Small World
Attendees celebrate 35 years of the protocol
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THE COMMUNICATIONS CENTER MANAGER COURSE
ONLINE SESSION BEGINS: September 22, 2014
ONSITE: October 19-24 | December 7-12, 2014

“I want challenges that make me uncomfortable, pushes me out of my comfort zone,” she said. “That’s how I can reach the next levels of my profession.”

—Laura Lee Cody, communications supervisor
Richmond Ambulance Authority, Va., USA

Presented by:
Fitch & Associates on behalf of IAED

NENA has approved this course as credit toward recertification for the Emergency Number Professional designation.

Online registration for the 2014 course is now open. Go to www.emergencydispatch.org/certccmcourse or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.
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BRETT PATTERSON
Brett is an Academics & Standards associate and Medical Council of Standards chair for the IAED. His role involves training, curriculum, protocol standards and evolution, quality improvement, and research. He is a member of the IAED College of Fellows and Rules Committee. Brett became a paramedic in 1981 and began his EMS communication career in 1987. Prior to accepting a position with the IAED, he spent 10 years working in Pinellas County, Fla.

SHAWN MESSINGER
Shawn is a police consultant and Emergency Police Dispatch instructor for Priority Dispatch Corp. He is a former chief deputy from the state of Washington where he was the director of a combined 9-1-1 communication center responsible for services to 32 law, fire, and EMS agencies. During this time he oversaw the deployment of a new CAD and countywide EMS system, a VoIP 9-1-1 phone system, and the deployments of ProQA® in EMS and EPD. Shawn was also commander of a multi-jurisdictional SWAT team.

ART BRAUNSCHWEIGER
Art is a regional software instructor and EMD-Q® instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 17 years and currently works at one of New Jersey’s largest regional EMS dispatch centers. Prior to that he was a fire, EMS, and air medical dispatcher at CenCom, one of the state’s largest regional EMS dispatch centers. He has been involved in dispatch training and 9-1-1 medical quality assurance since 1999.

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

TRACEY BARRON

Jim, a certified EMDR therapist (M.A. Clinical Psychology), specializes in 9-1-1 mental health and treatment of traumatic stress. Jim is director of the 911 Training Institute and co-founder of the 911 Wellness Foundation. Since 2005, he has trained more than 2,500 telecommunicators in management of PSAP stress and call-related trauma. Jim is co-chair of the NENA Working Group on Acute, Traumatic, and Chronic Stress.

Veronica began her career as a volunteer EMT on Long Island, N.Y., in 1993 and was hired on full time one year later at North Shore-Long Island Jewish Health System’s Center for Emergency Medical Services (CEMS). Veronica has worked as a field medic in their interfacility, New York City 911, and first responder divisions. In 2010, she left the field for a permanent role at North Shore’s Command and Control center. She has earned several letters of commendation and awards for exemplary EMD performance.

COLLEEN CONRAD
Colleen is deputy director over Operations for SLC911. Colleen is responsible for the day-to-day operations of the bureau, as well as many other duties. She assisted in the consolidation of fire and police dispatch offices and the move to the city’s new Public Safety Building. She was the project manager for the implementation of PPDS®. She has worked for Salt Lake City since 1982.

Jim is director of the 911 Training Institute and co-founder of the 911 Wellness Foundation. Since 2005, he has trained more than 2,500 telecommunicators in management of PSAP stress and call-related trauma. Jim is co-chair of the NENA Working Group on Acute, Traumatic, and Chronic Stress.

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JIM MARSHALL
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I have joined the list since then. The "pioneers" of dispatch were present—Dr. Jeff Clawson, of course, has never missed the event—and the halls were mobbed with EMDs, EPDs, and EFDs rushing to sessions and special events. Many of the people at the NAVIGATOR 2007 have returned seven times since; things just keep getting bigger and better.

Let’s look at some numbers for NAVIGATOR 2007: The conference featured 43 instructors. The awards ceremony recognized 10 new Accredited Centers of Excellence (ACE) and 24 reaccreditations. Attendance was at an all-time high at 1,200 people representing 45 states and 10 countries outside the US. Now let’s take a look at NAVIGATOR 2014: The conference featured 130 speakers. The number of new ACEs was the same (10) but reaccreditations had grown by a third (36); however, the bigger news is the 80 new ACEs that have joined the list since then.

Attendance keeps climbing (1,600); we’re up by three additional states, and despite the inter-national NAVIGATORS, the U.S. conference—where it all started—continues to attract visitors from 10 countries outside the U.S.

NAVIGATOR Conference Coordinator Claire Ulibarri attributes the increases to an awareness factor.

True, people took special note of this year’s destination—Orlando, Fla.—particularly those from the “worst-winter-in-a-decade” states. However, there’s also a lot of attention to the dispatch community that NAVIGATOR creates.

The “we’re-in-this-together-attitude” shines in the show of respect that 9-1-1 professionals have for each other. In 2007, hundreds signed the six-3-foot by 4-foot banners that 911Cares put on tables in the exhibit hall to honor centers responding to the mass shooting at Virginia Tech. Yes, it was seven years ago—on April 16—that a lone assailant killed 32 people before turning the gun on himself.

Kern County (Calif.) communication center manager Melinda Hurley summed it up this way: “When you sit in a communication center and watch something like this go on, you can’t help but empathize with those dispatchers and what they must be going through.”

This is a big part of what NAVIGATOR is all about: People in a very stressful and demanding profession are making a difference in the lives of the public and the lives of their fellow professionals.

I still don’t know exactly what to expect every year, although I know whatever happens will be genuine.
President's Message

Time for Pause
Week of national observance is the least the rest of us can do

Scott Freitag, IAED President

A sheet cake for every shift and baseball caps that could be worn all week while on shift were several ways Salt Lake City tried to show its gratitude to communication center staff during National Telecommunicators Week (NTW) in April.

That was only part of the effort. We had an event every day, starting Sunday, April 13, and running through Saturday, April 19—from hats and sterling silver key chains to a catered barbecue and cake—to honor the great job staff does 24/7.

We had a great time, both in the giving and the receiving, and a sincere thanks goes to all staff pitching in to make NTW something to remember, including non-comm. center employees taking a break from schedules to acknowledge the first, first link of emergency services.

We don’t do enough of that on a regular basis and, perhaps, if it wasn’t for NTW, we might let it drop altogether. Maybe that’s the reason why the week of recognition was established, so we don’t forget or let that expression of appreciation fall by the wayside in the rush of daily routine. Of course, we’re not forced to wait until NTW to provide the honors, but it sure helps to have the week pop up on our calendars.

The origins of a week commemorating telecommunicators dates back more than 30 years, although there were plenty of bumps along the way before the U.S. Congress passed the resolution to make it permanent in 1992. I doubt there are many public safety comm. centers that ignore NTW, despite down-to-the-bone budgets. We find a way.

Salt Lake City’s 9-1-1 Bureau pulled out many of the stops this year, having kept the party short in 2013 when staff was in the midst of moving into the new public safety building. The past 12 months comprised a lot of nip and tuck; it wasn’t about one side winning over but rather the ability to finally pull together a staff that hadn’t worked together in one room until the move. The result had to be certain—from the start—although at times the reality seemed indeterminable.

But that wasn’t the sole reason for celebration. Public safety dispatching takes—and you’ve heard this before—a unique personality.

The individual must be compassionate and persistent to assist callers who are quite possibly experiencing the worst moments of their lives.

They have to be polite and understanding no matter how badly they are treated by a stranger on the other end of the call.

They constantly listen to callers trapped by the emotion of the situation—fright, confusion, anger, and pain—knowing that they must break through to ask questions and, when necessary, provide life-saving Pre-Arrival Instructions.

They are second party to horrific situations that—if not for the sake of their profession—they might never experience in their lifetimes. Sometimes situations singularly, or over a period of time, take their toll, and dispatchers become the ones needing help (which demands courage to admit).

They work under extreme stress and everything that occurs in the center is pulled apart for quality review, with the media eager for a story (although I must admit some very positive articles in relation to NTW).

They work weekends, nights, and holidays. When their neighbors are taking cover from inclement weather, they’re either driving to the center or waiting for a ride from a designated public safety official. Many come in voluntarily to assist, but many times, they have no choice.

They go through an extensive interviewing process and, once hired, undergo weeks and months of training before taking calls (and that’s only after more time spent on the floor with a trainer).

They are required to multitask and adapt instantly to the ever-changing technology brought on by Next Generation 9-1-1 while often working in cramped spaces or buildings way past their prime.

The ones who do stay claim the good overrides the bad. It has to be that way.

The people at the center become part of their extended family. They watch the children of co-workers grow into adulthood, they grieve at each other’s tragedies and rejoice at each other’s successes, and they support each other when experiencing personal challenges and adversity.

They do the best they can do every day to hold together the world of their callers and their team.

NTW was created for continued recognition of the unsung heroes of emergency services, but whatever we do, it will never be quite enough of the recognition they deserve.
Police dispatch research has been one of our greatest challenges.

The law enforcement mindset is hard to change because of a perception that resists change. “We have always done it this way, and it works,” is the message we commonly hear or take away from agencies long-serving familiar communities.

The “If it ain’t broke, don’t fix it” attitude implies that something is working so well that attempts to improve it would only break the process. A “leave-it-alone” philosophy might have worked in the emergency communication services of the past, but not today. Change happens rapidly and to ignore reality flies in the face of quality improvement and performance.

That says, in a nutshell, why police and fire dispatch research is essential. What worked a decade ago or even five years ago is probably not generating the level of quality that modifications in the system could produce.

But before we suggest topics requiring further research, we need to demonstrate to more police agencies the crucial need for emergency dispatch protocol. We need to identify and validate the benefits that outweigh a reluctance we can attribute to misperceptions in the process. There’s a belief that questions will prolong response times or, in broad terms, agencies claim the questions hamper their cut to the chase.

Protocol does get to the point without wasting time—and agencies using the Police Protocol can testify to that. However, to confirm the advantages, we would welcome research comparing average time of dispatch between Police Protocol users and non-users. Obviously, we know there are other benefits that agencies rip from the use of protocol, e.g., quality data collection in terms of data completeness and accuracy. Consistency in collecting data is also a huge benefit that unified protocols provide as well. Additionally, the collected data is also readily available to users to immediately inform effective decision making.

Reality on the ground would go a long way in laying to rest misconceptions and clarifying the communication process developed to safeguard the public and responders while, at the same time, getting the situation under control.

Topics for police dispatch research only grow from there. For example, most agencies capture data but the capture tends to stagnate—the categories stay the same—or the captured data stored is seldom analyzed. Agencies would benefit from taking a closer look at the current data collection and, if necessary, updating the categories according to agency objectives that tend to change in each administration.

For example, Chris Knight illustrates in his article1 that one of the most pressing problems in police dispatch is identifying the amount of time elapsing between the initial call receipt in the communication center to the dispatch of responders.

An interesting column in the Wall Street Journal addressed this very issue.

According to Carl Bialik, response times (how long it takes for police officers to respond in person to a 9-1-1 call) are a staple of law enforcement measurement, at least for political reasons; politicians want the data (as long as it’s good data) as evidence of the success in their police initiatives.2

However, according to Bialik, law enforcement experts and police chiefs don’t say much about police success beyond response in terms of speeding to the scene—and every city wants the fastest response times possible. Yet as Bialik also points out, response times “don’t even do a particularly good job of measuring that, partly because of inconsistencies in how local departments define the measure.”

Agencies don’t have the technology in place to track response time using the same technology. And even if they did, a multitude of factors can get in the way of response time, including traffic congestion, weather, and (according to an article in American Police Beat) getting proper information from dispatchers to officers.3

Now doesn’t that tell you something? We need to get the word out. We need to conduct the research.

The Academy looks forward to the day when it has the police data sufficient for replication studies. Researchers delight in preliminary findings that stand up to repeated research. This is validation.

Sources
Live or Die by Expiration Date
Are expired drugs safe to advise in an emergency?

Jeff Clawson, M.D.

Hey Adam (Hinckley),

Not sure who to ask ... Day 2 of 12.2. The caller is having chest pain and when we start the aspirin tool says, “I have aspirin but it’s expired.” I can’t find a published Academy position on this. I know what I’d like to say but does IAED™ have any input before I issue direction?

Lt. Benjamin Kaufman
Training & Quality Assurance, Office of Professional Standards
Montgomery County Emergency Communications Center
Maryland, USA

Ben,

We have never addressed this issue, basically because it is a non-issue. In the U.S., every medication, no matter what it is, is given a one-year expiration date, because the government said they had to put one on every bottle. However, a one-year expiration for a medication’s clinical usability is simply not the case with the vast majority of medications kept at home.

If you started to have chest pain, and thought you might be having a heart attack, but the label on the bottle of aspirin on the nightstand said it had expired 3 years ago, would you not take one? Common sense says you would. I certainly would.

One of anything, other than the black cyanide pill that spies supposedly carry, no matter how outdated, can’t kill you as an adult. Even if the medication has degraded a bit in potency over time, some percentage of its effect is certainly still present. That doesn’t make it dangerous or poisonous.

The arriving paramedic should be happy that any aspirin was given. And if they wouldn’t give one aspirin because it was “expired,” they are not in the game.

Hope this helps ... Doc

PS. Don’t quote me, but if the aspirin is expired, maybe we should tell them to take two instead ...

Further Information on Expired Drugs

In researching the topic of drug expiration dates, an oft-referenced article by Richard Altschuler in Psychopharmacology Today came up. Several quotable sections are reproduced here:

“First, the expiration date, required by law in the United States, beginning in 1979, specifies only the date the manufacturer guarantees the full potency and safety of the drug – it does not mean how long the drug is actually “good” or safe to use. Second, medical authorities uniformly say it is safe to take drugs past their expiration date – no matter how “expired” the drugs purportedly are. Except for possibly the rarest of exceptions, you won’t get hurt and you certainly won’t get killed.

“In 2000, Laurie P. Cohen in an article for the Wall Street Journal reported that between 1993 and 1998, the military had the FDA test more than 100 drugs – both prescription and over-the-counter – finding that 90% of these medications were safe and effective far past their original expiration date. In some cases, eight to fifteen years beyond their expiration dates. Excluding nitroglycerin, insulin, and liquid antibiotics, most medications are as long lasting as the ones tested by the military.

“In light of these results, a former director of the testing program, Francis Flaherty, said he concluded that expiration dates put on by manufacturers typically have no bearing on whether a drug is usable for longer. Mr. Flaherty noted that a drug maker is required to prove only that a drug is still good on whatever expiration date the company chooses to set. The expiration date doesn’t mean, or even suggest, that the drug will stop being effective after that, nor that it will become harmful.” Manufacturers put expiration dates on for marketing, rather
than scientific, reasons,” said Mr. Flaherty, a pharmacist at the FDA until his retirement in 1999.1

**Use of an Expired Adrenaline Auto-Injector**

Another problem encountered by EMDs is having the caller state that the patient’s adrenaline (EpiPen) is expired. A seminal case occurred in March 15, 2013, when a new college student with a severe nut allergy unknowingly ate a cookie with nut particles in it, even after asking if might contain them. When he showed significant signs of a severe anaphylaxis, and the family balked at using the expired injector because it was “expired,” the 9-1-1 operator told them not to use it. Even though a neighbor, a fire chief, then retrieved his own and used it on the young man, he died later at the hospital.

The first-line treatment for anaphylaxis (severe, symptomatic allergy) is injectable epinephrine.

“So, if it’s common for people to have expired injectable epinephrine kits, would it be okay to use them for the treatment of anaphylaxis? Researchers in Canada studied this exact question in 2000.

“The two methods studied showed that the expired EpiPens contained less epinephrine compared to the non-expired EpiPens, there was still a surprisingly high amount of epinephrine in the expired EpiPens. Even EpiPens that were 5-7 years past expiration date still had more than 70% of the original dose remaining in the device. Many EpiPens that were 2-3 years past their expiration date had more than 90% of the original dose remaining.

“However, since injectable epinephrine kits—even those that are many years old—contain a significant amount of the original intended ideal dose of epinephrine would likely outweigh the theoretical danger of using an expired injectable epinephrine kit.”2

“This study conclusion stated, “If the only autoinjector available is an outdated one, it could be used as long as no discoloration or precipitates are apparent because the potential benefit of using it is greater than the potential risk of a suboptimal epinephrine dose or of no epinephrine treatment at all.”3

**New in v13.0 – Epinephrine (Adrenaline) Auto-Injector Instructions:** It is common to have an expired kit. Out-of-date injectors can still contain significant amounts of adrenaline (epinephrine) that can help him. (Expired injectors aren’t dangerous. They just might not be as strong.)

Again the Second Law of Medical Dispatch rings true — “When in doubt … (Always err in the direction of patient safety). In these cases, patient safety can be defined as “living” over “dying” since the stakes are so high.

Jeff Clawson, M.D.
Division of Research, Standards, & Academics
IAED

**Sources**
The Compassionate Side
Help in mental health crisis calls flows from psychological knowledge

James Marshall

The IAED™ emergency Medical Protocols are based on established scientific knowledge about medical conditions. Likewise, best practices relating to callers struggling with critical mental health crises must flow from reliable psychological knowledge. Relating effectively to callers reporting sexual assault will require the dispatcher to understand the nature of the victim’s distress and the predictable human reaction of the 9-1-1 professional.

The caller reporting sexual abuse and the dispatcher may each experience an unspoken internal struggle that can impede the success of the call: They will both often feel ambivalent about investing fully in the call.

The victim of sexual assault will often be “preloaded” to feel shame, self-blame, and fear of judgment and blame when reporting abuse to 9-1-1, police, and, later, in court. She may be ambivalent about staying on the call, fully disclosing information, pressing charges, and following through with legal action. And most crucial to the caller’s long-term well-being, she may fear seeking therapy for the same reason, particularly when conditioned by an “intimate terrorist’s” chronic coercive control. Two-thirds of victims of intimate terrorism (compared to situational couple violence) leave within an average of two years from onset of the abuse. But it can take years to resolve the trauma and reclaim sense of self and quality of life.

The dispatcher is also under enormous pressure. Highly distressing calls can activate an emotional boundary that can be conveyed through the dispatcher’s tone. She carries the weight of providing empathy in a horrific situation while, at the same time, protecting herself from expending too much of her emotional energy. Yes, this is an awful thing to happen to you, caller if true, but I can’t let myself be pulled into the pain of your drama.

The dispatcher cannot be expected to fully take on the feelings of the caller; that’s not her responsibility. However, the 9-1-1 professional must strive to respect the caller’s feelings and recognize and acknowledge her ambivalence.

What does the caller’s ambivalence look like? The survivor is torn by two competing thoughts that might be expressed this way:

A part of me says he must pay for what he did, and I need help so badly—I will do it (inform authorities and seek help). But another part of me is screaming, ‘This was so horrible!’ I just want it to go away, not feel the shame, or talk about it. This person may not even believe me and I’ll just end up feeling humiliated. Maybe I deserved this. He (the alleged perpetrator) is right. I’m not a good person. It was my fault … maybe it wasn’t as bad I am making it.

Sexual assault survival strategies
Defaulting to such beliefs can actually feel safer to the victim since the abuse remains private and seemingly more within her control versus if made public.

And if she dwells on the perpetrator’s control over her, she feels more powerless and at greater risk of future assault. Blaming herself for the sexual assault gives her a sense of safety and control over her environment. Shifting the blame—although misdirected—is a self-preservation strategy called The Locus of Control Shift. This shift (which may be unconscious) leads to a second belief: If I mute my protest and remain compliant, the perpetrator is less apt to hurt me again.

This Locus of Control Shift can often tip the ambivalence scale in her behavior choice from fully cooperating to hanging up, or minimizing and contradicting herself in disclosures to the dispatcher, field responders, and to medical and legal professionals.

Without understanding this survival strategy, the dispatcher’s response may swing from empathy and emotional investment toward more annoyance and a detached, more sterile response style: I’ve heard this before. Why don’t you just leave the tormentor?

The caller, already struggling with poor self-worth, may pick up on this attitude change fueling even greater shame, anxiety, and reluctance to cooperate.

The best response in complex psychological situations like sexual assault is guided by awareness of this ambivalence and the Locus of Control Shift. This is a tall order since the emotional labor demanded in such work with the caller can take its toll. Telecommunicators must be equipped (and choose to use) resilience skills to reset after such calls and to sustain resilience throughout their careers. Emergency dispatch leaders can ensure optimal response to calls involving mental health crises by providing appropriate training.

Sources
That’s How We Deal
Crazy calls are the Jeopardy of our business

Colleen Conrad

I’ll take “Crazy Calls to 9-1-1” for $200, Alex.

We all get them. Minding our own business, taking our 15th burglary or our 10th domestic violence call when the next one comes through. It’s one of those head-scratching calls that you honestly say to yourself, “And I thought I’d heard everything.” This is the kind of call that stays with you for a very long time, and when you think about it, you start to scratch your head all over again. If you tell your loved ones or friends outside of public safety, they wouldn’t believe you.

Most of the time, you really can’t discuss these calls because they can be offensive to those who don’t understand. However, because of the defense mechanisms people in the business build, we tend to burst out laughing and say, from time to time, “You remember when I got that call ... ?” The people that haven’t heard the story look stunned and their response usually is, “You’ve got to be kidding me,” and they start to laugh, too. It’s how we deal with stuff in our line of work. We’re not poking fun at any one person, or any group; it’s just what we do. If we didn’t laugh, we’d all be locked up in the old “rubber room” in a straitjacket.

These calls find their way to the Internet and television. Heck, Jay Leno (you remember, the former host of The Tonight Show) had a regular gig (called Dealing with the Public) in which he played actual 9-1-1 calls for his audience. People could hear exactly what we deal with every day. We’re not poking fun at any one person, or any group; it’s just what we do. If we didn’t laugh, we’d all be locked up in the old “rubber room” in a straitjacket.

Where I work, we have training tapes. We use some of these calls to show the new employees the kinds of calls they might have to deal with someday. They aren’t pretty. We have one recording that is incredibly inappropriate. A disturbing sense of humor on the caller’s part can’t even explain why. She is making a domestic violence call, and it takes a moment to realize the woman has a different sort of problem. The caller says she must self-gratify herself and the next thing heard—use your imagination here—gives you the sudden feeling that you’re intruding. The first time I heard it, I wasn’t sure that I was hearing what I was actually hearing. It was. Yep, you get it now.

We work in a crazy world. Some of the calls we receive are so crazy, you’d think we were making this up. We aren’t. Most of the “normal” people outside this profession would never understand that call. Leno couldn’t play it for his audience. It would be censored. But it’s one we still giggle about. Because that’s how we deal.

I AM ALWAYS GOING TO HAVE THAT PERSON WHO THINKS HE OR SHE KNOWS BETTER WHAT TO DO IN AN EMERGENCY THAN I DO.

I wish I received a nickel for every time I heard, “Stop asking me these stupid questions and send me the cops” or “You don’t need that information; send an ambulance to help us.” No matter now nicely I explain how this information is going to help the first responders, I am always going to have that person who thinks he or she knows better what to do in an emergency than I do. I’ve been at this for over 20 years.

So after taking the abuse, getting one of those freaky calls makes my day almost as exciting as Christmas. There is always the caller reporting an indecent exposure to make me giggle, especially when I ask what the naked man was wearing. There are the neighbors calling because they are mad as can be at their neighbors letting their dogs poop on their lawns. Then there’s the continuous caller or the frequent fliers that keep calling, and their stories keep getting further and further into Bizarro-land. I know it’s not always appropriate to find those funny, but it’s our defense mechanism. It’s the way we deal.

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Some time ago, I participated in a group study regarding the effects of alcohol consumption in large quantities and whether taking a trial medication would keep the anticipated hangover at bay. I like to call it “overindulging socially.” We were provided drinks over a six-hour period and at the end half of the people in the study received a trial medication and the other half a placebo (sugar pill).

We were examined the next morning to see how the “special” medication affected us; the results were astounding. Almost half of the participants receiving the sugar pill felt fine, as if the “special” medication had prevented the impending hangover. About a quarter of the participants receiving the real medication didn’t notice any change from what they figured would happen; they felt as horrible as they always did after a night out on the town.

While the question of whether or not the “special” medication would prevent a hangover was yet to be determined, I saw a bigger picture. What did it say about the sugar pill half? Mind over matter is critical in the outcome of how we heal.

Recently, my daughter was running to the backyard and fell and skinned her knee. I cleaned it and put a Band-Aid on but she was still crying. I bent down and kissed it. “All better?,” I asked. “Yes,” she replied. Did my kiss really make it feel better or was it mind over matter? Was it the comforting tone in my voice, or the combination of both? I believe it was both. It’s not much different from what we do when providing caller management in Pre-Arrival Instructions (PAIs).

For the record, my daughter also thinks chocolate milkshakes make her tummy aches go away. A Proposal for Change regarding tummy aches and milkshakes might be in the works.

I had forgotten about the study until a recent PAI call. When converting a call from a public service agency (fourth-party caller), I reached a woman panicking on the other end. She was experiencing strong contractions, soon determined to be less than two minutes apart. Seventeen years of experience as a paramedic and the fact that this was her second child told me that this baby was ready to greet the world. The fear in the woman’s voice was palpable, and I found myself emotionally caught up in the situation. Her OB team was now her 14-year-old daughter and someone who was about to tell her “exactly what to do next.”

As a medic in the field, I was able to recognize relief expressed on a patient’s face. In this case I heard only panic. To her, she was alone, and I was just someone on the phone asking questions and delaying the ambulance. I needed this “mom-to-be” to trust me and know I was there with her. Drawing from the experience of having my son four months earlier, I used calming statements: “I’m going to stay on the line and help you through this” and “I know you’re scared that the baby is coming but we can do this together.” I used these early and often to gain her trust. The instruction to gather a safety pin, towels, and blanket kept her daughter even though her mom was in a clear state of distress. I continuously reminded mom that she was far from alone or helpless.

This is the part of being an EMD that I find so challenging. My mindset had to change, and this call was proof. I used every effort to help this woman to trust in the PAIs and me. I was so convincing that in the end I actually felt like I was there with her, and I know she did, too.

Paramedics arrived and transported her to the hospital before her newborn made a home debut, but we were ready if it had come to that. The experience helped me with a new perspective: As emergency medical dispatchers, we have to be so immersed in these calls that, upon disconnect, we feel as if we had been there. We are “right there with them.” We have the chance to help them feel relief when they are in pain and safe when they are scared. When we recognize these situations, we can’t be in a rush to hang up or assume that the caller or patient is fine and doesn’t need our emotional support. Having someone to listen can be the greatest comfort in time of need.

It’s our job. It’s what matters.

As a field medic, I was convinced that no other job could ever be as exciting and give patients such relief. Apparently, it was just mind over matter.
Standardized
Agencies will have to adhere to new performance standards to achieve ACE

The International Academies of Emergency Dispatch® is pleased to announce the release of new Standards for Accreditation. The new standards will replace Point 9a in the Twenty Points of Accreditation. All other points remain unchanged. (see Table 1)

The new Standards for Accreditation are fully compliant with the recently released EMD-Q® 9a, EFD-Q® 4a, and EPD-Q® 4a Performance Standards. As shown in the chart above, they are based on both Compliance Levels and deviation percentages in Case Entry, Chief Complaint, Key Questions, Dispatch Life Support, Final Code, and Customer Service. To meet this standard, an agency must demonstrate that no more than 10 percent of cases fall in the Partial Compliance Level, no more that 10 percent of cases fall in the Low Compliance Level, and no more than 7 percent of cases fall in the Non-Compliant Level. An agency must also demonstrate that the total percentage of Critical, Major, Moderate, and Minor deviations fall within the thresholds shown on the chart. These percentages are derived by dividing the number of deviations recorded by the total number of possible deviations for each category.

An ACE Standards report containing the required information is available in AQUA® 6 software under the ACE tab. Agencies who have upgraded to AQUA 6 and the new 9a/4a performance standards must use this new report effective immediately. By March 2015 all accreditation applications must use the new report. Please contact Priority Dispatch® Software Support for information on upgrading to AQUA 6. (see Table 2)

To ease the transition for currently Accredited Centers of Excellence, the Academy has produced a graduated compliance scale. This graduated scale applies to the required biannual reports. If the submitted reports meet the ACE Standard, no additional reporting is necessary. If the submitted reports do not meet the ACE Standard, but fall within the 12-month, nine-month, or six-month thresholds shown on the chart above, the agency will be required to provide quarterly reports until compliance reaches the ACE Standard. If the submitted reports fall below the thresholds shown on the chart above, the agency will be placed on notice and will need to submit an Action Plan for improvement.

Table 1

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Table 2

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Authorities on the trail of phony dispatcher

Litchfield County Dispatch (Conn.) Executive Director Daniel Soule found the sure way to stop an unwelcome barrage of emergency requests.

“We broke it to the news,” he said.

The phony requests stopped the same day local media broadcast several of the recorded radio transmissions and, to Soule’s satisfaction, the attention in turn gave police fresh leads despite the absence of live transmissions to track.

There was really no other choice than to make the transmissions public, Soule said. Dispatchers can’t judge a request phony and deny response any more than ambulance crews, firefighters, or police officers can refuse to go for the same reason. The incident is real unless and until proven otherwise.

“Potential for something bad to happen was too high if we let it continue,” Soule said. “We had emergency vehicles and crews on the road unnecessarily when they could be needed somewhere else. Fortunately, no one was hurt, and we’re just happy it stopped when it did.”

The requests started on Christmas Day. An unfamiliar voice came over the frequencies Litchfield County Dispatch uses to send firefighters, ambulances, and police to calls in 20 northwest Connecticut towns. The broadcasts from the phony dispatcher hit on towners only in Litchfield County.

The transmissions continued into the new year until Jan. 6 with the male voice on the radio alternating among fraudulent claims that he was a Sharon firefighter; a Watertown firefighter; a Sheffield, Mass., firefighter; and a Litchfield firefighter.

The voice was not one anyone recognized, and it’s believed it was the same person each time.

The requests were typically for medical and fire assistance: an ambulance for a patient complaining of severe abdominal pains or fire engines to extinguish flames coming from the roof of a rural residence. Soule said the imposter was versed in the lingo of emergency communication; he knew the type of medical or fire situation necessary to have dispatch send the level of response he was requesting.

“Clearly he was someone who listens to the scanners all the time,” Soule said.

The fake requests stopped, thanks to the publicity generated by the recorded radio transmissions Soule provided to local media. State police are chasing down leads. If apprehended and charged, there may be serious consequences.

Section 53a-180d of the Connecticut Penal Code classifies the misuse of a 9-1-1 call as a misdemeanor. The statute makes it illegal for a person to call or otherwise make a false alarm or complaint to 9-1-1, or to report false information that would lead to the dispatch of emergency services. As of November 2010, the offense is classified as a class B misdemeanor, carrying a sentence of up to six months in jail and/or up to a $1,000 fine.

Soule “can’t even begin to guess” why someone would hijack emergency radio frequencies for malicious purposes. He said it’s not uncommon for the center to get the occasional garbled message from an accidental transmission, but it is rare for such a deliberate intent to disrupt emergency services for an extended period.

“This was straight-out malicious,” Soule said. “I have no idea about the thought behind this or where the person wanted to go with this.”

Litchfield County Dispatch was not the first—and certainly will not be the last—comm. center to experience the threat of phony radio transmissions. Arrests involving similar incidents have been made in the past.

For example, the volunteer Capitol Region Malicious Interference Tracking group helped police track down a man making malicious transmissions that affected police and firefighters in other rural Connecticut communities. The absence of a live signal, however, defeats their current offer to provide assistance.

The problem is not confined to Connecticut and for any agency, it’s a tough one to resolve.

People who interfere with public safety radio frequencies typically use police and fire radios purchased secondhand or go to online shops selling new radios and the software to program them. The radios can be programmed on the public safety channels from public listings of police and fire department radio frequencies. How-to instructions are also easy to find.

Radio system encryption that secures frequencies and blocks signal access to civilian scanners and online apps is expensive. And for Litchfield, the costs of a unified single encrypted system are prohibitive because of the county’s reliance on predominantly volunteer firefighters.

“We have nearly 2,000 volunteers in the field,” Soule said. “With that many radio frequencies, the cost would be phenomenal. We couldn’t do it.”

Established in 1989, Litchfield County Dispatch is the primary Public Safety Answering Point for Litchfield County, answering calls for 20 towns in northwest Connecticut and dispatching response for 41 fire, medical, and police services covering 945 square miles and 150,000 residents. Combined, the center averages more than 80,000 fire, medical, and police calls annually.
More states putting 9-1-1 surcharge funds where they should go

State spending on 9-1-1 services has increased, while the number of states diverting 9-1-1 fees for other projects has gone down.

That’s the good news from the annual federal survey of states, according to a U.S. General Accounting Office (GAO) report. With funding reaching $2.3 billion nationally, only four states reported using 9-1-1 surcharges for other than 9-1-1 during 2012; that’s six fewer states than the number that reported using the funds for non-9-1-1 related projects two years earlier. The states diverting funds typically used the money for emergency first responder programs unrelated to 9-1-1.

Several states still don’t track how they use 9-1-1 funds, and many failed to answer the questions, according to the GAO. Arkansas was the only state to ignore the survey altogether (at least, no response was received from “The Natural State,” known for its mountains, valleys, dense woodland, and fertile plain).

The survey found that Illinois, Kansas, New York, and Rhode Island diverted about $48.4 million of their 9-1-1 funds, or two percent of the national total. Of the 21 local funds expenditures Kansas investigated for uses potentially unrelated to 9-1-1, eight were required to reimburse the money. Rhode Island diverted 76 percent of its $16.5 million in 9-1-1 fees to other purposes.

Survey questions focusing on Next Generation 9-1-1 spending found that eight states are making notable strides toward the new technology. Kentucky led the list with $15 billion committed to creating a statewide NG9-1-1 network.

States collect 9-1-1 fees either on a state (19), local (10), or state-local (22) level, according to the survey, and total fees collected ranged from $2 million in Nevada to $212.8 million in Texas.

Inability to ‘buckle up’ puts obese drivers at greater risk

Obese drivers may be at a strikingly higher risk of dying in car crashes than normal-weight drivers because they frequently fail to buckle up, according to a new study in the American Journal of Emergency Medicine.

Based on an analysis between 2003 and 2009 of 194,120 drivers involved in auto crashes in which there was at least one fatality, the research team found that the closer to morbidly obese a person was, the less likely he or she was to have been wearing a seat belt.

Compared to the morbidly obese drivers, moderately obese people were 23 percent more likely to have been buckled up. The slightly obese were 39 percent more likely and the overweight were 60 percent more likely than the morbidly obese to have been wearing a seat belt. Normal-weight Americans were 66 percent more likely to have been wearing a seat belt than those who were morbidly obese.

According to Federal Motor Vehicle Safety Standards dating back to 1967, seat belts must be adjustable to fit weight ranges from those of a 5th–percentile adult female (102 pounds) to those of a 95th–percentile adult male (215 pounds).

Since then, obesity rates have climbed without subsequent federal changes in seat belt size tolerance. Some automobile manufacturers offer seat belt extenders specific to the maker, and there are universal extenders available for purchase.

Statistically, U.S. obesity increased from 13 percent to 32 percent between the 1960s and 2004. Currently, one-third of Americans are considered overweight and another third are considered obese, according to 2009 data from the Centers for Disease Control and Prevention (CDC). By 2015, close to 40 percent of American adults will be considered obese.

Obesity is typically defined by body mass index (BMI), a measure of weight relative to height. People with a BMI between 18.5 and 25 are considered normal weight. A BMI between 25 and 30 is considered overweight, between 30 and 40 is obese, and above 40 is morbidly obese.

Source


CDC study finds big drop in deaths among children in traffic accidents

Motor vehicle crash deaths among children ages 12 and younger decreased by 43 percent from 2002–2011. However, still more than 9,000 children died in crashes during that period, according to a Centers for Disease Control and Prevention (CDC) study analyzing 2002–2011 data from the Fatality Analysis Reporting System, collected by the National Highway Traffic Safety Administration (NHTSA).

Research has shown that using age- and size-appropriate child restraints (car seats, booster seats, and seat belts) is the best way to save lives and reduce injuries in a crash. Almost half of all black (45 percent) and Hispanic (46 percent) children who died in crashes were not buckled up, compared to 26 percent of white children.

According to the same study, only two states (Tennessee and Wyoming) have child passenger restraint laws requiring car seat or booster seat use for children ages 8 and under. Among five states that increased the required car seat or booster seat ages to 7 or 8 years old, car seat and booster seat use tripled, and deaths and serious injuries decreased by 17 percent.
High court to debate police action based on anonymous 9-1-1 caller tip

The U.S. Supreme Court is expected to rule this summer whether it’s lawful for police to detain individuals as a result of an anonymous 9-1-1 tip reporting suspicious behavior indicating them as suspects, although police witness nothing criminal upon their arrival.

The case goes back to August 2008 when a California state highway dispatcher in Mendocino County received a phone call from a dispatcher in Humboldt County saying that a 9-1-1 caller had reported being run off the road. The caller, who remained anonymous, identified the truck, the license number, and where the incident had occurred.

California Highway Patrol officers stopped the truck, smelled marijuana, and subsequently found closed bags of marijuana in the truck bed. The brothers were charged with illegal transport and illegal possession of transport, and before trial, their lawyer sought to have the evidence barred, arguing that the officers had not corroborated the anonymous tip leading them to chase and stop the truck.

The court’s decision could have a large bearing on dispatch operations. If the court decides against the reliability of anonymous tips, dispatchers could still relay the information, although police could not make the traffic stop without witnessing suspicious behavior or having probable cause. Call-takers could be put in the position of convincing the caller to provide identification.

According to observers, the primary issue is determining “reasonable” in police conduct, particularly when the tip is by an eyewitness reporting a “serious and immediate” threat of harm and, consequently, justifying a prompt stop “rather than awaiting additional dangerous driving that would place lives at risk.”

Source

INTERNATIONAL NEWS

IAED’s Asia NAVIGATOR hosted in Malaysia

The third annual Asia NAVIGATOR included a special birthday cake celebration at the conference’s March 4 gala dinner for Siew Phei Fun, a professional emergency officer with Telekom Malaysia’s 9-9-9 Response Centre Headquarters, who received Dispatcher of the Year honors on the same day as her birthday.

 Held March 4–6 in Kuala Lumpur, Malaysia, Asia NAVIGATOR is the second in the line up of the International Academies of Emergency Dispatch’s (IAED™) 2014 conferences held throughout the world.

Attendees at this year’s conference included those from Bomba (the Malaysian fire and rescue service), JPAM (the Malaysian civil defense department), APMM (the Malaysian maritime enforcement agency), Pilipinas 911 from the Philippines, the Foundation for Crime Prevention from the Philippines, Hong Kong Fire Services, and several others.

Claire Ulibarri, IAED conference coordinator, said 185 conference participants attended this year’s event, hosted at the JW Marriott Hotel Kuala Lumpur. Conference goers hailed from a variety of countries, including Malaysia, Vietnam, Brunei, the Philippines, Hong Kong, and Qatar.

Jerry Overton, IAED chair
Emergency Clinical Advice System & Standards, presented Siew with Asia NAVIGATOR’s Dispatcher of the Year Award on the conference’s opening day, and later that evening at the gala dinner, he and Ulibarri surprised Siew with a birthday cake, complete with candles.

“The call submitted with Siew’s nomination was one she took from a family trapped in a hotel elevator in Malaysia’s capital city. Siew was instrumental in helping placate the distressed parents, who were on a cellphone with her, and their frightened children while first responders raced to the scene.

“She was calm and professional when the individuals in the elevator began to panic,” said Carlynn Page, IAED associate director.

Ulibarri said Siew also had one of the highest compliance scores for her fire agency, Telekom Malaysia 9-9-9 Responce Centre, which only recently adopted and implemented IAED’s Fire Priority Dispatch System™ (FPDS®). Siew’s center is currently working toward certification.

“Everyone was impressed by what they learned in the sessions, and we had a new presentation on Protocol Implementation in the Middle East from Sonia Bounouh, who came all the way from Qatar,” Ulibarri said.

A full slate of informative sessions were the focus of the conference. On Tuesday, March 4, included those on the anatomy of a good public safety program; insights on disparities between dispatch center event classification and emergency responders’ final triage determination; how to implement international public safety dispatch leadership best practices; and an examination of the use of the override protocol in Malaysia. Wednesday, March 5, featured a session on call triaging and a look into if comm. centers may be “over-triaging” traffic accident calls; a discussion and tips on how to complete the road toward center accreditation; and ways to improve voice recording and make it a smoother comm. center process. Attendees also had the option of participating in medical and police leader seminars on Thursday, March 6.

Emergency communications vendors represented at the conference’s Exhibit Hall included Priority Dispatch Corp., Emergensiys Solutions, Bomba, JPAM, and APMM.

“The Academy has already started work on the 2015 Asia NAVIGATOR conference and plans for new sessions and event are underway,” Ulibarri said.

### Helicopter fitted for British EMS getting set for takeoff

South Western Ambulance Service NHS Trust (England) paramedics will be traveling faster to the scene with a new Wiltshire Air Ambulance helicopter expected to be ready December 2014.

The light medium twin helicopter—a Bell 429—will be built in Mirabel, Canada, and adapted to helicopter emergency medical services (HEMS) specifications with a maximum load capacity of two pilots, three paramedics, and a patient.

The helicopter can reach a top speed of 150 knots (172 mph) and a range of 400 miles.

The contract signed between Wiltshire Air Ambulance Charity Trust and Heli Charter covers a 10-year lease, maintenance, and flying for up to 19 hours a day, every day of the year. It also includes a replacement helicopter after five years.

The charity spent nearly two years reviewing its options and is mandated to use aircraft provided by the National Police Air Service.

The British National Grid took delivery of a Bell 429 last summer for its survey work and is delighted with its performance and handling. The Bell 429 is also already operating successfully as an air ambulance elsewhere in Europe and Canada, and the charity is confident that it will provide Wiltshire with one of the best emergency service aircraft available anywhere in the world.

### Women’s safety behind India’s emergency system improvements

India’s central government is setting up a location-based emergency response system integrating medical, fire, and disaster management, with special attention given to improving the safety of women.

With control rooms to be set up in 114 cities and districts nationwide, the project is expected to cover 32.6 percent of India’s total population, roughly 391 million people.

The dispatch platform will include GIS-based call response and GPS-based police vehicle dispatch system and track alarms generated by panic buttons, landlines, cellphones, and cellphone applications. The response system will be integrated with the existing Police Dial 100 system for coordination between various agencies, and it will incorporate Next Generation 9-1-1 technology to identify caller location and facilitate data exchange between emergency call centers, dispatch centers, and police, fire, medical, and disaster management command centers.

The project will be implemented in stages, with completion anticipated by late 2014, followed by a five-year operations and maintenance period. Future plans call for migrating the system to a single central emergency response number.

Estimated cost is $52 million (in U.S. dollars), of which $2.5 million was set aside for monitoring and evaluation. This project taps into the Nirbhaya Fund established in 2013 to support initiatives toward ensuring the safety of women.

**Source**
Take an emergency dispatch coverage area 28,150 square miles (roughly the size of South Carolina) and surrounded by maritime waterways on three of its four “sides.” Then throw into the mix the fact that the population, about 750,000 people served by the jurisdiction, is also bilingual; significant portions of its residents speak French and English. Its government is officially bilingual; all of its public services, including its emergency dispatch centers, must be capable of communicating fluently and interchangeably at any given moment in either French or English.

Meeting that linguistic challenge is just another day-at-the-office for Ambulance New Brunswick in the eastern Canadian province of New Brunswick.

According to the provincial government, New Brunswick is “the only officially bilingual province in the country.” That breaks down to about 40 percent of the populace being French-speaking, mainly Acadian (17th century French colonists) in origin, with the other 60 percent being English-speaking.

Since 2007, Ambulance New Brunswick, headquartered out of the southeastern city of Moncton, has been responsible for providing land and air ambulance and emergency medical dispatch services for the entire province. The agency’s centralized ambulance dispatch center—the Medical Communications Management Centre (MCMC)—is a secondary Public Safety Answering Point (PSAP), with a network of six 9-1-1 call centers acting as primary PSAPs that handle the province’s police and fire calls.

Because dealing with challenges is the nature of their business, MCMC operations
managers and staff were undaunted when initiating the agency’s efforts to become an International Academies of Emergency Dispatch™ (IAED™) medical Accredited Center of Excellence (ACE). It earned the accolade in March 2013, a recognition for which MCMC’s manager, Jean-Pierre Savoie, is rightly pleased. “For me it was a dream come true,” Savoie said. “I’ve been in my position for 12 years, and I’ve been dreaming about accreditation for 12 years. We’re really proud to be an accredited center.”

MCMC, and its previous incarnation, had been users of the Medical Priority Dispatch System™ (MPDS®) for at least a decade and a half, and Savoie set an organizational goal to become an accredited center. Twelve months later, that goal was realized, in part due to a team effort from Savoie; Michel Gravel, MCMC senior manager of operations; the center’s five floor operations managers one of whom, Tiffany Good, also doubles as a training and quality assurance officer; and the center’s 50 EMDs.

“We wanted to make sure that the folks reviewing the calls were all on the same page,” Savoie said. “Tiffany really took the lead in ensuring that the ops managers were really following protocol and doing quality review in the right manner.”

Savoie said MCMC’s largest obstacles on the road to becoming an ACE were straight out of the Twenty Points of Accreditation. More specifically, Point 5, “full activity of quality improvement (QI) committee process,” and Point 7, “case review at the Academy’s recommended number and percentages of randomly reviewed cases.”

MCMC implemented a Quality Improvement Unit (QIU), a dispatch review committee, and a dispatch steering committee to satisfy Point 5. These groups began improving the center’s quality processes and identified areas of concern where increased staff training was required.

“We immediately concentrated our efforts on feedback for all staff and also created biannual in-service instruction,” Savoie said. “This process led to consistent case evaluations meeting or exceeding the Academy’s minimum performance expectations.”

Not that Savoie and MCMC went it alone. They relied on significant assistance and expertise from Colleen Bachewich, a quality assurance officer with Medicine Hat Regional 911 Communication Centre in Alberta, Canada, and also Carlynn Page, IAED associate director. One of Savoie’s managers bumped into Bachewich while attending a Communication Center Manager course and the two became fast friends. “We needed medical accreditation and Medicine Hat was already a triple-ACE,” Savoie said. “She was more than willing to help us out.”

Bachewich reviewed 30 MCMC calls, including instances of cardiac arrest, and provided managers with feedback to ensure that the center was ready and compliant with Academy standards. “Colleen’s review of our calls confirmed and instilled confidence that we were on the right track,” Savoie said.

Page filled the role of mentor, reference librarian, and cheerleader, responding to the agency’s questions or pointing them in the right direction on the off chance that she didn’t have the answer. “I was happy to guide them through the process,” she said.

Page was impressed by the determination of Ambulance New Brunswick’s MCMC to achieve ACE status and also the innate bilingual intricacies that the center faces, day in and day out. “There was a definite level of commitment and passion for delivering a quality product to the citizens that they serve,” Page said. “And to maintain that high compliance level, whether done in English or in French, is a compliment to their communication center.”

In getting ACE status, Ambulance New Brunswick became Canada’s 11th agency to gain medical accreditation, according to Page. “Our staff commitment to excellence is evident in earning this recognition,” Savoie said. “It takes a great deal of talent, effort, and determination, not only to achieve such a challenging goal, but also maintain the highest standard. To be validated and recognized by the IAED that we are excelling in meeting and exceeding an international standard of excellence is icing on the cake.”
Accredited Centers of Excellence

New EMD
180 Weld County Regional Communications Center; Greeley, Colo., USA
181 Ontario Police Department; Ontario, Calif., USA
182 NorthStar EMS Inc.; Tuscaloosa, Ala., USA
183 St. Cloud Police Department; St. Cloud, Fla., USA
184 City of Calgary Public Safety Communications; Calgary, Alberta, Canada

EMD Re-ACE
06 Corporation d’Urgences-Santé; Montreal, Quebec, Canada
10 Miami-Dade Police Department; Miami, Fla., USA
18 Colorado Springs Police Department; Colorado Springs, Colo., USA
30 New Hampshire Bureau of Emergency Communications; Concord, N.H., USA
51 DeKalb County 911 Communications; Tucker, Ga., USA
52 Collier County Sheriff’s Office; Naples, Fla., USA
62 American Medical Response; Colorado Springs, Colo., USA
70 Bernalillo County Emergency Communications; Albuquerque, N.M., USA
96 Tampa Fire Rescue Communications; Tampa, Fla., USA
106 Dublin Fire Brigade; Dublin, Ireland
116 Loveland Emergency Communications Center; Loveland, Colo., USA
137 City of Oakland Fire/Medical Dispatch; Oakland, Calif., USA
144 Jersey City Medical Center EMS; Jersey City, N.J., USA
146 Pro Transport-1; Cotati, Calif., USA
147 Hunter’s Ambulance; Meriden, Conn., USA
149 Mobile Medical Response; Saginaw, Mich., USA

New EFD
26 Boone County Public Safety Joint Communications; Columbia, Mo., USA
27 St. Joseph County Fire Dispatch; South Bend, Ind., USA
28 Montgomery County Hospital District EMS; Conroe, Texas, USA

EFD Re-ACE
6 Kent County Department of Public Safety; Dover, Del., USA
7 Medicine Hat 911 Communications; Medicine Hat, Alberta, Canada

Looking Ahead

You’ve probably heard of the tap-tap method for answering a calltaker’s questions when the caller needs to remain undetected to avoid serious danger. But have you read a story about a calltaker who recognized the urgency to change direction from talking to tapping because of potential injury compounded by the caller’s difficulty to communicate due, in part, to the trauma? In the July/August issue, Lisa Riccio Nickel talks about this call answered by calltaker Jon Lewis and how he skillfully and compassionately handled the situation.

Other contributors in the next issue of *The Journal* include Kevin Pagenkop, who regularly writes for the magazine and this time takes a look at the topic of stress as it relates to the ED.Q™; Anthony Favreau, a first-time contributor who addresses the common question about “asking all of those questions”; and regular columnist Ivan Whitaker, who continues his conversation about leadership. Readers will also have the opportunity to catch-up on the latest research from Tracey Barron and find the answers to protocol questions from expert Brett Patterson.

Our continuing dispatch education articles will feature dog bites and the appropriate emergency medical response and, on the fire side, the explosive nature of accumulated product dust in industrial settings.

We are always excited to receive articles from our readers and ideas for articles (technical and feature) that you would like us to cover. You can reach us via email at editor@emergencydispatch.org. Looking forward to hearing from you.
Getting past the hard sell of protocol implementation

Dispatcher attitudes to implementing the medical, police, or fire protocols can vary considerably depending on staff makeup. As a regional software instructor for Priority Dispatch Corp.™ (PDC™), I get to watch dispatchers’ first-time reactions to protocols as they go through them in ProQA®. At some centers the staff is clearly enthusiastic and can’t wait to use them. In most places, the dispatchers are cautiously optimistic and there are usually a few in the group who get excited over a particular feature or two that they like. The majority of implementations go smoothly, with emergency dispatchers quickly realizing that they’ve gained a powerful tool with some significant advantages, compared to doing things the old way.

There is, however, the occasional comm. center manager who despairs over the staff’s apparent reluctance to accept the new protocols. My former dispatch center was one such example. The Medical Protocols were met with significant resistance from some of the dispatchers and their resistance ultimately held us back from our goal of being accredited. Interestingly, the very strengths that contributed to our center’s success were responsible for the problem, teaching us some good lessons that I’ll share.

Some dispatch centers either require or encourage their employees to be trained to a field responder level. In practice that means the fire dispatchers are firefighters, and the medical dispatchers are either Emergency Medical Technicians (EMTs) or paramedics. In our case, every applicant had to be either an EMT or a firefighter with first responder training.
training. It was also a requirement that applicants had a year of public safety experience. Largely because of a word-of-mouth chain that resulted in most of our hires, almost everyone had a significant amount of field experience in patient assessment. As a regional EMD center this was a big plus for us; our dispatchers could readily understand and visualize the majority of complaints reported to them. More importantly, they had an intuitive understanding of what calls required Advanced Life Support (ALS) and why.

Given the experience field responders who are dispatchers the Medical Priority Dispatch System™ (MPDS®) to use (or the Fire Priority Dispatch System™, FPDS®, or the Police Priority Dispatch System™, PPDS®, for that matter) is a hugely powerful tool in their hands that streamlines the information-gathering and decision-making processes. But that was from the perspective on the side of the administrators and the “Qs.” What we failed to anticipate was that our dispatchers weren’t all looking at it in the same way. After implementation, it turned out that a significant percentage of our dispatchers were distinctly unhappy with the change. Comments were frequently made, some in the spirit of tactful debate and others not so tactful.

Now let’s pause to put things in perspective. Not all of our staff felt that way; many were ambivalent about the protocols and others were quite positive about them. Attitudes generally fell along the typical bell curve, although outspoken criticism from some quickly quenched the optimism initially displayed by others. Occasionally I encounter the not-so-happy participant in ProQA courses I teach for PDC; typically, it’s a firefighter or EMT in the room who doesn’t say much but, when asked, admits that he or she isn’t enthusiastic about what the respective agency is moving to. The question is why, and as trainers and administrators, how do we deal with it?

My experience in implementation is with EMD, so I’ll speak to that particular protocol system. EMS is a fast-paced, challenging profession. It’s often a life-or-death business, quite literally, where split-second decisions leave no room for second-guessing.

The best EMTs are the ones highly confident in themselves and their skills. Therein lies the root of the problem. In our case, it was multiplied several times over because our EMDs (pre-implementation) were allowed to ask whatever questions they thought best, providing they were focused on the chief complaint and “triaging” the call ALS or Basic Life Support (BLS). And most of them were very good at determining the need for ALS with a high degree of accuracy and a minimum number of questions. Now, we were telling them that they couldn’t do it their way, and had to follow a scripted protocol. “I can do it better and faster” was their complaint.

In retrospect, we should have recognized that implementation of MPDS was going to result in a huge culture shift. With the proverbial hindsight being 20/20, we should have better prepared for the changeover with some pre-implementation education. This would have laid the foundation for developing positive attitudes early on rather than letting negative ones take root later. The following lessons we learned might be helpful for those with similar employee structures and/or situations.

Emphasize consistency

Point out that there are a hundred different ways of doing EMD, and doing it your own way doesn’t necessarily mean you’re doing it wrong. Could someone’s personal way of handling a specific call be as effective as using protocol? Yes, but you can’t guarantee that every dispatcher’s personal approach would be as effective. We can, however, guarantee that if everyone follows the protocols, then everyone’s way of handling the call will be highly effective. In the realm of medical assessment and treatment, many procedures have long since been standardized. As the International Academies of Emergency Dispatch™ (IAED™) notes in the textbook, Principles of Emergency Medical Dispatch (Fourth Edition, 2009, pg. 120), “There could be a million ways of doing CPR, but there aren’t.” The AHA/ILCOR unified method of resuscitative practice is widely, if not universally, embraced.

Plus, the reality is that no emergency dispatcher, regardless of knowledge, skill, or experience, can expect to handle every 9-1-1 situation as effectively as the same dispatcher using the MPDS, PPDS, or FPDS. The dispatcher might be able to handle some calls as well as the protocols, but not every one, every time. It’s also a fact that 10 dispatchers—even experienced dispatchers—will have 10 different ways of handling the same call based on what they think is the best way of doing it. The EMS field long ago recognized the need for standardized protocols for patient assessment. As the Academy notes: “The practice of pre-hospital medicine [and in fact, any type of time-critical medicine] is not guideline—or judgment-driven—it is protocol-driven. Judgment by all pre-hospital care providers is a function of deciding which protocol applies and how to apply it in specific situations.” (Principles, pg. 13.5)

Best practices

This is a point that anyone who works in EMS can relate to. Law enforcement and the fire service also have long-standing procedures for doing things. Whether it’s how an officer should take down and handcuff a suspect or how firefighters should conduct a primary search for occupants in a burning building, all follow procedures that have evolved and are taught within those professions as the proven, best way of performing those actions or tasks.

Taking the above point one step further, it may help to explain that the architects of the medical, fire, and police protocols within the IAED are professionals in each discipline, working directly in those fields. They include fire chief’s, paramedics, law enforcement professionals, and other industry experts whose careers have been devoted to advancing the science of dispatch in their respective disciplines. These are the individuals who make up the IAED Councils of Standards and the International Standards committees. As a result of their efforts, the protocols are continually evolving and advancing based on research and case data from high-volume call centers, and they’ve been around for a combined 60+ years:

- 35 years in the case of the Medical Protocols,
- 14 years in the case of the Fire Protocols,
- 12 years for the Police Protocols.

Proposals for Change

It’s also likely that experienced dispatchers might express frustration over their perception of having no say in the set of protocols that’s been handed to them. Surprise them—that’s not the case. Introduce them...
to the Academy's Proposal for Change (PFC) form. The form—as the name suggests—gives protocol users the opportunity to recommend changes and forms the basis for a great in-service presentation. Most dispatchers have no idea that an agency can submit recommendations for change.

“Really? We can do that?” was the surprised response from one of my dispatchers when I informed him of the process.

While you’re at it, note to your dispatchers that we’re moving to version 13.0 of the MPDS, having introduced version 1.0 in 1979. Since that first edition, more than 4,000 changes have been made, the majority identified by dispatchers at user agencies. Widespread use of the protocols unifies a center into a “users’ group” with thousands of others around the world. This, according to Principles (pg. 13.17) allows the MPDS to be “built on knowledge and experience that is wider in scope and deeper in content than could be generated by even the largest communications center.”

Build acceptance

When asked questions about protocol, always—always—take the time to follow up and find the answer. Emphasize that just because the reason for a protocol question or its wording isn’t immediately apparent (or you can’t tell them why) doesn’t mean it’s a dumb question. Your Quality Improvement Unit (QIU) is the first place to go for answers, and, in addition, there are several other avenues for inquiry—writing to Dr. Jeff Clawson (the Ask Doc column in The Journal) or Brett Patterson (the FAQ column in The Journal), the Q Forum on the Academy’s website, and the highly popular Q Forum Live at NAVIGATOR, to name a few. Without exception, I’ve found that once I explain the reasoning behind a particular question or the way it is worded, a dispatcher is far more likely to appreciate why it’s here. Building acceptance with the protocols starts early, and it is a never-ending job.

In retrospect, knowing the culture of my former dispatch center—one that encouraged initiative and expected dispatchers to rely on their good judgment—we should have taken the time to identify the challenges and plan the best way to address them when introducing and implementing new protocols and/or ProQA to dispatchers. As we teach in Q classes, protocol implementation must be viewed from a project management standpoint. Your dispatchers’ world is about to change, and you’re giving them new tools to use. You can’t just plug in the protocols and expect dispatchers to accept them because you say so.

Protocol implementation isn’t a science, and it’s not something that happens because you put a policy in place that says so. It has to be approached as an art. It means taking the time to understand your employees and educating them about the pending changes before their first protocol class.

Do you need to sell them to your staff? You better believe it. If you’ve got good dispatchers, they care about what they do and take pride in doing it well. If you can get them to understand that you’re giving them a powerful new tool that will let them do their job at a whole new level—with a whole lot of benefits to your customers, your responders, and your agency to boot—they’ll be ready for the change when it happens.

Prepare in advance

Start preparing for the arrival of your new protocols well ahead of the first EMD, EFD, or EPD classes. Let your dispatchers know what to expect. Address their concerns, and ask them what they’ve heard about the protocols. Correct any misconceptions. Allow them to express their concerns, and answer them directly and honestly. Don’t blow smoke their way. Dispatchers are smart people who respect an honest answer. Be up front and acknowledge what they might not like about protocol, and turn the negatives into positives. For example, dispatchers might not like the idea of losing their freedom to ask whatever questions they want. Turn that around by pointing out that scripted questions allow them to focus their expertise on managing the caller and evaluating their responses, rather than dividing their attention to consider where to go next.

Protocol implementation isn’t a science, and it’s not something that happens because you put a policy in place that says so. It has to be approached as an art. It means taking the time to understand your employees and educating them about the pending changes before their first protocol class.

Do you need to sell them to your staff? You better believe it. If you’ve got good dispatchers, they care about what they do and take pride in doing it well. If you can get them to understand that you’re giving them a powerful new tool that will let them do their job at a whole new level—with a whole lot of benefits to your customers, your responders, and your agency to boot—they’ll be ready for the change when it happens.

Remember, despite a wealth of skills and expertise, emergency dispatchers typically view change with the greatest reluctance. In the middle of the stress and chaos that characterize the job, falling back on the tried and true offers some degree of predictability. Take that away, and you’re taking them out of their comfort zone.

Source

1 American Heart Association / International Liaison Committee on Resuscitation.
Say Now
Counting breaths identifies AGONAL pattern

Brett: I am a calltaker/dispatcher with Lee Control in Lee County, Fla. Our center is a dual Accredited Center of Excellence (ACE), using both the ProQA’ EMD and EFD. I had a question on the use of the AGONAL BREATHING Detector in Protocol 31: Unconscious/Fainting (Near) that I am hoping you can clarify.

When you have a patient that is unconscious and breathing, the call is going to be a DELTA-level call (unless ineffective breathing is identified during Case Entry). Why then are we performing the breathing diagnostic prior to sending the call? It is potentially time consuming and can delay the dispatch of help to a time-life priority complaint and, ultimately, will not change the level of the call.

I understand that it does determine the final Determinant Descriptor, but again, the level of the call will remain the same. Is there a way that the call could be sent with the “D” level descriptor before the diagnostic is performed, and then the diagnostic could be used afterward to ensure the correct pathway is followed?

Thank you for your time in considering this question, and I await your reply.

Alexis Franz
Communications Officer
Lee County Dept. of Public Safety
Fort Myers, Fla., USA

Alexis: The simple answer is that the Cardiac Arrest Quotient (CAQ is the percent of paramedic outcome cardiac arrests found in a code) is very high in 31-DELTA. In other words, many of these unconscious patients reported as breathing at Case Entry are actually in cardiac arrest and the caller and/or EMD mistook AGONAL respirations for effective respirations.

After seeing this data, the Council of
Standards decided to make the AGONAL BREATHING Detector mandatory for all unconscious patients triaged on Protocol 31 who were not breathing completely normally. This is not so much about the response code; it’s about getting hands on chest. In short, the detector is a safety net to catch cardiac arrest patients potentially missed but known to exist in this code.

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

Brett: Thank you for your quick response, I appreciate it. I think my concern was more the timing of when the diagnostic is supposed to be used.

The software indicates that it should be used prior to dispatch. Is it possible that that could be changed so that the diagnostic can be used after dispatch since the result does not change the level of the call? Using it after dispatch was initiated would still allow for recognition of a possible cardiac arrest patient and the initiation of compressions.

Alexis: I think getting the code right initially is important to response, although the code could certainly be reconfigured if the dispatch happened first. Please submit your idea in a Proposal for Change (PFC) to the Academy.

Brett

Alexis: To answer your question, please understand what to do in these kinds of situations?

Thank you very much,
Sara Justice
Southwest Summit Communications
Norton, Ohio, USA

Brett: Call came in involving a 41-year-old male who was having a seizure. Caller also mentioned the caller was a diabetic. Patient was having a seizure and was not conscious or breathing.

Rule 1 says seizure in a person greater or equal to age 35 is considered cardiac arrest until effective breathing is verified (Protocol 9: Cardiac or Respiratory Arrest/Death).

Rule 3 says when the initial Chief Complaint appears to be seizure, go to Protocol 12: Convulsions/Seizures regardless of consciousness and breathing status.

Our EMD chose Protocol 31, which I believe is incorrect. I think she should have gone to Protocol 12. Thoughts?

Paul Hacker
Supervisor
Manitowoc County Division of Emergency Services
Manitowoc, Wis., USA

Brett: Protocol 12 is the best choice for the complaint of seizure. If the seizure is the result of an arrest (hypoxic seizure), the protocol evaluates this and sends the EMD to Post-Dispatch Instructions. The Chief Complaint selection Rule on Case Entry regarding selecting Protocol 12 for the complaint of seizure you mentioned reinforces this.

The Rule regarding suspicion of cardiac arrest in a seizure patient equal to or greater than the age of 35 is not a Chief Complaint selection Rule but rather an action Rule within Protocol 12. It reminds EMDs that if the caller cannot physically verify breathing after a seizure in a patient in cardiac age range, we must err on the side of the patient and code the call in the DELTA level. In a patient under age 35, the chances are higher that we are dealing with a grand mal seizure, rather than a hypoxic seizure, thus the BRAVO-level code.

Protocol 31 should be used when a patient is unconscious, has fainted or nearly fainted, and does not have a complaint specific to other protocols, i.e., diabetic or trauma or scene safety related.

Sara: Judging from the Chief Complaint description (which is key), I think the EMD did the right thing. The complaint was a fall, and the protocol discovered a possible reason for the fall, and shunted. The important thing is that the decreased level of consciousness was discovered and triaged accordingly.

Going directly to Protocol 31 would not have been a problem if the EMD knew the cause of the fall initially. I cannot agree with using Protocol 30 initially, however, since there was a mechanism of injury addressed by protocol.

Hope that helps.
Brett
The caller—concealed under a pile of laundry inside a bedroom closet—whispered to Emily Utterback that a pair of men clad in dark clothing had forced their way into his suburban Sacramento home just after 9 p.m.

Falling back on her training, Utterback calmed the caller, quizzed him using the Police Priority Dispatch System™, and assured him that police officers were on their way.

“You get an adrenaline rush when you take a call,” Utterback told The Sacramento Bee regarding the Nov. 21, 2013, call. “It’s a rush when you help.”

If Utterback’s enthusiasm for emergency dispatch comes across a bit “newbie-ish,” it’s with good reason. A teenager, Utterback is a student at Center High School in Antelope, Calif., enrolled in a pilot program that provides juniors and seniors with hands-on 9-1-1 dispatch training. Though the break-in call was not real, the quality of instruction the two-year track provides students is the genuine article; upon graduation, seniors can depart Center High with cap and gown, diploma, and emergency dispatch certification.

“It is perhaps the most comprehensive such program available at any high school or community college,” Shawn Messinger, police consultant with Priority Dispatch Corp.” (PDC™), told the Sacramento daily newspaper. “These kids are getting access to a level of training that professional 9-1-1 centers have been using for almost 34 years.”

Introduced at the school two years ago, the program already counts one Center High graduate as a new hire for an emergency dispatch agency.

Utterback and her classmates in the prep school program could, in the very near future, form the vanguard of a new breed of dispatcher entering 9-1-1 comm. centers as the profession continues to evolve in the 21st century. Forward-thinking secondary education programs like Center High’s may begin to trend as high schools continue to move away from outdated vocational training, like metal and wood shop, and instead introduce in-demand, technical career programs, such as emergency dispatch.

But no matter what trends may be on the 9-1-1 dispatch horizon, experts agree that emergency dispatch remains an industry in flux. With change as a veritable constant, the profession continues to attain increasingly greater relevance as a destination career as opposed to merely being a speed bump on the road to other pursuits in emergency services.

A changing field

As call volumes and public expectations about what services emergency dispatch provides have spiked in recent decades, 9-1-1 comm. centers have reshuffled to meet those demands.

Few centers, if any, can afford to operate with minimally trained staff using archaic, homegrown protocols, and in the absence of computer-aided dispatch (CAD) systems, said Ivan Whitaker, a veteran EMT/paramedic and PDC consultant.

From a liability standpoint alone, comm. centers are almost forced to adopt standardized call protocols that include lifesaving instructions while also increasing staffing numbers and the level of training telecommunicators receive.

“When I came into dispatching, training was like one month,” said Whitaker, also a former comm. center manager. “Now, at larger metro call centers, training can be six to 12 months. For many centers, training is similar to the equivalent of an associate degree.”
Some states require the same amount of training for dispatchers that EMTs receive, according to Whitaker. In Florida, for example, state law requires that emergency dispatchers complete 232 hours of training to obtain certification, he said.

Jennifer Kirkland, operations support supervisor with Vail (Colo.) Public Safety’s comm. center and a frequent presenter at NAVIGATOR, said the introduction of standardized protocols has directly impacted public attitudes regarding the emergency dispatch industry.

“As public expectations of those protocols has increased, it provides an extra level of expertise and increases the perception that dispatching is a professional endeavor,” Kirkland said. “It’s changed the viewpoint of dispatchers as temporary employees or as a foot-in-the-door type of position to a profession that has really come into its own.”

Advances in technology are also an ever-moving X-factor with which public safety agencies and comm. center managers have had to adapt. Cellphones, protocol software, texting, and emerging video and audio capabilities have kept comm. center IT techs on their toes and forced agencies to re-evaluate the industry’s traditional phone-based public interface.

“Great multitasking skills are essential,” Whitaker said. “I’ll sit behind a dispatcher in a high-volume city, and it’s just amazing the call volume and degree of multitasking involved.”

The more things change …

But as much as some elements of the 9-1-1 world are in a rapid state of transition, others aren’t changing nearly fast enough.

Some agencies perpetuate the stereotype of emergency dispatch as a “dead-end job” or a temporary assignment for staff returning to the field, according to Whitaker. Centers can also undermine the profession when field officers with little to no dispatch experience are promoted to take command of a comm. center, or when an agency’s dispatcher/calltaker salaries and benefits pale in comparison to its EMTs and other field personnel.

“Instead of viewing dispatching as a career, some centers are still paying minimum wage,” Whitaker said. “We’re making some headway, but we still have a lot of work to do.”

In contrast, a comm. center in Lake Oswego, Ore., for which Whitaker provided consultation, offers benefits more in-line with other emergency service professionals.

“They’re very big on competitive pay, retirement, training, and resources,” Whitaker said. “I was totally amazed at [Lake Oswego’s] view on dispatching.”

Yet bleak dispatcher/calltaker retention rates also remain a continual struggle at many comm. centers, with the current national average hovering between 17 and 19 percent, according to Whitaker.

One factor that may help stem that tide is comm. center managers are beginning to recognize that younger generations of dispatchers challenging the status quo of some longtime center practices can improve retention rates, Whitaker said. For example, as an employee’s needs change through various stages of life, so do his or her priorities, such as family and earning a college degree. To this end, some comm. centers allow more flexible scheduling, such as working 12-hour shifts Friday through Sunday, so a dispatcher can continue spending more time with family or pursuing an education.

As a comm. center manager in Florida, Whitaker said he was a strong proponent of
“DISPATCHERS THAT FEEL SUPPORTED IN ALL ASPECTS OF THEIR LIVES WILL BE MORE DEDICATED TO THE AGENCY.”

— Jennifer Kirkland

Moving on Up Jennifer Kirkland of Vail (Colo.) Public Safety 911

supporting telecommunicators’ continuing education efforts.

Kirkland said another key to improving retention rates is careful candidate selection from the get-go. Finding good matches doesn’t end at the pre-screening. New hires must receive the training and tools necessary for success and be made to feel like they’re a valued part of the team. Dispatchers also need access to healthy outlets for letting off steam and dealing with stress as well as continuing education opportunities to help them meet their personal goals that can aid in preventing telecommunicator burnout.

“You have to build a team atmosphere,” Kirkland said. “A lot of it rests with the individual person, and how call center managers support dispatchers when they’re having family issues or looking at going back to school. Dispatchers that feel supported in all aspects of their lives will be more dedicated to the agency.”

Kirkland said the Vail Public Safety’s comm. center has found greater stability and employee success in recruiting former members of the military because of the same attributes they brought to the armed forces.

“They’re not afraid of pressure, they’re used to shift work, they understand the chain of command, and they’re extremely loyal to the agency,” she said.

What impact is the popular trend of comm. center consolidation having on the profession’s accessibility?

Logic might indicate that it would lead to fewer available positions. Not so, some say. Employment in the profession is estimated to grow by 12 percent between 2010 and 2020, according to the U.S Bureau of Labor Statistics. And while consolidation might signal some reductions in force, Kirkland pointed out the anticipated employment opportunities that Next Generation 9-1-1 adaptations will bring to the comm. center, such as texting and live video and audio streaming.

“You can’t expect a person who is already busy doing calltaking to also monitor these,” Kirkland said. “There will be a consolidation of positions but not a consolidation in terms of type of work that needs to be done.”

The future’s so bright …

Within the next five years, comm. centers will face sizable transitions in leadership as Baby Boomers enter retirement, Whitaker said. Those vacancies will pose an opportunity for public safety decision makers to promote personnel from within the trenches who have demonstrated management potential.

For 9-1-1 telecommunicators who want to advance their careers, Whitaker recommends reviewing dispatch supervisory and managerial job descriptions and requirements, including those from industry online job postings at the IAED, the National Emergency Number Association (NENA), and 911 Magazine.

“By following this method, the dispatcher can develop a conceptual view of what it takes to become a supervisor or manager across the country,” Whitaker said. “I personally believe that broadening the scope of the dispatcher’s knowledge, skills, and abilities to fit national and even international requirements provides the best opportunity for success.”

Most higher-level supervisory and management positions require an associate degree or a bachelor’s degree; 5–10 years managerial experience; knowledge of radio, GIS, and CAD systems; the ability to manage budgets and personnel, develop policies, procedure, and SOPs, and write request for proposals; and excellent project management, conflict resolution, and business writing skills, according to Whitaker.

Dispatchers should develop a strategic plan to complete a college degree and acquire the necessary skills for advancement. For example, they could ask the center’s manager or director to train them on how to manage the budget and ask to be included in the annual budgeting process. Employees could also look into local community and technical colleges offering adult education courses that help them acquire marketable management skills, Whitaker said.

“This is where I learned the ins-and-outs of business writing, the Microsoft Office Suite, tactical and strategic planning, and much more,” Whitaker said.

Kirkland said emergency dispatchers seeking to propel their careers forward should also become active in the IAED, NENA, and APCO; conduct themselves professionally at all times; and become certified training officers (CTO). She also recommends volunteering for projects in the center that pique their interest.

“This displays teamwork, a positive attitude, and a willingness to work,” Kirkland said. “This will reflect positively on you when opportunities for advancement arise, and look good on a résumé.”

Another way to stand out from the crowd is to find someone you admire who is in the type of position you desire, either within your agency or at another call center, and ask them to mentor you, Kirkland said.

“Mentoring is a great way to learn skills in a non-pressure environment, and you may learn aspects of the position that you hadn’t realized before,” Kirkland said.

Whitaker adds that dispatchers can raise their market value by taking advantage of in-house step ladder and promotional programs; attending professional dispatch conferences, such as NAVIGATOR; getting published in industry magazines; and briefly interviewing 5–10 area leaders in different
industries to learn why they are good leaders. You may even glean some management tips from them. It also doesn’t hurt to brush up on your interview skills by conducting mock interviews with family members or friends for practice, he said.

“Stay motivated and do not become discouraged,” Whitaker said. “Not being selected for a position can be disappointing. Use the disappointment as fuel to dig deeper and continue to develop. Don’t be afraid to apply for positions with different agencies. The process alone will be invaluable.”

**Going the distance**

Wherever the future takes the profession of emergency dispatch, Whitaker and Kirkland agree that the occupation is on an upward trajectory and offers opportunities for growth and advancement to those willing to work hard.

“I think the future is bright as long as technology continues to change and so do demands,” Whitaker said. “As demands increase, so will training that will give added value to the position as an important profession. The training, professionalism, protocols, and technologies will continue to grow dispatch into a stable profession that draws talented people.”

According to Kirkland, the greatest challenge to the emergency dispatch profession going into the future will be for its leaders to keep up with the pace of change while also identifying and training quality candidates. Comm. centers that secure the best talent, Whitaker said, will be the ones that educate candidates about the realities and challenges of the profession. Screenings should include panel interviews, during which tough questions can be posed to candidates, in addition to having applicants participate in a variety of ability, multitasking, and behavioral testing, he said.

But, ultimately, Kirkland said, the responsibility of successfully navigating and managing one’s career falls to the individual.

“I know people who have been in the business for 30 years or more, and also people who get in and leave within six months to a year,” Kirkland said. “I think it’s a mistake for anyone interested in public safety to think they can’t make a career out of emergency dispatch. It’s just like any industry; not everyone is suited for it and not everyone stays. You have to have a good self-care program in place, be proactive, and take charge of opportunities. No one can expect the agency to do it all.”

**Profiles in Dispatch Success**

The Journal of Emergency Dispatch spoke with several people working in the emergency communications field about challenges unique to the profession that they’ve had to overcome to be successful. The following are their responses in their words:

**Kyle Sneesby | 44**

Operations Manager
Medical Transportation Communications Centre (MTCC)
Brandon, Manitoba, Canada
Certifications: EMD, EMD-Q®
Yrs. in emergency dispatch: 7½
Yrs. in current position: 7 ½

One challenge has been our constant growth and change. As a brand new organization in 2006, we spent six years implementing all of our different phases of operations, adding personnel at each stage. The best solution to this constant challenge has been surrounding myself with the right people. We have built a talented and dedicated team at MTCC. I am very proud every time I give them a new challenge and they exceed my expectations.

Another challenge has been finding the right people to put on our team. Rather than falling into the trap of only adding people who come with all of the skills and certifications, we look for good people who will be a good fit for the job and organization. We then help them to achieve all of the certifications and learn all of the skills.

**Laura Lee Cody | 44**

Senior Communications Officer
Richmond Ambulance Authority
Richmond, Va., USA
Certifications: EMD, Paramedic
Yrs. in emergency dispatch: 8
Yrs. in current position: 5

One of the most important things for me in dispatch has been developing a separation from work. Sometimes you find that the job takes over your life when you spend time with co-workers outside of the call center. I am friends with the people I work with, but choosing friendships with people outside of the comm. center gives me a different perspective and helps me to relax when I’m not at work.

Another challenge is the lack of movement. When you work 12-hour shifts in a chair, it is exhausting. I schedule times to exercise and make my health a priority. The healthier you stay physically, the longer you can do the job mentally. I schedule a specific time to run each day.

**Tammy Jewell | 43**

QI/Training Officer
Winnipeg Fire Paramedic Service
Winnipeg, Manitoba, Canada
Certifications: Emergency Telecommunicator, EMD and EFD-Q™ instructor, EMD, EFD, and National Q member
Yrs. in emergency emergency services: 13
Yrs. in current position: 6

One of the challenges that communicators face is the ability to have a work/life balance. At the time of my hiring I had a young child at home and shift work did not always enable me to get the rest that I needed to be effective and efficient at my job. I had to come up with a solution to ensure that I was getting the rest that I needed to perform at an optimum level.

It is also really important to have supports in place such as family and friends that understand the shift work that a communicator performs. There will be times where you will miss those Sunday family dinners or gatherings, and you may need to sleep during a warm summer day when everyone else is at the beach. Preparing your family is just as important as preparing yourself for this career.
CELEBRATING 35 YEARS OF EVOLUTION

The proof is in the protocols
I f the protocols could speak for themselves—and they do in their own sort of way—they would have been elated at their NAVIGATOR reception in Orlando, Fla., marking the 35th anniversary of their introduction to the world.

“We are here celebrating 35 years of structured calltaking,” said Brian Dale, International Academies of Emergency Dispatch® (IAED™) Board of Accreditation chair. “All the things we have done [over the years] have made protocol stronger. We have brought other disciplines into a process to make protocol as scientifically valid as possible. Just think of the number of people impacted by a crazy doctor who had a sincere desire to find a better way.”

Dr. Jeff Clawson, creator of the dispatch protocols, took the honor in stride, turning the attention to an audience collectively holding their breath, so it seemed, to hear a few words from the “crazy doctor” they all admire.

“It’s great to see so many people gathered in the same place to talk about our successes, failures, and the future,” said Dr. Clawson, whose protocols hatched from his experience as a resident in Emergency Medicine at Charity Hospital in New Orleans, La., and as the fire surgeon of the Salt Lake City (Utah) Fire Department more than three decades ago. “And as we have learned, it’s all about the process of change and moving forward as scientifically valid as is possible.”

At the heart of NAVIGATOR is the protocol bolstered by the scientific method, professional organizations, and proposals submitted by the medical, fire, and police users that has drawn more than 3,600 centers worldwide during the past 35 years since Dr. Clawson unveiled the Medical Protocol to the world. The Academy has since followed with the fire, police, and Emergency Communication Nurse protocol systems.

It was in 1979 that Dr. Clawson introduced the Medical Protocol at the Salt Lake City Fire Department Comm. Center in answer to his experience as the department’s fire surgeon. He recognized the absence of tools available to what has become known as the “first link” in the chain of response and devised a solution that through its evolution stands as the gold standard in emergency communications.

Dr. Clawson used the analogy of process to prep his audience for v13.0 of the Medical Priority Dispatch System™ (MPDS®) enhancements in the fast-track “Obviously NOT Breathing & Unconscious (Cardiac Arrest)” feature that dramatically reduces time to hands-on-chest, and enhances other changes with the same aim introduced in v12.2 and further shortened in v13.0.

“We operated in one of the most time-restricted environments on Earth so we have to make sure we do it right the first time and...”
promptly," he said in remarks met with a standing ovation during NAVIGATOR’s Opening Session on Wednesday, April 30, at Disney’s Coronado Springs Resort. “The clock is ticking.”

The fast-track feature bypasses all questions and instructions on Case Entry, checks for AED availability, then navigates the EMD directly to the appropriate Pre-Arrival Instructions (PAIs) when a caller describes an obvious, medical cardiac arrest. This direct link was created to meet American Heart Association (AHA) scientific recommendations to reduce the time from discovery of cardiac arrest to “hands-on-chest,” which can dramatically increase a patient’s chance of survival.

In an audio clip presented during the Opening Session, a call recording was adapted from v12.2 to the soon-to-be-released v13.0 to illustrate the new fast-track feature. In the call, Jessica Lecik, of the Richmond (Va.) Ambulance Authority, a finalist for last year’s Dispatcher of the Year, answers a call from a frantic female reporting that her husband isn’t conscious and isn’t breathing. Twenty-seven seconds into the call, including getting him out of his chair, the caller has her hands to her husband’s chest following the EMD’s instructions for chest compressions.

“Twenty-seven seconds, that’s all,” Dr. Clawson said. “Time to dispatch in ProQA® is only three seconds after ANI/ALI confirmation—it can’t get any faster than that. By providing CPR instructions earlier, we are emphasizing immediate care for our patients.”

The protocol’s PAIs for CPR underscore the dispatcher’s vital role as the first link in a process known as the Chain of Survival, a metaphor adopted by the AHA for the series of actions that can reduce the mortality associated with cardiac arrest, stroke, and other emergencies.

The three-day official conference, preceded by three days of pre-conference workshops, struck a cord immediately at the Opening Session with a 90-piece marching band from Freedom High School (Orange County Public Schools, Orlando, Fla.) playing the National Anthem as part of the presentation of the colors.

“This is so awesome,” commented Susan Feiertag, dispatcher, Los Alamos County (NM) 9-1-1. “This makes me realize the amazing jobs we do.”

The “amazing jobs” were celebrated through several on-stage events: the 2014 Dispatcher of the Year Award; the Dr. Jeff Clawson Leadership Award; the recognition of Accredited Centers of Excellence (ACEs)—both new and re-accrediting; presentation of the 2014 Communication Center Management (CCM) Course graduates; and the announcement of four more agencies added to the National Center for Missing and Exploited Children (NCMEC) 9-1-1 Call Center Partner program.

A new feature at NAVIGATOR was the special lanyard with the ACE logo worn by individuals from accredited centers.

Hamad Medical Corporation Ambulance Service in Doha, Qatar, was the first center from the Middle East to become an ACE, officially accredited just two weeks before the conference.

“We came running to NAVIGATOR after getting the word,” said QI Manager Sonia Bounouh, who was wearing her ACE lanyard. “We are so excited to be here and plan to have a big celebration [at the center] when we return.”

Keynote speakers included Stuart Levine, of the Disney Institute,
and Pat Williams, senior vice president of the NBA’s Orlando Magic. Both speakers touched on customer service and motivation—in the magical Disney sort of way.

Similar to dispatchers using protocol, Levine said Disney cast members (employees) strive to deliver perfection in customer service.

“The power of service lies in the ability to make an emotional connection rather than purely a rational connection,” said Levine, former animal programs education manager at Disney’s Animal Kingdom Lodge. “People remember how they felt within the moment and creating those positive moments at every chance adds up to a tremendous experience.”

The exhibit hall featured 150 booths, both commercial and nonprofit, while the Opening Gala Reception events gave dispatchers a chance to mitigate the everyday stress of their profession and network.

“That’s what’s so cool about this,” said Todd Allen, from Powder Springs, Ga. “The conference helps us find ways to do things better and, at the same time, we meet people from all over the world who want to work toward that higher standard. We make lifelong contacts.”

The high note, of course, was the conference, which made its debut 15 years ago with no more than 100 people attending a one-day block of sessions. This year, a record 1,345 attendees from 14 nations participated in more than 100 educational sessions punctuated by a gala reception, an exhibit hall, special events, and guided tours of two area 9-1-1 communication centers (Osceola County Sheriff’s Office and the Reedy Creek Communication Center).

Notable changes at the conference included the continued evolution of the number and type of sessions held and a poster contest to promote the importance of continuing dispatch education sponsored by the research team (the winner was from the Yorkshire Ambulance Service, National Health Service Trust, U.K.).

For 2014, NAVIGATOR introduced Power Sessions, which were modeled after the European style of professional conferences. The four held—Research, National 9-1-1 Issues, 9-1-1 Data and Analytics, and ACE—brought together IAED panels of experts taking turns at the “podium” covering four to six related topics.

The amount of rainfall in Orlando during the week was about the only record NAVIGATOR was not pleased to exceed. A line of thunderstorms walloping central Florida resulted in three inches of rain falling in southwest and northwest Orange counties, according to the National Weather Service. Drenching rainfall forced the outdoor Beach Party at Disney’s Typhoon Lagoon Water Park and the ACE Reception at Cabanas Beach to halls inside.

The rain, lightning, and carpet rather than sand underfoot, however, did not dampen the spirits of dispatchers (at least not for long).

“I don’t care what happens, once you go to NAVIGATOR, you never want to go anywhere else,” said Virginia Szatkowksi, EMD-Q®, EFD-Q®, and ETC® instructor. “This is my third, and I’m still starstruck by the opportunity to meet the best people in the profession. It’s an amazing place to be.”
Santa Fe, N.M.

When Ken Martinez, director, Santa Fe Regional Emergency Communications Center, received word of medical accreditation there was no stopping his announcement to the Board of Directors.

“It was a great feeling saying it was done, and that we had achieved what we had set out to do,” he said.

Martinez said accreditation was top priority when he was promoted to director. The medical ACE, awarded in 2012, will be followed with the fire and, then, police ACE. He anticipates the going to be smooth, considering the buy in he has achieved.

“The tough part was getting everybody on board, and taking the necessary steps to make it work,” he said. “There were difficult decisions to make but once we were through the problem-solving and became a team, we got the ACE going.”

Martinez, however, cautioned against going too fast and, at his center, decided to keep compliance scores at ACE levels prior to applying.

“The worst thing you can do is achieve accreditation and then lose it by not maintaining your scores,” he said.

Martinez was sure they would continue that pace to achieve re-accreditation in 2015 when applicants must use new recently released performance standards (see the Official Statement on page 13).

“Compliance scores haven’t dropped since achieving ACE, and I expect them to stay at the same high level,” Martinez said. “Keeping with current high standards of compliance is worked into the routine.”

The Santa Fe Regional Emergency Communications Center was established in 2002 to consolidate E9-1-1 and emergency dispatch operations for the Santa Fe Police Department, the Santa Fe County Sheriff’s Department, and the city and county fire departments. The dispatch center was part of the public safety building completed the same year, which employs 49 dispatchers, calltakers, and other administrative staff.

Salt Lake City, Utah

Laurie Wilson-Bell has been in emergency communications at the place where it all started for almost the same amount of time as the protocols.

Wilson-Bell began her career as a police dispatcher in Salt Lake City in 1982—three years after the Medical Protocol was introduced at the Salt Lake City Fire Department communications center. She grew up around them, professionally speaking, but was a bit hesitant when it came apparent that she would be making the transition to structured calltaking.

Now she wouldn’t have it any differently, and the same goes for praise of the tri-ACE the consolidated (police, fire, medical) Salt Lake City (Utah) 9-1-1 Communications Bureau achieved in 2013.

“ACE is the gold standard for dispatch,” said Wilson-Bell, the quality assurance supervisor. “When you’re at the top, it’s a huge advantage for your staff and the public you serve.”

Salt Lake City merged its emergency communication services in 2013, putting more than 70 employees in the same center to handle an anticipated 550,000 9-1-1 calls during the first year of working together. Medical dispatch was accredited in 1997, followed by fire in 2007, and police in 2013.

Lower Austria

Christian Laucher wanted proof before he was willing to accept the transition to scripted calltaking using the Medical Priority Dispatch System™ (MPDS™).

The former 144 Notruf Niederösterreich (Lower Austria) processing manager had worked in dispatching for eight years when the protocol was implemented, and he needed some convincing before embracing the change.
“This is something American that wouldn’t work in our country, and I took it upon myself to prove it,” Laucher said. “Well, it proved me wrong. It did work.”

The protocol not only changed his way of thinking but it, also, led him and the center in new directions.

Laucher made his first trip to NAVIGATOR in 2005, skipped two years, and has been a steadfast attendee for consecutive years since 2008. In 2009, he was at NAVIGATOR to accept the ACE awarded to 144 Notruf Niederösterreich.

It was the first center in continental Europe to become an ACE and staff has become the protocol’s torchbearers in their part of the world.

Laucher and Heinz Novosad, the center’s training manager, are members of the International Academies of Emergency Dispatch® German Cultural Committee (covering Germany, Switzerland, and Austria) and the Medical Council of Standards Readers Group. They are certified in medical and fire protocol instruction and quality improvement.

Novosad said the conference provides time for long discussions among peers about how they can do their jobs better and faster.

“Our voices are heard,” Novosad said. “We are respected for the perspective we bring. It’s also great to know that we are helping to further international use of protocol and making Dispatch Life Support more common in Europe.”

144 Notruf Niederösterreich, which dispatches more than one million events a year for the state of Lower Austria, has a service area of 7,403 square miles and a population of 1.6 million German speakers. It is the first accredited comm. center in continental Europe, having accredited in 2009 and re-accredited in 2012. Christof Chwojka is the chief executive officer.

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ATTENDEE PROFILES

NORMAN RIVERA
TORONTO EMS (TEMS)
TORONTO, ONTARIO, CANADA

Rivera’s first trip to NAVIGATOR far exceeded his expectations; at least that’s the perspective from his first day at the conference from inside the gala event preceding the first full day of sessions. Rivera, a medical dispatcher for eight years, was the TEMS recipient of the Communicator of the Year Award, which included his trip to NAVIGATOR. He was looking forward to the educational sessions scheduled over the next three days.

JYL MCGONIGAL
TORONTO EMS (TEMS)
TORONTO, ONTARIO, CANADA

NAVIGATOR 2014 was the ninth conference McGonigal has attended since 2002 (missing only two during the span of years). McGonigal credits Brett Patterson, IAED™ Medical Council of Standards chair, for originally inspiring her dedication to protocol. “He was incredibly passionate about the protocol when he came to Toronto to teach the EMD course,” she said. “What he had to say clicked with me. I instantly wanted to learn more.”

ANDREA MCLEAN AND NANCY MCCULLERY
RED DEER EMERGENCY SERVICES
RED DEER, ALBERTA, CANADA

McLean and McCullery made it a point to drop by the 911 CARES booth at NAVIGATOR since it’s another great venue at the conference for talking with others from outside their center. NAVIGATOR is also the place where they learn ways to improve what they’re doing (which must be great considering the almost non-existent turnover in a center that employs 130 people—including 17 dispatchers—and provides fire and EMS in a central part of the province).
A FIRST FOR THE MIDDLE EAST
Hamad Medical Corporation achieves region’s first medical ACE

April 20, 2014, is a date that will go down in Hamad Medical Corporation Ambulance Service (Doha, Qatar) communication history.

Although the day started out along the same routine—if there is such a thing for an ambulance service—by mid-day Sonia Bounouh was ready to put on her jogging shoes after completing one of her longest races of her life.

“We were ACE,” she said. “We received word that weekend, and I knew we’d be running to NAVIGATOR.”

Bounouh, the communication center’s QI manager, and Ezeldin al-Yafei, operations manager, were among the representatives from 10 agencies worldwide accepting certificates of new medical and fire accreditations during the Opening Session at NAVIGATOR 2014. Forty-six comm. centers qualified for medical and fire re-accreditation.

The Hamad Medical Corporation comm. center is the first ACE recipient in the Middle East.

“We’ve worked so hard to measure up to the ACE standard,” Bounouh said. “Being the first ACE makes this even more exciting.”

And now, she said, it would be party time in Qatar.

Following NAVIGATOR, Bounouh and al-Yafei planned to extend invitations for an ACE celebration to Hamad Medical Corporation leaders and local dignitaries. They will “unveil” the medical ACE certificate and acknowledge staff for the strides made since reintroducing the Medical Priority Dispatch System” (MPDS”) Protocol in 2010 following a several year hiatus.

The going wasn’t easy, at least at first, said al-Yafei, who started as a calltaker at the center in 2005. Then came the turnaround.

“When I look back, it was like the American scrambled eggs,” he said. “Once they learned the right way, they forgot how they were working before.”

Hamad Medical Corporation manages eight hospitals in Qatar and the national ambulance service under the command of the Supreme Council of Health.

The ambulance service responds to more than 90,000 calls each year through the support of 167 ambulances, 20 rapid response vehicles, and a Life Flight air ambulance helicopter.

According to Hamad Medical Corporation’s annual report (2012–2013): “There was a significant increase in ambulance service volumes during the year driven by a combination of improved call handling and increased public awareness in regard for the service.”

Qatar is located in western Asia, occupying the small peninsula of Qatar on the northeast coast of the Arabian Peninsula. It borders Saudi Arabia to the south. Only about one-quarter of the 1.8 million people living in Qatar are citizens.
The prelude to announcing Bryan Anta as the 2014 Dispatcher of the Year had many in the audience scratching their heads. It’s not that Anta fell short of making significant contributions to the Academy’s values and mission, as required by the award, but there were some bewildered expressions at the broad array from which he drew his experience.

Anta’s high-profile cases included coordinating response following a tornado at Great Smoky Mountains National Park (Tenn.), helping an anxious mom find her son at the 2013 Boston Marathon, and giving Pre-Arrival Instructions (PAIs) to assist a woman having an asthma attack on the side of the road somewhere between Massachusetts and the border of North Carolina and Tennessee.

How does one person connect with so many callers in such a short period of time despite a calling card outside of the U.S.?

The answer lies in the location of his connection. Anta is an emergency adviser for OnStar, an in-vehicle security and navigational system that, in 2013, became an Academy Medical Accredited Center of Excellence (ACE).

“Bryan does an excellent job of transporting himself into the car,” said IAED™ Associate Director Carlynn Page, who presented the award. Anta is one among 250 emergency medical dispatchers with OnStar processing an average of 1,200 calls a month requiring the use of the Medical Priority Dispatch System™ (MPDS™). Total call volume throughout the OnStar service area (seven million subscribers in the U.S., Canada, China, and Mexico) averages about five million per year.

He works out of OnStar’s Oshawa call center in Ontario, Canada. Anta, who has been with OnStar four years in May, is a former customer service representative for businesses that did not require emergency services. The ability to “engage” his customers and an opportunity to help someone forced his hand. The knack to think in the moment, he said, is a plus recognized in an environment in which calls are made by a push of a button in an OnStar subscriber’s vehicle.

The calls cited at NAVIGATOR showed Anta’s commitment and the reason behind his break from the call center to accept the award and visit Walt Disney World Resort.

“I liked the job from the start,” he said.

Anta’s call, using “Honk once for ‘yes’ and twice for ‘no’” instructions, was crucial for a woman who couldn’t speak because of a serious asthma attack on the side of the road. The woman—on her way to the hospital with her 3-year-old daughter at the first sign of the attack—had called her mother by cellphone and, also, pressed the OnStar button for emergency assistance.

While another adviser contacted first responders, Anta stayed on the line to provide emergency instructions to the woman’s mother since the woman’s asthma attack made direct communication difficult.

“Even though the connection was good, the situation inside the car—a woman gasping for air and a frightened, crying child—made it impossible for Anta to determine what was going on at the scene. He heard the sound of a car honk.

“She honked and then I knew exactly what to do,” he said. His “think in the moment” reaction without diverging from Key
Questions put Anta on OnStar’s nomination list, said Grant Heaslip, the OnStar director of operations at the Oshawa call center.

“Bryan does things others might think about after the fact,” Heaslip said. “He’s dedicated to the core and does everything above and beyond.”

In addition to assisting in an asthmatic emergency, Anta has assisted with a number of other notable emergency calls during the past year.

He answered a call from an anxious mother trying to find her son following explosions near the finish line of the 2013 Boston Marathon. Anta navigated her to the interstate closest to where her son had arranged to meet her after completing the 26.2-mile run.

During another call, Anta relayed CPR instructions to a woman whose husband suffered a severe heart attack in the vehicle. The man has since recovered. A small portion of the call was played during NAVIGATOR’s Opening Session.

In 2012, Anta directed first responders to a campground made inaccessible by fallen trees following severe thunderstorms at Great Smoky Mountains National Park. OnStar subscriber Carole Cooper initiated the call and volunteered the use of her Chevrolet Tahoe for a makeshift public safety communication center giving rescue workers access to the OnStar connection for communicating with other emergency personnel. Anta stayed on the call for nearly four hours.

OnStar Medical Director Dr. Paul Stiegler said Anta represents the best of what the EMD job is all about.

“He’s incredibly focused on the scene,” Stiegler said. “He’s caring and gets to the core of the situation.”

Anta chalks it up to luck and job satisfaction.

“The attention is an honor,” Anta said. “But the amazing part is being here around so many people who continue to protect us all.”

HOLLI JORDAN
LEE COUNTY PUBLIC SAFETY
FORT MYERS, FLA.

The self-proclaimed 9-1-1 and Walt Disney World Resort fanatic—although not necessarily in that order—said NAVIGATOR keeps her as well-versed in protocol as her family’s frequent trips to the theme parks keep her up on the magic of Disney. Jordan knows where to get the best food, the best place to watch the fireworks, and the best time to visit (Christmas). She’s just as passionate about her job, and that’s after 26 years in the profession. “Every time you answer the phone, you don’t know what’s going to happen,” she said. “And on top of that, we get to help people. How many others can say that about their jobs?”

JENNA ARMSTRONG AND KIM BOYD
COLORADO SPRINGS PUBLIC SAFETY COMMUNICATIONS CENTER
COLORADO SPRINGS, COLO.

Armstrong and Boyd are in the profession for the long haul. “It’s a career for me,” said Armstrong, who has been in 9-1-1 communications for 11 years. Boyd, who has been a dispatcher for nine years, feels the same way. “This isn’t a job for me,” she said. “I want to be that person who can help when the call comes in.” Both women applied for “the job”—as they thought about it at the time—without knowing exactly what they were getting into. Now, they wouldn’t leave 9-1-1 for anything because where else can you find something that helps people, while at the same time is exciting and gives you an opportunity to attend a “great conference”?

CHUCK THOMPSON AND CLIVEICA CAESAR
GRADY EMS
ATLANTA, GA.

Caesar, center director, and Thompson, an EMD-Q®, find training and quality assurance critical to the welfare of their callers and the well-being of staff. “We all worry about the patient,” Caesar said. “By making sure we’re doing it right, we know we can make that difference in a person’s life.” Caesar was put to the “Q” test not too long ago when taking a call involving a 4-year-old choking on a hotdog. “Staff was listening,” she said. “It was like all of us were together in that moment.” This is the third NAVIGATOR for Caesar and the first for Thompson. “I really looked forward to meeting so many people interested in the same thing,” Thompson said. “Now we get to bring back what we’ve learned.”
Dr. Stiegler had a new look about him this year. He wasn't carrying his guitar to entertain audiences with his music dedicated to protocol, and he wasn't sitting in the audience applauding at the announcement of this year's Dr. Jeff Clawson Leadership Award recipient.

Stiegler was the award's honoree for 2014. "He is walking the walk," said Dr. Jeff Clawson, who presented the award. "He's doing what the Academy has set out to do."

Stiegler is the medical director for both the Dane County Public Safety Communications Center in Madison, Wis., and OnStar, the in-vehicle security communications provider. In 2013, Dane County was accredited as a tri-ACE (medical, fire, and police), while OnStar also achieved its medical ACE.

Stiegler said he was extremely honored to receive the award yet also somewhat self-conscious. "It is humbling to be given this award from the very person who embodies the vision, the leadership, and the academic acumen of this amazing system," he said. "It's also somewhat embarrassing to be recognized for something that is just plain fun to do."

Stiegler was introduced to protocol in 2001 or, rather, he was introduced to Dr. Clawson, who was in Madison on matters of protocol and the Academy. The two medical doctors talked and in about a "nanosecond," Stiegler said, he was convinced.

"I saw what could happen," said Stiegler, Dane County 9-1-1 medical director since 1999. "I believed in what he was doing." Stiegler didn't waste any time.

He jumped in with both feet and, during that same year, took the emergency medical dispatcher (EMD) course and certified. In 2002, Stiegler certified as an EMD-Q®. Two years later, he became an EMD instructor, and Dr. Clawson invited him to join the Academy's College of Fellows.

Stiegler is devoted to emergency medicine and protocol, interests followed closely by his second career as a singer/songwriter. His music ranges from pop, to show tunes, to barbershop, to opera, and he was singled out as the 2011 winner of the U.K. Songwriting Contest. In 2013, he wowed the emergency dispatch community at NAVIGATOR with a song he dedicated to them. The nearly three-minute tribute, available on his website (paulstiegler.com), welcomes people to the conference held in the city where "it all began."

Stiegler does walk the walk, acting upon his belief that protocol and Pre-Arrival Instructions were the best things to happen in emergency communications and pre-hospital care during his 30 years in emergency medicine.

"You have probably saved more lives in dispatch than I have as an EMS physician," Stiegler said at NAVIGATOR's Closing Luncheon in acceptance of the award. "Thank you all for what you do every day."
IT TAKES TWO
Reedy Creek and Osceola County share magic of Disney dispatch

The magic of Disney would be at a loss without the Reedy Creek Improvement District communication center. Nestled at the edge of Epcot—close to the site of the evening’s $40,000 fireworks display—the center takes on an imaginative spin when it comes to matching the potential of mishaps at the roughly 47-square mile Walt Disney World Resort.

“I couldn’t ask for a better place to work,” said Michael “Bo” Jones, assistant chief of emergency services, who spent the better part of two days taking bus loads of visiting dispatchers through the center. “The team is great, and Disney gives us the same attention as the theme park whenever we have a problem to solve.”

The 12 dispatchers, four to five per shift, answer 450,000 calls each year, including a combined total of 28,000 fire, rescue, and EMS calls.

Accidents do happen, and when it’s beyond the scope of fire and ambulance, it’s just like Jones said: Disney to the rescue.

In 2012, a computer hard drive failure shut off power throughout the monorail system, leaving 300 passengers stranded on the track high above the ground for several hours. Reedy Creek fire and rescue rushed to the scene in response to the influx of 9-1-1 calls coming into its communication center.

Unfortunately, the scissor-lift vehicle the district had purchased specifically for large-scale monorail evacuations couldn’t reach the point along the beam where the train was stuck.

Well, that’s when Disney’s engineers were called into the process. They retrofitted the existing scissor-lift with an extension that added another 10 feet to its reach, making it a 32-foot lift.

The Reedy Creek Improvement District is comprised of two cities (which include all of the Disney properties)—Lake Buena Vista and the City of Bay Lake—and provides full public service, including fire EMS, 9-1-1, building and safety, and environmental land management. Reedy Creek firefighters have been protecting the properties since 1968.

The communication center is the Public Safety Answering Point (PSAP) for all calls to 9-1-1 within the district’s jurisdiction. In addition to fire EMS calls, the center provides status information minimizing radio traffic, serves as the monitoring station for 5,475 alarm points throughout the district, and tracks the activities of fire safety inspectors and operations personnel during inspections and daily activities.
The communication center at the Osceola County Sheriff’s Department shows how the other half lives, at least in terms of emergency dispatch for Walt Disney World Resort fire and emergency medical services.

Osceola provides fire and EMS services for Disney’s Animal Kingdom Theme Park parking lot and the 230-acre ESPN Wide World of Sports Complex. The Orange County Sheriff’s Office provides police response to Walt Disney World Resort.

As far as guest and staff security goes, Disney retains more than a thousand employees in security operations at the Disneyland and Walt Disney World resorts. Some wear the typical security guard uniform while others are dressed as tourists in plain clothes. Disney personnel are not allowed to carry weapons.

But Disney’s role in security and the existence of the Reedy Creek Improvement District don’t make days slow for the 85 dispatchers (when fully staffed) at the Osceola comm. center. They answer on average nearly 390,000 calls a year, dispatching 25,000 fire and EMS responses, and 150,000 law enforcement calls for service.

Telecommunicators must go through 232 hours at the training academy located in the consolidated 9-1-1 services and emergency management facility completed in 2009. Once trained, they answer emergency and non-emergency calls involving police, fire, EMS, and animal control.

The consolidation between the sheriff’s office and animal control in October 2012 was requested by fire rescue to minimize dispatch times. Dispatchers at the comm. center take animal calls (about 18,000 during the first year), while response is still in the hands of animal control.

ATTENDEE PROFILES

VIRGINIA SZATKOWSKI
CITY OF LAWTON EMERGENCY COMMUNICATIONS
LAWTON, OKLA.

NAVIGATOR 2014 was the third conference in as many years for Szatkowski, a training coordinator and Q at the City of Lawton comm. center. Szatkowski looks forward to attending the sessions, networking, and meeting the “rock stars” of the profession (Dr. Jeff Clawson, Brian Dale, Brett Patterson, Chris Bradford, and Alan Fletcher, to name a few). “Coming here gives me a real feel for what it’s all about,” she said. “It’s amazing. We’ve been EMD certified since 1995 and, at this point, we don’t know what we’d do without it.”

VICKI KOVALSKY
MEMPHIS FIRE DEPARTMENT
MEMPHIS, TENN.

NAVIGATOR wouldn’t be the same without Kovalsky—featured on the cover of the NAVIGATOR 2011 issue of The Journal. She’s attended the conference in the years even before it was known as NAVIGATOR. “I’ve watched it grow from a roundtable with Dr. Jeff Clawson to the size it is today, and it’s always been my favorite conference,” said Kovalsky, who has been with the Memphis Fire Department comm. center for 24 years and now Qs full time. “I always have questions, and I arrive with lots of them, eager to get them answered.”

ALEXANDRA “ALLIE” FOLEY
PALMER POLICE DEPARTMENT 911 COMMUNICATION CENTER
PALMER, ALASKA

Foley left her job at a hospital to help care for her grandmother when she decided, also, to call the 9-1-1 center to observe what the work involves. She was sold. “It was exciting and looked really interesting,” she said. “I applied and here I am. I love my job. Every day is a school day because I’m always learning something.” Foley was recently one of four dispatchers at the center to provide Pre-Arrival Instructions in the delivery of four babies on four separate occasions. “It was nerve-wracking, scary, and exciting all at the same time,” she said.
NAVIGATOR 2014 | By The Numbers

14 countries represented

620 attendees at the Typhoon Lagoon Beach Party

1,345 attendees

118 session speakers

3,826 room nights booked by Disney

47 exhibitors

400 attended the Closing Luncheon

2.6 million chocolate-covered Mickey Mouse ice cream bars sold at Walt Disney World every year

96 sessions

2,300 weddings take place in WDW each year
In the world of emergency dispatch, it is common for an incident to span more than one discipline type. When these situations arise, it is important to take into account what the most pressing, or primary, concern at the scene is to help determine which of the three protocols should be chosen to handle the call. Some of these incidents are fairly obvious, while others can be more difficult, which is why a good policy is necessary to aid calltakers in making the appropriate selection for their agency.

Common crossover incidents include motor vehicle accidents, assaults, and sexual assaults. Let’s take a look at sexual assaults.

As mentioned, looking for the primary concern is the rule of thumb for choosing the correct primary protocol in a combined incident. For example, the dispatcher answers a call reporting sexual assault (rape). The victim reports that he or she was just assaulted and suffered injury due to the assault. In this situation, the victim may be in need of medical attention; however, this would typically be a police call first for several reasons:

- Time frame of the assault (recent)
- Scene has not been cleared by law enforcement
- Suspect may still be in the area, which gives precedence to scene safety

This does not negate the sending of medical help, but it does mean that medical crews will likely not enter the area prior to law enforcement arrival due to safety concerns. In this situation, law enforcement will likely need to respond to the scene with medical crews, which also might require collecting SEND information, depending on local agency policy.

In a situation without the presence of scene safety issues, but with medical issues, the Medical Priority Dispatch System™ (MPDS®) could be used to better address the victim’s injuries; evidence collection could be left to law enforcement as a secondary concern. Again, law enforcement will likely need to respond to the scene with medical crews, which also might require collecting SEND information, depending on local agency policy.

In either case, the close working relationship among disciplines translates into the best outcome and service to the victim—caring for the patient’s medical needs, promoting scene safety, collecting evidence, and prosecuting the offender. The ability of the calltaker to access the correct protocol for the situation and the clear direction given by the agencies involved are critical in providing a professional standard of care.
“WE NEVER PUSH. MOST PEOPLE DON’T KNOW WHAT TO DO WHEN THIS HAPPENS.”

— Traci Sheehan

ers who are known to victims, making the person assaulted less likely to seek medical care or have evidence collected.³

“Victims are often reluctant to get help,” said Traci Sheehan, RN, BSN, CEN, an emergency services nurse and educator for CoxHealth, Springfield, Mo. “They blame themselves. They think ‘maybe I shouldn’t have had that drink’ or they feel it was their fault for the way they were acting. It’s not the victim’s fault, and the victim needs to hear that.”

Research has found that overcoming the hesitancy to report the crime can depend on coordination among professionals involved in immediate response. This includes the EMD, EMTs and paramedics sent to the scene, police officers, and the doctors and nurses receiving the patient in the emergency room.

According to Sheehan, victims are more likely to seek further assistance when responders work together in a presenting manner sensitive to the victim’s needs and level of trauma. A multi-disciplinary effort, she said, also enhances medical care provided to victims as well as evidence collection.

Sheehan is coordinator for the CoxHealth Sexual Assault Nurse Examiner (SANE) program; SANE focuses on the confidential, forensic, and medical care that sexual assault victims require. The 14 nurses in the SANE program at the Missouri health center go through constant training, starting with an extensive 40-hour certification course.

Sheehan is coordinator for the CoxHealth Sexual Assault Nurse Examiner (SANE) program; SANE focuses on the confidential, forensic, and medical care that sexual assault victims require. The 14 nurses in the SANE program at the Missouri health center go through constant training, starting with an extensive 40-hour certification course. The program teaches responders how to relate to the sexual assault victim in an understanding and non-judgmental manner to ensure appropriate care, Sheehan said. They provide lists of resources to address the victim’s medical, spiritual, and psychological needs.

The approach isn’t the same for every person, since, clearly, the level of trauma is unique to each victim.

“We never push,” Sheehan said. “Most people don’t know what to do when this happens. They’re scared, they’re traumatized, and we start the process toward helping them to heal.”

**Sexual assault**

Medical Priority Dispatch System™ (MPDS™) Protocol 4: Assault/Sexual Assault addresses both potential injuries and scene safety concerns associated with assault. The criminal behavior in an assault distinguishes the use of Protocol 4 over Protocol 30: Traumatic Injuries (Specific) in these incidents.

While this portion of the CDE focuses on the MPDS, keep in mind that the way the calls are handled will be dictated by agency policy, particularly since many centers dispatch all three disciplines (police, fire, and ambulance), according to Shawn Messinger, police consultant with Priority Dispatch Corp.” (PDC™).

“What we have in many cases is medical being used, or not used, as a secondary protocol to the law incident,” he said. “It’s the criminal behavior involved that connects the call to law enforcement and, when medical is used, the criminal aspects of the incident such as evidence collection and referral of the victim to support agencies still need to be addressed.”

In the case of a sexual assault and the MPDS—particularly the violent crime of rape—the EMD must recognize the potential for physical injury. Medical dispatch should always try to obtain complete information, with specific priority symptoms driving the response.

If not obvious from the caller’s description, during Case Entry, the EMD will ask whether more than one person is hurt (was assaulted). The safety issues of multiple victims can increase the level of response.

The EMD should remember that the initial complaint might not portray the complete story. A victim of sexual assault (first-

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**The Medical Approach**

**Audrey Fraizer**

Generally speaking, sexual assault is the sexual contact of one person with another without appropriate legal consent. This definition includes, but is not limited to, a wide range of behavior classified by state, territory, federal, and tribal law as rape, sexual assault, sexual misconduct, and sexual battery.

Forcible rapes known to law enforcement have declined sharply since 1979, when the reporting of these crimes was at an all-time high.²

Nevertheless, a recent National Intimate Partner and Sexual Violence Survey shows that sexual violence, in many forms, remains pervasive. Most of these crimes are committed by males against females, and by offend-

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³ According to Sheehan, victims are more likely to seek further assistance when responders work together in a presenting manner sensitive to the victim’s needs and level of trauma. A multi-disciplinary effort, she said, also enhances medical care provided to victims as well as evidence collection.

² The approach isn’t the same for every person, since, clearly, the level of trauma is unique to each victim.
This interagency cooperation is described in greater detail later on in this article.

The subsequent Key Questions allow the EMD to collect information about the patient’s condition and, in the case of a sexual assault, whether the patient has sustained other injuries.

The caller’s responses to this interrogation dictate which Determinant Code is appropriate. The EMD should also select the appropriate suffix “S=Sexual Assault” to clearly define the type of problem for specific response and safety purposes.

Key Question 7 identifies the time frame for when the assault occurred. If the sexual assault is NON-RECENT (6 hours or more have passed since the incident or injury occurred), the presence of current priority issues is the issue of most concern, not the location of injuries per se (Axiom 3).

Severe injuries or conditions resulting from an assault—such as ineffective breathing, spinal injury, or serious hemorrhage—should be addressed with appropriate Pre-Arrival and Post-Dispatch Instructions to meet the immediate needs of the patient. These conditions are also explained in the Rules and Axioms on Protocol 4.

Critical medical needs take precedence over evidentiary needs; however, as explained in Rule 1, “The preservation of evidence in sexual assault situations may be of much greater eventual importance to the patient than initial response and treatment of physical injuries.”

As directed in Post-Dispatch Instruction b, sexual assault victims (of either gender) must be encouraged not to change their clothes, bathe, shower, or go to the bathroom. The preservation of evidence is critical and the activities described destroy valuable evidence that may lead to the eventual conviction of the assailant. The EMD should tactfully try to get the patient to stay as she or he is while providing a compassionate helping hand.

Foremost, the EMD must understand that patients who have suffered a sexual assault need immediate assistance for multiple reasons: the patient may still be in danger, may be physically injured, and/or may be experiencing emotional trauma. The patient’s immediate reaction is also unpredictable: The patient may be openly upset, even hysterical, or she or he may be numb and seemingly calm.

In each case, the patient requires a high level of compassionate care, and the EMD is often the first step in meeting this immediate need. Sexual assault calls put the EMD’s compassionate and caring nature to the test.

When dealing with sexual assault victims, talk to the patient with respect and without passing judgment, said Kim Rigden-Briscall, Toronto (Ontario, Canada) EMS, commander of Central Ambulance Communication Centre (CACC) Education and Quality Improvement. There are many opportunities to provide reassurance and to show compassion while using the protocol.

“Good customer service allows for the introduction of PDIs, so you can say something like, ‘I know you may want to, but please do not change clothes, bathe, shower, or go to the bathroom,’” she said.

The EMD should also keep in mind that the patient feels powerless after being sexually assaulted.

“So, I explain every single action and ask permission of the patient as much as possible,” Rigden-Briscall said. “For example, you can reassure the patient by saying, ‘I am going to help you,’ or ‘May I ask your name?’”

**Interagency cooperation**

The SEND Protocol (Secondary Emergency Notification of Dispatch) included in the Additional Information section underscores the cooperative interagency nature of the complaint as both criminal behavior and medical injury need to be addressed in sexual assault incidents.

The SEND from police should include Chief Complaint, approximate age, level of consciousness, breathing status, presence of chest pain, and severity of bleeding (and opinion of need for lights-and-siren response).

According to Messinger, the SEND elements are sufficient to send a medical response (alongside a police response) without further interrogation.

Most sexual assault cases would be handled by the Police Priority Dispatch System™ (PPDS®) Protocol 106: Assault/Sexual even if injuries of a non-serious nature are involved, as described in the Police CDE accompanying this Medical CDE.

“The need to preserve and collect evidence at the scene and from the victim is paramount,” Warner said. “Police, also, generally provide follow up services to victims such as a crisis worker and referrals to victim resources.”

The “how” of handling these situations is inevitably governed by agency policy, Messinger said. “We do recommend that any time scene safety is questioned, the agency should use the PPDS as the primary protocol tool.”
It reads like a story ripped from today’s 24/7 news in Anytown, USA—a woman or a teenage girl is sexually assaulted, in many cases by someone she knows, such as a boyfriend, co-worker, or other acquaintance. A report by the U.S. Bureau of Justice Statistics states that between 2005 and 2010, “Females experienced 270,000 rape or sexual assault victimizations at a rate of about two victimizations per 1,000 females age 12 and older.”

The U.S. Bureau of Justice Statistics report, Female Victims of Sexual Assault 1994–2010, in 2010, “Females experienced 270,000 rape or sexual assault victimizations at a rate of about two victimizations per 1,000 females age 12 and older.”

Victimization of the young

One disturbing phenomenon that may be gleaned from the CDC report is the young ages at which females are being sexually assaulted:

- According to a nationally representative survey of adults cited by the CDC, The National Intimate Partner and Sexual Violence Survey (NISVS), 37.4 percent of female rape victims were first raped between ages 18–24.
- In a study of undergraduate women, 19 percent experienced attempted or completed sexual assault since entering college.

Also according to the NISVS:

- 42.2 percent of female rape victims were first raped before age 18.
- 29.9 percent of female rape victims were first raped between the ages of 11 and 17.
- 12.3 percent of female rape victims were first raped when they were age 10 or younger.

Securing scene safety

For law enforcement, sexual assault cases can be difficult to investigate, solve, and prosecute. Often, cases go unreported. In fact, the U.S. Bureau of Justice Statistics report states that in 2010, only 35 percent of rapes and sexual assaults were reported to police. Also, when cases are reported to police, victims can be uncooperative because of the nature of the crime itself or because of their relationship with the perpetrator. Typically, there are no witnesses or, at least, none willing to come forward.

“The response of law enforcement to sexual assault situations can vary widely from one responding agency to another,” said Dave Warner, PDC™ police consultant. “This can be attributed to organizational policies, resources within the responding agency, or by a variety of other mandates placed on them by local authority or mandates in law.”

In v4.2 of the Police Priority Dispatch System™ (PPDS) Protocol 106: Assault/Sexual Assault defines ASSAULT as, “An unlawful attack, or attempted attack, upon another person, including threats with an immediate show of force.” It further defines SEXUAL

“The PPDS helps to ensure that each call is handled appropriately by gathering pertinent information.”

— Dave Warner
ASSAULT as, “An assault or attempted assault of a sexual nature. It can vary from unwanted touching of areas of the body to violent, invasive sexual intercourse.” RAPE is defined as “Sexual intercourse by physical force or duress without consent.”

So essentially, any conduct from unwanted groping of a victim over his or her clothing to forcible rape would be included in SEXUAL ASSAULT for the purposes of the protocol.

“The Police Priority Dispatch System helps to ensure that each call is handled appropriately by gathering pertinent information to determine a correct response to the incident, while also gathering important details to increase the likelihood of an apprehension of those responsible,” Warner said. “Protocol 106 provides calltakers with instructions designed to keep a caller out of harm’s way until help arrives and also to attempt to preserve evidence important to the overall investigation and eventual prosecution of offenders.”

For dispatchers and police, the caller’s responses to the red scene safety questions are of paramount importance as these questions collect information to help ensure the after-the-crime safety of individuals at the scene, including the victim, caller, and other witnesses or bystanders.

The first Key Question on Protocol 106 is one of these scene safety questions: “Were weapons involved or mentioned?”

If the caller confirms that a weapon was involved or mentioned, the calltaker asks the subquestion “What type?” Based on the caller’s description of the weapon, the calltaker may ask for further clarifying details as listed in the Description Essentials (e.g., “What kind of gun is it—pistol, rifle, shotgun?”). The calltaker should also review the Determinant Suffixes listed on Protocol 106 to select the appropriate weapon suffix—G=Gun, K=Knife, C=Club, E=Explosive, and O=Other.

After collecting this essential weapon information, the calltaker continues with the next subquestion “Where are the weapons now?” Each of these questions is critical not only for formulating the appropriate response to handle the incident, but also for responders who must prepare for potential dangers at the scene.

Another red scene safety question is Key Question 7, which asks, “Are you or anyone else in immediate danger?” If the caller states that someone else is in immediate danger, the dispatcher follows up with the subquestion “Exactly where are they now?” to identify where responders may be immediately needed. If the caller answers that he or she is personally in immediate danger (perhaps because the suspect is nearby), the calltaker is prompted to go immediately to the Caller In Danger (CID) Protocol and provide instructions for the caller to get to safety.

“It’s important for every calltaker to remember that they should suspend questioning when it is necessary to give instruction pertaining to victim safety or care, such as the Caller In Danger Protocol instructions,” Warner said. “Upon completion of any necessary instructions, the calltaker should return to the question sequence.”

When using the CID Protocol, the calltaker may ask the caller to communicate by tapping on the phone or trying to make the conversation sound casual to prevent the emergency call from being overheard by the suspect. If the caller is able to take the phone with him or her while getting to safety, the EPD should return to the caller interrogation (when safe to do so) to obtain further information about the incident. If the caller is unable to take the phone with him or her, she or he may choose to call back from a safe location. In any case, the safety of the caller is of greatest importance.

Gaining critical information

Beyond the objective of securing safety, the Key Questions on Protocol 106 are also designed to gain critical information that will help the calltaker formulate the appropriate response (DELTA- or BRAVO-level) and also help responders prepare for their arrival at the scene. These factors include when the assault happened (just occurred or PAST), how many people are involved (individual, SMALL group, LARGE group), and the age of the victim(s) (CHILD or ADULT).

These questions are intentionally placed early in the interrogation to gather enough information to dispatch DELTA-level codes (in progress or just occurred) as soon as possible.

Because these factors may be handled differently according to local resources, policies, and procedures, the protocol requires local authorities to define and authorize for dispatch purposes what time lapse constitutes a PAST event, what age ranges constitute a CHILD versus an ADULT, and what number of people constitutes a LARGE versus SMALL group for their area.

The next priority is reflected in Key Questions 4–6, which are designed to help responders apprehend the suspect. These questions solicit information on the suspect’s description; where s/he is now; how s/he left; a vehicle description, if involved; what direction s/he was going; if detained, whether or not s/he is cooperative, etc. This is especially time-critical information for situations that have just occurred, as there is a greater likelihood of locating a fleeing suspect either at the scene or nearby.

Many of these Key Questions also correspond with the Description Essentials list, which provides specific details that the calltaker should inquire about. For instance, when obtaining the suspect’s description, the EPD should ask for (at least an approximation of) the suspect’s race, gender, age, clothing, build/height/weight, hair color/length/style, other identifiable characteristics, complexion, eye color, demeanor, and (especially if the suspect is known) the name/relationship and address/phone number. Similarly, the calltaker should ask for specific details on the suspect’s vehicle, which are easily remembered with the acronym CYMBALS: color, year, make/model, body style, additional (paintwork, damage), license, state/province.
CALLTAKERS SHOULD SUSPEND QUESTIONING WHEN NECESSARY TO GIVE INSTRUCTIONS (FOR) VICTIM SAFETY OR CARE.”

– Dave Warner

b. Lock your doors and windows.
c. If the person returns, do not let him/her in, and tell me immediately.
d. Do not disturb anything else at the scene, including weapons, tools, or objects found nearby.
e. (SEXUAL ASSAULT) Do not change clothes, bathe, shower, or go to the bathroom. Do not have anything to eat or drink. Do not clean the carpet or floor. Do not handle or wash the bedding.

These instructions should be provided immediately after dispatch or spontaneously during the interrogation if the caller’s responses or questions relate to an instruction (e.g., the calltaker should interrupt the interrogation to provide PDI-e if the caller states, “Okay, she is just going to go take a shower before they get here.”)

As stated in the Principles of Emergency Medical Dispatch, “Unfortunately, legal action may not be an immediate priority to rape victims. They just want to get the filthy feeling associated with the rape off their bodies. The [calltaker] should tactfully try to get them to stay as they are while providing a compassionate helping hand.”

As also explained in Principles, sexual assault is a crime of violence and hate, not of passion. Calltakers should be cognizant and sensitive in their investigation when questioning and working with a sexual assault victim. As Axiom 1 states, “The collection of evidence after an individual has alleged a SEXUAL ASSAULT (rape) may be psychologically as well as physically traumatic.” The calltaker’s encouragement to preserve evidence, while providing compassionate care, may be of much greater eventual importance than treatment of physical injuries (Axiom 2).

COLD CALLS come through

Because the criminal justice system seeks to extend justice to victims and prosecute offenders within the scope of any given jurisdiction’s statutes of limitation, it is important to report a crime like sexual assault even after time has passed. COLD CALLS can be key factors to police investigators in solving sexual assault crimes.

The PPDS defines a COLD CALL as “A call for service involving a PAST event that does not require a full interrogation because, by the caller’s assessment, the suspect/person/vehicle is not in the area.”

Because the suspect is not on the scene, the EPD shortens the interrogation to bypass scene safety questions and suspect description questions (as apprehension at or near the scene is no longer a possibility). Therefore, to handle COLD CALLS on Protocol 106, the EPD need only ask KQ 3, “How old is the victim?” KQ 8, “Obtain the victim’s description,” and KQ 12, “Does s/he have any other injuries?” This initial call interrogation provides responders with enough information to meet with the victim and collect the rest of the necessary information to proceed with their investigation.

SOURCES

3 See Note 2.
1. What is one important factor that enhances both the medical care provided to victims and evidence collection following a sexual assault?
   a. multi-disciplinary effort
   b. blaming the victim for the assault
   c. telling the possibly hysterical victim to get a hold of herself/himself
   d. sending police to investigate without medical assistance to prevent destroying evidence

2. When using the MPDS, what is the factor that distinguishes the use of Protocol 4 over Protocol 30 when injury is involved in assault incidents?
   a. whether the event is recent or non-recent
   b. proximity of assailant
   c. criminal behavior
   d. type of injury

3. After Case Entry, the first two Key Questions on MPDS Protocol 4 address:
   a. scene safety.
   b. serious bleeding and whether the patient is completely alert.
   c. whether the incident was recent or non-recent.
   d. preservation of evidence.

4. Post-Dispatch Instruction b on MPDS Protocol 4 instructs the sexual assault victim to:
   a. stay on the line while the dispatcher tells the caller what to do next.
   b. provide a “best guess” of the assailant’s location.
   c. treat injuries while awaiting medical response.
   d. not change clothes, bathe, shower, or go to the bathroom.

5. The SEND Protocol included in the Additional Information section underscores the:
   a. cooperative interagency nature of the complaint.
   b. importance of sending data to the appropriate agencies compiling statistics of sexual assault.
   c. necessity of sending the assailant’s description ASAP for police apprehension.
   d. value of notifying forensics to collect evidence.

6. According to a report by the U.S. Bureau of Justice Statistics, between 2005 and 2010, the offender was known to the victim in what percentage of sexual violence cases?
   a. 28 percent
   b. 58 percent
   c. 78 percent

7. Version 4.2 of the Police Priority Dispatch System’s Protocol 106: Assault/Sexual Assault defines SEXUAL ASSAULT as:
   a. an assault or attempted assault of a sexual nature.
   b. an assault or attempted assault of a personal nature.
   c. an assault or attempted assault of rape or forcible rape.

8. The first Key Question on PPDS Protocol 106 is:
   a. “Are you or anyone else in immediate danger?”
   b. “Exactly where is the suspect now?”
   c. “Were weapons involved or mentioned?”
   d. “Give me a physical description of the suspect.”

9. After collecting scene safety information and sending the appropriate response, the Post-Dispatch Instructions (PDIs) on PPDS Protocol 106 are very important to urge the caller to take safety precautions and:
   a. protect the victim.
   b. preserve evidence.
   c. apprehend the suspect.

10. To handle a COLD CALL on PPDS Protocol 106, the EPD need only ask:
    a. KO 3, “How old is the victim?”
    b. KO 8, “Obtain the victim’s description.”
    c. KO 12, “Does s/he have any other injuries?”
    d. all of the above

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.

Clip and mail your completed answer sheet along with the $5 USD (must be U.S. currency) NON-REFUNDABLE processing fee to:

The International Academies of Emergency Dispatch
110 South Regent Street, Suite 800
Salt Lake City, UT 84111 USA
Attn: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

Please retain your CDE acknowledgement for future reference.

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

ANSWER SHEET + MEDICAL + POLICE

May/June 2014 Journal “Sexual Assault”

Please mark your answers in the appropriate box below.

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

To be considered for CDE credit, this answer sheet must be received no later than 06/30/15. 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.

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Stefana Dershko has a naturally calming influence.

Someone could be trapped in a car following an accident, trying to control bleeding after a fall, or—as in the most recent incident—assisting in a breech delivery, and she is at her ultimate comfort level giving instructions.

Dershko likes people. She likes figuring them out, even if it’s only by listening to their voices. She likes knowing she has the knack to help during an emergency. While it might be the pitch of a roller coaster rush when things go well, it’s also gratifying to know she can affect a smooth ride.

As an EMD, she’s in the profession that she’s supposed to be.

“We definitely receive the training to do this,” said Dershko, an EMD with the Toronto Emergency Medical Services (EMS) Communications Centre in Ontario, Canada. “But it also takes the ability to relate to peo-
ple. We have to get our callers to trust us.”

The trust was running strong on both ends of the phone on Dec. 6, 2013, when Dershko took one last call before her shift ended. The caller, David Bennett, said his wife, Liz Maier, was in active labor. Her water had broken, and in the rush to the hospital, she had made it from their bedroom to the foyer. She wasn’t going any farther.

Bennett didn’t know exactly how far along his wife’s labor had progressed, although the baby, the couple knew, would be breech. Doctors had monitored Maier weekly during the pregnancy, which was considered high risk because of the baby’s known fetal position. The baby’s breech position had alternated among the variations (frank breech, complete breech, lotus breech, and footling breech) over the last trimester.

Seconds into the call, Bennett reported that the baby was indeed visible, although, as expected, not head first.

“He saw a foot,” Dershko said. “The baby was breech.”

This was Dershko’s first-ever over-the-phone delivery. She had been an EMD with Toronto EMS since September 2013.

Dershko followed protocol and began giving Pre-Arrival Instructions (PAIs) for a breech delivery. She relayed to the caller “exactly what to do next.”

The birth was going as well as can be expected in a footling breech, which is considered the most precarious breech position because of the higher chance of cord prolapse.

“The father was so calm,” Dershko said. “He and his wife were totally focused and did exactly what they should be doing in this type of situation. They were both fantastic.”

A particularly distressing complication came minutes into the delivery.

The baby’s head was wedged inside the birth canal, which is an inherent risk of a footling breech. Delivery of the feet through an incompletely dilated cervix can lead to arm or head entrapment and obstruct the umbilical cord.

Rescue arrives at the door

In the background, Dershko heard the couple’s two other children, ages 3 and 5, excitedly announce the arrival of the first responders.

Dershko stayed on the line when the firefighters arrived and continued to provide PAIs to the firefighter who took over the phone call. A few short minutes later Toronto EMS paramedics Ornella Guizzo and Michael Toliver arrived and completed delivery.

The first signs were unnerving. The umbilical cord had wrapped tight around the baby’s neck and the baby was born without vital signs.

Dershko left work understandably anxious about the outcome and stopped her car by the side of the road when her cellphone rang. It was the Toronto EMS Communications Centre.

“She pinked up in the ambulance,” Dershko said. “It was such good news. I was very relieved.”

Six weeks later, a coincidental connection made a visit to Toronto EMS headquarters possible, said Maier, who had been determined to say thank you from the day of baby Stephanie’s birth. Although Maier didn’t remember much from the actual 10-minute ordeal, she clearly recalls her husband’s calming voice, the firefighters and paramedics, and fragments of conversation swirling around her.

“I could hear the paramedic [Guizzo] saying, ‘Come on, beautiful. Come on,’” Maier said. “Then I heard a cry. It was our baby. That’s it, except for looking up at the four gorgeous firefighters and four equally gorgeous paramedics standing in my foyer.”

Maier was determined to thank everyone involved. But there were obstacles relating to patient and personnel confidentiality. Toronto EMS could not release the names of the dispatcher or responders.

“A thank you relayed over the phone might have been the “end of story” had it not been for the surprise baby shower hosted by Maier’s office one week later. In the “small world” kind of way that things sometimes happen, Dershko’s Toronto EMS dispatch trainer, David Neave, and Maier’s boss had stayed buddies since high school. Following a few calls, a visit to Toronto EMS headquarters to meet everyone involved was arranged.

“I hugged everybody,” Maier said. “I am so grateful for everything they did. A few more seconds and this would have ended in a very different way.”

Dershko was genuinely pleased to meet the family. She had her photo taken with Maier and Bennett, and described the use of PAIs.

Toronto EMS Chief Paul Raftis presented Dershko, Guizzo, and Toliver with stork pins, an honor paramedics and emergency medical dispatchers receive after assisting in the delivery of a baby. Paramedics used a mannequin to demonstrate the maneuver they used to free the baby’s head for a prompt delivery.

“They were really, really a nice family,” Dershko said. “Mom gave us all big hugs. They knew how close they came in losing the baby. It was great being part of this.”

The enthusiasm of her brother-in-law and sister for 9-1-1 piqued Dershko’s interest in the profession and that, along with the knowledge that she’s the type who responds well in an emergency, convinced her to pursue the job.

Dershko also had another reason. She was motivated by a call—or rather the response to a call—she made to 9-1-1 years ago when her grandfather died.

“If I could make someone feel the same way [the dispatcher] helped me, I knew that’s what I wanted to do,” Dershko said. “I’m thrilled to be here. This is the last job I’ll ever have, and I’m happy to say that.”

Toronto EMS Communications Centre processes about 263,600 calls per year and responds to approximately 750 per day. They deliver more than 50 babies a year out-of-hospital.

“A FEW MORE SECONDS AND THIS WOULD HAVE ENDED IN A VERY DIFFERENT WAY.”

—Liz Maier
DeKalb County (Ga.) residents can rest easier knowing that when a storm threatens to close down the metropolitan area, the county’s police department communication center is prepared for the response.

And contrary to the ugly weather-related mess bringing everything to its knees in January and February, center personnel were at the CAD working hard to aid residents overwhelmed by the snow and ice stranding motorists, shutting down power, and—for at least one caller—nearly prompting the delivery of a baby while stuck in a ditch.

“The city was in complete shutdown from the January storm,” said Cecile Graham, who has been through six winters at the communication center handling calls for a core of the Atlanta metropolitan area. “We don’t normally get snow, and if we do, it’s usually a flurry that begins in the morning and is over by lunch.”

This time it was different, and notably so, said Director Marshall Mooneyham. The National Weather Service forecast called for “precipitation” on Tuesday, Jan. 28, although it teetered on how much, how long, and what type.

“We had a briefing that morning with emergency management,” Mooneyham said. “Something was coming in and if that did happen, we’d be going to 12-hour shifts.”

Graham arrived at the center for her morning shift on Tuesday, thinking she’d be home safe before the storm hit later that evening. She wasn’t. The storm started coming in mid-afternoon and by the events that followed, it seemed that everyone working downtown had looked out the window at the same time.

“At about three in the afternoon, people figured it was time to start heading home,” Mooneyham said. “That’s what caused the major problem.”

The storm, stretching from Texas through Georgia and into the Carolinas, paralyzed Atlanta. The massive dash out of the city hampered crews from getting equipment on the road. Highways turned into parking lots, resulting in a reported 800 traffic accidents, although without serious injury. Some abandoned their cars, while others waited in overnight traffic jams. Call volume quadrupled from normal levels and at its peak reached 500 calls per hour. The center recorded a whopping 10,574 calls in a 24-hour period.

“Ice rink” is how Graham described the roads.

Graham said staff automatically fell into place.

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Graham stayed until 10 p.m. that night, along with her young son who had been dismissed early from school when weather predictions suggested something more onerous was coming. The generally 15- to 20-minute commute took nearly two hours and that was in a Special Operations Unit that police officers were driving to escort the stranded dispatchers.

“They had chains on their tires,” she said. “The roads were so bad we could have crawled faster.”

There was no reprieve from the everyday emergencies.

Graham spent 10 minutes on the phone with a very anxious dad-to-be trying to get the mom-to-be to the hospital before the baby was born. His car had spun down a drive leading from the couple’s apartment complex and was now stuck in a ditch at the side of a road.

The ambulance couldn’t make it up the hill, Graham explained, and she was in the process of preparing for delivering the baby when the crew arrived on foot, gurney in hand. They carried her down the hill to the waiting ambulance and made it to the closest hospital, although not the hospital the couple had previously arranged.

Two weeks later a second storm hit, bringing winds gusting up to 30 mph, toppling trees and cutting power for hundreds of thousands of homes and businesses.

Georgia Power Co. officials had recruited repair crews from other states in anticipation of downed power lines, and office staff answering customer calls took names and numbers that they then reported to the DeKalb County communication center for welfare checks.

Graham called an older woman who was reportedly alone and without heat.

“She was wrapped in a blanket and said she would be OK,” Graham said. “I said we could send help, and she said she didn’t want us to waste the gas.”

Graham called her every two hours throughout the night.

Graham was among the personnel staying three consecutive nights, sleeping on cots set up at the fire department’s public safety building next door to the 9-1-1 center. The overnight dispatchers kept warm at night tucked underneath blankets brought from home, and they ate hot meals brought in from the few restaurants that were able to open for business.

Calls were down from the level experienced two weeks earlier, which was a relief that Graham credits to Mooneyham and her fellow dispatchers.

Mooneyham said staff automatically fell into place.

“We get the job done,” he said. “Like every center, we have our ups and downs, but it always amazes me how well we come together when something like this happens.”
Red Cross Hero Awards
Dispatchers honored for saving one life, bringing another into the world

Nearly electrocuted

The precise application of CPR by following Pre-Arrival Instructions (PAIs) that EMD Tiffany Hotaling provided combined with rapid ambulance response are credited with saving the life of a 20-year-old who was nearly electrocuted at his job.

Hotaling, a Syracuse (N.Y.) Police Dept. dispatcher at the Onondaga County 9-1-1 center, received the 9-1-1 Dispatch Real Hero Award from the American Red Cross, Central New York Chapter.

Hotaling said she was flattered by the dual recognition, and the once-in-a-lifetime honor to walk across the stage in a line of 15 other individuals receiving awards for extraordinary efforts in emergency services.

Accolades aside, however, Hotaling’s dedicated to emergency communications. The awards were icing on the cake for the on-the-job opportunity, she said, to get a real sense of making a difference in a person’s life.

“We take a lot of calls and you never know when something like [saving a life] will happen,” Hotaling said. “This was incredible, not the accident, but the ability to help.”

Hotaling was on the phone for 7 minutes and 36 seconds giving CPR PAIs to the man’s co-worker during the July 3, 2013, call to report the potentially fatal accident. A young man, who was in the process of cutting down a tree, stepped onto an aluminum extension ladder that, unbeknownst to him and co-workers, was touching a live electric line.

The man was unconscious and not breathing when the call came in. Hotaling provided CPR instructions to a “very cool and collected” caller, who in turn relayed them step by step to a third person—the victim’s father—at the job site.

The patient made a full recovery.

Hotaling credits the training EMDs receive and the ability to remain calm that, in turn, reassures the caller during a traumatic event. She also praised the “amazing” ambulance crew and a caller who did exactly what she said to do.

“They [ambulance crew] continued CPR, and he came to just as the ambulance pulled into the hospital,” she said.

After seven years in emergency communications, few calls bring Hotaling to tears like this one did, she said. Her father and brother are in construction and not until the call ended did she let emotion almost get the best of her.

“It’s the same way about calls involving children,” Hotaling said. “There are just some calls that hit closer to home than others. I’m extremely grateful for the way things turned out with this one.”

Baby delivery

A dispatch supervisor from Syracuse, N.Y., was also honored during the Red Cross awards presentation for her part in a medical emergency.

On Dec. 7, 2012, Rural Metro of Syracuse Dispatcher Cathy North provided PAIs for childbirth to a teacher assisting in an undeniably unexpected delivery.

According to the events—all happening within minutes—the woman was part of a larger group visiting a park when the baby decided it was time to arrive. Christopher Brooks, an assistant Head Start teacher and part of the same group, called 9-1-1, and under North’s guidance, provided aid, while in the meantime, three park employees rushed over to assist.

It was over almost as fast as it started.

The Rural Metro ambulance crew had pulled into the parkway when they were notified of the baby’s birth.

“The baby was out, and I had made sure the baby was breathing by the time they arrived,” North said. “It was fast.”

Park employees Sarah Kohler, John Moakler, and Liz Schmidt received “Above and Beyond” Award plaques from Rural Metro; the employees, Brooks, and North accepted Real Hero Awards for their roles in safely bringing the baby into the world under the most unusual circumstances.

The team, including the park employees, also received commendation awards from city and county officials.

This was not North’s first brush with the childbirth PAIs.

“We do quite a few deliveries,” she said. “Not every day but every few weeks. They seem to come in spurts.”

North has been with Rural Metro for 33 years, including 11 years on the road as a critical care technician and the past 22 in dispatch. She has used nearly every protocol in the Medical Priority Dispatch System™ (MPDS®) and the more common Chief Complaints many times over.

The variety and the unexpected, however, are North’s primary reasons for her long career in emergency communications.

“When I think I’ve seen it all, something else happens,” she said.

The Red Cross awards were presented on Dec. 4, 2013. “The baby was out, and I had made sure the baby was breathing by the time they arrived,” North said. “It was fast.”

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Seeing the Light
Stars aren’t the night’s best traffic navigator

Audrey Fraizer

If there isn’t adequate space on the highway between your car and the next to avoid an accident by applying the brakes, it could be you’re driving too fast or you simply lack what it takes to navigate anything other than local roads.

Or, it might be because your attention is elsewhere.

In most cases, it isn’t because the sun is in your eyes and, in fact, most times it’s because the lighting isn’t in your favor. Night driving is the worst in terms of traffic fatalities, and that’s particularly true for pedestrians.

According to a Federal Highway Administration study, the probability of being killed in a crash during late-night/early-morning hours is as much as three times greater than during the day.

Things haven’t changed much since the early days of motoring.

In 1934, 20,000 of the 36,000 motor vehicle accidents in the U.S. occurred at night, despite traffic being three times heavier during the daylight hours. Pedestrians accounted for 69 percent of the deaths in the dark because drivers were going too fast and had too slow of a reaction time.

Former New Jersey Gov. Harold G. Hoffman attributed “death at night” to an inability of a majority behind the wheel to “physically and emotionally” drive their vehicles at 60 miles an hour, let alone his suggested speeds of no greater than 35 miles per hour at night. Speed was power.

Hoffman insisted.

At 30 miles an hour, a car travels 44 feet a second. It takes a driver up to three-fourths of a second to react to an emergency and apply the brakes. During that time, the car has traveled 33 feet. At that speed, the braking distance is 40 feet. Add to that the 33 feet required for the driver’s mental and physical condition, and you have a total of 73 feet. If you’re going 60 mph, you’ll need 226 feet in which to stop in ideal conditions.

But that wasn’t the only problem.

At night, braking distance carried little impact and that’s something Hoffman said could be alleviated by proper highway lighting, which was just starting to make the rounds to various cities in the 1930s. Pedestrians in particular, he said, were not safe from the motorized things that could go bump in the night.

“As a nation, we have failed to grasp the fact that as the sun goes down, so must our speed,” Hoffman said. “We are simply driving too fast for our eyes.”

The principle of improving highways by better lighting at danger points was not a novel idea in the mid-1930s. In 1926, The American City magazine—advocate of city beautification projects that included illuminating business districts—explored the practicality of street lighting. The lamp could be held over the street rather than on top of a pole, in that way, enabling drivers to see farther and put a sheen on the pavement to case obstacles as silhouettes.

In 1930, the Illuminating Engineering Society published a recommended street lighting code, classifying urban streets by traffic count, with progressively higher light levels as traffic increased.

Although well received by municipalities, the money wasn’t there. The Great Depression hit and the urgency to light streets took its place far back in line. Many cities turned off the streetlights they did have.

Lighting manufacturers fought back, fighting on the fears of urban life. The International Association of Electricians warned that a reduction in services might turn out to be a net loss “resulting from increased accidents and crime.” Graybar Street Lighting published full-page magazine and newspaper ads suggesting that proper lighting could negate the need for auxiliary police.
Regarding criminal activity, it appears that lighting has had a positive impact on crime (or negative impact on criminals). Good visibility is a key to crime prevention. The potential risk to offenders outweighs potential benefits.

A review of 13 studies of streetlighting interventions in the U.K. and U.S., spanning four decades, found that crime decreased by 21 percent in areas that received streetlighting improvements compared to similar areas that did not. The review also noted that streetlighting seemed more effective at reducing crime in the U.K. compared to the U.S.—a 38 percent reduction compared to 7 percent, respectively. However, the U.S. studies reported just nighttime crime, rather than both nighttime and daytime crime.10

As far as traffic safety, the results are, again, positive. Increasing luminance levels of existing lighting systems, or providing overhead lighting where necessary, can reduce late-night/early-morning crashes at intersections.

The Lighting Research Center and The Pennsylvania State University, funded through a grant from the National Cooperative Highway Research Program, found that fixed lighting reduces crash risk by about 30 percent. The statistic was based on a review of state-by-state traffic literature since only two states—Minnesota and California—had electronic databases amenable to the correlative search.

The downside is the driver and his or her inability to gauge conflicting traffic and other road uses. In fact, inadequate street lighting doesn’t even make it to the top three causes of road fatalities. Distracted driving, speeding, and drunk driving occupy these berths.9

Distracted driving continues to be the No. 1 leading cause of car accidents in America. Drivers who use a hand-held device are four times more likely to get into a car accident than drivers paying closer attention to the road ahead. Texting while driving increases the likelihood of an accident 23 times.

Speeding contributes to about a third of all car accidents in America. Over 1.41 million drivers were arrested in 2010 on suspicion of driving under the influence. Mothers Against Drunk Driving (MADD) estimates that 300,000 incidents of drunk driving occur daily.

Maybe the bigger problem is what Hoffman suggested nearly 80 years ago.

Few people are actually physically and emotionally equipped to drive. We simply like to go too fast for our eyes to see or, in the modern electronic age, prefer focusing our eyes on something else while behind the wheel.■

Sources
5 An Authoritative Street Light Code, The American City, November 1930
7 See note 3.
10 See note 1.
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