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The National Academies of Emergency Dispatch

November | December 2012

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SHAWN MESSINGER

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

GREG SCOTT

Greg is a regular contributor to The Journal. He was supervisor of the San Diego EMS 9-1-1 Center from 1985 to 1997 and has directed many emergency dispatch implementation projects across North America. He is currently a dispatch consultant and lead EMD-Q® instructor for Priority Dispatch Corp. He was the lead writer for a white paper report on best practices in 9-1-1 center management for the International City/County Management Association.

BEVERLEY LOGAN

Beverley joined Greater Manchester Ambulance Service in 1987 as a call-taker and worked through the ranks as dispatcher, supervisor, and control manager. Her promotion to paramedic emergency control training coordinator introduced her to MPDS®, and she certified as an EMD and ED-Q in March 1997, and then as an EDQ-I and EMD-I in July 1998. She is now the IAED™ National Accreditation Officer and works within agency control centers to support QA/QI processes, ACE application/recertification, and Audit the Auditor reviews for all three emergency disciplines.

RONALD RICHARD

Ronald is from Cambridge, Mass., and has been a fire dispatcher for over 27 years. He is an active regional EFD instructor and serves on the NAED Fire Council of Standards.

BILLI JO BANECK

In 2008, Billi Jo lost her parents and younger brother in a devastating house fire. Billi Jo’s mother, Peggy Ann, had been a dispatcher, and Billi Jo had recently become a dispatcher for Brown County (Wis.) Public Safety Communications at the time of the tragedy. Because of the help the three surviving siblings received, Billi Jo began giving back to the Red Cross and her community. She spearheaded the “Wautoma’s Got Talent” contest, which benefits local disaster relief, and is a trained Red Cross disaster services volunteer.
DearReader

Messy desk sign of work in progress

Audrey Fraizer, Managing Editor

It’s mid-September and I’m looking at the stacks of paper, binders, reminders, and assorted business cards that have accumulated on my desk for the past several months. I do sweep crumbs from the zillion pretzels consumed during the same time, but by most standards, probably not often enough.

No one in the office has ever complained, at least to my face. I don’t think they judge my organizational skills. My mess is work related. I like to think of it as visual cues to help me get things done. Notes I write each evening prioritize the next day’s goals. The stacks fall in line. My desk is organized in some particular fashion, known only to my interpretation.

As most “desk wounds” would say, I know right where to go when looking for something. A neat desk would confuse me. How can anyone possibly find a stack of paper or notes from an interview neatly tucked away in a drawer? What I need that day or next is in the stack closest to my keyboard.

I’m not boasting of my environs. It’s just the way it’s always been during my 25+ year career. This is not a reflection of my inner soul. Numerous studies, found that a cluttered desk could actually enhance the employee’s creativity in problem-solving and boost work efficiency. Messiness tends to activate a need for simplicity—and, to some extent, represent endless and unstructured possibility.

Albert Einstein had a messy desk, not that I’m in his league. Soon, however, I will be given the opportunity to change.

In November, our department will be among the first to move into the new IAED™ office building. Years of accumulation will be forced from my desk during a day or two of frantic packing. Things will be tossed. Desk drawers will be emptied; the box near the corner of my desk will be discarded.

Some might say, herein lies the possibility. Has fate handed us a chance to start anew, to begin my march to eternal desk civility? I don’t think so. I might knock off the pretzels, but don’t expect me to cease getting things done.
President’s Message

You Can’t Fix A Chain Unless You Know Where It’s Broken

Call level sets tone for emergency response

Scott Freitag, NAED President

Traveling with Brian Dale as much as I do gives me the opportunity to learn more about the guy. Brian is a deputy chief with the Salt Lake City Fire Department and speaker extraordinaire at both the Euro and UK Navigators that were held in Berlin and Bristol, respectively, in 2012. While Brian can talk of most matters Academy, his strength lies in quality performance and that takes in everything the Academy does.

Brian is the long-standing Accreditation Board chair, which is more than a figurehead position. Yes, he does hand out the Accredited Center of Excellence (ACE) awards at the Navigator conferences in the United States and abroad, but he also sits in a lot of meetings where an occasional nod of the head is not considered acceptable behavior. Discussion gets fairly pointed among a table of career-minded emergency services professionals and far be it from Brian to back off from debate.

Brian was among the first to recommend the Academy move away from a strictly point-based scoring system divided into broad sections to a process that looks at incremental steps. The process also assesses the dispatcher’s attempts and ability to calm callers and persuade them to follow instructions. The scoring system did not take those variables into account, which, as every dispatcher knows, is primary to patient satisfaction and delivery of appropriate care.

The results of the relatively new performance standards provide a gradient observation of quality indicators. The standards pinpoint an area where a tweak in the call routine can improve the dispatcher’s overall service. From monitoring our Q Forum, he believes the refined approach is better at defining the Academy’s goals.

As Dr. Jeff Clawson has preached from Day 1, emergency dispatch is part of the EMS chain; it is not an entity unto itself. Performance at any link in the chain has a direct impact on patient outcomes. What happens at the call level sets the tone for each succeeding level of patient interaction. From the call analysis, the EMD-Q® can determine performance fix-it spots and whether the subsequent advice or training was sufficient. Even modest change can have measurable effects down through the line.

The one hot spot has been the dispatch perspective and trying to make it clear that this is not a punitive procedure. In fact, the philosophy behind quality management is quite the contrary. This is about dedicating time to synchronize. Everyone’s contributions are important in the overall scheme of operations.

Although dated, conclusions reached in a 1991 United States General Accounting Office (GAO) study of Malcolm Baldrige National Quality Award applicants speak to the relevance of bringing employees into quality review. The GAO was asked to examine the impact of quality management practices on the performance of companies following an on-site evaluation, independent of whether or not the company was selected for the award.

According to GAO findings, companies that adopted quality management practices—and, remember, these were not necessarily the award winners—achieved better employee relations and greater customer satisfaction. The employee relations result was determined by increased job satisfaction, improved attendance, and decreased turnover. The companies used quality indicators to improve performance to their advantage consistent with goals that included customer focus, management leadership, employee involvement, an open culture environment, and partnerships. In fact, companies without a quality advantage were found to be at a disadvantage. In addition, failure to take into account quality gives rise to distortions in evaluating service. Customers go someplace else to find better service, when the option to do so is available, and without quality processes, we might never know why.

Of course, our customers, 9-1-1 callers, and the fire, police, and medical responders we serve, do not have that option. Their calls cannot be transferred to a second, third, or fourth choice on a list of communications centers, law enforcement agencies, ambulance providers, or fire departments. Contracts can be reassigned, but not in relation to the immediacy of the caller’s event. We must be committed to doing it right from the start to help guarantee the success of subsequent steps.

This leads me to the point I am trying to make. Quality management and quality performance are staples in the Academy’s philosophy; it’s the Academy’s culture. Brian can harp on the benefits of quality standards—and he will—but it’s your use and understanding of performance indicators that qualifies the strength of your link in the EMS chain. After all, no one wants to be considered the link that tangles the connection.
**Consensus Shifts**

Increased use of optional instruction signals change in PDI qualifier

Jeff Clawson, M.D., Brett Patterson, EMD-I

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**Dr. Clawson:**

We are told that it is always appropriate and necessary to say from the Case Exit, Panel 2 Post-Dispatch Instruction (PDI): “If he/she becomes less awake and vomits, quickly turn him/her on their side.” Is this so?

Thanks.

Jo Anne Fleming EMR, EMD-Q
Alberta Health Services
Alberta, Canada

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**Jo Anne:**

As chairman of the Academy’s Council of Standards, Dr. Clawson has asked me to respond to your question.

In the current version of the Medical Priority Dispatch System™ (MPDS™) (v.12.2), the PDI you are referring to is qualified with (Appropriate), which makes the instruction optional and dependent upon the EMD’s judgment of the patient’s clinical condition.

When this instruction was added to the MPDS, the Council of Standards debated this very question and there was sufficient consensus to make the question optional. The argument in favor of doing this was based on patients who are obviously stable and, therefore, not likely to pass out and vomit; in these types of situations, it was felt that EMDs should have the option not to read this instruction. The discussion was lengthy, however, and there were members who thought it should be mandatory.

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**Likely revision will make instruction mandatory.**

Your question happens to be most timely. The Council of Standards revisited the topic when meeting to consider Proposals for Change (PFCs) regarding MPDS v13. After several years of experience with this instruction, consensus has changed. Many agencies encourage the use of this instruction for all patients (2nd party callers), citing that the instruction does no harm to stable patients and, if it is not given and the patient passes out and vomits, the caller needs to know what to do BEFORE calling back.

So technically, and according to ED-Q™ scoring standards, the instruction is currently optional, although as I mentioned many agencies are encouraging its use for all 2nd party callers. However, in v13 of the MPDS, due to be released next year, the (Appropriate) qualifier will likely be removed, making the instruction mandatory for 2nd party callers. I use the term “likely” because v13 has yet to be formally ratified by the Council of Standards and the College of Fellows.

Thank you for your interest in the MPDS.

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

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**MPDS® v12.2, NAE-std © 1979–2012 PDC.**
How Do You Define Your Place In Emergency Response?
You make the call

Shawn Messinger

Is emergency telecommunications a “job” or a “profession”? To answer that depends some on how you define a profession. A quick Internet search will produce several definitions for a “job” and a “profession.” Here are a couple I found.

Job:
“A regular activity performed in exchange for payment.”

Profession:
“A paid occupation, especially one that involves prolonged training and a formal qualification.”

In the past, the role of a dispatcher was compared to clerical staff and to this day, their salaries still often suffer from the comparison. To be fair, this comparison did make sense 50 years ago. The emergency number 9-1-1 did not exist and callers generally dialed 7-digit numbers to request help. Dispatchers listened to the caller explain the problem, jotted down notes on a piece of paper or 3 x 5 card, and told the caller that they would send assistance.

Caller interrogations were limited, if done at all; providing any type of instruction to help the caller before help arrived was non-existent and there were no sophisticated diagnostic tools that could be used over the phone.

Today, we have Enhanced or E9-1-1 systems capable of routing emergency calls to the correct PSAP and providing a name and location of the caller. Many states are already using, or are migrating to, Next Generation or NG9-1-1 systems with the technical capability of providing not only name and location but also receiving text, video, and vehicle crash telematics, to name a few. Today’s telecommunicators answer multiple radio channels and phone lines, conduct thorough caller interrogations, provide lifesaving instructions to callers, and enter the data into a computerized CAD system in real time. They are highly trained and must continually refresh this training to maintain certifications.

Scholars agree that modernization of law enforcement in the United States began in the 1920s with Berkeley, Calif., Police Chief August Vollmer. Vollmer recognized the need for law enforcement to professionalize, adopt new technologies and strategies, and focus on the training of officers. This push was continued on by other police officers such as former Chicago Police Superintendent O.W. Wilson and former LA Police Chief Daryl Gates. Adding standards for performance and the conduct of officers, as well as standards for training, guided law enforcement into professional status.

While the telecommunicator’s role has evolved, it has taken a back seat to field operations. This began to change in the 1970s, however, and this evolution from job to profession has reached an almost exponential pace in the 21st century. The public and the agencies relying on dispatchers have learned to respect the work they do.

Along with the adoption of new technologies, there is a growing expectation from the public for trained and certified telecommunicators to provide a higher standard of service. A major portion of this expectation can be tied to the structured calltaking movement pioneered by Dr. Jeff Clawson. Regardless of whether the public knew about protocols and structured calltaking or not, they did see a vast difference between the service provided by agencies using them and those that did not. TV shows and news stories highlighting actual 9-1-1 calls gave the public a preview of the type of service they could expect. As this public awareness has increased, so has the anticipation that 9-1-1 centers should provide this higher quality service.

The days of minimally trained, unscripted telecommunicators flying by the seat of their pants, with little or no interrogation, and the failure to provide lifesaving instructions are fleeting at best. Public expectations and court decisions in a litigiousness environment compel public service agencies to move their communications centers into the modern and professional world of emergency dispatch.

It’s not only the public demanding better service. The employees of these same centers want the tools—technology, education, certification, and training—to meet public demand. Dispatchers want to be viewed as professionals. They are an integral part of the emergency services system and are serious about their role in protecting the public and responders. They want training, continuing education, and certification. They pride themselves on providing a lifesaving, zero-minute response to callers in need, as the “first, first responder.” That sounds like a professional to me.
Sunday shutdown isn’t day of rest at Medicine Hat

Sunday is a day that doesn’t give much rest to dispatchers at Medicine Hat Regional Communication Centre in Alberta, Canada.

In fact, for one unlucky shift, Sunday can turn absolutely exasperating.

Sunday, a.k.a. shutdown Sunday, means eight hours without computer-aided dispatch. The CADs are shutdown and everything is taken down on paper. Even data is entered manually. There is no ProQA available during that particular shift, forcing dispatchers and calltakers to rely on the card-sets, which for the Alberta tri-ACE translates into the Fire, Police, and Medical Protocols.

Since the center rotates shifts, everyone on staff has the opportunity at least once each month. Center Director Ronda Grant said the shutdown keeps skills fresh. If there’s a power outage, practice makes the switch to cardsets flawless.

“The new people really don’t like it,” she said. “They learned on ProQA and know what the system can do. It’s just not the same without it.”

Snoop apps appall police

Smart phone applications available to anyone are making listening in on public safety agency communications too easy, say a growing number of call center supervisors who note that dozens of policing agencies nationwide are considering adopting total radio encryption to thwart eavesdropping criminals.

The Washington, D.C., police department is the latest to block channel surfing in their

“Job well done” is more than a handshake at Guilford Metro 911

The number of awards Guilford Metro 911 presents at its annual National Telecommunicators Week (NTW) celebration depends on the year.

The number, however, has nothing to do with the budget, size of their staff, or a draw between nominations for top EMD.

Since 2009, the communication center in Greensboro, N.C., has honored every EMD who successfully provided Pre-Arrival Instructions (PAIs) for bystander CPR. So far, 44 engraved plaques have made it off the stage—2 in 2009 (the program started late in the year); 17 in 2010; and 25 in 2011.

“That’s 44 people they helped give another chance,” Quality Assurance (QA) Administrator Mark Shepherd said. “It does a lot for our folks to receive these in recognition of the tremendous job they do.”

Award criterion defines a CPR save as the spontaneous return of circulation via bystander CPR that begins during the call and before paramedics arrive and continues through the patient’s admittance into the hospital (makes it out of the ER). Nominations do not take into account the unknown outcome past that point.

“That’s beyond our control,” Shepherd said.

EMD Ryan Kitchel took his turn on stage twice, earning the award for two CPR saves in which bystanders receiving CPR instruction provided a cumulative 500 chest compressions to the patients.

Although CPR was successful in both cases, Kitchel said the second call was a case-book example of how things should happen.

“I had to reassure the caller once or twice that together we were going to get through this, but she listened and did exactly what I asked her to do,” Kitchel said. “Everything fell into place.”

Kitchel, a former university police department emergency dispatcher, has been with Guilford Metro 911 for six years. He said the potential to help save the life of a person in cardiac arrest is a “phenomenal” part of the job.

“The award is like the icing on the cake,” he said.

Shepherd said he developed the program to honor the link in EMS that often goes unnoticed on the awards platform. The number of awards presented so far, he said, doesn’t reflect the actual number of people affected, and—unless you stop and think about it—the impact on lives.

“Even if the patient dies, the family knows they were hands-on close to that person during the last minutes,” he said. “They did everything they could to help.”
communications network. Agencies in Florida, Kansas, Orange County, Calif.; and Santa Monica, Calif., have already done so.

Monitoring police radio bands is part and parcel to most news media outlet crime coverage, but until now the general public had been unable to monitor public safety channels. Most news scanners are fixed desktop scanners tuned to a specific area’s emergency services frequencies. Technology has apparently cracked the problem of how to monitor emergency communications from a moving vehicle and across the wide range of public safety and emergency frequencies.

Just like smart phones can be used for mobile e-mailing or video transmission, they can be used to see what police are up to and ostensibly by criminals to know where police are and to check for public safety activity at any time. Such was the case during the riots last August in Tottenham, England, in which looters monitored law enforcement radios to avoid being caught, despite the U.K. and many other countries using trunked radio to avoid being caught, despite the U.K. and many other countries using trunked radio with a built-in encryption interface.

Smart phone apps take the legwork out of eavesdropping by streaming the content for a wide range of emergency services from the Internet in almost real time. One prominent iPhone app, Scanner 911, costs only $1.99 and supports hundreds of North American services.

Texting focus of new bill

A bill that adds several rules for NG9-1-1 upgrades, including mandating that cell phone service providers alert emergency callers if a 9-1-1 text doesn’t go through, has been introduced in the U.S. House.

Rep. Kathy Hochul, a first-term congresswoman from New York, said the Allowing Local Emergency Response Technicians to Accept Cellular Texts Act, or ALERT Act, will help close gaps in 9-1-1 text calls that she says are simply not getting through at many call centers around the country.

Administrators at the National Emergency Number Association (NENA) said while many dispatch centers aren’t equipped to handle text calls for help, all are in the process of making upgrades. All centers are addressing the gap, and many are waiting for upgrades necessary by the large cell phone service providers to make sure that text calls for help aren’t dropped or not responded to.

“This bill will ensure that in an emergency situation, Americans will not be waiting for help that’s not on the way,” Hochul said in a news release. “We must, at the very least, alert victims that their text message did not go through. Next, we must modernize our 9-1-1 call centers to keep up with 21st century communications.”

Those modernizations include a nationwide upgrade, completed in 26 states, to new generation or E9-1-1 retooling of their current 9-1-1 infrastructure to allow for continuing communications technologies.

Laws and initiatives hurry AEDs to the scene

Several counties in Florida are updating their CAD software to store automated external defibrillator (AED) location data following a change in Florida law that went into effect July 1. The bill amends state medical privacy laws to give dispatchers the authority to notify a business with an AED when a confirmed coronary is taking place and encourages AED owners to notify their local EMS director to provide the location for inclusion in the data system.

Florida is not the only place jumping on the AED wagon to save lives.

At least 12 National Health Service (NHS) ambulance companies support the initiative. If a SCA is suspected, the 9-9-9 caller is directed to the nearest cabinet and given the access code to retrieve the AED. The dispatcher talks the caller through the steps while an ambulance is on its way.

Defibrillation within three minutes of SCA increases the chance of survival to more than 70%.

The University of Pennsylvania added 1,500 AEDs to its My Heart Map campaign through a two-month drive that attracted more than 300 participants. Two people won the $90,000 grand prize for submitting the locations of more than 800 AEDs and the Children’s Hospital of Philadelphia Youth Heart Watch program awarded AEDs to the top three Philadelphia schools participating in the event held between Jan. 31, 2012, and March 27, 2012.
Cell calls still a moving target

With most U.S. states still without legislation to bring their old 9-1-1 telephone-based networks into the wireless world, call center managers across the country are obtaining grants and approvals on a local level to improve their ability to deal with the text, data, images, and video that the public has become accustomed to in personal communications.

The public expectation that 9-1-1 services are somehow keeping up with their personal capacities is driving the upgrades to the mobile world whether call centers like it or not, call center supervisors have repeatedly told The Journal in recent months.

This could be the first time in the history of the 9-1-1 emergency calling network that the general public’s use of communications technology is more sophisticated than calling centers. It will create a new set of headaches for emergency services providers, who are far behind the massive expansion and variety of communications.

“Most agencies are being dragged almost kicking and screaming into using even Facebook and Twitter,” a deputy sheriff in Utah said recently, noting that during the 100-year windstorm that rampaged through five states the first week of December 2011 “they were invaluable communication sources to the general public. Call centers, first responders, and the government agencies that oversee them need to embrace every possible connection rather than keep trying to avoid them.”

Hitching a ride

Painesville, Ohio, city officials call them “frequent fliers”—a not-so-nice term of endearment for residents who are using ambulances to be transported to hospitals for clearly non-emergency reasons.

According to The News-Herald newspaper, northern Ohio residents are taking advantage of the “soft billing” loophole in the city-operated ambulance service that allows people without insurance coverage to pay later for ambulance transportation.

Fire Chief Mark Mlachak told The Journal in August that 930 of the 2,029 9-1-1 calls city dispatchers received during January were actually non-emergencies in nature—684 calls were logged as non-emergencies with transport; 246 resulted in no transport. Of those, 79 involved individuals under psychiatric care undergoing panic attacks and 49 were non-serious alcohol-related calls.

Mlachak said the trend is compounding the agency’s decreasing funding problems by residents making calls—four people had called more than 10 times each in the latter part of the year—trying to save money themselves.

The issue is just an example of a trend around the country—public safety agencies strapped for funding right at the time when people who have lost their jobs have lost their medical benefits.

Mlachak said the calls not only bog down the call center, but it’s wasted time and money for the ambulance service. He noted that the city has set a definite amount for how much money could be saved. It has let the public know that the city is cracking down on non-emergency transport and he suggested other cities do the same.

Mayes County 9-1-1 center benefits from Google community grant

MESTA is the Public Safety Answering Point (PSAP) for most of Mayes County’s 41,000 residents. MESTA also dispatches for 10 of Mayes County’s fire departments.

This isn’t the first time the Internet search engine giant has contributed to Mayes’ economy. In 2007, Google announced its intent to build a data center in the county. The $6 million facility, which opened in 2011, employs 100 people, ranging from technology assistants to experienced data center managers.

Google’s community grant program supports organizations and initiatives that focus on the issues of technology literacy and innovation, renewable energy innovation, access to high-speed Internet, and new economy entrepreneurship.

Fall from a ladder tests power of nearly implemented MPDS

Mayes Emergency Services Trust Authority (MESTA) is a fan of Google or maybe it’s the other way around.

In July, the Oklahoma ambulance and dispatch center received a $10,000 grant from Google's community grant program to purchase computer-aided dispatch software for its 9-1-1 center. According to the grant announcement, the grant will be combined with community-raised funds to pay for the new emergency equipment, which totaled just under $250,000. The equipment links fire, police, and ambulance service together in a single, coordinated dispatch and communication service and directly connects emergency services personnel through cell phone messaging. The software also enables GPS tracking of emergency vehicles.
The first month of using the Medical Priority Dispatch System™ (MPDS™) and the Hendry County (Fla.) Sheriff’s Office 9-1-1 center is already seeing the advantages.

In late July, a frantic caller from Montura Estates in central Hendry County requested assistance for her husband bleeding from a cut to his head resulting from a fall from a ladder. The dispatcher—a newly-certified EMD—asked the Case Entry Questions, turned to Protocol 17: Falls, and after sending response, gave the caller Post-Dispatch Instructions to apply direct pressure to the cut using a clean, dry cloth. The individual survived.

Communications Supervisor Margie Phipps, who has been with the sheriff’s office for 12 years, said she recommended MPDS for just that reason.

Storm prompts 9-1-1 introspection

The Public Safety and Homeland Security Bureau (PSHSB) is asking for comment on the background, causes, and restoration of communication services in the wake of a fast-moving storm on June 29, 2012, across the Central, Mid-Atlantic, and Northeastern United States.

The intense wind and thunderstorm, called a derecho, wiped out electrical power for periods ranging from a few hours to more than a week during the middle of a heat wave, including isolated breakdowns among 9-1-1 networks in Ohio, Kentucky, Indiana, and Pennsylvania, and systemwide failures in northern Virginia and West Virginia. Northern Virginia was hit particularly hard, with more than 1 million residents unable to call 9-1-1 for assistance due to outages partially or completely shutting down Public Safety Answering Points’ (PSAPs’) facilities and related backup systems. Traditional networks, broadband networks, and wireless networks were affected.

Since the storm, the bureau has held several meetings with public safety officials and communications service providers to evaluate the existing system to improve the “reliability, resiliency, and availability” of communication networks in times of natural and man-made emergencies. The latest step, taken in August, adds public comment to the mix in determining action by the Federal Communications Commission (FCC).

Several areas specific to 9-1-1 included the role back-up power for network equipment played in the 9-1-1 outages, how 9-1-1 call completion was affected by outages, suggestions for improving the ability of communications to operate longer when commercial power is lost, and the impact 9-1-1 outages had on the public and the abilities of public safety officials to perform their work.

Word from the top

As usual, Cambria 9-1-1 EMD Paul Zabinsky didn’t know who he was reassuring over the phone—at least until the call was mentioned at a county commission meeting and his name later published in the local newspaper.

According to the story (Tribune Democrat, Aug. 24, 2012), Commission President Douglas Lengenfelder gave his personal thanks to the 9-1-1 staff, recalling that his mother had a medical emergency during a recent visit to his home, and 9-1-1 was called for help. It was reassuring to hear from the calm dispatcher, “Help is on the way,” Lengenfelder said. The dispatcher was later identified as Zabinsky.

Cambria 9-1-1 in Ebensburg, Pa., uses the Fire and Medical Protocols.
International conferences complement European sensibilities

It’s not exactly like stepping into a different world when attending the Euro and UK Navigator conferences in September, but the experience is a notable contrast from their predecessor Navigator held in North America.

There are similarities, of course. The conferences held in September—Euro 2012 in Berlin and UK 2012 in Bristol—clarify and promote the International Academies of Emergency Dispatch’s (IAED®) philosophy and cater to the emergency services community. They also draw on the expertise of research, experience, and familiarity.

The contrast lies in the approach and the audience consequently attending the three-day conferences, particularly Euro Navigator, explained Tudy Benson, IAED director of European Relations.

“The focus is the academic and scientific appeal resulting from the Academy’s research and the protocol that develops from the process,” she said. “They want data. They want quantifiable evidence supporting protocol’s effectiveness.”

It’s not that North Americans are more easily persuaded.

“Hardly,” said IAED Conference Coordinator Claire Colborn. “But we have organized the conferences to better reflect the style of conference Europeans prefer.”

As far as approach, North Americans have been exposed to emergency medical dispatch protocol for more than 30 years, and while the same timeline basically applies to English-speaking countries in Europe, the same doesn’t hold true in the German-speaking and Low Countries, which include Austria, Switzerland, and Germany. Benson made her initial breakthrough in 1996 when Austrian Gernot Vergeiner, then manager of the Kufstein call center, traveled to the U.S. for an early NAED™ conference held at the Snowbird Ski Resort in Utah.

“He was interested in the protocol and purchased a set to take home to study,” Benson said. “He happened to have the cards in front of him when a call came in from a mother pleading to get help for her child. The child was choking and he used the protocol to give the mother instructions. The child survived.”

The episode made a strong proponent of Vergeiner, now the director of the consolidated Tirol Communications Center in Innsbruck, and he has worked with Benson and other Academy members to advance the use of protocol in countries now represented at Euro Navigator. Going on its sixth year in 2013, the last two years have seen big increases in attendance. The 124 attendees and 34 speakers show numbers 30% higher than 2011 and 106% higher than 2010.

Colborn said international Navigator planners stepped up three years ago to tailor the conference to European tastes.

“We weren’t missing the ball, but there were definite comparisons,” Colborn said. “The changes we introduced have been well accepted.”

These include sessions divided into specific blocks, such as quality assurance, dispatch life support, research, and less frequently occurring medical emergencies. Each block is further broken into 20-minute topic...
focused segments. For example, the morning might be dedicated to five 20-minute segments all covering quality assurance.

A second change is an emphasis away from purely a “user” audience. The international conferences attract an audience combining long-standing and recent protocol users, agencies considering protocol implementation, and people—particularly academics and medical professionals—interested in the research correlated to protocol outcomes. Euro Navigator even includes an “open mic” session in which users talk frankly about the implementation process.

“They’re candid and honest,” Benson said. “They admit to challenges along the way. It wasn’t always easy. But they also provide tips on how to get through issues they expect common to other agencies.”

UK Navigator saw similar increases in attendance, with 2012 numbers at 75 attendees and 17 speakers offering 21 sessions. Protocol users in the U.K. taught most of the sessions, which, Colborn said, has been a goal all along.

“It only makes sense for those most familiar with the U.K. to give the presentations,” she said.

A second welcome change, Colborn said, was the mix of people attending and their opportunity to network with others from varying backgrounds. Unlike the U.S., emergency call centers in the U.K. are not consolidated into one agency providing police, fire, and medical service.

“There is less interaction in the field because they operate separately,” Colborn said. “The great part about Navigator was watching everyone discuss what they did and exchanging ideas and experiences. Navigator brought them together.”

When it’s all said and done, Benson and Colborn come back to the states and their offices anticipating the next year’s conferences.

“These are my favorite people and I’m sincere when I say that,” Benson said. “I may talk to them daily over the phone, but it’s a real treat when we’re able to meet face-to-face and honestly hear how things are working out for them.”

Euro Navigator Dispatcher of the Year

Valerie-Salima Hödl from Leitstelle Tirol, Austria, is not easily surprised.

After all, she is an emergency medical dispatcher (EMD) for the Tirol Communications Center in Innsbruck, which has 18 dispatchers working in three shifts daily handling more than 220,000 events per year.

But in September, during the opening session of Euro Navigator in Berlin, Hödl was truly stunned by the unexpected.

Hödl heard her name called from stage in connection with the Dispatcher of the Year Award.

“Only a few people knew, and Valerie wasn’t one of them,” said Tudy Benson, IAED™ director of European Relations. “It took her a few minutes to realize that she was the dispatcher receiving the award. She was amazed.”

Hödl started in dispatch in 2004 and during the past eight years behind the console
she has seen many modifications in the way the system operates. She takes it in stride, said Director Gernot Vergeiner, who was present when the award was announced. “Valerie has the ability to move with the changes,” Vergeiner said. “That’s one of her strengths. This is one of the few times I’ve ever seen her taken off guard.”

Tirol is a regional center, consolidated from several centers over the past five years to coordinate response, particularly in light of disasters that demand multiple agencies. The Avalanche Disaster of Galtür in February 1999, Vergeiner said, was the tipping point. “It was the worse avalanche in the Alps for 30 years, and despite heroic efforts to rescue people, we knew changes were in order,” said Vergeiner, then manager of the Kufstein call center that was folded into the consolidated center in Innsbruck. “We needed a central point to coordinate emergency services.”

According to news reports, heavy winds affecting above normal snow mass near the Tyrolean village of Galtür created powder snow avalanches that in one day buried 60 people and killed 31. Homes and businesses were destroyed. Roads blocked by debris were closed in the immediate aftermath, forcing helicopter evacuation of 12,500 people. No other transportation could reach the valley.

The massive rescue efforts in the supposedly safe zone signaled changes in risk zone management and the urgency for regional emergency service oversight coordinated by a central control center.

Tirol and Innsbruck finalized plans for a National Control Center in 2003, and the building in Innsbruck opened for operation four years later.

“We coordinate all Tyrolean forces, except police,” Vergeiner said. “It was a huge project that took the cooperation of many organizations. Everyone agrees it was the right goal.”

The facility is ultra-modern and allows for future improvements. Technology includes an integrated digital map display with address data identifying the location of public buildings, mountaintops, and emergency call boxes along highways and ski lifts. Dispatchers process calls using the Medical Priority Dispatch System™ (MPDS™) and the Fire Priority Dispatch System™ (FPDS™).

CEO Mag Ing Martin Eberharter congratulated Hödl for the dedication and outstanding service, he said, that led to the recognition.

“She puts the needs of others above her own, making her contributions very valuable to the people seeking help from our control center,” he said.

The Tirol Communications Center serves a population of more than 700,000 people residing in the 270 municipalities making up the area’s nine districts.

UK Dispatcher Elisa Harrison, Bracebridge EOC, was selected as the UK Dispatcher of the Year.

UK Navigator Dispatcher of the Year
By Beverley Logan

The UK Navigator 2012 Dispatcher of the Year Award went to Elisa Harrison, EMD, Bracebridge Emergency Operations Control (EOC) within East Midlands Ambulance Service (EMAS) NHS Trust. Prior to receiving the award at UK Navigator, she received a BBC 999 Award.

EMAS Service Delivery Manager Simon Tomlinson wrote this about Harrison:

Elisa Harrison has always approached her role with a consummate professionalism and dedication to duty. Elisa is passionate about the EMD role and has a genuine belief that she can make a difference in the patient experience. She sets a very worthy example to other EMDs and other staff groups in EOC in striving to be the best she possibly can be and I, personally and as the Service Delivery Manager for EOC, along with the rest of EOC and EMAS are immensely proud of Elisa’s achievements. It is testament to Elisa’s nature that she has received the BBC 999 Award with humility and appreciation but is just as grateful that the awards recognize the role and raise the profile of the EMD within the patient experience.

The following story is a summary of a call Harrison answered in March 2012. Tomlinson submitted the audiotape as part of Harrison’s nomination.

In March 2012 Elisa took a call from a father who had found his baby son lying face down in a pond not breathing. Taking the father through the AMPDS™, Elisa instructed the father on how to perform CPR to his 1-year old son.

Elisa could hear the fear, anxiety, and terror in the caller’s voice immediately on receipt of the call. For the next 17 minutes, she calmly provided reassurance and clear instructions in an attempt to ensure the 1-year-old received effective CPR from his father through to when the paramedics arrived.

She encouraged the little boy’s parents—the father having made the call and mother who arrived on the scene during the call—to continue with the CPR instructions.

Prospects for survival were not good when paramedics arrived, according to the boy’s mother.

“Due to the time frame, they believed the baby had little chance,” she said.

The prognosis changed dramatically once the Lincolnshire & Nottinghamshire Air Ambulance reached the hospital; his heart was beating. Needless to say, the parents were grateful for the help they had received.

Tomlinson credited Harrison and the protocol for the boy’s survival.

“If Elisa had not followed protocol, supported with reassurance and empathy, it is highly likely the little boy would not have survived,” he said. “In my career as a control room manager, I have never heard an EMD talk callers through CPR instructions as well as Elisa did that day. It was a superb call and if she had not insisted the outcome would be very different.”

Harrison took the call in stride.

“This is my job and this is what we do,” she later said.

The boy, now 17 months old, is recovering well and making good progress.

“They want to stay in touch with Elisa and keep her posted on his recovery,” Tomlinson said.

In appreciation of the help and encouragement since the accident, the family is raising funds for the Lincolnshire & Nottinghamshire Air Ambulance Service. The service is completely voluntary and depends on donations and fundraising to cover its operational costs. It receives no funding through the NHS Trust.
ATLANTA—The New South envisioned by Henry W. Grady more than a century ago didn’t include Atlanta’s main emergency medical services agency becoming an Accredited Center of Excellence (ACE) in 2012, but the 19th-century newspaper editor and public health visionary certainly would have expected it.

Grady Emergency Medical Services being named the third ACE in Georgia and the 165th worldwide would have fit nicely into his big picture of post-Reconstruction Era in which all could prosper, and where all, particularly the poor and destitute, would have access to excellent healthcare.

The roots of excellence in the Grady Healthcare System starts with Grady, who 121 years ago helped develop a system of care the public taps into every day. Grady EMS responded to more than 120,000 9-1-1 calls in 2011, dispatching its fleet of 46 ambulances deployed by a communications center staff of 40 dispatchers.

“Not bad,” Grady Communications Director Cliveita Caesar told The Journal. “To us, it’s very much a source of pride. It says that we’re the best of the best when it comes to Emergency Medical Dispatching” in Atlanta, and we’re not just saying so, the NAED™ says so.”

The effort to become an ACE was “well worth it,” Caesar said, noting that the center had been consistently scoring far below acceptable levels in how well dispatchers followed the Medical Priority Dispatch System™ (MPDS®) Protocol.

“Within eight months, we were in the 90th percentile and we’re working hard to maintain that,” she said, adding, “it’s not about the score, it’s about what the score means in how well we’re serving the public.”

Grady EMS covers 132 square miles in the central zone of Fulton County and...
responds to calls in all areas within the City of Atlanta and Fulton County as the primary 9-1-1 ambulance provider. Caesar has had 18 months on the job, although she has 13 years of experience in police dispatching in Atlanta.

“I’m so glad to be in medical dispatching because every call is different,” Caesar said, noting that police calls are just as much a part of maintaining public safety as medical emergencies. “But every call is unique in EMD, and I learn something new every day. It’s very rewarding work because I know we’re making a difference, and I know the next call could very well be helping save someone’s life.”

She and other staffers, both in the call center and the paramedics responding to the scene, like to say the medical calls run the gamut of seriousness, giving dispatchers an array of situations in a single year that dispatchers in other parts of the country won’t see in 10.

That’s a systemic trait of Grady EMS. It was providing top-flight emergency services seven years before the Wright Brothers took flight. Henry Grady started the country’s first citywide ambulance service in 1896. The vehicles he designed were literally one- and two-horsepower medical supply-loaded buggies that became the forerunners for today’s fleet of ambulances stationed all over Atlanta, which cut response time to a bare minimum.

Deploying the vehicles throughout the coverage area also permits Grady to continue its method of response: As soon as the address is taken on a 9-1-1 call, an ambulance is on its way as a result of the use of status system management. If the call is downgraded or the emergency is deemed noncritical, the vehicle stands down and returns to its original point or is sent to another location perhaps to cover a large event or go to a part of town that seems to be generating increased emergency call traffic.

Betsy Cobb, quality assurance and improvement director for Grady, said the so-called “Grady Way” is to go above and beyond. In the case of the ACE, that was achieving higher standards than the “Twenty Points of Excellence” ACE award from the NAED™ signifies. In addition to requiring proper system oversight, medical control, and quality management programs, accreditation requires careful MPDS compliance and certification for all emergency calltakers and medical dispatchers. And, it’s achieved just because a center wants the designation—it’s voluntary, not required.

When the award was announced, Bill Compton, Grady Health System vice president of Operations/EMS, said, “As Atlanta’s 9-1-1 emergency ambulance service, Grady EMS works to meet the highest quality standards at every level. [The ACE designation] confirms that we have developed a system that provides the highest quality medical response to the citizens of Atlanta when they need emergency care.”

Grady EMS seems to have “new and improved” ingrained in daily life. It has been through a series of software upgrades, including adopting version 12.2 of the MPDS. Grady also has a new training lab to perform hands-on training for dispatchers ranging from first-day to veteran. The lab is equipped with TriTech’s CAD system, ProQA®, and a phone system to simulate real-life emergencies in real time. It also just made the ultimate hardware improvement by moving to a new communications center.

“So, yes, there have been a lot of changes we’re dealing with, but they’re positive and all based on always finding ways to do what we do better,” Caesar said.

**Next up?**

“Who knows, but it will be about expansion,” she said. “We just want to see our service expanded outside Atlanta itself. I think we’re at that caliber now and can expand into nearby counties.”

The ACE designation comes in the wake of Dr. Arthur Yancey II, Grady Emergency Medical Services medical director, being named EMS Medical Director of the Year by the Georgia Association of Emergency Medical Services and Georgia EMS Region III. Dr. Yancey is also the recipient of the 2007 Dr. Jeff Clawson Leadership Award from the International Academies of Emergency Dispatch. The award singles out exceptional leadership in the field of the trilogy of police, fire, and medical emergency dispatching combined.

**In memoriam**

An article about emergency communications in Atlanta wouldn’t be complete without mentioning an event that Grady personnel could do nothing to prevent but are still talking about—the death of dispatching supervisor Nikita Thomas.

A year ago September, Thomas, age 34 and a nine-year veteran dispatcher, was killed after someone attempted to steal the car at gunpoint that she, her fiancé, and her 13-year-old son were riding in. Thomas, a police dispatcher for the city of Atlanta, and her family were returning home after an evening out when an unknown masked gunman approached their vehicle and began shooting. Her wounded fiancé got out of the car and died shortly after the car began rolling and collided with an oncoming city bus. Thomas was killed on impact. Her son, riding in the back, was seriously injured, but has since recovered.

Caesar said the region’s public safety agencies have raised money to help with the child’s hospital bills, which are considerable.

“The loss is still felt, not just because she was one of ‘us,’ but because she had a ready and warm smile, and a warmer spirit,” she said. “She was just a good person, and it’s left a big hole in our community.”

At the time of publication, police were offering a $5,000 reward for any information leading to the arrest and conviction of the assailant. If you have any information, call Crime Stoppers at 404-577-8477.

A 9-1-1 Cares response is still active. Anyone wanting to find out more can contact Gwen Favors, Atlanta 9-1-1 assistant director. E-mails can also be sent to jonathan.jones@athensclarkecounty.com and to Angela Jennings at ajennings@gsu.edu.

The center’s mailing address (for cards and letters) is 180 Peachtree Street NE, Suite 500, Atlanta, GA 30303.
“COLD” Response Chills
Ambulance contradicts EMD call

By Brett A. Patterson & Greg Scott

Greg:
I have an issue concerning a patient with a compound fracture just above the ankle, although unsure whether it was tibia or fibula. The patient’s bleeding was described as “not very much...just a drop.” Using Protocol 30: Traumatic Injuries (Specific), the Determinant Level would be an ALPHA, since the lower leg is listed as a “Not Dangerous Body Area.” Our final code was a 30-A-1. The ambulance, however, upgraded to a DELTA sighting, as described:
The response was upgraded due to it being a compound fracture (open fracture). Any open fracture will require immediate ALS intervention through appropriate treatment and pain management that must be performed. My concern is that an open fracture was dispatched as a non-emergent BLS response via EMD criteria. This should never have occurred and I would recommend reviewing the EMD process as it relates to appropriate EMS intervention requirements. If a BLS crew had been dispatched, ALS assistance would have been requested once an assessment was completed. This would have delayed ALS and also committed unnecessary resources to a single event.

Could you provide the Academy’s reasoning for running “COLD” and only responding BLS, which seems to contradict the ambulance company?

Carl:
Jeff Clawson, M.D., Brett Patterson, and I have reviewed your question. Dr. Clawson has written the official opinion below.

1. We agree that coding as a 30-A-1 is correct.
2. The prehospital care of lower leg fractures has been a BLS COLD level response for 32 years per the MPDS® response matrix list. Also, a HOT transport is not clinically necessary for this type of case. In my personal experience (JC), I have treated a few dozen of these types of injuries in the ER and many of them came in via private vehicle, with only splinting and contamination protection being compromised.

3. The case at hand is not a new concern. These types of cases were considered in the development of Protocol 30. The argument, if presented to the Council of Standards, in our opinion, would not be persuasive as it was written; however, anyone can provide a Proposal For Change (PFC) to the Academy, once approved by the Dispatch Review Committee and signed by the medical director. It will receive formal evaluation.

4. The issue of pain management per se is an ALS treatment. However, whether the fracture is open, partial, closed, deformed or not, has no bearing on the need for analgesics. The level of pain of any injury, regardless of where it is, may warrant pain meds. Having four fingers dislocated might be more painful than the injury in this case.

5. Unless the EMS system wishes to send an ALS unit on every fracture or soft tissue injury called in, ALS will not be at the vast majority of these types of calls in a tiered ALS/BLS system. It is much more common that in special cases of severe pain, ALS is later dispatched, or much more commonly, the patient is simply transported to the care center in nearly the same amount of time as the response of an ALS unit.

Please let us know if you have any further questions or concerns regarding this case.

Gregory Scott
Operations Research Analyst
National Academies of Emergency Dispatch® (NAED™)
### TUESDAY, APRIL 16TH

**Exhibitor Gala Reception**

**WEDNESDAY, APRIL 17TH**

**Opening Session**
Dispenser of the Year Award

**Keynote**
Jim Shea, Jr, Olympic Men’s Skeleton Gold Medalist

**7:30-8:30 AM**

**8:30-10:30 AM**

**10:30 AM-12:30 PM**

**12:30-1:30 PM**

**1:45-2:45 PM**

**3:00-4:00 PM**

**4:15-5:15 PM**

**6:00-8:00 PM**

**6:00-8:00 PM**

**8:00-9:00 AM**

**9:00-10:00 AM**

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<td>1:45-2:45 PM</td>
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<td>Kim Ryden-Broch, Michael Sparsh, Brian Dale, James Ermitt</td>
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<td>A Lesson Before Dying: How to Avoid Being</td>
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<td>When People (and Things) Won’t Behave</td>
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**THURSDAY, APRIL 18TH**

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<tr>
<td>8:00–9:00 AM</td>
<td>ACE Reception For all Accredited Center of Excellence Attendees</td>
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**FRIDAY, APRIL 19TH**

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**FREE BOX LUNCH IN THE EXHIBIT HALL**

**Next GEN 9-1-1**

**Technology in a Consolidated Center**

**Communications Centers—How They Work To Improve the Experience**

**PSAP Challenges for the Next Generation**

**Building a Bureaucratic Culture in the PSAP**

**Closing Luncheon**

**Sponsoring by:**

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THE PREMIER CONFERENCE FOR POLICE, FIRE, AND MEDICAL DISPATCH

REGISTRATION FORM

Please complete a copy of this form for EACH PERSON who will be attending.

CONFERENCE REGISTRATION OPTIONS
APRIL 17-19, 2013 (WEDNESDAY–FRIDAY)

Passports INCLUDE admission to all regular conference sessions, the Opening Gala, the Exhibit Hall, and two box lunches.

 CONFERENCE PASSPORT $515

DISCOUNTS (CHECK ONLY ONE, AS ONLY ONE APPLIES)

 NAED Membership (ID: __________ )  $-30

 or NAED (ID: __________ )  $-40

 or Group Rate (3 or more from same agency, submitted at the same time)  $-70

 or Accredited Center (Current ACE)  $-100

1-DAY (Price per day, Wednesday–Friday, check below)

 April 17  $195

 April 18  $195

 April 19  $195

Spouse/Guest Admission (Name: __________ )  $50

(Signature of friend/relative: __________ )

(Assignment only to Exhibit Hall. Includes two lunches and Opening Gala.)

SPECIAL EVENTS

Closing Luncheon, Friday, April 19, 1:00 PM–2:30 PM  $25

12th Annual NAVIGATOR Golf Tournament, Tuesday, April 16, 8:00 AM–1:00 PM  $65

PRE-CONFERENCE PROGRAM SUMMARY
APRIL 14-16, 2013 (SUNDAY–TUESDAY)

NAED CERTIFICATION COURSES
(Prices as marked. NAED materials and testing fees INCLUDED)

3 DAYS, SUN–TUE, APRIL 14-16, 8:30 AM–5:30 PM

 EMD: Emergency MEDICAL Dispatch® Certification Course  $295

 EFD: Emergency FIRE Dispatch® Certification Course  $295

 EPD: Emergency POLICE Dispatch® Certification Course  $295

 ETC-I: Emergency Telecommunicator® Instructor Course  $475

2 DAYS, SUN–MON, APRIL 15-16, 8:30 AM–5:30 PM

 EMD-Q: MEDICAL Dispatch QI Certification Course (Class 1)  $550

 EPD-Q: POLICE Dispatch QI Certification Course  $550

2 DAYS, MON–TUE, APRIL 15-16, 8:30 AM–5:30 PM

 EMD-Q: MEDICAL Dispatch QI Certification Course (Class 2)  $550

 EPD-Q: FIRE Dispatch QI Certification Course  $550

NENA, NAED, and PSTC SPECIAL TOPIC WORKSHOPS

1 DAY, MONDAY, APRIL 15, 8:30 AM–5:30 PM

 NAED: Recertification Workshop  $250


 PSTC: It’s Your Ship, Navigate it!  $190

1 DAY, TUESDAY, APRIL 16, 8:30 AM–5:30 PM

 NAED: Recertification Workshop  $250

 NENA: Overcoming Negativity in the Communications Center  $190

 PSTC: The Fire Within!  $190

½ DAY, TUESDAY, APRIL 16, 8:30 AM–12:30 PM

 NAED: Executive Workshop  $95

 NAED: Data Mining 101  $95

½ DAY, TUESDAY, APRIL 16, 1:30 PM–5:30 PM

 NAED: Accreditation Workshop  $95

 NAED: Data Mining 201  $95

FREE T-SHIRT WITH PRE-REGISTRATION

Prepay your registration fees before the conference, using a credit card or check/money order, and you will receive a free, custom-designed NAVIGATOR 13 conference T-shirt at check-in. (See details on the Web.)

METHOD OF PAYMENT

Registration will NOT be accepted without one of the following:

 Check/Money Order Payable to: NAED

 Purchase Order (A copy must accompany the registration form)

 Credit Card

 MasterCard  Visa  American Express

 Card # __________________________

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Second Time At Bat
Bunker’s grand slam took lessons from earlier strikeout

By Audrey Fraizer

Don’t expect smooth sailing when implementing state-level protocol and training standards but if you listen to someone who has “been there, done that,” the trip can be a lot less bumpy.

Stephan Bunker is a primary force in “how it’s done” and readily admits that failure was nothing he expected the first go-around with Maine’s legislators.

But that’s just what happened.

“It took me two times in the fishbowl with them,” said Bunker, at that time director of Maine’s Emergency Services Communications Bureau (ESCB). “The first time I failed miserably. The second time I came prepared.”

“Failed miserably” is an overexaggeration. Bunker was prepared, having studied the legislative process and arranged his talking points in order when he approached the legislative committee responsible for public services in February 2002. He described the purpose of standardized protocol, the importance of training and certification, and the gaps existing in Maine’s 9-1-1 system. He explained how the lack of standards affected the quality of response and, in some cases, led to litigation.

“A majority of Maine’s PSAPs were providing emergency medical dispatch, but the point was getting every PSAP to provide the same, consistent response,” he said. “I also wanted more attention paid to quality assurance across the state.”

Bunker’s presentation might have been well received, but it did not make the impression he intended.

“I hadn’t rallied the troops,” he said. “I didn’t have stakeholders lined up to come in to testify on my behalf. I came across as another speaking head from the state wanting more money and more authority.”

Getting his ducks in a row

Bunker did not make the same mistake in 2003. He amended his strategy to emphasize standard of care. He talked about the impact on community and how standards were the right thing to do. He built consensus, enlisting the aide of public service employees prior to meeting with legislators. He brought in heavy hitters like the American Heart Association as an ally.

“Their emphasis on caller safety and increased survival due to Pre-Arrival and Post-Dispatch Instructions sent a strong message,” he said. “Their credibility with the legislators was very influential as a true stakeholder organization.”

At the public service committee meeting, each individual—and there were 15—gave testimony different from the last person.

“It’s unmercifully painful to watch 15 people come up and say the same thing,” he said. “Figure out your presentation and arrange testimony in an order that supports your argument.”

He suggested a funding strategy and calculated an appropriate estimated expense since “unfunded mandates tend to be the kiss of death for public policy approach.”

The second time around won the committee’s serious consideration, with one caveat. His proposal to increase the state surcharge would not fly since the ESCB was already asking for a 20-cent subscriber increase over the next 18 months to cover the cost of Next Generation 9-1-1 technology.

“Timing is everything,” he said. “The committee suggested waiting until the downside slide of the surcharge increase and asking the ESCB to take 15 cents instead of the entire 20 cents. The extra pennies would be saved for our request.”

The legislation, enacted in 2005, mandates, with funding support, the statewide implementation and ongoing evaluation of Emergency Medical Dispatch™ commencing on Jan. 1, 2007. Although the ESCB remains a critical partner, the Maine Emergency Medical Services bureau coordinates oversight.

The state’s approximately 700 public safety telecommunicators in 26 PSAPs are certified EMDs and in August 2010, the Maine Board of Emergency Medical Services approved the use of Priority Dispatch® as an option for Maine’s licensed EMS services, in accordance with board-approved standards.

The bureau also mandates the NAED’s™ Emergency Telecommunicator™ Course (ETC™) for all newly hired full-time dispatchers, the Emergency Medical Dispatch Quality Assurance (ED-Q™) program for
Tips from the pro:

- **Devise a plan**
  Create a model through ideas available from other sources, such as the NAED

- **Make an argument for implementation**
  Callers have certain expectations and if you’re not meeting the expected standard of care, what does the public think of you? And, who wants to be known as the person who could have made a difference, but chose not to?

- **Seek communications center support**
  Don’t take for granted your philosophy is understood; spend time talking to dispatchers, managers, and supervisors to help them understand what state policy could mean for them.

- **Put together a stakeholders group**

- **Review existing policies and procedures**
  Know what’s in place since the lack of documentation or ignorance of existing practices is a recipe for disaster

- **Learn about state policymaking and get to know legislators, office staff, and committee powerbrokers**

- **Develop a funding plan**

- **Don’t give up**
  “If you fail the first time, that’s not reason to stop,” Bunker said. “Regroup. There are a lot of resources out there. You don’t have to struggle alone.”

Just Ahead

Your next issue of The Journal will provide stories you surely won’t want to miss. Kick your year off right by reading about social media usage in our Jan/Feb Journal. Get a sampling of other centers’ policies and what to avoid when using Facebook, Twitter, and other social media outlets.

Hop on board the technological trend by reading about Next Generation 9-1-1 and 9-1-1 related apps.

We know you rely on continuing dispatch education articles (CDEs) to keep your credentials up-to-date. In our next issue, receive expert advice on handling suicidal callers and callers in danger.

Read a first-hand account of a Post-Traumatic Stress Disorder survivor working in the public safety field.

As always, look forward to timely news briefs about the industry as well as the latest information about advances in protocol and software.

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The number of calls to 9-9-9, the three-digit emergency services number in the United Kingdom, was down substantially during the Opening Ceremonies of the London Olympic Summer Games the evening of July 27. That's good, because several dispatchers for the London Ambulance Service (LAS) weren't at the console that night anyway.

They weren't at home watching the celebration along with more than a billion viewers worldwide who had tuned into the gala kickoff of the 30th Modern Olympiad, they were being watched.

Near the center of the world's attention that night was Emergency Medical Dispatcher Meryn Crocker-London. She was in uniform, but instead of the white shirt and shields of her occupation, she wore the more hands-on healthcare attire of a nurse, complete with the vintage stiff-as-a-pin nurse's cap.

On her mind at that moment wasn't the call center console screens but traffic of a different sort—dozens of iron-frame beds, each complete with a child/patient from the Great Ormond Street Hospital. Crocker-London and her 10,000 or so fellow volunteers comprised the National Health Service's (NHS) portion of the Opening Ceremonies. It took center stage as the nurses portrayed settling the youngsters down for a group bedtime story—a passage from the famous Peter Pan tales written by hospital benefactor J.M. Barrie and read live and aloud by Harry Potter creator J.K. Rowling.

Crocker-London told The Journal that participating in the rehearsals for the Opening Ceremonies was a lot of work, but fun. Being a part of the festivities the first night showing off England's worldwide influence through the ages was “an amazing, exhilarating, and magical experience,” she said.

The occasion was almost as exhilarating as some of the 9-9-9 calls she's handled recently, including the child-centered event of delivering a baby over the telephone, which she managed deftly thanks to Protocol F: Childbirth–Delivery in the Medical Priority Dispatch System™. The call was one of the 1.4 million calls the London Ambulance Service (LAS), which is an Accredited Center of Excellence (ACE) with the International Academies of Emergency Dispatch (IAED™), handles in a normal year.

“The telephone delivery was highly gratifying, but a little lower on the appreciation scale compared to performing
in front of tens of thousands of people at the stadium,” Crocker-London said. “I have to say it was a wonderful feeling when you are performing and you hear the roars of appreciation and the audience clapping when they love your performance.”

The call center atmosphere can turn a bit electric at times, as well, she said. But by being in the ceremony, “I was part of history and felt really proud showing the world what we have done and what we can achieve. I still get a bit high just thinking about it.”

Dispatcher Sean Fullerton, another LAS staffer who volunteered to be in the Opening Ceremonies, said being one of 1,000 drummers who played as the athletes entered the stadium gave him a hint of what fellow Brit and musician Mick Jagger feels as the singer of the durable-as-the-Crown-Jewels rock band, The Rolling Stones.
It must be what it's like to be at the center of attention at a stadium concert,” Fullerton said. “It was an amazing night—a cross between a great party and a concert. I can now boast that I have shared a stage with both Paul McCartney and the Arctic Monkeys.”

The ambulance staffers also praised ceremonies and Oscar-winning film director Danny Boyle. “He's an amazing man,” dispatcher Robert Walsh said. Walsh managed to attend the weeks of rehearsals despite having back surgery. “[Boyle] singled me out and thanked me personally for my effort in still coming in to rehearse. That meant a lot. He was great to work with and made it a great show, as he was involved in every aspect and always made sure all us volunteers knew where the hot drinks were and had a poncho if it rained.”

For their efforts, all of the performers got to keep their costumes as a souvenir.

Let the games begin

Days before things were to get under way in earnest, the importance of being well-prepared in the LAS control room at the Waterloo dispatching center was clearly the event of the games to Peter Thorpe, LAS head of Olympic Planning.

“We're very well-practiced at covering large-scale events, such as Notting Hill Carnival and the London Marathon,” he said. “However, it will be a challenge for us to be so busy over such an extended period of time.”

To put the effort in proper Olympian scale, take the 2012 Notting Hill Carnival, held over two days starting Aug. 27, which attracted more than 1 million people, times it by eight London Marathons that annually include 35,000 runners and 1.5 million spectators and you'll have grasped the size of the public safety job posed by the Olympics.

“Formidable,” was the wildly understated British way dispatchers, police officers, and their supervisors used most often when describing the effort to *The Journal*.

“A bit daunting, too, you'd have to say,” Thorpe said. “By any measurement or scale, it was the biggest event we've ever been involved in—and we know big. But we had been at this seven years—from Day 1 in 2005 when it was announced that London would be the 2012 host city.”

The quadrennial summer games is the biggest sporting event in the world. The Paralympics, the world-class competition for athletes with disabilities that comes two weeks after each Summer and Winter Olympics, is the second-biggest sporting event, larger by far than the World Cup soccer tournament.

Maintaining the public’s health and safety was the fundamental planning issue for the London Olympic Summer Games, which had gotten off to a grim start: On July 7, 2005, the day after the capitol city was named the Olympics host city for 2012, a series of four suicide attacks targeting civilians at rush hour killed 52 and injured 700. The British refer to the bombings now as “7/7.”

In ramping up for the events, the NHS spent an additional $1.4 million just on private ambulances to cope with the extra demand, adding up to 50 vehicles to the 300 LAS has on duty every day, along with their famous cadre of bicycle and foot-borne responders.

The service’s dispatching staff at the communications center in Waterloo did their part to handle the extra demand by working 12-hour shifts to handle an estimated increase of at least 350 calls a day, or an increase over normal traffic of around 10%.

The LAS spent an additional $1.1 million to bring in 220 dispatchers from other NHS ambulance services located throughout England. It also offered frontline staff working extra hours double their usual daily pay plus work differentials of $80, $161, or $241 for early, late, or overnight shifts.

On the security front, the Olympics were the biggest peacetime security operation in
Under the shadow of “7/7,” emergency medical crews and law enforcement officers from 11 regional agencies and eventually the military began to sort things for the Olympics (July 27 to Aug. 12) and the Paralympics (Aug. 29 to Sept. 9):

14,700 athletes coming from 205 countries

8 million ticketholders for the Olympics; two million for the Paralympics

26 Olympic sports held in 34 different venues

20 Paralympic sports in 21 venues

800,000 people using transportation to travel to the games on the busiest days

20,000 members of the world’s news media with accredited access to the games; an estimated 20,000 more bloggers and social media reporters

carrying 9 mm semi-automatic weapons—an unusual sight in Britain, where armed patrols are normally found only at airports.

On the busiest days, 12,500 police officers were to be on duty while 12,200 soldiers carried out the venue security searches assisted by at least 7,000 contracted civilian security workers. An additional 5,500 military personnel were added for good measure.

In final assessments of the planning strategy, emergency medical and police response supervisors said they were as prepared as they could be, though none would go so far as to promise the event would be free of a major or marring incident.

Get ready, get set

The gamut of possible threats to security and public safety of the games ranged from terrorist attacks to food poisoning. To help keep all those agency communications static-free whatever the incident, a completely new communications radio network was built, the second since one was installed after the 2005 bombings.

It was added to ensure that the existing emergency services radio network could handle the increased call load, especially in extremely crowded areas such as the Olympic Stadium for both the Opening and Closing Ceremonies and the track and field events.

Law enforcement administrators said radio communications upgrades replaced the mobile phone network that was quickly and constantly overloaded during the 2005 bombings. The new network had already had a real-life test during the 2011 London street riots during which communications across the city and the outlying venues was reportedly static-free and without “cross-talk” or other interference from other two-way systems.

The LAS staff and those from other ambulance services were assigned a variety of roles during the Olympics. There were four zone commanders in charge of overseeing any incidents in their areas. Dozens of venue commanders were based in each site along with frontline medical staff ready to treat any patients attending celebrations all over town.

Londoners were being urged to think carefully before dialing 9-9-9 since the previous May 22 when the LAS responded to 1,345 seriously ill and injured patients due to extreme heat. That’s a 29% increase in the number of calls from the previous week, and apart from New Year’s Day, was the busiest weekday on record.

The period of hot weather was a real-time test of the communications center, said

Security gives gold medal performances

The final toll of people arrested during the London Olympic Games was 242, a score worth a trip to the medal stand that will arguably be an impossible record to beat for Summer Olympics host cities in the future.

According to London’s Metropolitan Police (The Met), only seven of those arrests were made inside an Olympics venue. The total is about half the number of people taken into custody near or around Olympic venues or events before and the games and after the Closing Ceremonies.

One teenager was arrested under section 58 of the 2000 Terrorism Act, which is invoked when police suspect that someone is collecting or is in possession of “information of a kind likely to be useful to a person committing or preparing an act of terrorism.”

The most serious suspected offenses included possession of a firearm (1), possession of an offensive weapon (2), robbery (5), and assault (16). There was one bomb hoax. The 17-year-old, who was picked up at Stratford railway station near the Olympic Park on Saturday, July 28, was released after questioning and “de-arrested”, according to a Scotland Yard statement.

One person who decided the Thames might be a good spot to cool off from a hard day of spectating got to dry off under the auspices of Olympics security officers.

Two people were arrested for impersonating a police officer.

The most common arrest—some 140 people—was ticket scalping, or ticket touting, as they say in London. The offense carries fines of up to $32,000 per count if the person is convicted.

Two people were arrested for begging, 10 for drug-related offenses, one for assaulting a police officer, and 11 for disorderly conduct that included several racially-motivated scuffles.

The Met reports that the largest single arrest incident involved 182 people taken into custody for participating in an unsanctioned, traffic-clogging bicycle ride protest the night of the Opening Ceremonies. The police were criticized the next day for the abrupt manner in which the procession and riders were treated. But a spokesperson for the Met said the cyclists had abruptly ignored a police order prohibiting the protesters from traveling into the Olympic Park. Three cyclists have since been charged.
LAS Assistant Chief Ambulance Officer John Pooley. “We saw an unprecedented increase in demand from patients suffering potentially life-threatening conditions, such as chest pain and difficulty in breathing.”

As was the case during the heat wave, “we urged Londoners with less serious illnesses such as sore throats, skin complaints, earaches, or minor injuries to consider other healthcare providers in the community, for example your local pharmacy or walk-in center,” he added.

Londoners were advised by the LAS through the news media and its website that the essential services they receive from the NHS, police, fire service, and other emergency services would still be available to them during the 2012 Olympic Games.

At the heart of it all and on the minds of Olympic organizers since the city first bid on the games 20 years ago was a single element mission—risk management.

That sums it up in two words, and the lesson learned from previous games or any large event for public safety communicators and responders, risk management expert Will Jennings said in assessing the run-up to the London Olympics.

“Managing risk involves a judicious mix of preventing the risks that can reasonably be controlled, learning to recognize the ones that can’t be prevented, being prepared to react to limit damage, and having the resources to recover from the problems that do occur,” he said.

**Crossing the finish line**

In a news release issued Sept. 14, LAS Deputy Director of Operations Jason Killens summed up the service’s sense of how things went when the world was watching: “Pleased.”

“Satisfying as well,” he added, “for all staff involved. A massive amount of work has gone on in planning our level of support at venues throughout both the Olympics and Paralympics, as well as ensuring that we have been able to continue to provide the best service we could to the rest of the capitol.”

The single lesson learned, Killens and others told *The Journal*, is that the best way to handle communications planning for any mass event is to carefully examine every possible internal channel of communication, make sure they’re operating at their best, walk through every possible scenario and test it—on the tabletop or in real life—and then do it again and again.

Citing good luck, prudent planning, and excellent execution, Chris Allison, National Olympic Security Coordinator for the London Olympics and Paralympics, was delighted to report: “security services continued its excellent track record of successfully delivering major events safely and securely.

“That is one of the main reasons the U.K. won the Olympic bid in the first place,” he continued. “Avoiding any kind of intentional attack or potential disruption in an event that is a prime target for terrorist attacks and crowd mayhem becomes the chief goal of any event safety protection strategy. That’s the one big thing that just can’t happen, but has all the same—not for a good long time—and fortunately didn’t mar these games.”

Perhaps the most minor yet practical point of preparation was the directive to security personnel and responders to medical emergencies not to run toward any site of...
Security tightest in British history

London had already won the gold medal in mass event security well before the Olympic Torch reached town.

Several news organizations confirmed what London Ambulance Service (LAS) contacts had told The Journal—the games were the largest peacetime security operation on British soil. Status information kept flowing across London to the joint command and communication centers of the Metropolitan Police (the Met) and the government control center at New Scotland Yard via 1,850 closed-circuit television (CCTV) cameras trained on the Olympic Park.

The U.K. has 4.2 million such surveillance devices, more than any other country in the world. That number does not include cameras used by private companies and residences. The images as well as facial and license plate recognition were fed to Interpol and to U.S. security agencies including the CIA, FBI, and the Transportation Security Administration.

Emergency medical services and police were kept apprised by on-scene security officers. Every car entering the park was searched, as were their occupants and drivers.

Security had a big hammer to use should things at the games suddenly get out of hand—six temporary ground-to-air missiles stationed mostly at undisclosed locations. Two were mounted on the roofs of apartment blocks Bow and Waltham Forest. Residents of Waltham Forest lost their bid in court to have their building’s missile removed.

Britain’s terror level during the games was labeled “Substantial”—a notch below “Severe,” which has been the daily level for much of the past decade in London. A “Substantial” threat level indicates an attack is a strong possibility.

MSNBC reported the latest anti-terrorist weaponry being used in the Middle East was also part of the protection plan—unmanned drones. They hovered over the venues, along with helicopter-mounted cameras said to be able to identify the color of a suspect’s shoes from a mile away.

Britain’s biggest warship, HMS Ocean, was also stationed on the River Thames, while Royal Fleet Auxiliary vessel Mounts Bay spent the games near Weymouth, Dorset, where Olympic sailing events took place. Six helicopters—three Royal Navy Sea Kings and three Royal Air Force Pumas—were at the ready as well.

To top off the highest security ever in the country’s history, four Royal Air Force Typhoon fighter jets were on standby to intercept “with lethal force” aircraft that happened to venture into the flight-restricted air space above the venues.

Prior to the games, Paul Haskins, general manager of London Terminal Control—an air traffic control agency—told NBC News, “If an aircraft has not spoken to an air traffic controller for a long time and it’s becoming a concern to ourselves and the military, various different methods will be used to communicate with that aircraft. If all those fail then an intercept will be provided by the military to ascertain exactly what is going on.”

Although other Olympics have taken place since 9/11—Salt Lake City, Athens, Turin, Beijing, and Vancouver—London offered a different breed of security challenge. Many events took place at venues as far away as Scotland, creating a further security risk—that terrorists could avoid locked-down London and choose less high-profile targets instead.

A cadre of bomb-sniffing dogs were also on patrol throughout the Olympics and Paralympics.

Combined, the two events were an enormous test of all city services but especially the vaunted National Health Service (NHS), the name shared by three of the four publicily-funded healthcare systems in the United Kingdom. The British are quite proud of the system, and having a section of the Opening Ceremonies at the Olympics celebrating the 64-year-old network to showcase the influence of England on the world was a natural to games’ organizers and ceremonies director, Danny Boyle, who is probably best known in the United States as the director of the Oscar-winning film Slumdog Millionaire.

That staff members of the emergency services sector of the NHS would be among the centerpiece performances that got the games officially up and running made perfect sense to ceremonies’ organizers.

Although healthcare and its skyrocketing costs is a source of constant debate in the United States and what many state and federal elected officials cite as the definitive example of healthcare run amok, the British say by every comparison, including emergency dispatching services, the NHS is as good if not better than any healthcare system in the world. It is funded through heavy general taxes and not from insurance premium payments and medical billing for services as it is in the United States.

The NHS is the world’s fifth-largest employer, with 1.7 million staff members.

“It would have been a gap in the story of British influence we were trying to portray not to have something about the NHS,” Boyle said more than once during interviews with the news media in the days after the Opening Ceremonies. “We were showing off, and so we wanted to show off our system as something we’re very proud of. It is very expensive, but after World War II, we as a country decided on a system in which everybody pays and everybody benefits.”

It was their approach to managing the minutia that public safety officials said made the London Olympic Summer Games the safest ever. They weren’t without incident, but the LAS and fellow NHS dispatchers and responders called in for the occasion posted some world-class numbers:

1,250 people became games-related patients during the Olympics and Paralympics

83% of those with serious illness or injury were responded to in eight minutes; the government goal was 75%

86,000 incidents were attended to by the LAS—up from 80,527 in the same weeks in 2011

670 patients needed to be transported to area hospitals

More about the London Olympics at www.naedjournal.org
Future Of EMS Is Here
Emergency Nurse triage offers alternative care for low-acuity callers

By Audrey Fraizer
Horror stories within emergency medical services (EMS) can make even the layperson shudder. These aren’t stories about patients who couldn’t be helped—those who don’t survive—as much as stories about patients EMS did help and by doing so jeopardized someone else.

“What happens to the guy down the road having chest pains when the paramedic is called out on a twisted ankle?” asked Rick Roller, of Louisville Metro EMS (Ky.) (LMEMS). “It might sound like I’m exaggerating, but it happens. Everyone in the field has their horror stories.”

The stories are as old as emergency phone services, and the same goes for the question of what to do about it. As a former Lt. Colonel over Operations at LMEMS, Roller wanted more emergency vehicles, if the usual destination of the ER remained the standard response for 9-1-1 callers.

But while most of his paramedics might have agreed at the time, there were others in EMS who did not.

“Dr. Richmond disagreed,” said Roller, now a program manager for LMEMS working in the city’s 9-1-1 communication center. “He said the answer was in distinguishing the non-emergent calls from the true emergencies.”

Dr. Neal Richmond is chief executive officer of LMEMS and five years ago, he was before the city council describing the definitive EMS operation.

A major issue holding back optimal service, Dr. Richmond recognized, was familiar to every EMS. People were calling 9-1-1 expecting ambulance transports for injuries or ailments that did not require a trip to the ER. Every time an ambulance was diverted for a patient with a sprained ankle or broken toe, definitive care was delayed for someone, such as a cardiac arrest or choking victim, desperately needing medical attention.

The issue boiled down to the inability to manage patient flow, particularly against public expectations of 9-1-1. The hands of EMS were tied. How do you limit ambulance transport to the most critical cases? Socioeconomic concerns added to the mix. For example, someone who does not own a car is more likely to call for an ambulance compared to an individual with a car at his or her disposal.

It was at about this same time that Dr. Richmond heard about the Priority Solutions Integrated Access Management (PSIAM) system developed by Priority Solutions, Inc., available to Medical Priority Dispatch System® (MPDS®) and ProQA® users. The doctor, who was already a strong proponent of the dispatch protocol and quality improvement software, contacted the Academy.

“He watched a couple demonstrations and was sold,” said Kristen Miller, LMEMS chief of staff. “We had been tackling this problem for quite some time and had looked at various models for triage. The Academy offered the type of program we needed for alternative medical care.”

The Fourth Pillar

At Navigator 2012, the International Academies of Emergency Dispatch (IAED®) unveiled the Emergency Communication Nurse System™ (ECNS™) to complement the philosophy behind PSIAM. The name of the triage software (PSIAM), developed by Priority Solutions®, Inc., was changed to LowCode™ to better describe what the software achieves.

ECNS, when used with the MPDS Protocol, can provide alternative care for Academy-approved, low-acuity, OMEGA Determinant Codes.

“Calls that do not require emergency response, after very compliant MPDS evaluation, are transferred to the ECN,” said Tami Oliver, R.N., IAED Emergency Communication Nurse specialist. “This specialized nurse further assesses the patient using the LowCode protocol to narrow down the type of assistance necessary.”

ECNS is the Academy’s Fourth Pillar of Care, with the same criteria of protocol, training, and “know-how” as the medical, fire, and police dispatch certifications and the same high-level oversight through the ECNS Standards Council. This detailed emergency nurse triage system is comprised of 212 protocols and designed for use alongside the MPDS and interfaced with the ProQA software. Accreditation as a Center of Excellence is required for use of the ECNS protocol.

The process is straightforward. A call comes into the communication center; ProQA is launched by the EMD, and, if after questioning the patient is assigned a pre-determined and locally defined low code (OMEGA Code), the call is transferred to the ECN. The ECN gathers more information and based on this structured assessment, provides a Recommended Level of Care (see sidebar on pg. 35).

LMEMS and MedStar Mobile Healthcare (formerly MedStar EMS), Fort Worth, Texas, are the two active users in the United States, although the United Kingdom and Australia have used the system extensively for the past 14 years. There are more than 1,000 trained and certified ECNs throughout the world.

Louisville MetroSafe

LMEMS launched the ECNS (then known as PSIAM) as a pilot program on April 19, 2010, and went full throttle with the full program within months. The year prior was spent in testing, training, and determining which of the more than 60 OMEGA determinants would be sent to the ECNS for further evaluation and alternate care.

“Even if we didn’t have a ton of data that it would work we had a ton of data that something like this was needed,” Miller said. “It had potential for solving a problem everyone in the system knows exists.”

Roller admittedly had doubts about the program. Could it address the range of conditions they hear in the 103,000 medical calls the center answers each year? How do you convince an agitated caller that a lights-and-siren response is not necessary? Would the public accept the system, and what would it take to convince people?

One of the first calls transferred from the 9-1-1 line to the ECN made a believer out of Roller, at least as far as public acceptance.

“The caller was thankful,” he said. “She had been overwhelmed and said we did her a big favor by just talking to her and reassuring her. We were able to help and that felt good.”

Some calls, he said, may still require ambulance transport and that includes calls...
during which patient status changes while speaking to the ECN or after a complete evaluation determines ambulance transport is necessary. Not long after the program was implemented, Roller was talking to a caller having an allergic reaction that went from mild to critical in minutes.

“She started sounding agitated, and her voice went squeaky,” Roller said. “She was going into anaphylactic shock so I immediately sent an ambulance. The phone dropped, and then I heard the sirens. In a way, ECNS saved her life. An allergic reaction, without priority symptoms, would have placed her on a lower tier for response.”

**MedStar Mobile Healthcare**

MedStar launched its pilot program on May 21, 2012, in collaboration with Baylor Health Care System, John Peter Smith Health Network, and Texas Health Resources. MedStar hired Susan Pelton, R.N.—a former paramedic with experience in dispatch—with funding for the initial one-year position through the hospital systems. For the first week of the program an ambulance was still sent on low-acuity calls while the ECN discussed options with the patient.

Matt Zavadsky, MedStar, associate director of Operations, said the “soft start” aided in transition. They got the “kinks” out of the system and tweaked the process in relation to public reception. It gave them a chance to weigh in on the year they spent behind the scenes before going live.

“We knew that it was no longer affordable to sustain EMS in the direction it was going,” Zavadsky said. “We were confident with PSIAM being used by certified ECNs. We were excited about it and we had to convince the community of the same.”

Public education took center stage. The first round was dedicated to the healthcare community and regulatory officials. Zavadsky went to every single municipal council—and there are 15 in their service area—armed with a presentation listing the benefits and countering real concerns the councils might have, such as liability issues.

The second level was a media blitz: television, print, radio, and live broadcasts. They wrote press releases and gave interviews.

“People knew just what to expect,” Zavadsky said.

And, for those who may have missed the messenger, the nurse educated callers one at a time once ECNS went live.

A “soft start” that included sending an ambulance on low-acuity calls while the ECN discussed options with the patient aided in Medstar’s full transition.
What about dispatch?

Zavadsky and Roller paid careful attention to the people directly affected at their place of work. Not all dispatchers and calltakers were jumping up and down with joy; some were apprehensive. Would they accidentally drop calls? Would callers receive the same level of care? What happened if mistakes were made? They didn’t want to take chances because that’s not what they do.

EMA/MetroSafe Deputy Director Debbie Fox radiates a positive attitude; even over the phone her enthusiasm is unmistakable. In the business for 27 years, you’d think another new program to maintain in addition to EMD and ACE might ruffle her demeanor.

“We don’t think like that,” she said. “We think about the right thing to do. We think about what more we can do to ensure success for our community. The ‘what if’ stuff doesn’t go far here.”

Fox learned about the plan from Miller, who contacted her with this “really great idea,” and in the fashion of the “awesome partnership” established among the agencies, scheduled a meeting among the “stakeholders.”

Of course, Fox had reservations. She said so.

“Dropping a call was certainly a great concern and that can happen whenever there is a transfer,” she said. “I certainly had confidence in EMS, and what they wanted to do, but I wanted to make sure the process was as seamless as possible.”

They ran innumerable test calls in house before releasing the system to the public, and to date, they have yet to drop a call.

The calltakers and dispatchers—and MetroSafe has 60 positions with generally 35 active during each shift—rolled right along. There was no interruption in service, the calltakers have been receptive, and they can earn continuing dispatch education (CDE) hours toward MPDS recertification in classes taught by their in-house EMD instructor Diane Bagby.

Fox paused when asked about whether the EMDs (calltakers and dispatchers) felt threatened by someone—the ECNs—taking over their calls.

“I hadn’t thought about that,” she said. “The nurse is a piece that completes what we do. It’s a resource allowing us to refer our callers to somebody who is just as concerned about them as we are. Our dispatchers see it as a real plus to their work. It complements what we do.”

LowCode and EndPoint are high powered

The clinical content product LowCode™, developed by Priority Solutions, Inc., is a software application used to identify low-priority calls based on the patient’s answers to questions at Case Entry. Low-priority (OMEGA) calls are automatically redirected to an alternative triage program for referral to more appropriate sources of medical care.

But don’t let the word “referral” throw you. The nurse receiving the redirected call conducts an in-depth interview and evaluates the caller’s medical condition. After verifying there are no priority symptoms, the ECN gathers additional information about co-morbid conditions, medications, and allergies. A symptom-based protocol is selected.

Based on the information provided, the ECN provides a Recommended Care Level (RCL) from the 22 built into the system. The RCLs include scheduling an office visit with the caller’s primary care provider, dental care, poison control, crisis lines, or connection to a medical provider for advice and self-care instruction.

EndPoints™, an integrated Directory of [local] Service application, interfaces with LowCode to provide accessible local community resources that allows the ECN to assist the patient in scheduling the RCL appointments and offer other assistance, as necessary. EndPoints also operates like a confidential electronic medical record: it confidentially passes patient data to all resources involved in the specific case and stores call handling data for analysis and quality assurance.

“Actual emergencies will always happen but a large percentage don’t require hot response,” said Matt Zavadsky, associate director, Operations, MedStar Mobile Healthcare (formerly MedStar EMS), Fort Worth, Texas. “So, do we really want to use the costliest level of care when an alternative is better for the patient? We’re getting the patient to the right provider and into a continuum of care.”

LMEMS and MedStar EMS are the country’s two active users, and centers in New York, Florida, and South Carolina are close to roll out.
“This is the coolest thing I’ve ever seen. We’ve taken the training wheels off and are now ready to see what else we can do.”

— Kristen Miller

MedStar Communication Manager Tammy Moore is no less enthusiastic. Although MedStar shared the same concerns as LMEMS—dropped calls and the transition in general—the program has met with success inside the communication center. The Academy provided hands-on, interactive training, and Moore discussed the logic of having an ECN available for the low-acuity calls.

“The ECN is right here on the same phone line,” Moore said. “No time is wasted in transferring the call and since we are all in the same room, we know what’s going on with each patient. It’s gone really well.”

Outside the center has been the harder side of acceptance, Moore said. Despite a media blitz prior to going live, callers tended to be wary when it came to alternative care for their emergency. The tide, however, is turning, she said.

“People now actually call and ask for the nurse,” she said. “Faced with a medical situation that’s confusing, they want advice.”

The ability to give genuine assistance in a low-acuity incident is a big plus, Roller said. Dispatchers, paramedics, and hospital staff providing emergency care rarely have the time to stop and talk. They understand that what they consider a low-level emergency is a crisis for the individual. But, face it, they don’t have the time or resources to offer consolation.

“That’s the nature of EMS,” Roller said. “We’re trained to move quickly so we can get to the next person.”

Public response

Community acceptance was also a priority.

“Our community’s reaction was a big concern,” Fox said. “We didn’t want them to think we were blowing off their calls. Yes, we have the repeat callers, but most of our callers have never had a medical emergency and they call 9-1-1 because they’re in the worst possible situation. We reassure them [if transferred to the ECN] that the nurse considers their care and their situation a priority.”

During the LMEMS pilot program, callers were given the choice of an ambulance in a situation that did not—by vetted low-acuity standards—require emergency transport. In one case, the caller’s wife complained of flu symptoms and alternative care provided at a doctor’s office was not an option he would entertain, despite the anticipated length of wait they might experience in the ER. The caller insisted on an ambulance. The next day, when Roller called for a follow-up, the patient was rather chagrinned.

“He said they should have gone with my advice,” Roller said. “The patient processed at noon, went into ER by 1 a.m., and was released at 5 a.m. A visit to their primary physician would have maybe taken a couple hours that afternoon.”

The dispatcher no longer verbally provides this option, although ambulance transport is always an option available at any time during the process.

MedStar callers with MPDS-vetted low-acuity complaints are transferred to the ECN. The ECN provides treatment options, based on further assessment. The second time during the same call the caller demands ambulance transport, the ECN will suggest sending a community health paramedic in a non-emergency transport vehicle.

If that doesn’t work, MedStar will send an ambulance, Moore said.

“We will not refuse an ambulance to anyone that insists, and we certainly don’t want to discourage people from calling 9-1-1,” she said. “But the calls we receive from people asking for the nurse proves people are beginning to understand the system. It’s not about saving resources, it’s about doing what’s best for the patient.”

One leads to another

Zavadsky said the “through the roof” results of a customer satisfaction survey and savings—and who can discuss healthcare without economics—have prompted spin-off programs. MedStar has saved nearly $500,000 during the first three months of operations, a number Zavadsky estimates from the avoidance of ambulance and ER costs. The 99 ECN-assisted calls added up to $148,500 for ambulance (at an estimated charge of $1,500/patient) and $356,400 for ER (at an estimated average ER expense of $3,600/patient).

The success earned MedStar a $2.1 million grant spread over five years for the “MedStar Patient Navigation” program. The money from the federal Centers for Disease Control and Prevention (CDC) will pay for around-the-clock ECN coverage and two additional community health paramedics. They also have a contract through a local Hospice agency to incorporate 9-1-1 ECN triage into patient-at-risk services. The ECN talks to the patient while, at the same time, a community health paramedic and Hospice nurse are sent to the home or other facility.

“We’ve been thrilled with the results, and exceptionally excited about where we can go with this,” Zavadsky said. “We are living the future of EMS.”

A two-year retrospective study of the 1,712 LMEMS callers receiving alternative care through ECNS showed an estimated $552,270 savings in ambulance costs, for a 26% decrease in overall transportation spending.

The savings combined with patient satisfaction led to a shared $4.8 million Bloomberg grant awarded to five Metro Government agencies in Louisville. LMEMS plans to invest its share in reducing the number of low-severity medical 9-1-1 calls and related EMS runs.

ECNS is the hub of plans, Miller said.

“It’s proven to us that it does what the Academy has said it will do,” she said. “The system does not produce false positives and I can count on one hand the number of calls sent back to dispatch.”

Partially supported by the grant, LMEMS will fund a second full-time ECN, a third dedicated console, a care management pilot program, and outreach in areas with a high volume of 9-1-1 low-acuity calls.

Miller said plans call for increasing the number of triage calls and participating health facilities and transportation systems during the three year life of the grant. They recently signed a contract with a local cab company to provide transportation to appointments scheduled through the ECN.

“This is the coolest thing I’ve ever seen,” Miller said. “During the time in development, we either banged our heads on the wall or wondered at just how amazing this would be. We’ve taken the training wheels off and are now ready to see what else we can do.”
OnTrack

The Big Chill
Winter puts different spin on standard Chief Complaints

By Ronald Richard

Winter really starts before its official date of Dec. 21st. Some parts of the Northern Hemisphere experience cold, winds, and snow before the holiday season truly gets under way and, for certain parts of the United States and Canada, winter 2012/2013 could spell “chill out.”

According to the 2013 Farmers’ Almanac, temperatures will be much colder this winter from the East Coast westward to a line from the Dakotas in the north to Texas in the south. Canada’s temperatures will be colder than last winter everywhere except for the northern Maritimes and western British Columbia. The Almanac predicts snowfall above and below normal, but nothing in between.

The winter season could be considered one of the hardest times for emergency responders. Spring ushers in mild weather with maybe a few storms, but usually little that has to be removed from the roads. Summer brings the heat, fires, and the occasional afternoon thundershowers. Then comes the season heralded by ski and snowboard fans, although not highly anticipated by sunbirds—as evidenced by the increasing numbers moving to warmer climates.

Every year, severe winter weather causes injury and death in a variety of ways including falls, overexertion (shoveling snow), hypothermia, and traffic fatalities due to icy roads. Severe winter weather also causes mil-
lions of dollars in damages as freezing temperatures and heavy snowfall are two of the most damaging causes of equipment freeze-ups and building collapses.

This was evidenced in the Northeast U.S. on Oct. 29, 2011, when an early snowstorm brought 32 inches of snow and 70 mph winds to the coast, killing at least 22 people in its wake. Even the trees were caught unaware, having not yet lost their leaves. Branches snapped beneath the weight of the snow, bringing down numerous power lines and leaving at least three million people without electricity. Damage in Connecticut alone was estimated at $3 billion, exceeding the damage from Hurricane Irene.

In similar fashion, the Groundhog Day Blizzard in 2011—which was one of Chicago’s top five snowstorms on record—paralyzed the Midwest, dumping one to two feet of snow in some areas and causing $1.8 billion in damages and 36 weather-related deaths.

**Winter determinants**

The Fire Priority Dispatch System™ (FPDS™) does not designate a special Chief Complaint Protocol to handle severe winter weather such as blizzards, ice storms, and damages from wet, heavy snow. Instead, the Chief Complaint Protocols address the emergency or problem caused by the winter storm or condition, as shown in Figure A.

Winter weather poses a threat to pipes, particularly overnight when temperatures plummet and water demand is minimal. Water has a maximum density just above freezing, but once the temperature hits around 37° F, it reverses course and expands. The pressure of water freezing and expanding (2,000 pounds per square inch) attempts to enlarge the pipe, pushing against its sides as well as its nearby valves, seams, and faucets.

The oxygen in water can also lead to rust, further weakening pipes. Underground pipes can stay warm if they're deep enough, but the cold water running through them can create cracks and leaks. The water doesn’t have to actually freeze to cause a problem; the expanding pressure alone can eventually force a crack to rupture.

Frozen pipes feeding boilers and heating units can render the equipment inoperable, and broken pipes in sprinkler systems can send showers of water throughout the building, damaging areas far from the original problem. If this occurs during off hours, the damage can go undetected, spilling several hundred gallons of water per hour.

To prevent flooding, a water flow alarm can be used to detect water movement from a broken pipe and alert the building’s contracted alarm company. These calls, handled on Protocol 52: Alarms, most often receive a CHARLIE-level response.

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

For the homeowner, a water problem can become a real emergency, particularly if she does not know where to find the shutoff valve. Water can destroy electrical services and pour down into the ceilings and walls, weakening plaster to the point of collapse. Occupants may need to be displaced if it becomes a major problem.

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

**Carbon monoxide poisoning**

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

Homeowners and property maintenance crews can unknowingly activate carbon monoxide alarms when starting snow removal equipment inside or close to detection areas. Poor ventilation systems and blocked ducts can also trap the deadly gas, creating a danger that is imperceptible without an appropriate CO detector.

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

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

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

Wires down

Another common winter danger is electrocution from downed power lines. A build-up of only one-half inch of heavy snow can bring down tree branches onto power lines and, subsequently, disrupt electrical services. Callers should be advised to never go outside to investigate downed or hanging electrical wires since snowdrifts, tree branches, and debris can hide the potentially live wire underneath.

A person touching a live wire can be electrocuted or, at the least, suffer serious burning. All electrocution patients are assumed to be in cardiac arrest until breathing is verified, but no one—outside of emergency responders—should touch any unconscious person or anything touching the electrical hazard, as emphasized in the Post-Dispatch Instructions on Protocol 55: Electrical Hazard.

Snow covered roofs

Problems don’t stop when the snowstorm ends. Rising temperatures melt the snow and increase its impact on the roof. Though the mass of the snow stays the same, the volume, due to melting and compacting, decreases and in turn causes a rise in density. Heavy, wet snow can weigh in excess of 10 pounds per square foot.

Removing this snow, especially by hand, can cause back pain, physical exhaustion and strain, frostbite, slip-and-fall injuries, and chest pain. Each shovel full of snow can weigh about 50 pounds. Two feet of snow on an average-size roof can be the equivalent of 38,000 pounds or 19 tons, increasing the weight if combined with rain and sleet.

Those attempting to remove the snow from a roof should only do so if the building is determined to be structurally safe (to prevent structure collapse/entrapment). Maladies incurred during snow removal may be addressed using the MPDS.

Structural damage

If snow is not removed from the roof, snowmelt during the day freezes when the sun goes down, creating sheets of ice and freezing drains. This process, repeated throughout the season, can result in “ice dams,” which are heaps of ice that form when the melting snow refreezes at the edge of the roof, blocking the path for further runoff.

On a flat roof or a roof with a low slope, it doesn’t take long for an ice dam to cause water backup, leakage, and eventually roof collapse. The record snowfall of 2010/2011 in the Northeast collapsed dozens of roofs across New England, where flat roofs are common. Heavy snowfall in Connecticut also crushed 85,000 egg-laying hens housed in a single building egg farm. The tremendous number of potential roof collapses closed schools and many commercial facilities.

A roof collapse endangers the people inside and also threatens responders entering these hazardous spaces, some with roof’s pre-dating fire code. Leaking chemicals and other toxins can also intensify the danger.

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

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

Survivors of building collapses have described hearing creaking and popping and seeing walls buckling seconds before they evacuated. Other signs of an impending structure collapse include doors popping open, lowered sprinkler heads, jammed doors, stuck windows, and deformed steel members.

During the last year alone (2011), insurance companies paid out over $2.6 billion for these structural damages.

Smoke investigation vs. structure fire

A caller’s report of smoke during the winter months could be from a series of different origins. Outside smoke could be from homeowners firing up their fireplaces for the first time of the season or could be the result of an exhaust dryer vent operating off the side of a house, mixing with the cold air outside.

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

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

Mutual aid

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

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

Agencies may need to invoke the Emergency Rule to distribute resources and work outside of normal guidelines until the situation passes.

After a long winter’s shift

The winter season brings a unique set of problems when Mother Nature decides to come out and play. Let’s just hope she doesn’t decide to play rough this year!
Answers to the CDE quiz are found in the article “The Big Chill,” which starts on page 37. Take this quiz for 1.0 CDE unit.

1. The Fire Priority Dispatch System (FPDS) designates a special Chief Complaint Protocol to handle severe weather such as blizzards, ice storms, and damages from wet, heavy snow.
   a. true
   b. false

2. Water has a maximum density just above freezing, but once the temperature hits around ____° F, it reverses course and expands.
   a. 28
   b. 32
   c. 37
   d. 98

3. Which FPDS Chief Complaint Protocol addresses alarm activation due to a broken water pipe?
   a. 52: Alarms
   b. 54: Confined Space/Structure Collapse
   c. 55: Electrical Hazard
   d. 57: Explosion

4. Symptoms of carbon monoxide poisoning can include:
   a. headaches and fatigue.
   b. nausea and dizzy spells.
   c. confusion and irritability.
   d. all of the above

5. Which MPDS Chief Complaint Protocol addresses carbon monoxide poisoning?
   a. 6: Breathing Problems
   b. 8: Carbon Monoxide/Inhalation/HAZMAT/CRBN
   c. 26: Sick Person (Specific Diagnosis)
   d. 31: Unconscious/Fainting (Near)

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

7. The term “ice dam” refers to:
   a. a frozen creek blocking river flow.
   b. a blocked ice cube maker in a residential freezer.
   c. a heap of ice on the edge of a roof that blocks the path for further runoff.
   d. a lump of ice on a sidewalk that is dangerous to pedestrians.

8. A structural collapse and entrapment (confirmed) involving hazardous materials requires a(n):
   a. ALPHA-level response.
   b. BRAVO-level response.
   c. CHARLIE-level response.
   d. DELTA-level response.

9. Chief Complaint Selection Rule 6 in Case Entry states “If smoke is seen or smelled inside a building, use Protocol ____.”
   a. 54
   b. 60
   c. 61
   d. 69

10. Protocol 65: Mutual Aid/Assist Outside Agency addresses:
    a. an incident involving a gas, liquid, or solid that, in any quantity, poses a threat to life, health, and property.
    b. an outside agency agreement that allows for the exchange of equipment for use during an emergency.
    c. the use of force or skill in freeing someone from a difficult position or situation.
    d. any building that has a potential for catching on fire.
She’s Having A Baby
Dispatchers keep callers from having a cow
Childbirth is said to be the most natural thing in the world. That doesn't mean it isn't a serious event. Under the wrong circumstances, nature can veer off course into a life-threatening emergency, which can qualify that 9-1-1 call as one of the most problematic a dispatcher can face.

In the developing world, giving birth is still the No. 1 cause of death among women. According to Amnesty International and the World Health Organization, a woman dies in childbirth every minute, and the number of women who died giving birth in 2010 was approximately 358,000 worldwide.

Maternal death in the United States has gone down dramatically in the last century, but is increasing again according to the National Center for Health Statistics. Figures from 2007 show the U.S. maternal mortality rate was 12.7 deaths per 100,000 live births, or 548 women a year. That's nearly twice as many as 20 years earlier. In 1987, the rate was 6.6 per 100,000.

Of course, the probability of a calltaker handling an emergency childbirth is on par with being struck by lightning. And experience shows that the chances of a calltaker actually hearing the babe's first cry over the phone are slim. It's far more likely that the calltaker will have to do little more than offer support to the mother and give basic Post-Dispatch Instructions (PDIs) before an ambulance arrives. Yet, it does happen—in remote areas, traffic jams, blizzards, and even at home—and those events can test the abilities of even the most veteran calltakers.

Fortunately, certified emergency medical dispatchers have been trained on how to handle emergency births from the second the call comes in to those celebrated last words, “Congratulations! Is it a boy or a girl?”

The Medical Priority Dispatch System’s (MPDS’) Protocol 24: Pregnancy/Childbirth/Miscarriage allows the calltaker to collect the patient’s information and provide instructions on what to do before the ambulance arrives, no matter the nature of the pregnancy or childbirth-related call.

Whether an OMEGA-level response (the patient’s water has broken) or DELTA-level response (HIGH RISK complications), MPDS dispatchers worldwide have been taught what to do next when a call sounds like anything but “the most natural thing in the world.”

EMD instructors at the International Academies of Emergency Dispatch (IAED) say the only routine element of emergency deliveries is that they're always serious, even when mother and baby come through fine. These situations can become tricky, with a host of risk factors that can suddenly turn the event from blessed to tragic.

“Remember, childbirth is a time-life priority situation in the same category as cardiac arrest and choking,” long-time EMD instructor Chris Sims tells dispatcher trainees. Sims is no stranger to situations threatening emergency, which can qualify the event from blessed to tragic.

By James Thalman & Cynthia Murray

Childbirth is unique and different from other time-life priority incidents, Sims notes in his lectures on Protocol 24, “It is a patient-driven event.”

That means that while childbirth is natural and will “run its course,” so to speak, the mother is really the one in control of childbirth, no matter the location, the position of the baby, or the number of multiple variables that predict how the event might go.

“In other words, the patient dictates the speed and progress through the PAIs, not the EMD,” Sims said.

Key Questions

Though the mother may be the one in charge, when a laboring woman is on the line, it’s reassuring to know that “there’s a protocol for that.”

The first Key Question on Protocol 24 is: “How many weeks (or months) pregnant is she?” If the caller’s response indicates that she is 5 months/20 weeks along or more, the calltaker then asks, “Can you see any part of the baby now?” or, if speaking to a first-party caller, “Can you feel or touch any part of the baby now?”

If the baby’s head is visible or out, the calltaker should immediately send a 24-D-2 Determinant Code, provide PDIs, and link to Protocol F: Childbirth–Delivery for instructions as birth is considered IMMINENT.

However, if a caller reports seeing the umbilical cord, hands, feet, or buttocks first (BREECH), the delivery becomes a dire prehospital emergency. The calltaker immediately sends a 24-D-1 Determinant Code, provides PDIs, and links directly to Protocol F, Panel 20: Evaluate BREECH.

Sending responders is of highest priority in BREECH situations as Rule 3 states, “Often the only chance for survival of the baby is at the hospital.” In the meantime, a BREECH Positioning/BREECH Delivery sequence provides the calltaker with directions to position and prepare the mother, providing reassurance until responders arrive.

If the caller does not report seeing (feeling) any part of the baby, the calltaker continues with Key Question 3, “Is she having contractions (labor pains)?” If so, the calltaker asks if this is the patient’s first delivery and for the number of minutes between contractions.

The caller’s responses to these questions help the EMD determine whether the delivery is “IMMINENT” and where to begin on childbirth-delivery instructions. Axiom 1 reminds the EMD that patients delivering for the first time progress through labor more slowly than those delivering for the second (plus) time. For a first full pregnancy patient, birth is considered IMMINENT if the labor pains are ≤2 minutes apart. For a second (plus) full pregnancy patient, having contractions ≤5 minutes apart is an indicator of an IMMINENT delivery.

Continuing Key Question interrogation, the calltaker should also inquire as to whether there is any SERIOUS bleeding. Minor or infrequent bleeding in pregnancy—often referred to as “spotting”—may occur normally, though SERIOUS bleeding or hemorrhaging may be a sign of miscarriage or another complication.

The last remaining Key Question, “Does she have any HIGH RISK complications,” refers to conditions that may include a premature birth (20–36 weeks), a multiple birth (≥20 weeks), a bleeding disorder, or a patient on blood thinners, etc. These HIGH RISK complications are defined locally, but each of these situations is best handled with full awareness of the condition and cautious care.

After completing Key Questions, the calltaker should send the appropriate

The patient dictates the speed and progress of childbirth through the PAIs, not the EMD.
Determinant Code, provide Post-Dispatch Instructions, and link to the appropriate panel of Protocol F: Childbirth–Delivery (if appropriate).

If the calltaker determines that the patient’s contractions are not frequent enough to consider the birth “IMMINENT,” he or she will refer to Panel F-12 to reassure the patient that “There should still be some time left before the delivery occurs. Help is on the way.”

In the case of an IMMINENT delivery, the calltaker begins instructing the caller on delivery preparations on Panel F-1, “Listen carefully and do exactly as I say.”

In either case, the mother should be told not to try to prevent the birth as indicated on PDI-b “Do not cross your legs.” This instruction is important because any attempt to prevent or delay the birth can cause serious brain damage to the baby and even death, as stated in Axiom 2.

**Time to deliver**

“Childbirth is common, but never routine,” veteran EMT and EMD instructor Richard Russo said in a recent three-day course through the IAED®. Russo echoes the golden rule for both dispatcher and on-site emergency care provider: Mom is in control.

“Allow it to go at her speed, grant every request if possible, but never attempt to prevent the baby from being born, and be ready for anything,” Russo said.

To illustrate his point, Russo said he has attended three public births, one where the mom could be made only as comfortable as a tile floor and a group of concerned mall shoppers could make her.

“In this case, we had several people form a circle facing out from the woman to offer as much privacy as possible,” Russo said. “The woman, even in the throes of labor, and like anyone caught in such a private moment in a public place, hoped to prevent embarrassment by holding back her baby’s arrival. Right as my dispatcher was about to remind me to tell her to let nature take its course, I told the woman, ‘You’re among friends, and we’ll make this as private as we can, but that child is coming.’

The baby actually didn’t arrive for another half hour. Just as the ambulance arrived, the woman started to hemorrhage. As things turned officially dire, all elements of the event, including public embarrassment by holding back the baby’s arrival, Right as my dispatcher was about to remind me to tell her to let nature take its course, I told the woman, ‘You’re among friends, and we’ll make this as private as we can, but that child is coming.’

The baby actually didn’t arrive for another half hour. Just as the ambulance arrived, the woman started to hemorrhage. As things turned officially dire, all elements of the event, including public embarrassment by holding back the baby’s arrival, Right as my dispatcher was about to remind me to tell her to let nature take its course, I told the woman, ‘You’re among friends, and we’ll make this as private as we can, but that child is coming.’

Things turned out fine for both mother and baby, he said, but the story exemplified the nature of childbirth, which at times can be wildly unpredictable. “Therefore, the second nature required of dispatchers is to be pretty much ready for anything.”

**Born ready**

Sims points out that a trained and certified EMD should be able to recognize a situation as it occurs and provide appropriate support, advice, and information to assist the patient and the caller whenever it is needed.

“Bear in mind that this is based on answers to carefully scripted questions and the ability to assess the scene non-Visually,” he added. “Following the protocol correctly will ensure that you have the protections of a proven medical dispatch system behind you.”

**Sources**

Answers to the CDE quiz are found in the article “She’s Having A Baby,” which starts on page 41. Take this quiz for 1.0 CDE unit.

1. Figures from 2007 show the U.S. maternal mortality rate was ____ deaths per 100,000 live births, or 548 women a year.
   a. 6.6
   b. 7.3
   c. 10.4
   d. 12.7

2. The MPDS Protocol 24: Pregnancy/Childbirth/Miscarriage is designed to handle any possible situation or scenario related to pregnancy or childbirth.
   a. true
   b. false

3. Childbirth is considered to be an “instruction-driven event.”
   a. true
   b. false

4. The first Key Question on Protocol 24 is:
   a. “Is she pregnant?”
   b. “How many weeks (or months) pregnant is she?”
   c. “Can you see (feel or touch) any part of the baby now?”
   d. “Is there any SERIOUS bleeding?”

5. A BREACH birth situation is considered a dire pre-hospital emergency.
   a. true
   b. false

6. If a caller reports seeing the umbilical cord, hands, feet, or buttocks first, the calltaker should send a 24-D-1 Determinant Code, provide PDis, and link directly to:

7. Patients delivering for the first time progress through labor more quickly than those delivering for the second (plus) time.
   a. true
   b. false

8. HIGH RISK complications are defined locally, but may include:
   a. a premature birth.
   b. a multiple birth.
   c. a bleeding disorder.
   d. all of the above

9. It is important not to prevent or delay the birth because:
   a. this puts the mother through unnecessary strain.
   b. the responders will get there really quickly.
   c. it can cause serious brain damage to the baby and even death.
   d. it is not part of the Pre-Arrival Instructions.

10. Richard Russo echoes that the golden rule (regarding childbirth) for both dispatcher and on-site emergency care provider is:
    a. Do not panic.
    b. Help is on the way.
    c. Mom is in control.
    d. Take deep breaths.

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CDE Quiz Mail-In Answer Sheet

Answer the test questions on this form. (A photocopied answer sheet is acceptable, but your answers must be original.) WE WILL NOT PROCESS ALTERED SIZES.

A CDE acknowledgement will be sent to you. (You must answer 8 of the 10 questions correctly to receive credit.)

Clip and mail your completed answer sheet along with the $5 NON-REFUNDABLE processing fee to:

The National Academies of Emergency Dispatch
110 Regent Street, Suite 880
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.

Name _________________________________
Organization _____________________________
Address _________________________________
city __________________ St./Prov. _____________
country _________________ ZIP _____________
Academy cert. # ___________________________
Daytime Phone ( ) _______________________
E-mail _________________________________

PRINCIPAL 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
November/December Journal 2012 “She’s Having A Baby”
Please mark your answers in the appropriate box below.

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

To be considered for CDE credit, this answer sheet must be received no later than 12/31/13. 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.

Expires 12/31/13
CLEARFIELD, Pa.—Marc Hatten and Todd Howe are what you might call full-service emergency responders. They are dispatchers at Clearfield County Emergency Services and active members of the local volunteer fire department.

This past August, they had the opportunity to put the combination to work in response to one call.

The two men were leaving their consoles for the evening shift change Aug. 3, when an incoming call alerted the center to a small blaze at 900 Leonard St. in Lawrence Township. They gave a quick hand-off of their headsets to the night crew, checked the image from the security camera on top of the radio tower behind the center, zoomed in on the blaze and saw, sure enough, that the fire was burning along the office of Magisterial District Judge Richard Ireland located about 100 yards from the call center.

They ran out of the center with one of the center’s handheld fire extinguishers and with no plan other than, “Let’s go see what we can do.”

Hatten and Howe extinguished the blaze before firefighters from Lawrence Township arrived on scene. The fire, which started in the mulch landscaping near the building, would have certainly been well on its way into the building’s wooden structure had the two not responded so quickly, Jeremy Ruffner, dispatch manager and quality assurance coordinator for Clearfield County Emergency Services, told The Journal in August.

Things would have turned out much worse had they not been so quick to respond,” Ruffner said.

The fire department just had a few hot spots to mop up when they arrived. Other engines that had been dispatched were called off en route.

Because the men rushed to the scene, the incident was much shorter and obviously had a far less damaging outcome, Ruffner said.

“It’s always appreciated when dispatchers go above and beyond during an incident,” Ruffner said. “This was a prime example of that and then some.”

The call center serves about 82,000 residents in the central Pennsylvania region, which lies about two hours northeast of Pittsburgh almost exactly in the center of the state. It handles all police, fire, and medical calls in Clearfield County except those for the Pennsylvania State Police.

Ruffner said more than half of the call center staff is also either active or listed on the volunteer fire department rosters.
Protocol’s Night Out
EMD provides on-site PAIs to choking victim

The Corralejo family was catching up with friends from out of state over dinner at a local restaurant when fate challenged Bernie Corralejo’s visual application of Emergency Medical Dispatch™.

Bernie, an EMD™ and senior ED-Q™ at El Paso Fire Department (EPFD), Texas, had scarcely taken a bite from his sandwich while a diner across the restaurant was having the greatest difficulty even thinking about her next bite.

“Someone working there called out asking if anyone knew CPR or the Heimlich method,” said Bernie’s wife Elizabeth Corralejo. “Bernie immediately got up from the table to help.”

The diner Bernie went to aid was apparently in distress; she was standing up from her chair and holding her throat in the universal “help me, I’m choking” sign. Bernie momentarily lapsed into Key Questions—checking her ability to respond—and without her answer forthcoming took his place behind her, wrapped his arms around her waist, and grasped with one hand his other hand balled into a fist.

“I helped the lady,” Bernie said. “I used the same instruction that I give over the phone and by the third thrust, the food was out. She could breathe.”

In addition, just like during related phone calls, Bernie calmed the victim and her startled husband. He ignored the commands of other patrons to “slap her back” or “give her something to drink.”

He truly was with her the whole time.

“She was very scared and asked Bernie to pray for her,” Elizabeth said. “She was breathing by that time but Bernie stayed, assuring her that she was going to be fine.”

Paramedics arrived in minutes, having received the request for response from the same communications center where Bernie has worked for going on 17 years. The woman refused transport and was able to walk out of the restaurant unaided. Bernie returned to his dinner table.

“That’s when it hit him,” Elizabeth said. “He was worried if he had done everything right. He didn’t eat much after that and had his sandwich packed to go.”

His family and friends were silent, momentarily, but once the conversation started they never stopped talking about Bernie’s spring to action.

Bernie said the incident proved the effectiveness of instructions and reassurance he gives over the phone, and his response to the waiter was like the automatic dispatcher switch to Pre-Arrival Instructions (PAIs).

“At the moment, I reacted and didn’t think about it,” he said. “It was a very random situation.”

Bernie didn’t impress just his friends and family, including his two children at the table. Word reached the EPFD and he was nominated for the department’s Civilian Citation Medal for his lifesaving actions while off duty. He was presented with the award on Sept. 20.

“I’m not surprised at all that Bernie did what he did,” said Frances Jimenez-Lucero, EPFD public safety shift supervisor. “He’s just that kind of guy.”

Cooking For A Win
Fire department stations take friendly rivalry to the kitchen

Salt Lake City Fire Department Stations 5 and 8 put their cooking skills to the test in June as part of the reality TV show pilot Dining With The Chief, each battling for the prize and the prospect of Fire Chief Kurt Cook’s praises ringing in their ears.

Familiar with a producer for LNZ-works, based in Salt Lake City, Utah, firefighter/paramedic Rob Stafford, part of the team at Station 8, helped get the competition rolling. Dining With The Chief is a spin off of LNZ-works’ pilot Dining With The Dean, which focused on college students cooking for the dean.

“We brought the idea to the chiefs and they loved it,” Stafford said.

Before making their cooking talents public, Chief Cook made sure that the competition wouldn’t impact their No. 1 priority—serving the public.

“This didn’t impact any of our service delivery,” he said.

With fire department approval and Station 8 already on board, it was only natural
for Station 5 to take part in the friendly competition. The stations are about two miles apart and on the outskirts of the city proper.

“We’re kind of their nemesis, rival,” said Station 5 heavy rescue team firefighter/chef Mike Berry. “They put it all together and wanted us to be a part of it.”

The rules were clear: Each station was given $30 and three hours to cook a three-course meal for Chief Cook—without knowing what the chief’s likes and dislikes are. There would be a secret ingredient identified once they returned from shopping. The clock started ticking when they left to buy groceries.

“When we got back there was the secret ingredient on the counter, which was coconut,” Berry said.

Camera crews shadowed the two teams of eight from start to finish, catching the competition and capturing each team’s ideas to incorporate the mystery ingredient in two of their three courses. Practical jokes were expected by both sides.

At the start of the contest, Station 8’s team was dealt a blow when after returning from shopping they discovered their oven’s control knobs missing. Although neighboring Spring Mobile Ballpark was willing to pitch in, camera crews were unwilling to relocate. The culprits at Station 5 relented—the knobs were hidden in Station 8’s own kitchen.

“It didn’t hold us back much,” said Station 8 paramedic/firefighter Ryan Curtis.

Retaliation came quickly when Station 8 firefighters turned off the gas at Station 5, shutting down the stove. Quick to figure out the problem, Station 5’s stove was back on within minutes.

“We clearly outcooked, outpranked, and outclassed them,” said Station 5 heavy rescue team firefighter Paul Koetitz.

In between the pranks and cooking, calls came in for both stations, requiring response but luckily not the kind that emptied the stations.

“I think it was a perfect scenario the way everything shook out,” Stafford said.

Done on time, each station packaged its food in insulated to-go boxes and delivered them to Station 1 where a hungry Chief Cook was ready to sample what was brought to a table decorated by white linen and candles. The food was taken from the boxes and served on silver platters. The chief’s bites were the real thing.

“You only get that one chance to make that first impression,” Chief Cook said. “You only get one chance to film that piece; no takeovers.”

Station 5 brought coconut sauce covered bacon wrapped dates, cornmeal crusted halibut and mixed vegetables in a balsamic butter sauce, and coconut cheesecake quesadilla.

Station 8’s kitchen produced pork, apple, and coconut stuffed potstickers, Oakley chicken (pork stuffed chicken breast), thriced-baked potatoes, sautéed green beans, and coconut éclair pie.

“They had no idea (of my tastes),” Chief Cook said. “The meals were prepared very exquisitely. I was completely surprised and amazed. I’m not a big fan of coconut but they put it to great use.”

The hardest part for the teams was waiting for the winner to be chosen (the team with two or three dishes selected) and ignoring their growling stomachs—the fast pace had kept both stations from eating much all day.

“It (waiting for Chief Cook’s decision) was more nerve wracking than I thought it was going to be,” Stafford said.

The grand prize of $3,000 was donated to the winning station’s charity of choice—in this case, the University of Utah Health Care Burn Camp.

“It was a great experience for the crews,” Chief Cook said. “The camaraderie and rivalry were well represented. I’m glad we did it.”

Want to find out who won? Vote for your favorite menu items in the three categories by visiting naedjournal.org and then check back to find out the team taking the cake—the chief’s and yours. A clip from the show will be available at a later date on our website.
My name is Billi Jo Baneck, and I’m a 9-1-1 dispatcher—a person trained to help the public when life-changing events are happening to them.

But on Dec. 5, 2008, the most tragic, life-changing event happened in my life. I was in Appleton, Wis., attending a week-long training for new dispatchers learning how to calm callers experiencing the worst day of their lives while still gathering the information necessary both for appropriate response and scene safety for arriving police, fire, and medical crews.

At 2 a.m., while in my hotel room sleeping, the phone rang. At that hour, I ignored the call. The phone rang again so I answered. A family friend told me there had been a fire at my parents’ house and she was on her way to the hospital to be with my younger brother and sister. I asked a million questions while trying to get dressed and hurry out the door, but our friend wasn’t answering many of them. I was told they had been taken to Berlin Memorial Hospital, which was about an hour drive from where I was.

When I arrived, my sister Katie was being put into a helicopter for transport to Children’s Hospital of Wisconsin in Milwaukee. She had been intubated and her burns had been bandaged. I pushed away her singed hair, kissed her forehead, and told her I loved her and would see her soon. My brother Tony, 22, was in the emergency room; his hands were blistered and cut. My mom’s friend offered to shut the door, but I said “no.” I was waiting for the nurses to tell me where the rest of my family had been taken.

In the next moment, the world stopped moving.

My mom’s friend told me that my mother, a dispatcher for Waushara County Sheriff’s Department, Wis.; my father, a self-employed truck driver and farmer; and my 16-year-old brother Charlie, a high school student, did not make it out of the burning house.

I went into the room where family members were gathering, recruited volunteers to be with Katie at Children’s Hospital until I could get there, spoke with the sheriff about what had happened (suspected wood stove malfunction), made a few phone calls, and thanked the officers from Waushara and Green Lake Counties for their support. I took my brother Tony to my home once he was released from the hospital.

The first people knocking on my door were American Red Cross volunteers. I asked, “What can I do for you?” The volunteers replied, “We are here to help you. May we come in?”

For the next hour the volunteer told me how the American Red Cross was going to help my family. They would provide financial assistance to buy clothes for Tony and Katie, food, payment for medications, and gas to travel to visit Katie. I didn’t need the gas money for long. A couple that owned a home around the corner from the hospital allowed us to stay there while Katie recovered. My first visit finally gave my sister Nellie a break from the ICU. I lay next to Katie all night just listening to her breathing.
Katie spent the first week in the ICU. They did emergency skin grafts to cover exposed veins on her wrists and later, more skin grafts to repair the burns on her hands and arms. Since Katie was legally considered an orphan, I was granted temporary guardianship to make decisions regarding her healthcare.

Katie came "home" the day prior to the funeral. The three of us were living in Wautoma so that they could attend the same schools. Everything was new—clothing, furniture, and the size of their family.

The funeral was held in the high school gymnasium to hold everyone we knew would attend. Local Amish, who had worked with my dad, brought in desserts; local restaurants donated lunch; pictures lined the halls from the entry to the caskets; and quilts that my mom had made were hung on the walls. The line for the viewing looped around the halls and backed up outside the front door. People stood out in the snow waiting to pay their respects. Officers from across the state lined the streets from the school to the cemetery. At the cemetery a final call was put out over the officers' radios honoring my mom for her work and dedication to 9-1-1. A sheriff's department guard, one of two standing at attention by the caskets, later told me that my mom was his favorite dispatcher and his reason for being the officer that he is today.

In the weeks following the funeral the community continued to amaze me. Farmers donated time and equipment to harvest my dad's crops off the fields. They held an auction of my dad's farm equipment. The farm bureau organized a benefit to create a college fund for Katie. The kids at Charlie and Katie's school sold T-shirts to raise money for our family.

My home life was turned upside down. I worked the night shift but as soon as I got home I had to make breakfast for Katie, change her bandages, comb her hair, do her makeup, and help her dress. When Katie and I finalized the guardianship papers, she threw her arms around me and announced, "It's a girl!"

A few months after the fire, Vicki Jenks of the American Red Cross asked me to be the guest speaker for a Heroes fundraising event. I was honored. With all of the generosity at the time of our emergency, I had wanted to do anything I could to give back and told Vicki of my interest to do more for the community. She introduced me to the Disaster Action Team. Since then I have assisted victims of natural disasters. I promote the Red Cross in TV interviews, work behind the scenes to set up for Red Cross events, and have been a guest speaker at the Red Cross awards ceremony. I have also hosted my own fundraising events with the proceeds benefiting the Red Cross.

People ask me all the time how I got through such a tragedy. Honestly, I don't have an answer for how, except in the healing that comes from helping others. As a dispatcher I've always known in my heart that what I do is helping someone, whether they remember you for that or not.

In June 2011, I left Green Lake County and started as a dispatcher for Brown County, which allows me to teach the importance of 9-1-1 to kids attending local public schools. I challenge others to reach out as a volunteer at a homeless shelter, talk to a child victim of abuse, or sit down with a person who needs someone to listen. Whether you volunteer with a non-profit or donate clothing to Goodwill, something that might only take five minutes out of your day could make a profound impact on another person's life. Believe me, you can make a difference and it doesn’t have to take a personal tragedy to begin.
Celebrating 75 Years
Women’s deaths spark U.K. emergency call system
By Audrey Fraizer

Editor’s Note: The following article is compiled from several U.K. news sources.

Scottish woman Alexandrina Lamont made history, although in a most tragic way for a 22-year-old woman trying to start a new life in London.

The date was Nov. 10, 1935, and Lamont was maybe scrubbing floors, dusting, or sweeping when fire broke out at the home of London Aural Surgeon Philip Franklin, M.D. No doubt the housemaid was desperate to escape the burning home of her employer along with Dr. Franklin’s wife, niece, cook, and kitchen maid.

A neighbor, seeing the smoke, placed a call but never made it through the lengthy queue of calls waiting for the operator’s assistance. Just like everybody else taught to dial “0” in an emergency, she waited her turn in the Metropolitan Police emergency queue. By the time the fire brigade arrived, it was too late. The five women had perished.

The tragedy forced the hand of emergency services. Dialing “0” and asking for police, fire, or ambulance had been the recommended method since 1927. If a passerby noted an emergency outside of the home, public kiosks equipped with “emergency call” buttons to push were available; no money was necessary to secure the connection. The caller could also ask the operator for Whitehall 1212—the Information room set up in 1934 at the Metropolitan Police’s headquarters at Victoria Embankment. Messages from calls received were transmitted via radio waves to police vehicles.

The trouble, however, was the number of people unaccustomed to using a phone—a relatively new invention at the time—and, instead, rushing on foot or motorcar to the nearest police station during an emergency. Neither system—dialing “0” or Whitehall 1212—offered a method for identifying and prioritizing calls.

The Belgrave Committee solved the problem by deciding on a three-digit number system to request assistance in an emergency. The number would be unique to emergency calls, provide an automatic connection, and the three digits would be easy to dial even when thick smoke or darkness made seeing and spinning the phone dial difficult. After considerable debate, the committee chose the number 999.

Two years after the fire, on June 30, 1937, London became the first city to offer a direct
three-digit number emergency phone service when it introduced the number 9-9-9 to 91 automatic telephone exchanges in London.1 Described as the telephone users’ S.O.S., a notice published in the London Evening News provided cursory instructions:

“Only dial 999 if the matter is urgent; if, for instance, the man in the flat next to yours is murdering his wife or you have seen a heavily masked cat burglar peering round the stack pipe of the local bank building. If the matter is less urgent, if you have merely lost little Towsor or a lorry has come to rest in your front garden, just call up the local police.”

A phone ad introduced at the same time showed how to dial a telephone, in general, with a postscript for the free emergency line:

1. Before commencing to dial, lift receiver and wait for dialing tone (a purring sound)
2. Insert finger in hole showing first letter of name of exchange required
3. Turn dial to finger-stop
4. Lift finger. Dial will then return to normal position

The 9-9-9 call would go to a telephone exchange where an alarm would sound and a warning light would flash alerting the operator to the emergency call. Once asked “Emergency—which service, please?” the caller was put through to fire, police, or ambulance depending on his or her response.

The system started small, covering a 12-mile radius around London’s Oxford Circus. Since few households had telephones, telephone boxes in the area were modified to take the 9-9-9 calls without charge.

The first call resulting in an arrest occurred on July 7, 1937, from the private phone of a wealthy North Londoner who had scared off a stranger in the midst of breaking into his home. In less then five minutes, after his wife called 9-9-9, the would-be infamous for a bad decision cat burglar—24-year-old Thomas Duffys—was in custody and later charged with an attempted break-in with intent to steal.2

Like any new system, however, there were kinks to work out. For example, in the early days, 9-9-9 calls to Scotland Yard triggered such a loud buzzer alarm that the switchboard girls had to be carried out after fainting at their desks from the deafening racket. The problem was only solved when ingenious engineers stuffed tennis balls into the mouth of the kloxons to muffle the noise. Five pranksters were determinedly behind 91 “curiosity calls” out of the 1,336 calls placed to 9-9-9 the first week of service.

In 1938, the system was introduced to Glasgow but World War II delayed further expansion. The program later continued and was introduced in Wales, Birmingham, Bristol, Edinburgh, Liverpool, and Manchester in 1946.

By 1967, more than a million calls were being made for all emergency services across the U.K., a number that has grown to 31 million calls (an average of 597,000 calls a week) placed annually from fixed and mobile phones across the U.K. Of the calls British Telecom (BT) passes to emergency services, 52% go to the police, 41% to the ambulance service, 6% to the fire and rescue service, and 1% to the coastguard and cave and mountain rescue services. The early hours of New Year’s Day is traditionally the busiest time when up to 13,500 calls can be received each hour.3

In May 1993, the British Medical Journal recommended that the London Ambulance Service implement “a medical priority dispatch system, which differs from criteria-based dispatch systems by using algorithms rather than prompts.”4 Today, the Advanced Medical Priority Dispatch System™ (AMPDS™) is currently used by more than 90% of the National Health Service (NHS) ambulance services in the United Kingdom.

Party time
To celebrate the 75th anniversary, Scotland Yard opened its archive to reveal early emergency calls. Logs from 9-9-9 read:

A man aged 40, 5 ft or 6 ft, square jaw, brown suit, grey collar and a light brown trilby, smart appearance, at 3.45 pm entered a house on Kenvin Drive, Cricklewood, and gagged the occupier, stole £6 and decamped.

On the same day, two suspicious moustached men wearing trilbys were spotted hanging around the scene of a jewellery store shortly after it had been raided by a robber who made off with a bar of gold and a bundle of cash.5

A Facebook page set up by the Metropolitan Police features video interviews with 9-9-9 operators, photos, illustrations, and facts and figures relating to the history of the service.6

Sources
4. See note 3.
5. See note 2.