation of the ACE award at the Toronto center for the benefit of the entire staff.

The scope of TEMS’ commitment to the use of MPDS is reflective in the agency’s desire to use methodology that links patient outcomes with MPDS Determinant Codes to establish local ambulance response plans.

The system links MPDS Determinant Codes with patient outcome data gathered from the paramedic’s electronic patient care record. This clinical data has allowed TEMS to create Determinant Level-specific responses. Instead of having the four levels of responses typically seen in many centers (ECHO/Delta=ALS/HOT, Charlie=ALS/COLD, BRAVO=BLS/HOT, and Alpha=BLS/COLD), TEMS gives each individual MPDS Determinant Code its own response plan based on the historical data that shows the likelihood of an intervention. For instance, a 2-D-1M requires a BLS response within 8 minutes and 59 seconds with firefighter first responder response while a 2-D-11 requires an ALS response within 8 minutes and 59 seconds with a firefighter first responder response.

Response plans are built on clinical evidence, which is generated from a database of over 500,000 patient records linked to 9-1-1 calls from a three-year period. The data is continuously reviewed and response plans can be adjusted based on medical evidence. Not only does it improve patient care at the point of response but it also determines the level of EMS resources dispatched according to high- and low-acuity patient types.

Building response plans based on Determinant Codes and patient outcome data are highly dependent on high compliance in the use of the protocol and MPDS Determinant Codes, Rigden said.

**Optimal efficiency an ongoing objective**

Tsang commends Chief Paul Raftis for his “good work” in synthesizing teams and setting them in a direction for the future.

“He makes sure our voices are heard and invites research,” Tsang said. “He keeps up with medical best practices.”

Tsang has a paramedic background and is a product of the TEMS leadership program and has taken on several front line leadership positions. He certified as an EMD soon after taking over comm. center operations, although he has never answered a call to 9-1-1 or dispatched response.

“I was a fish out of water and responsible for 120 people,” Tsang said. “But I settled into the groove. The EMD course helped me to acclimate and understand the role.”

Tsang was introduced to MPDS several years ago when he was a paramedic. He sat down with a comm. center supervisor for an explanation of the protocols when a call— from his paramedic perspective—was mishandled. He was skeptical of the protocol’s benefits to EMS and the role that calltakers and dispatchers play in response.

He came away impressed by the system behind protocol and an appreciation of the job that comm. center staff perform.

“The tape told no lies,” Tsang said. “It was an eye-opener. Response could only be as good as the information the caller provides.”

Donahue was in awe of dispatchers.

“I had an idea of what an EMD did but to sit down next to a dispatcher was something else altogether,” he said. “Being an EMD is a job you have to watch to understand. It’s complicated. It’s challenging. Not many people realize how closely we work hand in hand with paramedics and, yet, stay in the background. We’re spokes in the wheel.”

**Training strides**

Rigden accepted her position a few months after Tsang arrived, determined to continue to meet the requirements for the center’s Accredited Center of Excellence (ACE), for a third time, and to optimize the center’s quality improvement program.

She was the ideal candidate with an extensive background in emergency response in the field and in comm. centers. Her reputation in all things Priority Dispatch System™ protocols and quality assurance precedes her, and she is careful not to tread too heavily on established grounds.

At TEMS, Rigden made some immediate observations: staff is driven, the center is always busy with little downtime, and there’s an expectation to deliver EMS in a high-performance service delivery model.

“People here feel strongly about what they do,” said Rigden, a certified EMD instructor, a master medical Q instructor, and a senior Q in the National Q program.

She asked questions and learned the history and culture of TEMS. If there was something she didn’t understand or if there was an issue concerning protocol, she asked more questions and looked for a solution.

Rigden chose her initial projects carefully. She invested time and resources into improving the EMD call review feedback procedure and streamlining the training and quality improvement processes, in general. She offered refresher courses in the Academy’s performance standards and ProQA®. She followed with an upbeat “catch them doing it right” approach to maintaining compliance.

“Emergency dispatchers are the most highly scrutinized people in the world,” Rigden said. “I am very dedicated to doing things in ways that are positive but at the same time correct a problem when it exists.”

She emphasizes consistency.

“It might sound odd but it’s about putting predictability in an environment that is unpredictable,” she said.

The calming, reassuring voice of the calltaker provides a large dose of encouragement to callers and patients in the throes of unpredictable and urgent situations. It’s the ability to help that makes the job most satisfying, combined, in optimum call scenarios, with providing Pre-Arrival Instructions (PAIs) leading to a baby’s delivery or the resuscitation of a patient in suspected cardiac arrest.

Donahue’s assistance with an over-the-phone delivery during his third year on the job provides a memorable and job-satisfying event. He heard the baby give its first cry and received a stork pin.

“MPDS gave me a focal point,” he said. “The steps were a big help. The call was personally quite rewarding.”

Awards are welcome, but they’re not the incentive behind Donahue’s or Rivera’s reasons for doing a great job. Rivera said they’re not the types looking for attention.

“We tend to like our work to speak for itself,” he said.
PAIs Build on Pre-Hospital Care
Pre-Arrival Instructions complemented EMS drive to survive and thrive

Audrey Fraizer & James Thalman
Phoenix (Ariz.) paramedic Bill Toon had barely settled in for the swing shift on Aug. 10, 1974, when a young mom in a full-flail panic called the fire department’s new emergency number to report that she had just pulled her 2-year-old son from the family swimming pool. The toddler wasn’t breathing, and he was turning blue.

The calltaker quickly obtained the address and phone number then asked if the child was still in the pool.

“We’re trying to give him mouth-to-mouth,” the mother tells the calltaker, who responds, “All right. I want you to stay on the line. I have a medic that is going to give you some help while I send someone. Stay on the line.”

Toon takes over the call, and asks the mother to describe the boy’s appearance and how long he might have been in the pool. Toon urges her to calm down then asks if anyone else is with her. She says her parents are trying to revive the child.

Toon says, “OK, here’s what I want you to do to make sure they’re doing [CPR] right.”

After about 30 seconds and bringing the child inside the house, the frantic mother loudly tells Toon, “He’s not breathing at all!”

“OK, calm down, ma’am,” Toon firmly tells her. “Listen, you’re going to have to listen to me in order to help him now, OK?”

Toon quickly moves through the instructions over the phone, and the mother repeats them to her father who is delivering mouth-to-mouth. About 40 seconds later, the child starts to moan. Ten seconds after that, desperation officially turns into elation as the boy coughs up the cup or so of water that flooded his lungs.

“He’s starting to cry,” the mother says.

“If he’s crying, he’s breathing,” Toon responds. “Just let him cry, all right. He’s going to be OK now.”

Toon, when asked to recall the incident, said in those days Phoenix Fire only had a single paramedic unit. At the moment of that specific call about the boy, the ambulance was so far away that chances were slim to none it would reach the scene in time to save the boy, he said.

“I began to give the caller a crash course in CPR because the only real chance the child had of being saved was for his family to do the saving,” Toon said. “I talked them through the resuscitation process, and in a few minutes, I heard the child begin to cry. That was a pretty sweet sound for everyone involved.”

Meridian moments

There were other examples of paramedics giving advice over the phone to someone caught in a desperate situation back then, but the 3-minute, 8-second “Baby Fell in Pool” is the first known recording of basic life support (BLS) provided to a caller over the phone while awaiting the arrival of field response. Toon’s advice was expert although ad hoc; he was among the first crop of firefighters trained in paramedic rescue to offer in the dispatch center what he knew from his experience evaluating and treating patients at the scene.

And that’s where the major difference lies between BLS, given in the field, and Dispatch Life Support (DLS), provided from the communication center.

“This is a very important point to make,” said Brett Patterson, Academics & Standards associate and Medical Council of Standards chair for the International Academies of Emergency Dispatch® (IAED®). “While these first calls were awesome to hear, and the celebrated ones saved lives, we actually learned more about what not to do. Responders ad-libbing made mistakes, simply forgetting important things that they would normally see.”

As the Salt Lake City (Utah) fire surgeon, Dr. Jeff Clawson was mindful of 9-1-1 center operations, especially as they related to state and national efforts to coalesce standards for emergency medical services. In 1966, the National Academy of Sciences of the National Research Council, released the report “Accidental Death and Disability: The Neglected Disease of Modern Society,” which gave incredibly low marks to the United States’ ambulance services and led to major reform in pre-hospital treatment.

Clawson had worked his way through medical school as a paramedic with Gold Cross Ambulance Service in Salt Lake City at the same time a number of cities were training firefighters to take on roles previously reserved for doctors. In 1971, Jim Page, a founding figure in EMS, coordinated paramedic rescue services through the Los Angeles County (Calif.) Fire Department. At the time, EMS was a mere child and, according to an article published in EMS Magazine (Founding Fathers of EMS, Aug. 1, 2007), built by individuals taking personal and professional risks to develop systems they believed would save lives. They—and this is also important to point out—allowed the next generation to build on a foundation with clinical, operational, and administrative improvements that helped EMS survive and thrive.

Clawson is cited in the same article as one of those pioneers. In the late 1970s, Clawson revisited a U.S. Department of Trans-
portation plan—never fully realized or implemented—to bring prehospital care to the earliest point possible by establishing guidelines for emergency medical dispatch. He put his protocols into motion at the Salt Lake City Fire Department (SLCFD) Alarm Center to reduce the number of Code 3 medical runs and the number of fire department-related vehicle accidents.

That initial motivation—reduction in the number of Code 3 medical runs—comes as a surprise to most people in emergency communications, Patterson said.

“Many people think Pre-Arrival Instructions (PAIs) were the impetus for the protocol, when it was actually ambulance triage,” he said. “It was an issue in Salt Lake and everywhere else.”

Clawson had borrowed his protocol design from a senior physician he worked with at Charity Hospital in New Orleans, La. He turned the doctor’s so-named “cookbook” of recipes for handling patient flow (triage based upon severity and resources) into processes for providing standardized care during step one of the prehospital setting.

He introduced the medical dispatch system he created at home in his spare time on 8-inch by 5-inch cards with an intra-department memo (dated June 4, 1979) requesting feedback from dispatchers as well as EMTs and paramedics to help fine-tune and maintain the system at a high level.

The original set of protocols contained 29 sets of cards. Each caller complaint was listed in alphabetical order, as they are today, and reflected either a symptom (e.g., abdominal pain, burns, cardiac/respiratory arrest) or an incident (e.g., electrocution, drowning, or traffic injury accident).

The protocols were scripted and per Clawson’s instructions, the script must be followed word-for-word to determine “exactly what happened”—the reason for the call and the appropriate response. The core card contained three color-coded areas: Key Questions, Pre-Arrival Instructions, and dispatch priorities.

Clawson sent out the first revisions, based on the feedback provided on medical dispatch feedback reports, in an intra-department memo dated Nov. 27, 1979. The reports were the predecessor of the well-known Proposal for Change (PFC) form.

“Dr. Clawson was always concerned about feedback from users,” Patterson said. “He knew from the start that in order for the system to work effectively for dispatchers and field responders, he needed the constant vigilance of people relying on them in the prehospital setting.”

The first PAIs released in the cardset were ballooned boxes with instructions connected with lines that flowed from one instruction to another. Some of those lines branched, depending on the next instruction, or looped back to earlier instructions. The result was accurate but so difficult to follow that Clawson nicknamed the renderings “Uncle Squiggly.” They resembled methods English teachers used to help students conjugate complex sentences. For example:

**Eye Problems**
- Abrasions
- Orbital fractures
- Hyphema
- Retinal detachment
- Penetrating wounds of globe
- Foreign bodies
- Contusions
- Burns
- Chemical

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**Crash Course**
Phoenix Fire Department Paramedic/Dispatcher
Bill Toon is credited with providing over-the-phone CPR instructions before there was a protocol to follow.

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**Help is on the way — you**

**Listen carefully and follow the steps.**

**Is the victim conscious?**
- **Yes** Get help.
- **No** Can you get the phone next to the victim? I’m going to tell you how to open the airway. Put him FLAT ON HIS BACK. If there is a pillow under the head, REMOVE IT. Place one hand under the neck, the other on the forehead and tilt the head back. Is he breathing normally now? 
- **No** Do you or anyone else know CPR? 
  - **Yes** Get help.
  - **No** I’m going to tell you how to give Mouth-to-Mouth. Tilt the head back the way I told you before. Hold the NOSE closed. Completely cover the victim’s MOUTH with your MOUTH. Force 4 deep BREATHS OF AIR into the LUNGS. Just like you are BLOWING UP A BIG BALLOON. Watch for the CHEST to RISE.

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**ADULT AIRWAY MOUTH-TO-MOUTH**
° Arc (welding)
° Contact lens problems

Pre-Arrival Instructions
° Lay patient down
° If chemical, flush immediately with H₂O for 10 min.

Key Questions: Type of problem
° Is eyeball leaking or cut?

Dispatch Priorities
° Most can be transported via personal auto
° Ambulance 10-40 for severe ocular trauma

For many, the protocols weren't love at first sight. Leaving first aid to what was then considered a bunch of lower-tier office staff invited trouble and widened the opening for liability.

“You have to keep in mind who was managing many dispatch centers back then,” said Ross Rutschman, a co-designer of Treatment Sequence Protocols—the forerunner of today's PAIs. “That was law enforcement and, therefore, any medical aid to be given over the phone was low priority. Also, keep in mind that this is well before computers, so many calltakers were treated as clerks, kept busy typing up police reports and doing other office tasks that came with the job.”

While Rutschman, Page, Clawson, and other dispatch sentinels could see as plain as day that remote life-saving instructions were logical, necessary, and even long overdue, “Back then, CPR had barely been accepted as viable treatment itself,” Rutschman said. “The thought of teaching someone to do it over the telephone was seen as very radical.”

There were claims that the Academy was practicing medicine over the phone.

“The answer was clearly no, and still is,” Clawson said. “The dispatcher is not making a diagnosis. The dispatcher using the Medical Priority Dispatch System™ (MPDS®) stays on the phone with the caller and instructs or coaches the caller to do something positive for the patient during the response time lag that proves fatal in so many cases.”

By using appropriate Key Questions, the dispatcher is able to identify the mechanism of injury and the presence of priority symptoms, and respond to the symptoms with PAIs designed to accomplish three goals:
1. Provide immediate assistance through the caller when certain emergency conditions are present
2. Protect the patient and caller from potential hazards
3. Give bystanders correct information and protect the patient from well-meaning bystanders inadvertently giving incorrect treatment

Progressive pace
In 1988, Clawson established the National Academies of Emergency Dispatch® (now the IAED) to become the certifying and standard development organization for both the MPDS Protocol and the EMD certification curriculum. The Academy was set up to evolve the protocols and provide a forum for the future of EMD.

The PAIs were always a hair's breadth away.

Over time, Clawson hired Mike Smith to convert the PAI algorithms into what we know today as the Panel Logic Sequence. Detangling the lines allowed the panels to easily adapt to the digital age and morph into today’s ProQA®—the most widely used emergency dispatch software in the world. Smith’s work is still regarded as the single most important invention to transform the delivery of PAIs in a safe and consistent manner.
“That was a watershed event in the ability to expand the PAIs to handle gender, age, and, in time, related condition instructions easily,” said Rich Saalsaa, one of the architects of ProQA. “This led to the ability to track the actual usage of the protocol, and eventually, the ability to add quality assurance and quality improvement processes.”

Post-Dispatch Instructions (PDIs)

In contrast to the complexity of situations PAIs are designed to handle, PDIs are given to callers dealing with specific incidents requiring a range of instructions with very basic, simple advice for mild or minor injury situations. They provide instructions of what to do and, in some cases, what not to do while the ambulance is on the way to the scene. Over time, PDIs and PAIs have become so common that callers sound surprised, even angry, when told by dispatchers from a non-MPDS call center that they don’t provide first aid instructions over the phone.

A high-wire act

Asked to define PAIs in one sentence, Greg Scott, IAED operations research analyst, said, “PAIs are used in low-frequency, high-risk events that dispatchers rarely encounter. But when they do, they must handle them in a highly compliant manner.

“They are precisely worded and meant to be read verbatim for very good reasons,” he continued. “They maintain the proper order of care and eliminate unintentional but critical errors. Dispatchers working without scripts, for example, can too easily omit an important instruction when the rescuer and patient cannot be seen, or assume something is logically being done when it is actually not. Careful, well thought out, and time-tested wording is critical to remote caller understanding.”

The evolution of emergency medical dispatch in the United States and abroad has been a movement to bring logic and order to emergency responses that were basically, “Send everything you have as fast as you can,” Scott said.

That’s why PAIs are the centerpiece of the MPDS-scripted calltaking method, Scott said, noting that they have been field-tested. PAIs continuously debunk the tired, old criticism that pre-arrival instructions is beyond the providence of dispatching and would open centers up to the real and likely risk of being sued if an incident were to be made worse, not better, by dispatchers intervening.

“In just over 30 years, EMD has fully inhabited its potential as the critical link to the best possible outcomes in an emergency,” Patterson said.

Spinning in unison are methods of interrogation and caller instruction evolving into tightly-scripted steps known today as PAIs.

“They have allowed dispatchers to offer immediate and successful Dispatch Life Support well ahead of the field responders arriving at the scene,” he said.

Similar to the main body of protocol—Chief Complaints—the PAIs are every bit as dynamic in meeting the challenges of medical discovery and technology. The innovations have also received their fair share of resistance.

But that’s not a bad reflection of the protocol or us, Patterson said.

“The greater insult would be a medical and dispatch community ignoring the changes, particularly in recent years with the release of diagnostic tools in the MPDS,” he said. “As the standard-setting organization, we expect scrutiny and our response is always backed by the research that goes into protocol development.”

THOUSANDS OF WELL-DOCUMENTED ANECDOTES OVER 35 YEARS ARE NOW BEING SUPPORTED BY ACTUAL SCIENCE.

For example, the North American release of MPDS v12.1 in March 2012 generated several inquires regarding Protocol 28: Stroke (CVA) and the required Stroke Diagnostic (Dx) Tool. Initial pushback focused on the extra time it added to the call (an average of 34 seconds) and the potential impact on local response options for stroke patients.

According to a subsequent IAED Official Statement addressing the concerns:

The Academy’s Council of Standards has evolved and approved the new Stroke Diagnostic (Dx) Tool in an effort to better predict the outcome of stroke early on in the EMS response, not only to enable early hospital notification in the interest of prompt and effective patient care, but as a study methodology to measure and improve the outcomes of stroke patients. The new protocol was released and used extensively in the U.K. for about a year prior to its release in North America, with excellent results and positive feedback.

In short, Patterson said, the stroke predictability and subsequent hospital notification were found to be well worth the seconds spent administering the tool.

“It took time, but it’s now recognized as universal, DLS standard of care that enables better outcome studies in the interest of patient care,” he said.

Revolutionary impact

Literally thousands of well-documented anecdotes over 35 years are now being supported by actual science showing irrefutably that PAIs have had a revolutionary impact on dispatch, Patterson said.

Coming to be was a slow, sometimes halting evolutionary journey that began with field responders sitting around in the dispatch center offering or being asked to talk to callers while crews were en route.

“Back then, it was literally paramedics saying, ‘Why not? Nothing else is going on,’” Patterson said.

The ambiguous wording of instructions or giving them out of order was immediately seen as problematic to the effort, he said.

Those early efforts had an important lasting upside: “They gave us a full appreciation of and commitment to the specifically worded protocol interrogations and instructions dispatchers use today,” Patterson said.

Rutschman said there are many great EMS systems in the world that became great because of the EMD program.

“The trained, certified EMD is truly recognized now not only as a medical professional but as the most pivotal person in the EMS system,” he said. “In many cases, it doesn’t matter how fast we get there, how good the paramedics are, or how good a hospital is. If there’s a lapse of care between the incident occurring and someone arriving at the scene, it doesn’t matter how good the paramedics or hospital is, damage has been done.”
Looking Ahead

- Nearly six months have passed since the Federal Communications Commission (FCC) released its proposed rules to help emergency responders better locate wireless callers who dial 9-1-1. The proposal—to include indoor location accuracy and particularly, location accuracy in challenging indoor environments—makes several demands of wireless providers, including the ability to deliver vertical location information that would enable first responders to identify the floor level for most calls coming from multi-story buildings. The Journal editor Michael Rigert looks into the public response to the proposal and provides a summary of the more than 200 9-1-1 professionals’ related anecdotes from a recent survey as part of the organization FindMe911’s filing response to the proposal during the initial comment period.
- The September/October issue of The Journal also highlights a lifesaving program introduced to The Villages retirement mecca in central Florida. Neighbors Saving Neighbors provides both AEDs and CPR training, which since the program’s inception six years ago, has resulted in a 41.2 percent survival rate in residents affected by sudden cardiac arrest.
- Along with these special features, our readers can look forward to continuing dispatch education (CDE) articles, stories about their peers in the dispatch community, columns from experts in the profession, and news from the backdrop of 9-1-1.
The Consolidation Question

A look at the industry trend of comm. center consolidation

Michael Rigert
If you set up a Google Alert for the terms “9-1-1” or “9-1-1 dispatch,” you’ll get a daily volley of Internet links to, in large part, the most recent news reports related to the emergency dispatch industry. Of those, a weighty portion of them will be news coverage surrounding the seemingly omnipresent industry issue of 9-1-1 operations consolidation.

There are online clippings about agencies considering consolidating, those in the process of consolidating, and for those who have undergone consolidation, an evaluation of the results. The trend toward consolidation—fueled by jurisdictions’ and agencies’ shrinking budgets and funding sources—is irrefutable.

In the face of tough economic times, jurisdictions have increasingly sought after ways to pool resources and eliminate redundancies. That has led agencies and government entities to consolidate comm. centers to cover multiple jurisdictions, counties, and regions.

“(Consolidation) has been a clear trend over the last 20 years. ... The result has been greater economies of scale, more efficient use of resources, and improved interoperability,” stated the Communications, Security, Reliability and Interoperability Council (CSRIC) Working Group 1A in its October 2010 final report to the U.S. Federal Communications Commission (FCC). The FCC formed the CSRIC group to advise it on issues related to the dispatch center consolidation process.

But that doesn’t mean that everyone is onboard with the idea. The emergency communications needs of each agency and the jurisdictions it serves can differ greatly based on a variety of factors. Though most jurisdictions seek to give residents the highest level of 9-1-1 dispatch center services that are reasonably affordable, some view consolidation as ceding too much power to the contracting agency and have concerns about the quality of service to residents that a merger would bring about.

“The consolidation process poses numerous challenges, however, from operation, governance, funding, and technical perspectives,” CSRIC also states in its final report, Key Findings and Effective Practices for Public Safety Consolidation.

The following sections will look at both the advantages and disadvantages of consolidation and identify ways with which agencies and jurisdictions can analyze how consolidation might specifically benefit them rather than asking public safety officials and decision makers to simply take a leap of faith.

“TWENTY YEARS AGO, WE DIDN’T HAVE THE TECHNOLOGY TO DO THAT. IT WAS STILL ALL COPPER WIRING.”

— Shawn Messinger

Consolidation models

Consolidation, traditionally defined, typically translates to smaller jurisdictions contracting their emergency dispatch needs out to a larger county or regional comm. center. But many other types of consolidation exist and are popular with agencies, such as co-location and centralization, said Shawn Messinger, a police consultant with Priority Dispatch Corp.™ (PDC™).

Co-location involves separate agencies or agency divisions sharing a comm. center facility that within the structure’s interior are separate areas divided by a wall or by pod, with each having its own staff, CAD, protocols, etc.

“The flow of information increases, leading to greater efficiencies,” Messinger said. “It’s pretty common.”

Jay Dornseif, a fire consultant with PDC, who from his own experience with firefighting agencies in North Carolina, said co-location can also be a distinct advantage to agencies when natural disasters hit. Many co-located comm. centers in North Carolina serve a dual-purpose as emergency operations centers (EOCs) when natural disasters strike.

“An EOC can monitor the increase or decrease of events in the comm. center because they’re right there,” Dornseif said. “On a large event, 9-1-1 comm. centers can have a pod of dispatchers dedicated to funnel calls about that event.”

Similarly, centralization, sometimes referred to as backroom centralization, is when expensive communications systems and equipment are shared between two or more agencies at a single location to reduce costly capital redundancies.

Though dispatch center consolidation is not a new concept, it is one whose implementation was impeded until more recently due to a lack of requisite technology, Messinger said. But more recent advances in modern communications have made everything from backroom centralizations to full on regional consolidations possible.

“Twenty years ago, we didn’t have the technology to do that,” Messinger said. “It was still all copper wiring. The centralization model saves money and preserves the calltaking positions at each local Public Safety Answering Point (PSAP).”

With the ongoing technology potential of initiatives such as Next Generation 9-1-1, those in the industry are seeing that, “For better or for worse the consolidation doors have been opened, and opened wide,” Messinger said. “It’s now technologically feasible that an entire state could decide to consolidate all of its PSAPs into one statewide 9-1-1 call center.”
Costs versus benefits

Cities’ and counties’ increasing public safety costs juxtaposed against an era of slowing revenues has left many agencies and jurisdictions with no choice but to consider the viability of communication center mergers.

In many states, legislation to modify existing tax revenue structures to be based on the number of cellphone lines instead of on the previous benchmark—the number of landlines—has failed, leaving agencies with funding shortages while cellphone 9-1-1 calls are on the increase.

In the U.S. alone, a staggering 240 million 9-1-1 calls are received by PSAPs annually, and this volume continues to increase, according to the National Emergency Number Association (NENA). Moreover, it’s estimated that some 25 to 60 percent of all calls received by PSAPs come from wireless phones, according to the CSRIC report.

“The biggest driver of consolidations is more people making 9-1-1 calls by cellphone than by landline,” Dornseif said. “Now more than ever, a caller stands a better chance of being bounced between (nonconsolidated) centers during transfers than by a center that’s a one-stop-shop.”

That’s left jurisdictions scrambling to come up with budgets to cover staffing increases and technology upgrade costs to cover the spike in call volumes while still providing a high level of service to residents.

“The convergence of technical systems when combined with the escalating costs of maintaining those systems makes consolidation a serious consideration for decision makers,” the CSRIC report states. Hence, all the Google Alerts in your inbox.

But at the same time, consolidation must be considered on a case-by-case basis; the cost savings and benefits may vary greatly based on each individual situation. A small municipality may be able to slash a full-time director position and one or two assistant directors by integrating with another communication center, Messinger said.

“But with so many agencies being tri-centers (that take medical, fire, and police calls) they typically can cover more calls with less funding,” he said. “If the agency is not yet a tri-center, there are almost no detriments to co-location, and in these situations it’s likely to continue because it makes sense.”

At the same time, a feasibility study may indicate that a good chunk of the potential financial savings of a merger might be offset by the necessity to hire supervisors for the new center, contract fees, or the lost investment of protocols and training that may not be used at the new consolidated center, Messinger said.

Dornseif said the only sure method for public safety officials and decision makers to know what type of fiscal savings and benefits a proposed consolidation will provide is to commission a comprehensive feasibility study by an independent contractor.

Potential benefits of consolidation might include budget savings based on commensurate reductions in staff, infrastructure, equipment, and other factors; improved and faster communications and coordination between agencies and agency partners; and access to more advanced emergency communications systems, technology, and standardized protocols that help eliminate mistakes. Messinger said consolidated centers are also characteristically answerable to a board of representatives comprised of participating agencies and jurisdictions that results in a heightened level of oversight and accountability.

On the flip side, there are also real and/or perceived disadvantages to consolidation. In some consolidation scenarios, displaced dispatchers may have long commutes, have to relocate, or lose their positions altogether, particularly in rural regions. Staff at a remote consolidated center may be less familiar with the unique geography of rural areas that local dispatchers could easily navigate for first responders.

Perhaps some of the most significant pushback to consolidation comes from decision makers’ sense of a loss of local control and a potential decrease in the quality of service residents might receive. Other considerations that hit too close to home may include staff concerned about how a proposed consolidation will affect their seniority and retirement benefits, Dornseif said.

Though most experience an increase in the quality of service as a result of consolidation, the reverse can also happen. But Messinger

“If you take what it costs to run a 9-1-1 center and divide the pie by 4 to 6, even 39 pieces, it will obviously benefit the active members.”

— John Ferraro
and Dornseif said those particulars should be fleshed out in a thorough feasibility study. Loss of local control, whether real or perceived, (despite the existence of an oversight committee of participating agencies) may be too much for some decision makers to accept.

“In the vast majority of cases, there are clear benefits to consolidation,” the CSRIC study states. “The sharing of resources allows for the elimination of duplicate costs, supports coordinated responses, provides greater interoperability, and ultimately leads to more effective and efficient service. Driving forces from political, economic, and service quality factors are increasingly demanding public safety officials consider consolidation with neighboring communities of interest.”

In the trenches

David Donovan, interim director of Scott Emergency Communication Center (SECC) in Davenport, Iowa, was a key figure in the center’s consolidation process from 2007–2011. A co-located consolidation, three PSAPs (Scott County Sheriff, Davenport Police and Fire, and Bettendorf Police and Fire) and a private nonprofit center (Medic EMS) constructed a new single facility to take all medical calls while also housing the agencies’ fire and police dispatchers at SECC.

Donovan said the consolidation put all SECC partners on a common CAD platform and a radio system that meets the new federal digital standard. It has also purged inconsistencies between jurisdictions, improved the level of customer service to residents, and fixed a taxing inequity for 9-1-1 services for rural areas of the county in which city residents were being double taxed.

“The benefits are more the capital expenses but there are some synergy and cost benefits from having all the jurisdictions on one platform and one radio system,” Donovan said.

John Ferraro is executive director of West Suburban Consolidated Dispatch Center (WSCDC) in River Forest, Ill., which dispatches medical, fire, and police for the villages of Elmwood Park, Oak Park, and River Forest. Prior to coming over to WSCDC, Ferraro was the deputy director of operations for DuPage Public Safety Communications (DU-COMM) in Glendale Heights, Ill. DU-COMM serves 39 agencies in DuPage County, averages 30,000 9-1-1 calls per month, and is one of the largest consolidated 9-1-1 centers in Illinois.

“There’s operational, and obviously, economic benefits to consolidation,” Ferraro said. They include operational continuity from town to town, information sharing, and coordinating resource availability. Similarly, cost savings can be substantial.

“If you take what it costs to run a 9-1-1 center and take that pie and divide it by 4 to 6, or even 39 pieces, it will obviously benefit the active members,” Ferraro said. “And anytime you consider adding another agency or moving away from being a single center, there are generally significant savings that go along with it. It’s less equipment and less money.”

WSCDC, which has 25 dispatchers and serves a population of 80,000, formed in 2002 between Oak Park and River Forest, and added Elmwood Park in 2004. Recently, the nearby city of Park Ridge has decided to become a member of WSCDC for its 9-1-1 call answering and police dispatching.

SECC, which employs 43 dispatchers and six shift supervisors and took 218,000 calls for service in 2013, is currently having dispatchers cross-trained on medical, fire, and police calls, an advantage that enhances flexibility and eases scheduling challenges.

Donovan said consolidation has also brought less concrete but equally important gains to emergency communications in Scott County. One is that it has created a forum of dialogue and interoperability between agencies and jurisdictions that was previously nonexistent.

“It’s a place to start those conversations, and it brings everyone to the table at once,” Donovan said. “If there are issues, it pulls us together.”

Internally, perhaps the most appreciated aspect of the SECC partnership is that not a single calltaker/dispatcher from any of the four comm. centers was laid off. One of the provisions of the center’s intergovernmental agreement was that every dispatcher would have a place at the new SECC, Donovan said. The provision was possible when the feasibility study found that one of the four centers was significantly understaffed for the call volume it received.

Ferraro said the human element of losing dispatchers can be a drawback to consolidation but that at WSCDC and DU-COMM, the standard procedure is to give laid-off dispatchers the first crack at new consolidated center positions pending they pass a standardized test.

“As a director, I’ve seen consolidation work,” Ferraro said. “I’m for it.”

Donovan said the greatest challenge during SECC’s consolidation process has simply been the cumulative amount of changes that public safety staff and officials have had to absorb, he said.

“It’s the whole learning curve,” Donovan said. “To this day we’re still adapting and trying to become more proficient. Initially there were some technology issues that haunted us for the
first 18 to 20 months. Now we’re asking ourselves, ‘How do we become better? How do we benchmark ourselves?’ We’re putting in place performance goals, taking it to the next level, and seeing the fruits of our labor in terms of the performance that we’re giving the community.”

That’s what the CSRIC says

But just because agencies and jurisdictions are interested in giving consolidation a look doesn’t mean it’s smooth sailing once a proposal is green-lit.

That’s why the CSRIC 1A Working Group, in its final report, also identified some key findings and effective practices of public safety officials and decision makers.

“The consolidation process often poses numerous challenges from operational, governance, funding, and technical perspectives,” the report states. “A key issue is how to assist agencies in the transition from system operator to user.”

As a result of the group’s research, in consultation with case study participants with successful consolidations, the CSRIC 1A Working Group singled out six phases that stakeholders encounter during a typical process:

• Identification of an effective champion—Successful consolidations usually have one trait in common, a well-respected champion to lead and spearhead the process from beginning to end. Respondents said consolidation represents a major culture change and is often threatening to participating agencies long accustomed to having complete control of their services.

• Interest building—The process of developing interest in consolidation among decision makers and stakeholders is often met with skepticism and rejection. The champion must meet with the affected parties and answer their initial questions with enough clarity to address those concerns and doubts in order to build a body of trust and secure ‘agency buy in.’ If enough interest exists, the process moves to the next phase of conducting a feasibility study.

• Feasibility study—A comprehensive study that (a) benchmarks current 9-1-1 and dispatch services by examining a wide variety of issues. These issues include staffing, call processing and dispatching, budget, technology, political environment, and facilities. (b) Determines if consolidation makes sense from a service level and political, technological, and financial perspectives. And (c) makes recommendations for consolidation models, governance, funding, staffing, technology, and facilities.

• Planning phase—Decisions regarding participation, funding, formulas, organizational structure, governance model, human resources issues, and facility and technology needs are made in this phase in addition to planning for procurements.

• Implementation/transition phase—Technology procurement, installation and training, facility construction or renovations, and procurement of furnishings all occur in this phase.

• Post-consolidation phase—This is the time immediately after activation of the new service. Service and technology issues are common during this phase. These issues are usually indicative of the success of the consolidation. Keeping these issues in proper perspective is vital.

For further reading, the CSRIC 1A Working Group’s final report also outlined 16 findings of effective practices to aid agencies and jurisdictions as they circumnavigate the complicated waters of consolidation.

The consolidation question

In summary, the trend of dispatch center consolidation isn’t going anywhere. Agencies and jurisdictions continue to grapple with rising costs of staffing, updating new technologies, and related expenses even as 9-1-1 comm. centers continue to experience shrinking budgets and problematic revenue sources. And as the industry continues to move toward Next Generation 9-1-1, the costs associated with realizing NG9-1-1 may accelerate the trend.

Obviously, a one-size-fits-all approach will not help decision makers and stakeholders; a feasibility study is instrumental in fleshing out the specifics of a consolidation proposal.

In fact, some would argue that a feasibility study may be worth its weight in gold if there is a least a modicum of interest from public safety officials—armed with information about how to approach and successfully navigating the consolidation process—in looking at the numbers.

“The consolidation trend is continuing,” Messinger said. “In fact, with looming budget shortfalls across the country, I think it is speeding up. If you are a city council or county government and looking at expenditures, I think they see consolidation as an option. As a general rule, if they’re not thinking about the political ramifications or similar concerns, it would be beneficial for 9-1-1 comm. centers to look at centralization, co-location, and consolidation in order to gain the highest level of service at the lowest cost to the taxpayer. But that’s with a perfect understanding of what consolidation entails.”
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
Where There’s Dust
Dust clouds in confined spaces can be deadly
RESPONDERS SHOULD TREAT COMBUSTIBLE DUST AS A SPECIAL HAZARD AND FORMULATE DISTINCT PRECAUTIONS.

A combustible wood dust explosion and fire at Inferno Wood Pellet Inc. in East Providence, R.I., on Aug. 20, 2013, injured a worker and partially demolished the building. The ignition of wood dust in the plant’s production room migrated to a retention bin, resulting in an explosion that spread through the building.

An investigation also found employees were exposed to wood dust, that parts of the operation lacked spark detection and explosion suppression devices, and that an opening allowed a fireball to enter a room full of wood chips and spread.

In a Dec. 9, 2010, explosion that ripped through a metal recycling facility in New Cumberland, W.Va., three employees—two of them brothers—were fatally injured.

According to the complaint filed by the West Virginia Department of Environmental Protection, the titanium and zirconium powder that the men were handling at the plant reacted, causing the release of hydrogen gas, which ignited and caused zirconium and titanium fines, dust, and swarf to combust with great force. Swarf is a collective term for fine chips or filings of stone, metal, or other material produced by a machining operation.

A huge explosion and fire at the Imperial Sugar refinery northwest of Savannah, Ga., on Feb. 7, 2008, killed 14 and injured 38 others.

The first explosion originated from a conveyor running underneath sugar silos, raising sugar dust that had accumulated on the floors and elevating horizontal surfaces. Secondary dust explosions moved throughout the packing buildings, parts of the refinery, and the bulk sugar loading buildings. The pressure waves heaved thick concrete floors and collapsed brick walls, blocking stairwell and other exit routes. The resulting fires destroyed the packing buildings, silos, and palletizer building and heavily damaged parts of the refinery and bulk sugar loading area.

Threat of injury or death isn’t confined to factory employees and the bystanders that might be in the area at the time of the explosion.

According to an OSHA report, responders (firefighters, fire brigade members, and others called to the scene) are also victim to combustible dust explosions. Factors that OSHA cites include inadequacy of facility-specific information and firefighter training.

**Exploding dust**

A variety of materials can explode in dust form, including food (e.g., candy, sugar, spice, starch, flour, feed), grain, tobacco, plastics, wood, paper, pulp, rubber, furniture, textiles, pesticides, pharmaceuticals, dyes, coal, metals (e.g., aluminum, chromium, iron, magnesium, and zinc), and fossil fuel power generation.

Any of these materials when ground to a fine powder can mix with air to form a dust cloud. A source of ignition (e.g., electrical spark) can set off mixtures of dust and air within the flammable range, causing a chain reaction that spreads the flame throughout the cloud.

Without sufficient venting capacity to safely release the pressures, a cloud dispersing within a confined enclosure can explode and the subsequent deflagration can disturb and suspend the combustible dust, which then serves as the fuel for a secondary (and often more damaging) deflagration or explosion.

The resulting flash fire spreads too quickly to outrun. Flying shrapnel, blast wave, and the collapsing structure can injure or kill individuals over a large area.

At the time of the incident, however, the explosive potential of the dust cloud is difficult, if not impossible, to measure, according to OSHA, although the agency does have the expertise to conduct tests at one of its facilities to determine the explosibility and combustibility parameters of samples collected during inspection or submitted by the facility.

OSHA recommends immediate cleaning whenever a dust layer of 1/32-inch thickness accumulates over a surface area of at least five percent of the floor area of the facility or any given room. As a rule of thumb, OSHA also suggests commencing evacuation procedures at the sight of a dust cloud that totally obscures a light source at a distance of six to nine feet, making nearby objects impossible to see. This indicates an explosive level.

**Preparations for response**

Emergency responders should treat combustible dust as a special hazard and formulate distinct precautions. They need to know about potential combustible dust hazards within their service area in advance, which can be achieved through a pre-incident survey. Operational permits required under state and local fire codes can also provide specific facility information.

Pre-incident surveys form the basis of organizing action plans. The catalog of potential hazards of each location should have corresponding safety data sheets for all materials present and, with that, an inventory of systems available on-site to prevent explosions, minimize spread, and limit damages to property and loss of life. In addition, firefighters should ensure that on-site firefighting equipment is compatible with their equipment.

**Dispatch**

When the EFD receives a report of an explosion of any type, she or he should select Fire Priority Dispatch System® (FPDS®) Protocol 57: Explosion, as this Chief Complaint addresses explosions caused by a number of triggers including bombs or unintentional events such as a gas leak with an ignition source.

Following Case Entry, and beginning with Key Question 1 on Protocol 57, the calltaker will ask the caller to identify what has exploded, which essentially determines the appropriate Determinant Code and level of response.

Definitions included in the Additional Information provide EFDs with descriptions to appropriately categorize the caller’s report of what has exploded. The 57-D-1 Determinant Descriptor “HIGH LIFE HAZARD” is a high priority response as it refers to any location that poses multiple life threats due to difficulty exiting or lack of mobility of the inhabitants. These places include churches, hospitals, large apartment complexes, lodging locations (hotels), nursing
homes, schools, and subway (metro) stations.

Determinant Descriptors for 57-D-2 through 57-D-6 are designated as structural explosions that likely involve occupants: HIGH RISE, GOVERNMENT building, COMMERCIAL/INDUSTRIAL building, and single or multiple residential units. Special definitions allow local fire administration to define and authorize what constitutes specific building types, such as HIGH RISE or GOVERNMENT BUILDING, for their area. Local policy is also designated to handle building evacuations as stated in Rule 1.

Determinant Descriptors 57-D-7 and 57-D-8 are for large or small NON-DWELLING building/structures (e.g., barn or detached garage).

Once the EFD has identified the appropriate Determinant Descriptor to match the structure, she or he should ask Key Question 2 to identify whether anything is burning as a result of the explosion and, if so, add the appropriate suffix “F=Fire” to the Determinant Code. At this point, the EFD has enough incident information to initiate the response for all dispatch codes.

Key Question interrogation

After sending the appropriate Determinant Code and suffix, if applicable, the EFD asks Key Question 3 (a and b) to collect information on any trapped individuals and, if necessary, notify medical responders. If the caller is trapped or in danger, the EFD will discontinue the interrogation and first provide Post-Dispatch Life Support (DLS) Instructions on either Panel B-2 “Caller Danger – Not Trapped” or Panel B-5 “Trapped in Confined Space/Structure Collapse (1st party),” depending on the caller’s situation.

While providing these DLS Instructions to the caller is very important, it is also critical that the EFD provides responders with any known information about potential hazards and the location and number of people trapped/in danger to enable earlier location and assistance of victims.

If the caller is not trapped or in any immediate danger, the EFD should continue the caller interrogation. Key Questions 4–6 help determine the extent of damage and the possible source of the explosion. For example, if a caller reports having heard a bursting or hissing sound and can smell an unusual odor (KQs 5 and 6), these elements could indicate the bursting of a high-pressure gas line accompanied by the hiss and smell of escaping gas. In any case, these questions help narrow down the origin of the explosion and may help responders take appropriate precautions as they arrive on scene.

After inquiring about details surrounding the explosion, Key Question 7 “Is anyone injured” and Key Question 7a “How many?” also direct the EFD to arrange a medical response and adjust the Determinant Code with the appropriate suffix to address the needs of injured individuals.

The final priority of the interrogation is to determine whether the caller saw anyone or anything suspicious. If so, the EFD should notify law enforcement to investigate. As indicated by Rule 2, all explosions are considered crime scenes and should be preserved by advising callers not to touch or disturb anything. Though incidents of exploding dust are often both unintentional and unexpected, the EFD should never completely rule out other possibilities.

Conclusion

The information gained through the Key Question interrogation on Protocol 57 allows responders to arrange an appropriate response while taking critical safety precautions as they arrive on the scene. The provision of PDS/DLS Instructions to callers who are trapped or in danger also decreases the risk of injury and death for facility workers. Everyone benefits when the EFD gathers the critical information necessary to better handle incidents involving combustible dusts.

**Sources**

You must be fire certified to take this quiz.

CDE-Quiz Fire

Answers to the CDE quiz are found in the article “Where There’s Dust,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. Swarf is:
   a. another name for a combustible dust cloud formed in a confectionery facility.
   b. collective term for fine chips or filings of stone, metal, or other material produced by a machining operation.
   c. incident involving a gas, liquid, or solid that, in any quantity, poses a threat to life, health, or property.
   d. OSHA safety warning.

2. OSHA attributes responder deaths and injuries associated with combustible dust explosions to the following factor(s):
   a. wind and outdoor temperatures at the time of the incident.
   b. lack of tobacco product smoking regulations.
   c. inadequacy of facility-specific information and firefighter training.
   d. location and type of structure involved.

3. Candy, sugar, spice, starch, flour, and feed are examples of materials that cannot cause a dust explosion.
   a. true
   b. false

4. OSHA recommends evacuating an area if the dust cloud:
   a. totally obscures a light source at a distance of 20 to 25 feet.
   b. spins similar to a dust devil.
   c. totally obscures a light source at a distance of six to nine feet.
   d. picks up speed at an astonishing rate.

5. Which FPDS Protocol should be used when an explosion is triggered as a result of a bomb or because of an unintentional event such as a gas leak with an ignition source?
   a. Protocol 54: Confined Space/Structure Collapse
   b. Protocol 57: Explosion
   c. Protocol 60: Gas Leak/Gas Odor (Natural and LP Gases)
   d. Protocol 69: Structure Fire

6. A High Life Hazard indicates:
   a. structural explosion of a mailbox indicating the possibility of a terrorist plot threatening the area.
   b. potential within a facility that persistent unsafe conditions could cause a dust explosion.
   c. high-priority response as it refers to any location that poses multiple life threats due to difficulty exiting or lack of mobility of the inhabitants.
   d. building level in which the explosion occurs.

7. On Protocol 57, the suffix F denotes:
   a. Fire.
   b. Fuel Spill.
   c. Refinery explosion.
   d. First aid required.

8. After completing Key Question 3 (a and b), if the caller is trapped or in danger, the EFD should discontinue the interrogation and first provide Post-Dispatch Instructions and then Dispatch Life Support Instructions.
   a. true
   b. false

9. Key Questions 4–6 help determine:
   a. the extent of damage and the possible source of the explosion.
   b. the number of people killed and/or injured.
   c. whether the explosion occurred in a vehicle or residential structure.
   d. if the caller saw anyone or anything suspicious.

10. Key Questions 5 and 6 involve:
    a. distinguishing between residential or commercial structures.
    b. suspicion of foul play and what type.
    c. hearing a hissing sound or smelling an unusual odor indicating a gas explosion.
    d. alerting fire and medical response.

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, 8th Floor
Salt Lake City, UT 84111 USA
Attn: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

Please retain your CDE acknowledgement for future reference.

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Organization ____________________________
Address ________________________________
City __________________ St./Prov. ____________
Country ________________ ZIP _____________
Academy Cert. # __________________________
Daytime Phone ( ) ______________________
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Primary Function
☐ Public Safety Dispatcher (check all that apply)
   ☐ Paramedic/EMT/Firefighter
   ☐ Comm. Center Supervisor/Manager
   ☐ Training/QI Coordinator
   ☐ Instructor
   ☐ Comm. Center Director/Chief
   ☐ Medical Director
   ☐ Commercial Vendor/Consultant
   ☐ Other

Answer Sheet Fire

July/August 2014 Journal “Where There’s Dust”

Please mark your answers in the appropriate box below.

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

To be considered for CDE credit, this answer sheet must be received no later than 08/31/15. 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.
Protocol 3: Animal Bites/Attacks
When canines bite

In February, in High Point, N.C., 3-year-old Braelynn Coulter was mauled by the family's pet pit bull and died from her injuries despite being rushed to a local hospital by her parents, who dialed 9-1-1 en route.

Neighbors said the family's two pit bull terriers had previously displayed aggressive behavior months earlier after the family moved into the neighborhood, breaking through a fence and attacking another resident's dog.

“The neighbor was taking her dog for a walk,” said Katherine Dixon, a nearby resident. “Another neighbor came out to help. That’s what put us on high alert about the dogs. When I’m taking the boys out to play, if the dogs are outside, we come back in.”

During the 9-1-1 call, a man tells the dispatcher that a dog had bitten the child.

“We’re trying to keep her breathing, and she’s dying,” the caller told the dispatcher. “I’m going to kill the dog. Or it’s getting shot. Put down.”

The dog was later euthanized.

An estimated 4.5 million dog bites occur in the U.S. each year, according to the Centers for Disease Control and Prevention (CDC). In addition, almost one in five victims who are bitten by a dog require medical attention for dog bite–related injuries, which total about 885,000 each year; of these victims, half are children.

Dog bites and children

The American Humane Association states that 50 percent of dog attacks involve children under 12 years old. In fact, rates of dog bites for children between the ages of 5 and 9 years old are dramatically higher than any other group of people. Researchers have found that the link between children and dog bites/attacks can be attributed to a few common factors including dogs’ territorial behavior, anxiety, protection of young pups, or coping with sickness or pain. In some incidents, the dog may be provoked by threatening to take away food or toys, invading its territory, sudden noise such as fireworks or thunderstorms, distress over separation or being isolated/chained up, or loud, energetic behaviors from children playing. At other times, an attack may be entirely unprovoked and unpredictable.

In any case, these statistical trends are concerning as children who are bitten are more likely to receive medical attention. Of course, injuries vary greatly depending on the size of the dog and the victim, the body area that was injured, and the immediacy of seeking medical attention, if necessary. Of the dog bites treated in the ER, 82 percent involve children under 15 years old, and 70 percent of dog-bite fatalities occur among children under 10 years old. These statistics may be in part due to children’s height/size and a dog’s accessibility to more vital areas of the body. Though 71 percent of all dog bites—including adult victims—occur to the extremities (arms, legs, hands, feet), about 65 percent of dog bites among children occur to the head and neck, typically resulting in more critical injuries.

Although most people who are treated in the ER are sent home a short time later, a small percentage—the majority of which are children—require inpatient hospital stays and reconstructive surgery.

Bites and breeds

Though any breed of dog can bite, approximately 92 percent of fatal dog attacks involve male dogs, 94 percent of which are not neutered. About 25 percent of fatal dog attacks involve chained dogs.

Though the pit bull terrier breed tends to dominate the bulk of dog attack headlines, particularly in recent years, it accounts for only a portion of breeds identified as more prone to bite. At least 25 different breeds of dogs have been involved in the 238 dog bite–related fatalities in the U.S., according to one study over a period of 20 years (1978–1998). More recently, in an attempt to identify the breeds most responsible for serious injury and death, Merritt Clifton, editor of Animal People, compiled U.S. and Canadian press accounts of dog attacks from 1982 through 2013. The findings indicated that the majority of incidents could be attributed to molosser breeds (solidly built, large dog breeds descended from the same common ancestor) such as pit bulls, curs, Rottweilers, Perro de Presa Canarios, Cane Corsos, Mastiffs, Dogo Argentinos, Fila Brasileiros, Shar-Peis, Boxers, and mixes of these breeds.

The study asserts that molosser breeds only embody roughly 9.2 percent of the total dog population, yet inflict 81 percent of attacks that induce bodily harm, 76 percent of attacks on children, 87 percent of attacks on adults, and 72 percent of fatal attacks.

In response to similar studies and statistics, breed-specific legislative bans in the U.S. have become popular over the past three decades; however, they are also becoming increasingly controversial. Dog advocacy groups have worked to reduce breed-specific restrictions on breeds like pit bulls and Rottweilers, arguing that these dogs are not inherently aggressive or dangerous unless they are made to be that way by irresponsible owners.

Prevention

Though it may not be possible (or desirable) to avoid all encounters with unfamiliar canines, the CDC suggests several measures that you can take before bringing a dog into the household, along with a few steps to best protect yourself if you should come “face-to-snout” with an aggressive dog:

- Work with a local animal shelter, rescue organization, or reputable breeder. They can often help you find breeds and dogs within those breeds that will be a good fit for your household.
- Choose a veterinarian who can help you identify a reputable trainer for your new family member.
- Be sensitive to cues that a child is fearful or apprehensive about a dog. If a child seems frightened by dogs, wait before bringing a dog into your household. Dogs with histories of aggression are not suitable for households with children.

Once you decide to bring a dog into your home:

- Spay/neuter your dog (this often reduces aggressive tendencies).
- Never leave infants or young children alone with a dog.
- Don’t play aggressive games with your dog (e.g., wrestling).
- Properly socialize and train any dog entering your household. Teach the dog submissive behaviors (e.g., rolling over to expose the abdomen and giving up food without growling).
- Immediately seek professional advice (e.g., from veterinarians, animal behaviorists, or responsible trainers) if the dog develops aggressive or undesirable behaviors.

Teach children basic safety tips and review them regularly:

- Do not approach an unfamiliar dog.
- Do not run from a dog or scream.
- Remain motionless (e.g., “be still like a tree”) when approached by an unfamiliar dog.
- If knocked over by a dog, roll into a ball and be still.
- Do not play with a dog unless supervised by an adult.
- Immediately report stray dogs or dogs displaying unusual behavior to an adult.
- Avoid direct eye contact with a dog.
- Do not disturb a dog that is sleeping, eating, or caring for puppies.
- Do not pet a dog without allowing it to see and sniff you first.
- If bitten, immediately report the bite to an adult.

Protocol

Medical Priority Dispatch System™ (MPDS™) Protocol 3: Animal Bites/Attacks addresses a variety of animal-related injuries from large animals (such as crocodiles,
sharks, and horses) to EXOTIC animals (any animal that may be poisonous, dangerous, or whose risk is unknown).

In order to narrow down the type of incident, the first Key Question is “What kind of animal is it?” Often, this is already apparent from the caller’s description on Case Entry. However, this question elicits a more specific response and serves as a safety net to shunt to Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites) if the caller identifies the source of the bite as an insect, spider, or snake, as emphasized in Rule 1. Otherwise the EMD continues Key Question interrogation, collecting scene safety information—such as where the animal is now—and determining the patient’s condition—SERIOUS bleeding, alertness, body area injured, kind of injuries, how recently the incident occurred, etc.

In conjunction with the large variety of animal incidents this Chief Complaint Protocol addresses (lions, tigers, and bears), Protocol 3 covers a spectrum of injury levels from a SUPERFICIAL bite (minor, usually shallow [non-penetrating] wounds without priority symptoms) to an ATTACK (mauling or savaging that produces serious, multiple wounds or injuries).

The area of the wound is also of large consideration because a serious bite to the armpit or groin would be deemed a DANGEROUS body area, whereas an injury to the abdomen would be POSSIBLY DANGEROUS, and a superficial bite to the ankle or foot would be considered NOT DANGEROUS. A more complete list of these body area categories appears in the Additional Information section of Protocol 3.

In relation to dog bites/attacks directly, Axiom 1 explains “Most mammal bites are not pre-hospital emergencies. However . . . some dogs (pit bulls, rottweilers) are capable of inflicting serious injuries. In these rare cases, a maximal response is indicated.”

In an effort to prioritize the response, patients who are reported during Case Entry to be unconscious or suffering an arrest require an immediate maximal 3-D-1 response before the EMD even begins Key Question interrogation.

After initiating the appropriate response for an unconscious or arrest patient, the EMD should ask Key Questions 1–3 to get a basic description of the incident, then leave the interrogation to provide Post-Dispatch Instructions (PDIs) and go to the appropriate DLS Link to provide further instructions (Danger, Arrest, Control Bleeding, etc.) before responders arrive.

When a patient in arrest also has SERIOUS bleeding—uncontrolled bleeding (spurring or pouring) from any area—Axiom 2 provides a background on which instructions take priority in best meeting the needs of the patient: “On certain Protocols (3, 4, 7, 17, 27, etc.), an arrest may have been caused by extremely SERIOUS hemorrhage. In these cases, controlling the bleeding before initiating CPR may increase patient survival.”

Of course, before callers and potential rescuers can administer any type of aid to the patient, they must first ensure that the animal is no longer a threat. For this reason, PDIs b and c instruct the caller to “Avoid further contact with the animal,” and “If it’s safe to do so, lock up or isolate the animal.” If the animal continues to be a danger, instructions on Panel X-9 of the Case Exit Protocol provide guidance on what else to do: “Keep very quiet and stay out of sight. Tell me immediately if the animal leaves the scene.”

As an additional service, the EMD should consider his or her resources and notify Animal Control, as mentioned in the CEI section. This step ensures the safety of others who may encounter the aggressive animal.

Sources
5 See note 2
6 See note 3
7 See note 3
9 See note 3
10 See note 3
12 See note 11
14 See note 2
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ.

CDE-Quiz + Medical

Answers to the CDE quiz are found in the article “Protocol 3: Animal Bites/Attacks,” which starts on page 38. Take this quiz for 1.0 CDE unit.

1. How many dog bites occur in the U.S. each year according to the Centers for Disease Control and Prevention?
   a. 45,000
   b. 550,000
   c. 4.5 million
   d. 5.5 million

2. Rates of dog bites for children between the ages of ________ are dramatically higher than any other group of people.
   a. 2 and 7 years old
   b. 3 and 9 years old
   c. 4 and 10 years old
   d. 5 and 9 years old

3. Approximately 92 percent of fatal dog attacks involve male dogs, 94 percent of which are not neutered.
   a. true
   b. false

4. At least 25 different breeds of dogs have been involved in the 238 dog bite–related fatalities in the U.S., according to one study over a period of 20 years (1978–1998).
   a. true
   b. false

5. Molosser breeds only embody roughly ________ percent of the total dog population, yet inflict 81 percent of attacks that induce bodily harm, 76 percent of attacks on children, 87 percent of attacks on adults, and 72 percent of fatal attacks.
   a. 3.4
   b. 5.6
   c. 9.2
   d. 14.3

6. If your dog develops aggressive or undesirable behaviors, you should play aggressive games (wrestle, etc.) with it.
   a. true
   b. false

7. Which of the following is a basic safety tip to teach children about how to respond to an unfamiliar dog?
   a. Approach the dog and pet it to show you are not a threat.
   b. Try to run and throw things back at it until you are far away.
   c. Scream and yell to show that you are bigger.
   d. Remain motionless (e.g., “Be still like a tree”).

8. Medical Priority Dispatch System (MPDS) Protocol 3: Animal Bites/Attacks addresses a variety of animal-related injuries from large animals to EXOTIC animals.
   a. true
   b. false

9. A superficial bite to the ankle or foot would be considered:
   a. DANGEROUS.
   b. POSSIBLY DANGEROUS.
   c. NOT DANGEROUS.
   d. none of the above

10. On certain Protocols (3, 4, 7, 17, 27, etc.), an arrest may have been caused by extremely SERIOUS hemorrhage. In these cases, controlling the bleeding before initiating CPR may increase patient survival.
    a. true
    b. false

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.)

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110 South Regent Street, 8th Floor
Salt Lake City, UT 84111 USA
Attn: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

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☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other

ANSWER SHEET + MEDICAL

July/August 2014 Journal “Protocol 3: Animal Bites/Attacks”
Please mark your answers in the appropriate box below.

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

To be considered for CDE credit, this answer sheet must be received no later than 08/31/15. 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.
Charleston County Consolidated 9-1-1 Center (S.C.) calltaker Jon Lewis was acquainted with ways to use the “tapping” method on an open line 9-1-1 call, but it wasn’t until such a call came in that he was put to the test.

Much to Lewis’ surprise, at 8:06 a.m. on Monday, Feb. 10, he received a 9-1-1 call from a wireless phone, and the caller was unable to speak. Lewis relied on his training and quickly began helping the caller by asking a series of questions relying solely on the caller to respond by tapping on the phone.

Thinking outside the box, Lewis asked questions such as “Are you in a building?” and instructed the caller to “Tap when you hear the first letter of the business you are near,” allowing the caller to provide more detailed information to narrow down his location.

With the help of the Phase II wireless GPS location as well as asking pointed yes or no questions, dispatchers were able to guide emergency responders to the location of the patient where he was found in a tree-lined ditch near a Wells Fargo Bank.

Upon their arrival, EMS found the patient with no obvious injuries; however, he had an altered mental status. The patient, who was not critical, was non-verbal for the EMS crew, and his chief complaint was undetermined until they arrived at the hospital.

Lewis credits his recent experience in tapping to locate the patient with the ongoing in-service training he receives (the method is taught during a Charleston County telecommunicator’s initial training session and then periodically reviewed during quarterly in-service training), the accuracy of the GPS, and the assistance of the dispatcher transmitting questions to him to aid in the process of the call. He and calltaker Deserie Porcher had even discussed the strategy just days before the incident occurred.

Charleston County Consolidated 9-1-1 Center is the hub for all public safety communications in Charleston County. The center is accredited through the International Academies of Emergency Dispatch for medical and fire and dispatches for 12 fire departments, 2 rescue squads, Charleston County EMS, and 6 law enforcement agencies. With a multijurisdictional area of over 900 square miles of land and 440 square miles of water, the average yearly call volume is 1.3 million and average yearly incident volume is 620,000.
Thanks to the quick thinking of a 2-year-old English boy whose mother had taught him the importance of knowing the U.K.’s three-digit emergency number, 9-9-9, his timely call to emergency dispatch likely saved her life.

Riley Ward’s mother, Dana Henry, 27, collapsed while making a cup of tea on the morning of Feb. 5 at the family’s home after experiencing abdominal pains.

Riley dialed 9-9-9, repeatedly said, “Hello,” into the mouthpiece, and said, “Mummy’s on the floor.”

East Midlands Ambulance Service (EMAS) calltaker Bonny Scanlon believed the call needed to be taken seriously and immediately sent first responders to the house in Barrow-upon-Soar in Leicestershire. The agency was able to obtain Riley’s location from the landline phone he used to call 9-9-9.

Paul Staples, the first EMAS paramedic to arrive on the scene, found Henry in a tremendous deal of pain and unable to speak. She was quickly transported to a nearby hospital where doctors discovered she had a large blood clot and dangerous bleeding of her ovary. Henry underwent surgery and made a full recovery, but added that if had she not passed out, she would have taken some pain medication and not called emergency dispatch.

“When the surgeon came to see me the next day, she said she had never seen anything like it before,” Henry said. “I asked her what would have happened if I hadn’t of come to the hospital, and she said I would have been very poorly. It really scared me, because if I didn’t pass out and Riley hadn’t rung the ambulance, I might not be here today.”

Staples said Riley was excited that he and a police officer had arrived on-scene and told them, “Mummy’s poorly.”

“I was concerned that Riley may be upset seeing his mum in so much pain, so I said to him, ‘Why don’t you show the policeman your toys?’,” Staples said. “He did so without question and with a great deal of enthusiasm.”

On March 31, Riley, believed to be the youngest caller to EMAS for an actual emergency, was awarded a paramedic teddy bear and a certificate for his bravery.

“Rob (Riley’s father) was just as surprised as I was when we realized Riley had called 9-9-9,” Henry said. “We had it drilled into both of our children since they were old enough to understand numbers. They know that if mummy and daddy are poorly and they can’t wake us up, they should dial 9-9-9.”

The incredible actions of the youngster, who had just recently learned to talk, received media attention across the U.K., throughout Europe, and as far away as Australia, including in the form of a congratulatory personal letter from British Prime Minister David Cameron.

“It made me really proud that Riley knew what to do,” Henry said. “We knew he remembered 9-9-9, but were so shocked that he was able to put it into action. He is mummy’s little hero.”

A father of five young children himself, Staples said kids never cease to amaze him.

“But Riley’s actions were particularly remarkable, and he demonstrated amazing sense of purpose in knowing exactly what to do,” Staples said. “I feel very privileged to have been able to help (Henry’s) recovery, but Riley played the biggest role in saving his mum’s life. He’s a star.”

The experience of Riley’s family underscores the importance of parents educating their children—at even the youngest of ages—to dial the appropriate emergency number when something is wrong.
Jamie Rockey didn’t experience a case of the jitters her first day on the floor at the Grand Junction (Colo.) Regional Communication Center (GJRCC).

And it’s a lucky thing she didn’t.

In an unlikely roll of the dice, Rockey answered two calls during the same shift requiring her to give CPR instructions. After both calls, doctors confirmed that both patients were breathing upon arrival to the hospital. Soon after the events, the center was advised of one patient’s survival—transferred to recovery—although no word had been received regarding the second patient.

Operations Manager Monica Million, who started with the agency 13 years ago, said Rockey definitely beat the odds.

“It was really an unusual set of circumstances to have two calls on the same day requiring CPR and both answered by the same calltaker on her first day,” she said. “It just doesn’t happen, at least in my experience it hasn’t.”

The first of the two calls on April 8, occurring a few hours into Rockey’s shift, was a caller reporting that a girl in the home was unconscious. Rockey, under the watchful ears and eyes of her training officer, collected the information needed to dispatch response and then navigated her way to the CPR instructions provided in ProQA.

Not only did Rockey repeat the instructions exactly as scripted, but she also conveyed the calming and encouraging voice needed to relax the initially anxious caller.

“It was a little difficult to understand the caller at first,” Rockey said. “But by the end of the call, she was calm. I assured her help was on the way.”

The second call came in a few hours later. This time the caller reported that she couldn’t wake her husband. Rockey walked the caller through the same steps and, this time, was impressed by the caller’s presence of mind, although it could have been a combination of that and Rockey’s confidence.

“She was great,” Rockey said. “She was calm and followed everything that I told her.”

During both calls, Rockey gave instructions to position the patient and check for breathing. She asked the individual administering CPR to count out loud so that she could count along with him/her. She asked the callers to evaluate their patients’ breathing patterns.

“Jamie did a remarkable job for having to do this on her first day,” Million said. “She really had it together.”

Providing the CPR instructions over the phone was the first and second time Rockey had actually applied the resuscitation technique to save a life. She learned CPR the manual way—practicing on a mannequin—while in training and is certified in CPR, and she figured that she’d be going through the steps someday on the job.

But twice on the first day was a bit of a surprise, she said.

“I didn’t know what type of calls to expect, and these were a big deal,” she said.

“But I felt confident. Protocol took me through the steps.”

Cardiac emergencies are far from an everyday event, and in 2013 GJRCC assisted in a total of nine cardiac emergencies.

“When some of us don’t have one cardiac save in a career, her chances of two in one day on her first day are phenomenal,” said Million, who during her 13 years has provided CPR instructions to callers but never two in a day that resulted in saving one life, and potentially another.

Rockey is at GJRCC for good reason: This is what she wants to do. She was interested in a career that was linked to public service and law enforcement—the communication center is located in the Grand Junction police station—and when the job opened, she wasted no time in applying.

First came four weeks of intensive training—learning the center’s procedures and policies, practicing simulated 9-1-1 calls, and earning an emergency medical dispatch certification. The training officer tapers off the monitoring when satisfied the trainee is ready to go solo. Most new hires move to dispatch following experience with calltaking.

The career route she chose seems to be going in the right direction.

“It’s a good fit,” Rockey said.

According to the American Heart Association:

• Nearly 383,000 out-of-hospital sudden cardiac arrests occur annually, and 88 percent of cardiac arrests occur at home.
• Effective bystander CPR provided immediately after sudden cardiac arrest can double or triple a victim’s chance of survival, but only 32 percent of cardiac arrest victims get CPR from a bystander.
• Less than 8 percent of people who suffer cardiac arrest outside the hospital survive.

GJRCC is responsible for answering 9-1-1 and non-emergency calls. GJRCC has a staff of 47 telecommunicators and supervisors who dispatch for nine law enforcement agencies and 12 fire/EMS agencies in Mesa County. In 2011, the Colorado chapter of the Association of Public-Safety Communications Officials (APCO) named GJRCC the Communication Center of the Year for the state of Colorado.
Initiation by Police
EPD helps saves her dad on first day of work

During training, most dispatchers are given a heads-up on how to handle a 9-1-1 call from a family member or close friend. But most don’t imagine in their wildest dreams that they’ll have to fall back on that instruction on their first day of work, as was the recent experience of a DeKalb County (Ga.) Police E-911 communications officer.

Crystal Morrow had literally finished the dispatcher section of her training (she’d been a calltaker with the agency for 11 months) the previous day, when on Aug. 6, 2013, about four hours into her first official live shift sans her trainer, she took a call that stopped her cold. On the line was her aunt whose identity and address was verified with a glance at her CAD screen. Worse still, her aunt told Morrow that her father was incoherent likely due to his diabetes.

“I recognized her voice and my heart kind of skipped a beat,” Morrow said. “My hands froze on the keyboard but I knew that I had to get the call in. I went through the ProQA® like any other call.”

After the call, Morrow notified her watch supervisor of the family emergency, and she was excused to contact her family and check on the status of her father, who had been transported by first responders to a local hospital.

Danielle Harvey, Morrow’s trainer and a seven-year veteran with the center, heard about her trainee’s jolting call, and came over and talked to Morrow who indicated her father would be OK.

“I said ‘Just leave and go and check on your family,’” Harvey said.

During the 9-1-1 call, Morrow’s aunt didn’t know that it was her niece on the other end of the receiver and only learned that fact afterward when Morrow called her back to check on her father. Morrow’s father, 56, was doing well later that day.

If it hadn’t been for Harvey’s thorough two months of dispatcher training, Morrow said things might have ended up differently.

“The first day of training she asked me if I lived in DeKalb County or had family there,” Morrow said. “She pretty much prepared me for that on day one.”

Marshall Mooneyham, the center’s director, said trainees are warned at the academy, and later during job training, are taught how to handle a family call.

“We all know it can happen,” Mooneyham said. “You have to fall back on your training and protocols. Danielle had been through an incident with a family member calling in and was able to convey that experience to Crystal.”

Mooneyham commended both women, Harvey for her instruction that prepared Morrow for the situation, and Morrow for her professional and calm demeanor during the call.

“A new employee, Crystal has shown dedication and is obviously good under pressure,” Mooneyham said. “She’s a very hard worker. She was outstanding on this call and followed all the protocols.”

As for Harvey, Mooneyham said the thorough and competent way in which she trained Morrow is but one of many examples of Harvey’s excellence in the comm. center. In fact, the DeKalb Police E-911 Center nominated Harvey for the 3rd annual Smart Telecommunicator Awards in part for her exemplary service and training record at the comm. center. Harvey was recently named a finalist for the national awards’ southeast region.

“Danielle is hardworking and selfless,” Mooneyham said. “She spends much of her off time assisting the homeless and needy outside of the job. She represents us in a positive way both on- and off-duty.”

As for Morrow, the experience has confirmed to her that her chosen profession is a good fit for her skills and abilities.

“I definitely know that I can handle this job,” Morrow said. “It gave me a lot of confidence in taking calls.”

DeKalb County Police’s E-911 Center uses Priority Dispatch Corp.’s® Medical Priority Dispatch System™ and is also a medical Accredited Center of Excellence. In 2013, the center received 1.2 million 9-1-1 calls.
As if answering 9-1-1 calls, asking questions, giving Pre-Arrival Instructions, and dispatching response don’t cause enough stress for dispatchers at the Walton County Emergency Operations Center (EOC) in DeFuniak Springs, Fla., add to that a bit of the supernatural during midnight shifts.

“Many midnight dispatchers reported hearing strange noises in the halls and in the bathroom,” writes former Walton County EOC dispatcher Stephanie Manning on a blog she posted October 2007. “They’d sometimes go into the bathroom to turn off a running faucet only to have it stop the second they came through the door.”

Some dispatchers reported being locked in the bathroom stall and unable to get out because it felt like something heavy was leaned against the door, preventing their escape. Others heard toilets flushing inside empty stalls.

The flushing, locking, and untimely water shutoffs were only a sampling of mischief the EOC dispatchers encountered. There were loud thumps and the click-clack of shoes on the hallway’s cement floors. No one came forward to admit a hoax. No one was found in the act. Something otherworldly was affecting the EOC. The only rational explanation: Walton County EOC was haunted.

Admittedly, the word rational doesn’t apply to most hauntings. Rational people would prefer finding a logical explanation, such as wind whistling through an open window, a hissing furnace, or bad plumbing. It was none of those things, Manning insists.

“While there is no definite way to prove whether or not the EOC was truly haunted, ask any dispatcher there at the time, and she’ll say without a doubt that it was,” she writes.

Dispatchers are, for most part, practical and no-nonsense personalities. They don’t let their imaginations get the best of them. They’re not known for a tendency to invent paranormal phenomena.

Most would probably follow Manning’s course. They would abide.

Walton dispatchers named their ghost “Sally Mae.” She wasn’t a malevolent or bad-tempered spirit. She was playful or, at least, a ghost that enjoyed attracting the attention of the dispatchers sharing her space. They never introduced Sally Mae to the new hires, figuring Sally Mae would see to it herself.

It might seem strange anyway, if they did. You start a new job and someone says, “Hey, I’d like for you to meet Sally Mae. She’s a ghost,” and the person would certainly think twice about coming back.

According to one story Manning tells, it only took two days for a new hire to call it quits. She made it through the first shift, but by her second midnight shift she thought her eyesight had gone fuzzy gray or there was really someone lurking in the shadows by the door trying to distract her. The dispatcher sitting in the next console ignored the new hire’s comments. After all, it was only Sally Mae.

“A few minutes later, she stood up and
screamed," Manning writes. “She got her belongings and after getting home, notified the supervisor that she had quit.”

The woman never offered an explanation. It was confusing. Sally Mae had never before caused such a strong reaction in anyone. Maybe Sally Mae wasn’t alone. Did she have backup? Maybe someone else was part of her story.

One dispatcher finally decided to do the homework. Her extensive research of county records turned up a tragic possibility. Sally Mae could be the aberration of a teenage girl heinously murdered in the late 1920s on the very spot where the EOC stands.

“Records show that she was in her yard when a group of males approached her,” Manning writes in the blog. “She was beaten, raped, and chained to an oak tree that was set on fire.”

Sally Mae died and the house burned to the ground.

Police found no evidence and never caught the suspects. Apparently, Sally Mae’s unsettled spirit stayed behind.

Although it’s likely Sally Mae’s haunting is connected to the particular plot of land and not the actual 9-1-1 facility, she may have abandoned her activities when Walton County relocated the communication center to a more modern setting. The former 9-1-1 center, built in 1978, was since renovated to house Walton’s Emergency Operations Management Center (EOMC).

The communication center-turned-EOMC is a model of Cold War charm: cold and foreboding.

“Cold” in the context of the increasingly chilly relations between the Soviet Union and its satellites and Western bloc countries during the period 1947–1991, although both blocs were copiously prepared to protect their countries’ security in case of an all-out nuclear World War III.

“Foreboding” because of the center’s Cold War architecture featuring reinforced concrete, equipment mounted on concrete pads to absorb shockwaves from a nuclear blast, blast doors, chain-link fences, stark landscape, and chemical, biological, and nuclear air filtration systems. Warning signs posted intermittently at perimeters prohibited unauthorized entry, under punishment of law.

These massive Cold War infrastructures were built in several states to support the development, testing, manufacturing, and storing of America’s offensive and defensive weapon systems. Military installations designated as staging and training centers complemented a network of defensive radar and communications stations and a host of command and control centers.

Some of these facilities are still serving their original purposes, some have new roles, some are disused and neglected, some have been demolished, and a few existed only as proposals.

The Cold War design of the Walton County EOMC is now the perfect fit for emergency operations, according to former EOMC Director Ed Baltzley during an interview available on the Haunted Places website (Baltzley never mentions the ghost, but describes the building’s construction and non-paranormal history).

There are no windows. Massive amounts of rebar were used to reinforce the concrete walls. A huge generator can provide emergency power during outages and when the facility is locked down. A high chain-link fence frames the grounds.

The Cold War-designed EOC still serves a purpose, particularly in areas such as the western Florida Panhandle frequented by hurricanes. During the past 138 years (1875 to 2013), records show that Fort Walton Beach has been within or near the core of a hurricane 54 times.

Maybe, someday, it will be the spirit of Sally Mae riding the eye to the next level, finally finding comfort.

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