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— Michel Gravel
New Brunswick EMS
Moncton, NB, Canada

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

Online registration for the 2015 course is now open. Go to www.emergencydispatch.org/certccmcourse or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.
Why do some people leave the headset and monitors behind within a few years and some people stay at their seat year after year? The answer ultimately may lie with the concept of motivation.

Why do callers turn to suicide? Awareness helps create empathy for public safety professionals. But what about when those handling calls for help need help themselves? There are resources available.
Paul’s career in EMS started in nursing in the ICU and ER, continuing through EMS operational management in the Netherlands, and, in 2007, establishing an EMS consulting business. In January 2016, he is retiring as the PDC representative in the Netherlands, a contracting position he has held for eight years. Paul will continue to provide training, coaching, and interim management through his private company.

Ingrid worked in an ER and as an assistant for a general practitioner prior to 2007 when she became a triage nurse for a general practice during out-of-office hours. In 2011, she began assisting her husband, Paul Engelen, in the Netherlands and she provides administrative assistance to a dispatch support organization that offers coaching, data analysis, cultural changes, and other services to communication centers.

Simon is a dispatcher for Outaouais Health Communication Centre, Quebec, Canada. After graduating with a degree in psychology and psychoeducation, he left the communication center to answer calls at a suicide hotline. Simon returned to dispatching after missing the multitasking, variety of calls, and the ability to provide lifesaving help. His writing focuses on public education.

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MAIL CALL
We’d love to hear from you! Has something outstanding happened in your comm. center recently? Or are you a budding columnist? Should your center be in the running to be our next Your Dispatch story in Your Space? Do you have a suggestion for The Journal? Email editor@emergencydispatch.org with your thoughts.
We love hearing from you. That’s right, your feedback lets us know that not only do you read the Journal, but that you care what we publish. At times, we feel like we write, edit, and lay out the Journal in a vacuum. Without hearing from you, our readers, it can be hard to know what we’re doing right, and conversely, what we could do better.

Sometimes, you might not have a lot to convey except that you had a favorite or least favorite article in the issue that you just finished reading. Other times, you might notice something that needs to be brought to our attention.

We can’t do this without your help. Column submissions give your fellow readers a chance to hear it from you—what you’ve found that can make your job (and theirs) easier or an issue that affects the dispatch community. We welcome guest columnists and also Your Space articles.

With that said, we do have guidelines for submissions that we’d like you to keep in mind. Please be sure that your work is original. If you do take ideas or information (such as statistics) from another source and incorporate them in your article, please ensure that you include source citation (we can help you with how to cite your source).

We take plagiarism seriously. We’ve added new steps to our existing editorial guidelines, specifically regarding plagiarism.

Going forward, if we believe that something published in the Journal has been plagiarized, we will investigate it. If we find that it has been plagiarized, we will contact the author and his or her agency. Then we will include a statement in the following issue of the Journal.

Please keep that information in mind when preparing your submissions and be sure to read the guidelines in their entirety. I have covered only part of what our guidelines outline. Columns and Your Space articles should range from 600–625 words, including attribution. We ask that you submit a high quality head and shoulders photo and a short bio (about 50–75 words) for potential College of Fellows and Your Space articles. Please ensure that you include source citation (we can help you with how to cite your source).

Be aware that all stories—whether written by Journal staff or contributors—are sent through the editing process. We review the right to edit for length, content, and clarity. After your article has been edited, we will email you the final draft for your review. Please check it for accuracy only. If there are any issues or questions, we ask that you let us know within three days.

Again, we strongly encourage and welcome your feedback and submissions going forward. We work hard to keep the Journal relevant, useful, and interesting, but we’re open to a helping hand.

\*The Journal of Emergency Dispatch is the official bi-monthly publication of the International Academies of Emergency Dispatch (IAED™), a non-profit, standard-setting organization promoting safe and effective emergency dispatch services worldwide. Composed of three allied academies for medical, fire, and police dispatching, the IAED supports fiscally independent, non-profit related research, unified protocol application, legislation for emergency call-center regulation, and strengthening the emergency dispatch community through education, certification, and professional development. General IAED membership, which includes a Journal subscription, is available for $19 annually. $35 for two years, or $49 for three years. Non-member subscriptions are available for $25 annually. By meeting certain requirements, certified memberships are provided for qualified individual applicants. Accredited Center of Excellence status is also available to dispatch agencies that comply with Academy standards. © 2015 IAED. All rights reserved.\*

Heather Darata
COPY EDITOR

YOU HELP US MAKE THIS BETTER
Minimum training standards for emergency telecommunicators is pulling divergent organizations together into the same sandbox.

And, guess what?

They’re playing nicely. Although the occasional flick of sand is unavoidable, those involved are intent on building the same castle and, at this point, working together to form a consensus foundation. Representatives from each organization—such as IAED™, NENA, APCO, and the Denise Amber Lee Foundation—participate in working groups set up to establish and circulate national standards to the individual states. For example, IAED Associate Director Carlynn Page chairs the Model Legislation Task Force.

Page calls the solidarity unprecedented. Historically, these organizations maintain separate profiles; however, minimum training standards, she said, are something they can all agree on, at least in principle. They’re starting at the ground level, using research and surveys that will result in standards bringing all PSAPs to an acceptable level of care.

While most states have some form of regulation, uniformity on any scale doesn’t exist, and state oversight is often inconsistent. On opposite ends of the spectrum are agencies prescribing to certification and accreditation—the IAED philosophy—and agencies flying by the seat of their pants, operating without the benefit of policies and procedures or protocols.

No one should anticipate federally mandated training requirements. The push is state-by-state legislation requiring baseline fundamental training. The object is to create standards that are sustainable and achievable, particularly considering the smaller PSAPs operating with fewer than 30 employees, which, by the way, are in the majority.

NENA Education Director Ty Wooten said this is a “walk-before-you-can-run” strategy. Get agencies started in the right direction and soon enough you’ll see the proverbial scratching of the head—“What took us so long?”

For Denise Amber Lee, training—even minimum standards—could have made a difference.

Lee was 21 years old when she was abducted from her home in Florida and murdered on Jan. 17, 2008. The mother of two small boys and others witnessing her struggle from the back of her assailant’s car called for help through the 911 system, but failures in the communication system prevented police and other emergency services from finding her alive. Investigations identified failures in the communication center that were later identified as an epidemic nationally.

I had the privilege of meeting Mark Lee—Denise’s father-in-law—and Nathan Lee—Denise’s husband—at NAVIGATOR in 2009, one year after the tragedy forever changed the direction of their lives. They were new on the 911 stage, representing the foundation established shortly after her death.

While Nathan doesn’t hesitate to credit the good work that many emergency dispatchers give, the two PSAPs contacted the day his wife was abducted and murdered provided woefully inadequate responses.

And that’s why he set out to do something.

Because of the foundation’s efforts, the Florida Legislature passed the Denise Amber Lee Act in April 2008; the act provides for voluntary training, and the foundation continues to lobby state legislatures to pass mandatory training and certification for all 911 dispatchers.

It’s unfortunate that it took such an overwhelming heartbreak to bring attention to the lack of national standards, much the same as events precipitating forward momentum of the Medical Priority Dispatch System™ (MPDS®). But that’s how things work, as long as there are individuals willing to run with determination and bring others into the fold.

“The public assumes that 911 professionals have the same level of training, but that’s not reality,” said Nathan, during a panel discussion at NAVIGATOR 2015. “We need uniform national standards. We need to take this to the top floor.”

You can bet that he will never stop fighting in the name of Denise.
EDUCATION NEVER ENDS
Making CDE relevant improves performance

Tracey Barron

When you’re hired for your first job in emergency communications, it might bring a sigh of relief after spending what seemed to be a lifetime searching for and finding the right job. And for the period of training and certification that follows, you morphed into an educational sponge, absorbing information from classes, mentors, peers, and, perhaps, webinars, covering the countless number of topics involved in your new career.

You were probably thrilled to finally go at it alone. “I made it. I’ll never have to take another test again or sit through another training course.”

But of course, you were wrong. After taking your first shift of calls without peer assistance, you realize that learning is even more important now than it was during the three-day certification course. To further your career, stay motivated, and enhance your ability as an Emergency Medical Dispatcher (EMD)/Emergency Fire Dispatcher (EFD)/Emergency Police Dispatcher (EPD), you need a structured action plan.

The more the plan is correlated to areas directly related to your areas of concern, the better it is for you and your willingness to participate.

Or, at least, those are the research findings presented in a poster for the annual contest sponsored by the International Academies of Emergency Dispatch (IAED®) at the Academy’s NAVIGATOR 2015 conference in Las Vegas, Nev.

Linden Horwood, EMD-Q®, Quality Auditor, Yorkshire Ambulance Service (YAS), NHS Trust, U.K., developed the poster resulting from her research into factors influential in motivating dispatchers (EMDs) and whether issues of non-compliance to protocols was skill, knowledge, or behavior based. She conducted a Web-based survey to determine the impact of continuing education and the type of lesson that would be most beneficial in improving performance.

Hands down, the EMD’s continuing dispatch education (CDE) was helpful. Overall, dispatchers were more likely to complete the assignment if mandatory. Taking on a task voluntarily depended on whether the EMD perceived the task as relevant and related to the EMD’s area of protocol compliance difficulty.

According to other study findings, CDE format also plays into a dispatcher’s favorable opinion. Face-to-face support, information handouts, and visual/caption-based CDEs are the highly preferred formats. A minority of EMDs in the study population would choose textbook training as the ideal approach to education.

Admittedly EMDs/EPDs/EFDs must earn CDE units to remain certified, maintain IAED membership, and, ultimately, keep their jobs. Compliance to the protocol also adds to a dispatcher’s confidence and diminishes concerns associated with non-compliance, such as punitive action plans.

Horwood said her interest, however, is directed at education that stimulates and is based on data collected by the agency.

“Audits produce a wealth of data, and it’s important to understand the information, using it to improve patient care and support EMDs,” said Horwood, who for the past eight years has been analyzing audit trends and developing CDEs based on her findings. “We should also make it a point to engage the dispatcher in education and create realistic expectations of what is required.”

Horwood’s background is not in research. She picked up a brochure about the poster research competition at UK NAVIGATOR 2013.

“I thought this would be ideal,” Horwood said. “With the Academy’s

It’s all rather exciting seeing it come together and knowing it will help.

Horwood earned the best research poster award at UK NAVIGATOR 2014 for her initial research. The work caught the attention of other agencies, fueling her interest to further research specific practices to improve performance for EMDs, EFDs, and EPDs, and resulting in the follow-up submission.

“It’s all rather exciting seeing it come together and knowing it will help support other agencies,” Horwood said. “We’ve had an ambulance service contact us after seeing the poster on your [IAED Research and Informatics Division] website for support in developing a QI department.”

IAED’s Research and Informatics Division sponsors the annual poster contest at NAVIGATOR conferences to encourage research into the use of the emergency dispatch protocols and to submit research papers for possible publication in the IAED’s official peer-reviewed research journal, Annals of Emergency Dispatch & Response (AEDR).
STOP THE BLEED
White House taps Academy as exemplary leader

Jeff Clawson, M.D.

Subject: Request for exemplary leaders in Bystander Stop the Bleed initiative to participate in White House event

This email is in follow-up to the April 29, 2015 Roundtable on “Bystanders: Our Nation’s Immediate Responders” convened here at the White House.

Attached please find a Request for Exemplary Leaders in Supporting the Bystander “Stop the Bleed” Initiative to Participate in White House Event and objectives for the initiative.

The White House plans to convene a signature event on October 6, 2015 that will include the celebration of actions by federal and private sector partners to create meaningful and lasting impact in support of bystanders as immediate responders in stopping life-threatening bleeding.

Our national preparedness is the shared responsibility of all levels of government, the private and non-profit sectors, and individual citizens. The goal of this initiative is to build national resilience by empowering the general public to take action to stop life-threatening bleeding. As we have seen in such tragic incidents such as the Boston Marathon bombings and the train crash in Philadelphia, anyone can contribute to safeguarding the nation from harm.

We are requesting information on efforts that are already in place or are planned that support the following objectives:

• The general public will know the phrase and associated logo: “Stop the Bleed”
• The general public will have access to effective personal bleeding control kits
• The general public will have access to effective public bleeding control kits
• Every bleeding control kit will provide “just in time” audio and visual training

As a stakeholder, you are invited to submit a description of:

1) our organization’s efforts to actively promote and implement the objectives for this initiative, and

2) the specific actions your organization has taken or plans to take to advance one or more of the objectives.

Further details are in the attachment.

Based on submissions a limited number of exemplary partners will be highlighted in this signature White House event on October 6, 2015.

Submissions are due by COB September 22, 2015 and should be sent via email.

Respectfully,

Richard C. Hunt, MD, FACEP
Director for Medical and Public Health Systems
Preparedness and Response
National Security Council Staff
The White House
Dear Rick,

Obvious Critical Injuries with Uncontrollable Bleeding – The Coming Lay Use of Tourniquets & the Dispatcher’s Involvement in the “Stop the Bleed” White House Initiative

Early battlefield use of tourniquets took place before the development of modern medicine, in past conflicts like the Crimean Wars, the American Civil War, and World War I and II. In those times, tourniquets were often used in severe situations common to war—amputations, bayonet wounds, bombs, and land mines. The long times to get these tourniqueted patients to definitive medical and surgical care (if that was even remotely available at the time), often resulted in loss of circulation and enervation, and death of limb parts of the world, domestic and militant terrorists’ use of mass shootings, bombs, axes, machetes, and other very dangerous weapons has created a more significant type and frequency of critical arterial bleeding encountered in civilian settings.

Better-designed hemorrhage control devices, quicker and directed delivery to trauma centers, and the increased exposure of civilians willing to be advised by EMDs to perform “just-in-time” treatments, has changed the playing field for improving this type of care.

The IAED has been invited to work with the President’s Task Force for “Stop the Bleed” White House Initiative

“Stop the Bleed” precursors, the IAED Mission:

Scope of use:

1. Organization: International Academies of Emergency Dispatch (IAED)
2. # of Members: 56,000
3. # of Communication Centers using the AMPDS: 3,005
4. Scope of use: 44 countries – 16 languages and dialects
5. IAED Mission: To advance and support the public safety, emergency telecommunications professional and ensure that citizens in need of emergency, health, and social services are matched safely, quickly, and effectively with the most appropriate care and resource. And to conduct an on-going review of the current standards of care and practice in EMD, Fire, Police, Nurse Triage, and other areas of public safety telecommunications and continually evaluate the tools and mechanisms used to meet or exceed those standards.

Role of the IAED in “Stop the Bleed”:

As the first contact from the scene, and often the involved bystanders, 9-1-1 Emergency Dispatchers must be able to understand, almost better than anyone, the real-time aspects of the Critical Bleeding Control process. Emergency dispatchers will deal directly with these patients and their citizen rescuers, so the Academy will create and/or modify the following for this “just-in-time” process to be safe and successful:

What IAED can and is committed to do:

a. Create scripted support protocols for citizen direction and assistance in directly applying a tourniquet (these are similar in nature to our EpiPen, Aspirin, and Narcan Administration Assistance Instructions).

b. Modify current training for all Emergency Dispatchers in applying these instructions.

c. Establish an ongoing method of ensuring all newly trained Emergency Dispatchers are updated with the necessary improvements as the evolution of this important process unfolds.

d. Modify the Principles of Emergency Medical Dispatch – 6th Edition textbook to outline and emphasize these important changes in pre-arrival scene care.

e. Create computer-based training “Special Procedures Briefing” CD for training all emergency dispatchers in these new processes.

The IAED will also assist the White House/National Security Council directly by creating and nearly instantly disseminating these dispatch assistance protocols and their associated, succinct computer-based training program nationwide (and internationally), which will then directly impact the dispatcher’s guidance of these “newly armed” citizen rescuers anytime the application of a tourniquet or included treatments are needed.

What IAED has done and is currently doing:

The Advanced Medical Priority Dispatch System Protocols have detailed pre-arrival instructions regarding bleeding control, that emphasize direct pressure and provide some advice as to lay rescuers not applying a tourniquet, but also advising not removing it if already applied by bystanders. These instructions have been modified within the last week in time for the release of version 13.0 on October 1st. The modifications include the following:


b. Modified the Critical EMD Information (CEI) to “If a tourniquet has already been applied, do not advise removing it. If asked about applying one, tell them to do what they think is best.”

c. Revisited practice scenarios in EMD Course Manuals to remove any reference to the former instruction “Do not use a tourniquet”

d. Began the Council of Standards process to create the scripted telephone instructions necessary to aid a lay rescuer in applying a tourniquet to an extremity where bleeding is clearly dangerous, or can’t be stopped by direct pressure instructions.

e. Update and quickly disseminate these changes and new instructions, constructed and approved by the Council of Standards, in the manual card system, the Quality Assurance Guide, and the automated ProQA logic engine system.

f. Add the capability to the automated ProQA system to cross link the Bleeding Control Kits to the locations of AEDs within various registries that are polled directly by ProQA.

The Academy welcomes the opportunity to aid you and the exceptional people at the NSC and White House in this most important and timely initiative. Keep up the great work!

Sincerely,

Jeff Clawson, M.D.
Chair, Rules Committee
Medical Council of Standards
Division of Research, Standards, & Academics
International Academies of Emergency Dispatch

cc: Scott Freitag, President
Jerry Overton, Board of Trustees
Pam Stewart, Chair, Board of Certification
Breit Patterson, Chair, Medical Council of Standards
Vicki Maguire, Chair, Curriculum Board

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Note: Shortly thereafter, IAED was recognized as an Exemplary Leader in this Initiative and Dr. Clawson attended the special celebratory event at the White House on October 6th.
Dispatch center named in honor of longtime communication manager

The new Caroline County’s (Denton, Md.) 911 dispatch center was named in honor of a longtime employee who dedicated his career to public service.

The honoree, Curtis Harvey, was communication manager for the dispatch center for 17 years. He had worked for the Denton Police Department for three years and had been a lifetime member of Greensboro Volunteer Fire Company serving as past chief and president.

In 2008, county commissioners signed a resolution stating a future public safety building would be named in Harvey’s honor; the resolution, however, was delayed until the county finalized construction plans. The 911 center is the second Caroline County site named in Harvey’s memory; in May 2008, a Greensboro park along the Choptank River was renamed the Curtis Harvey Memorial Firemen’s Park.

Caroline County 911 dispatch center provides services to four town police departments, Caroline County Sheriff’s Office, Caroline County EMS, and eight volunteer fire departments. Each 911 team at the center has a police, fire, and medical dispatcher and a commander and they work two 12-hour days followed by two 12-hour nights, with four days off before starting the next four shifts on.

In case you hadn’t heard, the Police Priority Dispatch System™ (PPDS®) v5.0, officially launched at NAVIGATOR 2015, is in a class of its own, powered by the invincible qualities of ProQA® v5.1. Updates and enhancements include:

- A new ECHO-level Determinant Descriptor (124-E-1) added for OFFICER DOWN situations defined as “an emergency situation, discovered during Case Entry, where the life of the officer is at stake.”
- Protocols 108 and 109 are modified to address PRODUCT CONTAMINATION situations (PRODUCT CONTAMINATION with 108 and PRODUCT CONTAMINATION THREAT with 109). They have new definitions, and unique Determinant Descriptors and Key Questions.
- A new definition for SPECIAL LOCATION has been added to Protocol 123.
- Blue prompts for obtaining weapons/person/vehicle descriptions have been replaced with scripted statements to help the EPD retain control of the call.
- Improved instructions for Sinking Vehicle and Vehicle in Floodwater situations.

Version 5.0 involved two years of meetings within the Police Council of Standards and Curriculum Council before it was ready for beta testing. It represents the fifth major revision since first released in 2001. Changes are based on Proposals for Change (PFCs) submitted by current users of the PPDS and reviewed by law enforcement experts on the IAED’s™ Police Council of Standards.

Maine approves funding for fire and police protocols

PSAPs in Maine will soon be adding the Police Priority Dispatch System™ (PPDS®) and Fire Priority Dispatch System™ (FPDS®) protocols to the already existing Medical Priority Dispatch System™ (MPDS®) protocols at their communication centers through funding from the state’s E-911 surcharge.

While implementation is voluntary, the money provides PSAP dispatcher training and certification, software, printed support materials, and a quality improvement (QI) program to measure compliance.

If the number of PSAPs applying for funds exceeds the funds available, the state’s Emergency Services Communication Bureau, within the Public Utilities Commission, will make selections based on criteria such as demographics, the number of 911 calls received each year, and the number of police and fire departments served.

The legislature is allowing up to 5 cents of each E-911 surcharge to fund the program. The bureau will give centers three years to phase in the implementation.

In 2009, the Maine EMS Board began the one-year transition period to the IAED™ Medical Protocol statewide, including certification and quality assurance (QA)/quality improvement (QI) programs. The QA/QI component requires reviewing 100 EMD calls monthly and maintaining a three-month average of 90 percent compliance to protocol.

The Maine EMS Board also requires EMS medical directors for approval and oversight of response levels and response modes.
Marketing company forfeits $2.96 million for robocalling violation

Travel Club Marketing Inc., its related companies, and owner Olen Miller will pay a heavy price for unwanted telemarketing.

In August, the Federal Communications Commission (FCC) announced a $2.96 million fine against the Tampa, Fla., based organization, for making or initiating at least 185 “robocalls,” all of which were unsolicited, pre-recorded advertising calls to more than 142 consumers without their consent; in fact, the majority had placed their telephone number on the National Do-Not-Call Registry.

This is the largest forfeiture order the FCC has issued for robocalling violations.

The FCC Enforcement Bureau reviewed complaints from consumers receiving the unwanted prerecorded calls to residential and cellphone lines promoting travel deals, free vacations, and time shares.

At the time of these calls, the Communications Act and the FCC’s rules required prior express consent for all robocalls to cellphones and either prior express consent or an established business relationship for advertising robocalls to residential telephone lines.

Travel Club Marketing did not have prior express consent or an established business relationship for any of the calls it made. The FCC amended the rules, effective October 2013, to rescind the established business relationship exemption and to require that prior express consent be in writing for all advertising robocalls.

FCC task force proposes new 911 funding assessment

A new 911 funding model that would likely include assessments charged to broadband connections could be in the offing to pay for the migration from legacy 911 to Next Generation 911 (NG911) technology nationwide, according to a recent report released by the Federal Communications Commission (FCC) Task Force on Optimal PSAP Architecture (TFOPA).

A draft of the working group’s report—subject to further review and a vote of approval this year—states that 911 fees should be assessed in a "competitively neutral manner on all technologies utilized to place a 911 emergency request for assistance to a PSAP through an emergency communications device."

The approach differs from past funding models, which have not included new technology in the 911 fee structure. The working group recommends the 911 funds be sustained in a fund outside of state general funds.

TFOPA held its first meeting January 2015 to study and report findings and recommendations for improving PSAP infrastructure and architecture to promote greater efficiency of operations, safety of life, and cost containment, while retaining needed integration with local first responder dispatch and support.

NENA standard would coordinate response between PSAPs and railroads

A standard operating procedure for emergency communication between PSAPs and railroad personnel might never be approved for public release, but the document accompanying the proposal provides insight into the complexity of coordinating response.

The standards, posted on the NENA collaboration worksite, would require PSAPs to develop operational policies for managing railroad personnel interactions, as well as incorporating new techniques into telecommunication training curriculum.

A review of the statistics substantiates the need. According to the Federal Railroad Administration, in 2014 there were more than 2,000 highway-rail grade crossing incidents resulting in more than 230 deaths and 763 injuries. Additionally, in 2014 there were more than 850 railroad trespasser incidents resulting in almost 500 deaths.

Along with the almost 8,000 Federal Railroad Administration reportable accidents and incidents, nearly 17 million carloads of hazardous materials are transported in North America every year. Local emergency responders are required to respond to between 40 and 50 accident-caused releases of hazardous materials and another 600 to 700 non-accident releases of hazardous materials every year in the U.S. and Canada.

In addition, passenger trains have health-related emergencies traveling through local jurisdictions that require medical assistance, or problems with unruly passengers that require police interaction.

For more about the task force visit www.fcc.gov/events/task-force-optimal-public-safety-answering-point-architecture-tfopa
Race and gender influence calls for ambulance

As of June 2015, there were 28 states and the District of Columbia that had passed Good Samaritan 911 laws granting limited immunity from prosecution on simple possession charges for people who dialed 911 to report a drug overdose, according to the Drug Policy Alliance.

Although laws differ among the states, immunity generally applies to any good faith effort to seek medical help, whether calling 911, taking the overdose victim to an emergency room, or running to get your neighbor who is a doctor.

Many extend immunity from possession charges to those seeking medical assistance for someone experiencing alcohol poisoning, and to the victims of alcohol poisoning themselves, even if under the legal drinking age.

It takes public awareness, however, for people to make the call.

For example, initial results from an evaluation of Washington State’s Good Samaritan law, adopted in 2010, found that police officers and paramedics were largely unaware of the law. However, 88 percent of people who use opioids said they would be more likely, and less afraid, to call 911 in the event of a future overdose after learning about the law.

Source

Check out these numbers of next-generation cellphone users

CTIA-The Wireless Association and the Wireless Foundation provide a fascinating (and, perhaps, startling) look at the world of cellphones among the younger generations in their co-developed “Growing Wireless.”

On average, children are 12.1 when they receive their first mobile device.

• 56 percent of children ages 8 to 12 have a cellphone.
• Of children 8 years of age and younger, 2 percent have their own cellphone.
• 37 percent of teenagers ages 12 to 17 have a smartphone, an increase from 23 percent reported in 2011.
• 78 percent of teenagers ages 12 to 17 have a cellphone.
• 51 percent of high school students carry a smartphone with them to school every day, compared to 28 percent of middle school students.
• 70 percent of parents of teens with a cellphone have reviewed their teen’s text messages, while only 39 percent of teens believe their parents monitor their cellphone somewhat closely.
• 53 percent of teenagers ages 13 to 17 say most of their calls last four minutes or less.
• 33 percent of teenagers ages 13 to 17 list texting as their favorite form of communicating with their friends.
• 53 percent of adolescents ages 8 to 17 report that they have been in the car with someone who is texting and driving.

More states granting immunity to 911 callers reporting overdose

Only about half of stroke patients use EMS to get to the hospital, but white women are most likely to call an ambulance, while blacks and Hispanics of both sexes are least likely, according to a study published in the Journal of the American Heart Association.

Race and gender seemed to influence who calls for an ambulance most often, although cultural differences may influence the racial disparities, particularly in the Hispanic community, with people who do not speak English feeling like they will not be able to communicate if they call 911.

Researchers used the medical records of nearly 400,000 stroke patients admitted to more than 1,600 hospitals participating in an American Heart Association/American Stroke Association quality initiative between 2011 and 2014.

With an average age of 71, half of the stroke patients were women and almost 70 percent were white. Almost 20 percent were black, 8 percent were Hispanic, and 3 percent identified as Asian. Slightly more than 60 percent of white women had been transported to the hospital by EMS, compared to 57 percent of white men. About 57 percent of Asian women took an ambulance, compared to 55 percent of Asian men.

Source
French firefighters propose 112 as the unique number for emergency services

The National Federation of Firefighters of France (FNSPF) plans to abandon the number “18” dialed to reach the fire brigade and rescue services, and to introduce 112 as the common emergency number for all French emergency services.

The European Emergency Number Association (EENA) welcomes this decision. According to EENA Executive Director Gary Machado (in an EENA press release dated Sept. 23, 2015), “EENA has been a supporter of this idea for many years so we would like to congratulate the French firefighters for this important initiative. In a country where the amount of emergency numbers recently rose to 11, most of which are unknown to the public, adopting a common number for all emergency services is going to be highly beneficial both for the French citizens as well as the emergency services.”

The plan to switch to a common emergency number is expected to reduce the costs of emergency services in France. Currently, there are about 100 emergency control centers dealing with calls to firefighters by dialing “18”, and firefighters want to set up between 10 and 20 major centers around France to receive and sort calls to the number 112.

Even after the firefighters put their calls under one number, there are still several phone numbers to remember in France during an emergency. For example, the coastguard is 196, and an aeronautical emergency is 191. For police, it’s the number 17, and for ambulance crews, it’s the number 15.

EENA, based in Brussels, Belgium, is dedicated to promoting one number (112) throughout the European Union.

On a positive note, the study reports that of the people surveyed, 92.6 percent of respondents wanted to learn CPR and 80.3 percent of respondents were willing to perform CPR and distribute information about lifesaving resuscitation.

In an earlier study conducted among students in the city of Wuhan, China, only 28 percent of the respondents reported that they had heard of CPR; however, most respondents expressed a desire to learn CPR (77 percent) and were willing to perform CPR and distribute information (73 percent).

Sources

Reluctance to provide bystander CPR is universal

According to a recent study, CPR technique, victim’s status, respondent’s specialty, and respondent’s gender affect the attitudes of respondents toward performing bystander CPR.

And the top four reasons why they don’t perform CPR?
- Lack of confidence
- Fear of legal disputes
- Fear of disease transmission
- Embarrassment

Sound familiar? If so, that’s because the results, although based on a study conducted in Tianjin, China, nearly mirror the same reasons found in the U.S.

Overall, the study (available at the link posted in the source list) indicated that except for the scenario where the victim was his or her own family member or close friend, all other scenarios showed a lower rate of positive response and a greater willingness to perform compressions-only CPR (CC) rather than chest compressions with mouth-to-mouth ventilation (CCMV).

On a positive note, the study reports that of the people surveyed, 92.6 percent of respondents wanted to learn CPR and 80.3 percent of respondents were willing to perform CPR and distribute information about lifesaving resuscitation.

In an earlier study conducted among students in the city of Wuhan, China, only 28 percent of the respondents reported that they had heard of CPR; however, most respondents expressed a desire to learn CPR (77 percent) and were willing to perform CPR and distribute information (73 percent).

Sources
Any agency that has achieved recognition as an International Academies of Emergency Dispatch® (IAED®) ACE knows the process does not happen overnight. In fact, attaining ACE status requires sustained effort, laser-focus, and complete commitment from every team member. But no one would say the challenging course to achieving this distinction wasn’t worth it.

Kathrina Murray can attest to this. The control manager at the National Emergency Operations Centre (NEOC) in Dublin, Ireland, played an integral role in helping the center become accredited in January 2015.

“The accreditation process requires clear planning, time, resources, and a change in management methodologies in order to achieve the award,” Murray said. “Tasks ranged from highlighting the potential benefits to senior management, to informing and educating staff to the benefits for patients as well as to their work processes.”

The NEOC is an agency within Ireland’s National Ambulance Service (NAS). Its 130 staff members work 12-hour shifts and serve 4.6 million residents. As the island of Ireland spreads over 32,599 square miles (84,431 square kilometers), there is a lot of ground to cover. The NEOC also dispatches for the aero medical desk and works closely with the Coast Guard, mountain rescue teams, Community First Responders, and Royal National Lifeboat Institution (RNLI) lifeboats.

Naturally, most calls NEOC dispatchers take are in English, but there is a smattering of other languages spoken in the country, including Irish (often referred to as Gaelic or Gaeilge), Polish, Lithuanian, and others.

Murray, who also served as the project manager for accreditation, said the NEOC fields about 13,000 emergency calls per month using the Medical Priority Dispatch System® (MPDS®). It was apparent to Murray and her colleagues NAS Director Martin Dunne, National Control Operations Manager Sean Brady, and Supervisor David Sweeney that working toward becoming an ACE would help the center better serve the people of Ireland.

“Improved patient care and best practices were the primary motivators for the NEOC and NAS to seek and become accredited,” Murray said. “It was recognized at an early stage that this accreditation could enable improved patient care delivered over the phone by calltakers in our NEOC. The accreditation would enable a standardized approach throughout the NEOC to how calls would be taken and dealt with.”

Murray had the added benefit of working in an accredited center prior to coming to the NEOC. Her previous...
experience taught her that accreditation would not only help the thousands of monthly callers but the communication center employees as well.

“Having worked in an accredited center previously, it was clear that there are many benefits that an organization can achieve through an accreditation process,” she said. “One such benefit was the opportunity to learn from others as well as ourselves and to foster a culture of continually learning and process improving.”

As if accreditation isn’t challenging enough, the NEOC had the added obstacle of dealing with in-house restructuring during the ACE process; the NAS significantly consolidated its operations from nine control centers to one center with two sites.

“This included integration of information technology platforms as well as staff, processes, and ways of working,” Murray said.

Murray said communication and preparation were critical elements of working through the accreditation process and ultimately becoming an ACE.

The NEOC accreditation project was led by a Dispatch Steering Committee that communicated frequently with senior management on milestones, achievements, and progress. Additionally, staff members were regularly apprised of the accreditation effort and its status.

“This enabled a more motivated and open culture within the NEOC where quality and continual process improvement is everyone’s priority,” Murray said.

Being an ACE gives the NEOC, and all accredited agencies, the advantage of having a consistent, standardized call-taking approach, which helps improve over-the-phone patient care. Because it is now an ACE, the NEOC has more defined, consistent standard operating procedures. It also has the support from the Academy in the form of workshops and continual learning opportunities.

Murray believes the benefits of being an ACE will serve the NEOC and NAS for years to come. For that reason, she believes becoming accredited is a no-brainer for any agency. And through planning and learning, this milestone is well within reach.

“It’s important that a clear plan is agreed upon and communicated to ensure commitment to the project at all levels of the organization,” she said. “Understand that the accreditation process takes time and resources, and it may require change. The opportunity to learn as part of this accreditation process has been valuable to NEOC.”

Understand that the accreditation process takes time and resources, and it may require change.
VENTILATIONS UNSUCCESSFUL
Should calltaker move to compressions only?

Brett Patterson

Brett:
We have a study session here at NORCOMM where new EMDs with less than a year's experience in providing EMD gather together QAs we have on staff to practice scenarios off the dispatch floor. (This was not an actual call; it was practiced in a scenario-based setting only.) Today, we were drilling in the scenario of a second-party caller reporting a heroin overdose of a 33-year-old male. The caller reported that the patient was not awake, and when Key Question 6 on Case Entry was asked, the caller reported that the patient was not breathing.

We started down the C Card, reading Panel 1, going to 2, and then 4. On Panel 4, the calltaker selected the Ventilations 1st pathway, since it was an overdose. She proceeded to Panel 5. When the question was asked, “Do you feel the air going in and out?” the answer was “No.” The calltaker proceeded to Panel 13. When the question was asked, “Did you feel the air going in and out?” the answer was again “No.” From there, the calltaker moved to Panel 6. This is where our question comes into play. The calltaker wanted to go down the Ventilations 1st pathway, since that was the initial choice with the call. Others in the group argued to go to the Compressions 1st pathway because ventilations were never successful. I am looking for a clear answer on how to proceed with this call.

Should the calltaker continue to attempt the ventilations and deliver 30 compressions with two attempted breaths or go to the Compressions 1st pathway and start Panel 11?

Nicole:
Interesting scenario!
Let me start with, “Continuing on with the V-1st pathway is correct.”

Several years ago, we limited the attempt to open the airway to one try when air didn’t initially go in, considering the time it was taking to reposition the airway, the potential inaccuracy of the rescuer’s assessment, and the very low probability of undiscovered foreign body airway obstruction (choking is almost always reported as choking).

In your scenario, and others like it, we continue down the V-1st pathway for basically two reasons. First, if the problem is simply airway positioning or rescuer inaccuracy in reporting whether air went in, each attempt itself requires repositioning and, eventually, some air should get in. I should mention that in your OVERDOSE scenario, it is unlikely two attempts to ventilate would be unsuccessful considering the flaccid nature

Nicole Stewart
Training & QA Manager
NORCOMM Public Safety Communications
Franklin Park, Ill, USA
of an OVERDOSE patient’s airway.

Second, in the rare event the airway was obstructed by a foreign body, there is a chance that positive pressure from attempted ventilations could force the object into the right mainstream bronchus, thereby opening the left lung to ventilations.

In essence, if the patient’s airway is obstructed by a foreign body, compressions will act to push it out, and, if that doesn’t happen, there is a slim possibility that blowing into the mouth will open up one lung to ventilations. Notice the situational instruction in Panel 7 and Panel 10: “(Previous airway blockage) Check in her/his mouth for an object and remove anything you find.”

We strategically placed this after compressions since the positive pressure created by compressions may expel an object.

I hope that answers your question and settles the scenario debate. Kudos to you and your staff for conducting scenario drills to better prepare your EMDs!

Thanks for submitting your question to the Academy.

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

Claude A. Rogers III
Captain of Communications
Reedy Creek Emergency Services
Reedy Creek, Fla., USA

“Party caller” should be thought of not by distance but rather the ability to answer Key Questions about the patient. Certainly, the caller does not need to be in the same room as the patient to be considered a second-party caller, provided the caller has access to the patient and is able to answer questions. Even a third-party caller may be considered second party if a quality assessment can be obtained from his/her recent memory of seeing the patient.

According to the definition in “Principles of EMD”: The second-party caller is directly involved with and in close proximity to the person having the problem. A second-party caller may be the friend who was with the patient when she collapsed, or someone who was in an auto accident and is unhurt, but is calling to report someone else who was injured.

Please let me know if you have any additional MPDS® questions.

Brett

Claude:

“Party caller” should be thought of not by distance but rather the ability to answer Key Questions about the patient. Certainly, the caller does not need to be in the same room as the patient to be considered a second-party caller.
**A FIRST FOR EUROPE**

Oldenburg Comm. Center goes live with PPDS

Audrey Fraizer

Alexander Militello is a straight shooter. He doesn’t sugarcoat.

The EPD Instructor and Quality Management Lead for the Oldenburg Communication Center in Lower Saxony, Germany, lays it right on the line when discussing the long road to implementing the Police Priority Dispatch System™ (PPDS®) in a new building merging six police communication centers into one.

“When I look back, I would change a few things,” Militello said during his NAVIGATOR 2015 presentation (“Implementation in Oldenburg, Germany”). “I don’t know if the changes would have affected us in the long run, but it might help future implementations in Germany. I am hopeful there will be many because I am very confident in the quality of the protocol.”

PPDS was actually the caboose on a succession of a total systems overhaul over a four-year period, challenging Oldenburg’s communication staff. In 2011, six separate dispatch centers in Lower Saxony merged into a single, two-story building that was a wondrous prelude to the new future of communications.

“My impression when I entered the building: wow,” Militello said. “And I don’t lie. This was very impressive.”

This interior was airy and modern. There were windows looking out into a landscaped pavilion. Floor space was spacious and workstations were ergonomic.

The configuration of workstations would ultimately transform the mode of communications the living room style encouraged, which was common among the small space in the former centers shared by four to five staff members. Now there would be 126 people, with fully trained police officers at the controls of calltaking and dispatch—15 each per three shifts answering and dispatching calls—in a 3,200-square-meter (approximately 10,500 square feet) space attached by corridor to the Oldenburg police station.

The operations floor was designed with calltakers and dispatchers sitting at stations on opposite sides of an aisle in the same room. They would handle a volume of 220,000 calls per year from a population of 2.4 million in roughly 15,000 square kilometers (approximately 9,300 square miles) of northwest Germany. A spiral staircase at the back of operations led to training and special ops rooms upstairs.

Technology and training took a quantum leap.

Four high-definition screens took the place of spiral bound notebooks, maps, and phone directories. Headsets replaced telephones, and desktop microphones used for dispatching resources were assigned to the pile of obsolete equipment in favor of digital radios. An education and training section that Militello oversees went into effect on the same day the first group of employees were assigned to begin a five-day training course on the new CAD system.
“Everyone was overwhelmed in a good way,” Militello said. “We jumped 20 years in a day.”

**Major leap forward**

The gap or silent spot in the middle of the communication center, however, was a detail alerting Militello to a situation that did not exist in the closer quarters of the living room type dispatch centers. It was more than a visible space issue.

“That is the thing that allows me to stand in front of you today,” he said. “We could no longer communicate in the same way.”

Dispatchers and calltakers separated into two sections meant the former model of vertical dispatching was out. A call would not be the interrogation and dispatch responsibility of one person from start to finish.

Militello moved to horizontal dispatching. Two people would be performing the two functions in parallel. A calltaker on one side of the aisle and a dispatcher on the other side would communicate through a CAD system. There would be no gap in communications with the caller. While the dispatcher was sending response, the calltaker would be gathering information.

Horizontal dispatching—the separation of functions—opened the door to new opportunities. The calltaker could provide more assistance since dispatching resources was no longer part of the same function. Consolidation of centers and cross-training in the separate functions also brought another factor to light.

“Interrogation was subjective in nature,” Militello said. “New standards were urgently needed. We wanted a process that provided consistency.”

Militello’s search led him to Salt Lake City. He liked the system described, and despite early misgivings from his colleagues regarding the sensibility of adhering to scripted protocol developed in America, he was given the go ahead and appointed project manager by Chief Heiko von Deetzen for PPDS version 4.2 implementation. Oldenburg would be the first German-speaking city to use the Police Protocol.

Things started happening fast. A class of 16 attended the first EPD certification class in June 2014. At the end of the three-day certification course, hesitation was evolving into “Why did we wait so long?”

“They were asking how we managed so many years without scripted protocol,” Militello said. “They no longer wanted calltaking without structure.”

**Tweaking the system**

Priority Dispatch System™ (PDS™) German Language and Localization Specialist Victoria Cheema completed the PPDS translation into German, and she—along with Irena Weight, Director of Protocol, Translation, Curriculum and Instructional Design, and Chris Knight, Chief of Program Management & Implementations—traveled to Oldenburg to attend a meeting of the International Academies of Emergency Dispatch (IAED™) German Cultural Committee, spending an intense three days reviewing the translated dispatch system one protocol at a time.

They returned to IAED headquarters in Salt Lake City, their work cut out for them during the six months remaining until the March 2, 2015, go live date. On the plus side, the accuracy demanded of protocol complemented the German penchant for precision. The work included both revising the translation to fit the German police terminology as well as modifying some of the ProQA® logic design to reflect the processes of German law enforcement.

“We had to adjust the logic system to their reality because some of their laws, training, and calltaking practices differ from North America,” Weight said.

What is said in English cannot always be expressed easily in German, said Cheema, who is also translating the Medical Priority Dispatch System™ (MPDS) Version 13.0 into German. Cheema said the main challenge was translating the clear and concise English sentences into “short” German sentences, as German usually requires longer sentences (longer words, more complex structures, etc.).

“Other than that, the challenges were obviously content related,” Cheema said. “We needed a translation that fits the German culture, while keeping the meaning, structure, and intent of the English text.”

Militello said the translation had to be on a broad scale.

**They were asking how we managed so many years without scripted protocol. They no longer wanted calltaking without structure.**

At the same time, there were adjustments to software. The existing catalog of response key words was adjusted to respect German police procedures without losing DETERMINANT DESCRIPTOR patterns established in ProQA. An interface in the CAD system purchased during the Oldenburg construction phase did not work seamlessly with ProQA. PDC™ European Implementation Specialist Mario Foletti was called in. The interface was modified.

They made the deadline.

“This is a compliment to Militello and the Oldenburg team,” said Knight, who taught the initial EPD certification course through a German translator. “They accomplished an intense amount of work in a limited period of time.”

The “few things” Militello would modify have more to do with preparatory stages for the user rather than the protocol and its application.

“That’s where we would make significant changes,” said Militello, a police officer since 1995 and in emergency communications for the past 10 of those years. “I would have prepared employees earlier and provided more information in advance about the restructuring of our calltaking process.”

Work remains. The German version of PPDS version 5.0 is in the translation stage, and the center anticipates becoming an ACE.

Militello said it hasn’t been easy leaving their comfort zone.

“We are pioneers, and not everyone volunteered for the adventure,” he said. “There is still a lot ahead of us, and we continue to welcome the challenge.”
UK NAVIGATOR was once again a resounding success, with more than 100 people from countries including England, Scotland, Northern Ireland, and Greece attending the conference held Sept. 22–24 in Bristol, England.

The reception held prior to the official start was well attended and offered an occasion to catch up with friends and colleagues. Scott Freitag, President, International Academies of Emergency Dispatch® (IAED™), kicked off the conference with the ACE and Dispatcher of the Year (DOY) awards during the Opening Session on Sept. 22.

Jerry Overton, Chair, IAED Board of Accreditation, presented an ACE re-accreditation award to East Midlands Ambulance Service; this is the agency’s third re-accreditation, having achieved the initial ACE designation in 2006.

East Midlands Ambulance Service provides dispatch services from two centers—Nottingham and Lincoln—serving a population of 4.8 million and covering 6,425 square miles across East Midlands (Derbyshire, Leicestershire, Rutland, Lincolnshire, and North and North East Northamptonshire). The two centers respond to approximately 616,000 emergency and urgent calls each year.

Building on last year’s success, the Academy extended invitations to the short list of 10 DOY nominees (from the initial 24) to attend the award presentation, with winner Zoe Scott announced by Beverley Logan, IAED Accreditation Officer. Scott is an EMD for the North West Ambulance Service, NHS Trust. (See accompanying story on page 21.)

North West Ambulance Service, NHS Trust was established in 2006 with the consolidation of the Cumbria, Lancashire, Mersey Regional, and Greater Manchester ambulance services to provide ambulance and prehospital care services to northwest England.

UK NAVIGATOR included sessions exploring quality assurance, customer service, continuous dispatch education, and protocol, among other relevant topics. The Academy also offered Q certification and recertification workshops.

RESOUNDING SUCCESS
More than 100 people gather for UK NAVIGATOR

Louise Todd
A two pence (2p) coin hidden in a sofa cushion brought far more than Zoe Scott could have ever bargained for without even spending it.

And, the North West Ambulance Service, NHS Trust, EMD couldn’t be more delighted that it worked out that way.

The story begins with 2-year-old Archie Davies who was watching TV and, like kids his age, exploring the world with his hands and finding small stuff between the cushions of the settee that might taste good. This time, however, his find wasn’t something edible; it was a 2p coin he found and put in his mouth that, when he leaned back, lodged in his throat.

The toddler was in obvious dismay, quickly alerting his mom, Vicky Martin, to the emergency. She frantically dialed 999, and Scott, answering the call, provided PAIs for the abdominal thrusts that ultimately dislodged the coin and saved his life.

Martin was, of course, elated.

“I’ve never been so frightened in my life,” Martin said, according to an article in the Great Manchester Evening News (published June 18, 2015). “Zoe answered my 999 call and somehow managed to completely calm me down and talked me through exactly what I needed to do. She was able to convince me that it was going to work. That day Zoe turned up for work, we found our guardian angel.”

Archie was able to meet his guardian angel in person when Scott visited their home to meet the family. Mom gave Scott a bouquet of red roses, daisies, and irises and thanked her profusely for the over-the-phone PAIs and reassuring voice.

“When Archie had the 2p coin stuck in his throat, as you can imagine, I was in a complete state of hysteria,” said Martin, as quoted in the same article. “Without her calming influence and prompt instructions, I know for a fact that my little boy would have died. He wasn’t far off when we got the coin out.”

Scott was equally delighted by the outcome and the opportunity to meet the people she had helped while doing her job.

“It was great to meet Archie and his mum,” Scott told the reporter from the Great Manchester Evening News. “Things like this make my job worthwhile and it’s lovely to feel appreciated.”

Scott received the UK NAVIGATOR IAED™ Dispatcher of the Year Award at the conference held Sept. 22–24 in Bristol, England.

Louise Todd, Clinical Support Officer, Priority Dispatch Corp.™, said Scott is a credit to the profession and the Medical Priority Dispatch System™ (MPDS™).

“Zoe has faced this and many other distressing calls over the course of her career; however, she continually demonstrates the ability to work well under stress,” Todd said. “She has demonstrated compliance to protocol and strives to continuously achieve this.”

According to her nomination, Scott “demonstrated with this call, and the many others that she takes every day, that she puts the needs of the public above her own. The media interest that this story gained due to Zoe’s actions assisted in improving the public understanding of emergency dispatching.” She is a strong team player and “a positive influence to her colleagues in demonstrating the standard expected of our EMDs.”

GUARDIAN ANGEL

Star shines at UK NAVIGATOR

Beverley Logan

Zoe answered my 999 call and somehow managed to completely calm me down and talked me through exactly what I needed to do.
THREE DAYS, THREE ROOMS, THREE LANGUAGES

Euro NAVIGATOR offers one fabulous event

Paul Engelen

Three days, three rooms, and three languages might sound like a parody of European travel, but for the 160 people attending Euro NAVIGATOR, it was probably the best packaged three days ever and all while staying in the same place.

Euro NAVIGATOR—held from Wednesday, Sept. 16 through Friday, Sept. 18 in Leiden, South Holland, Netherlands—was the epitome of giving something valuable to every Italian-, Dutch-, and German/Austrian-speaking user of the Priority Dispatch System™ (PDS™). And due to slight cultural nuances in each language-specific version of the fire, medical, and police protocols, the International Academies of Emergency Dispatch® (IAED™) sponsored three conferences in three rooms in one Dutch city under the same protocol umbrella.

The daily division, however, made no difference to the enthusiastic like-minded audience.

“The days were full with lots of discussions and presentations, and in the evening we took every opportunity to talk with each other while having a good meal and a nice drink,” said Paul Engelen, EMD, ED-Q™, IAED Instructor. “It’s really great to talk in so much depth to people who have the same interests.”

The conference opened with everyone gathered in the same room to hear introductory remarks by IAED President Scott Freitag and Leiden Mayor Henri Lenferink, who provided an entertaining welcome and, as a former historian, gave his listeners a brief history of the city. An unexpected surprise was the arrival of IAED Founder Jeff Clawson, M.D., on Wednesday.

An emotion-filled sound clip from a 112 emergency call galvanized the audience and served as the segue for the annual Dispatcher of the Year Award, presented by Harm van de Pas, M.D., Medical Manager, Regional Ambulance Service Brabant Midden-West Nord, Den Bosh, Netherlands, to Sjef Taabe, of the same center.

In an unexpected twist, the grateful recipients of Taabe’s MPDS™-driven Pre-Arrival Instructions for the delivery of baby Esmee came on stage.

“It was moving for everyone when Sjef reached out for baby Esmee, softly whispering her name, and had a moment with her and the family,” Engelen said.

In a second presentation, staff from 144 Notruf Lower Austria received the center’s medical re-accreditation award. In 2009, the center became the first medical ACE in continental Europe and has been re-accredited two times since.

Presentations ruled the rest of Wednesday, Thursday, and part of Friday. Events drawing everyone together included a tour of the National Ambulance and First Aid Museum in Leiden and an evening beach party in Katwijk, a coastal town of the North Sea in the South Holland province, both hosted by the Regional Emergency Medical Service Hollands Midden (RAVHM).

“The conference was a success in every way,” Engelen said.
EMD Sjef Taabe, Brabant Noord, possesses the confidence, mastery, and tenacity to gain the recognition of peers, managers, the IAED™, and the people he assists when they call 112.

“Sjef is first among his peers,” said Brabant Noord Dispatch Center Manager Harm van de Pas, M.D. “He has mastered the skill to challenge his colleagues to improve their skills and at the same being loved for doing so.”

With so much acclaim—on so many sides of the emergency call—it’s little wonder that Dr. van de Pas nominated Taabe for the Euro NAVIGATOR IAED Dispatcher of the Year award at the conference held Sept. 16–18 in Leiden, Netherlands.

Taabe accepted the award in a way demonstrating the very qualities he brings to emergency communications and, also, in typical Dutch style of shying away from public recognition.

“As a calltaker and dispatcher I’m used to working in the background and not in the spotlight,” Taabe said to Ingrid van Schalm, MSO, Meldkamer Noord Nederland (Netherlands), in an interview following the award. “So when I was called to the stage to receive the award, I was a little bit unsure. I also told my colleagues that I wasn’t very happy with them at that moment.”

It didn’t take long for those feelings to dissipate when the people in the 112 call highlighted as part of the presentation joined him on stage.

“I met the two proud, lovely parents and their children, including Esmee, the baby of the delivery,” he said. “It was an amazing feeling to have Esmee in my arms, knowing that a few hundred eyes were watching me. The call still echoes in my ears, and they are big.”

The many compliments and congratulatory words Taabe received in result of the award also intensified his already-deep appreciation of the profession.

“It is very special to have a headset on my head and help callers and patients in a structured way in every known emergency situation,” Taabe said. “I realize even more what a fantastic job I have as a calltaker and a dispatcher—the strength and motivation of my team, and how driven my organization has to be to ensure the ultimate goal of patient safety. So am I proud of this award and what we achieve every day with our team? Of course.”

Taabe is a nurse with many years invested in the Ambulance Control Centre (MKA) prior to the switch to the MPDS™. The process and the subsequent improvement in patient care soon turned him into a staunch advocate and vehicle for promoting quality assurance. His quick grasp of protocol and charisma naturally led to the drive to infuse the same enthusiasm into the rest of the team.

And he’s not afraid to use his calls to demonstrate how he could have done better.

“That takes courage,” Dr. van de Pas said. “It requires a great professionalism to do this in the context of all nurse-dispatchers being unsure about a newly introduced system.”

Those outside the control center also feel Taabe’s positive influence.

“He’s truly impressive,” Dr. van de Pas said. “He is able to take a 112 call strictly according to protocol and combine that with a nearly unprecedented empathy that is very much appreciated by callers and their loved ones.”

**FIRST AMONG PEERS**

**EMD wins award and meets caller**

Ingrid van Schalm

*Photo by Ingrid van Schalm, Meldkamer Noord Nederland, Netherlands*

*It was an amazing feeling to have Esmee in my arms, knowing that a few hundred eyes were watching me. The call still echoes in my ears, and they are big.*
Foundations of Motivation
How comm. center professionals find the will to succeed

Josh McFadden

A dispatcher with even only a handful of years’ experience is already an industry veteran. If you have worked as a dispatcher for four years or more, you have exceeded the average time in which a person stays in the profession. Why do some people leave the headset and monitors behind within a few years and why do some people stay at their seat year after year?

The answer ultimately may lie with the concept of motivation. The latest figures from the U.S. Bureau of Labor Statistics show that the average U.S. worker is in his or her job for 4.6 years. This may seem low, but the figure has actually risen steadily since the early 1980s. In fact, as recently as 2002, the average time in a job for U.S. employees was 3.7 years.

Still, dispatchers have always lagged behind in longevity. Tonya Warr, communications officer for Fayette County (Ga.) Communications, said three years is the norm for a dispatcher’s career. Warr, who recently presented on the subject of motivation at NAVIGATOR in Las Vegas, said several factors contribute to this shorter-than-normal tenure. For the most part, it comes down to continually dealing with traumatic situations.

“It’s the nature of the job,” Warr said. “No one calls 9-1-1 because they are having a good day.”

Pick any day of the year, and a dispatcher may take a call where the person on the other end is describing harrowing events of heart attacks, strokes, seizures, choking, drowning, burning, criminal activity, or devastating accidents. A dispatcher’s job is to calmly and professionally—but with care, concern, and compassion—assess the situation and help the other person administer care and relief to themselves or to those they are calling for until emergency responders arrive on the scene.

But sometimes, dramatic call after call can affect the dispatcher, leaving the person feeling the effects of post-traumatic stress disorder or feeling burned out and seeking other ways of earning a living.

“It takes a lot of personal and professional maturity to overcome burnout,” Warr said.

Warr, who has 13 years’ experience in the profession, said often by year three a dispatcher will either be ready to move on or will realize his or her true motivation for performing this important public service. She related a story in which she had hit her three-year mark as a dispatcher. Her attitude was poor, and her motivation for doing the job wasn’t what it should have been. As a result, her demeanor and level of service was below acceptable.

“When I was at my three-year mark, I answered a call and had the ugliest tone in my voice,” Warr said. “The last thing this person heard before committing suicide was my tone. Since then, I’m never at work when I don’t smile—no matter what goes wrong. People tell me on the phone that they can tell I’m smiling. People know there’s a friend.”

Be a servant-leader

Warr learned at the critical three-year point what a dispatcher’s motivation should be: to provide service to those people who are in their worst moments. Other successful dispatchers have caught the spirit of what this critically important profession is all about.

Patricia Jones, ENP, Terminal Agency Coordinator for Charleston County Consolidated 9-1-1 Center in Charleston, S.C., knows a thing or two about serving the public. She has worked in the profession for 16 years, and she is a certified Emergency Telecommunicator Instructor (ETC-I) for the International Academies of Emergency Dispatch® (IAED™). She presented at NAVIGATOR 2015 on the topic of motivation. Her presentation was titled “How to be a Servant-Leader in a Self-Serving World.” Portions of the presentation were based on the book, “The Purpose Driven Life: What on Earth Am I Here For?” by Rick Warren, founding pastor of Saddleback Church. Jones contends that in the dispatch world motivation comes by learning to get along with all the people with whom you interact.

“People want their humanity acknowledged and respected,” she said.

Jones insists that a dispatcher should strive to have positive interactions on the phone with each caller, and be part of a
do things without the need to receive recognition. These are people who recognize they have gifts and talents to use to help others.

For some people, being a servant-leader comes naturally. For others, it takes practice and conscientious effort. But it is possible to develop this trait.

"It can be learned, but you have to be willing to sacrifice and put yourself second," Jones said. "You have to want it. Some people will buy into it, and some people won't. Some people are never going to reach this attitude because they are resistant to changes."

At Charleston County Consolidated, considerable emphasis is placed on the idea of servant-leadership. Jones tells prospective dispatchers that if they don't enjoy serving others, they will not be successful in their jobs. Those who possess this trait or who can foster it, are much more likely to have that motivation they need to rise above the daily challenges of the profession.

**Living the dream**

Andre Lanier certainly does not lack motivation. The longtime educator exudes enthusiasm, and he has spent his career teaching others how to be the best at what they do and to love it at the same time.

Lanier is a Lead Contract Instructor with Computer Sciences Corporation. He retired from the U.S. Navy in 2009 and has been teaching for about 25 years, both in the Navy and outside. During this time he has taught about Crew Resource Management, Leadership, Management, Mentorship, Ethics, and Motivation.

At NAVIGATOR 2015, he presented sessions on Crew Resource Management and motivation (life in general). He believes that motivation comes from "living the dream." And living the dream to him does not mean owning a huge house, driving a fancy car, or having the latest and greatest products and fashions on the market. Living the dream means placing your heart and desires on the things that matter most. This comes from within and breeds motivation.

"Self-worth does not equal net worth," Lanier said. "There are many more good things going on than you realize. We need to focus on family and friends instead of materialism."

He also says when you have this outlook, your entire frame of mind changes, and you begin to look for ways to get along with and help others. Your motivation changes from yourself to your loved ones, neighbors, friends, and co-workers.

"You control a lot of destiny with yourself and others," Lanier said.

As a telecommunicator, "living the dream," as Lanier describes, gives you an advantage to handle the rigors of the job. Lanier advocates staffing a comm. center with self-motivated people who understand this concept.

"We want to hire people who have an intrinsic desire to be there," Lanier said. "We hope we can find the right people."

Still, he is certain that with the proper education and resources, people can learn to "live the dream," improve their motivation, and find ways to motivate themselves.

"Some people need to be trained to be motivated," he said. "A lot of people can be
motivated if they’re given the right tools. We need continued education. People need to know we have your back.”

Lanier said telecommunicators are unsung heroes and that their service is “honorable.” He also pointed out that the job can often be thankless and that the current 19 percent turnover rate in the profession is largely due to stress, much in the same way the telecommunicator’s career span is only three years, as Warr pointed out.

In his courses, Lanier teaches that despite the taxing environment, the motivation to succeed by helping others and the motivation to enjoy the job can lead to a rewarding career. He also emphasizes that motivation grows as group members learn to work together.

“The team has to understand than not one person can do it by himself or herself,” he said.

**Butterfly effect**

Within the subject of mathematics is a field of study called Chaos Theory. This theory “deals with nonlinear things that are effectively impossible to predict or control, like turbulence, weather, the stock market, our brain states, and so on.”

Part of this theory includes the idea of the Butterfly Effect. The Butterfly Effect essentially states that small changes can create larger changes. A popular example is the idea that an earthquake in one part of the world can be caused by the flapping of a butterfly’s wings on the other side of the globe. Some people also call this the Ripple Effect.

Warr said the Butterfly Effect is present in the dispatch profession.

“The smallest things—teaching people, doing good—can create ripples in performance, attitude, and behavior,” she said.

With this in mind, Warr and the staff in Fayette continually support one another and motivate one another through the good and the bad. It starts in the interview process before a person is even hired to work in the comm. center. Staff members give a presentation to prospective dispatchers, outlining everything entailed in his or her daily duties, including the travails that so often bring people to leave the profession.

If, after the presentation or even after being hired, the person isn’t able to handle the challenging responsibilities, or if the person lacks the motivation necessary to succeed, Warr said it might be best for the dispatcher to choose another path. She also said it’s appropriate to get assistance when necessary.

“There’s no shame in saying ‘This isn’t for me,’” she said. “Do it before it gets to the point where you have a bad attitude. It’s OK to get help—be ready to recognize when you need it.”

True to the Butterfly Effect, lack of motivation in the individual leads to an overall somber mood in the comm. center. This can lead to disastrous results.

“Performance is at its worst when morale is down,” Warr said. “That’s when people stop caring.”

On the other hand, motivation can be reborn or strengthened simply by talking to managers or co-workers. An effective training program, such as the one found at Fayette County Commu-

Sources


Finding Help
Resources for public safety professionals are available

Matter of life or death
Suicidal caller most often has plan in motion

Simon Delisle and Audrey Fraizer

As a professional EMD, Simon Delisle believes he made the right choice for a career. After all, he is a person who likes to help others, and in the communication center he can do just that without ever asking about payment.

“It’s ideal,” he said. “We are the first line of help.”

So, what happens when a dispatcher can’t help because the person calling has no intention to follow the advice given? Rather than a call to seek assistance, the caller has imminent plans of ending his or her own life and admits the intention independently or it’s discovered through the calltaker’s questions.

“It’s more often the MPDS helping us to figure out what’s going on, and, at this point, we can try to establish a personal connection,” he said. “It can help, but don’t expect miracles.”

Statistically (see sidebar on page 29), chances are high that a 911 calltaker will answer a call placed by a suicidal individual. Delisle goes one step further in his assessment, particularly for people in the 911 business for the long haul.

“It’s not a matter of if you’re going to get a call from someone suicidal,” Delisle said. “It’s more a matter of when.”

Delisle has answered calls from individuals threatening suicide—more of a call for help—and from individuals who have made the decision and are calling 911 immediately preceding taking their lives to save their loved ones the pain of finding the remains. The former made up the greater percentage of calls during volunteer work with a suicide prevention line; the latter is more likely for 911.

“The 911 caller is often at the edge of the act,” he said. “For someone that close, stalling until help arrives is your best bet. Stay on the line.”

How do you stall an individual on the critical threshold?

“Get the person to talk to draw attention somewhere else while help is on its way,” he said. He also suggested paying close attention to the caller’s tone of voice and the language used—“I’m thinking of ending it all” versus “I’m going to kill myself.”

Staying on the line can be crucial.

“Sometimes even talking can give the person relief,” Delisle said. Jim Marshall, Chair, 911 Wellness Foundation, emphasizes engagement, and it can begin with something as simple as asking the caller’s name and addressing the caller by name throughout the call.

“Appeal to that person’s will to live,” he said.

The steps
Delisle’s career in emergency dispatch was interrupted briefly with a job at a suicide hotline after completing a degree in psychology and psychoeducation.

“It’s kind of a hybrid between counselor and social work,” he said. During his tenure at the hotline, he noticed the similarity between the two professions. They both correspond to assisting people in crisis and, consequently, they
both appealed to the altruism he looks for in a job. He returned to dispatch, a profession requiring his compassion and ability to coordinate the complexity of response.

“I came back to the headsets,” he said. The time away, combined with his degree and experience, taught him a valuable lesson. People in the dispatch position can better negotiate with the distraught/suicidal caller when understanding the suicidal planning steps.

“Awareness creates empathy,” he said. “You can better put yourself in the caller’s situation.”

Step 1: Distress. An obstacle that requires a solution confronts the individual; this could include finances, personal relationships, or job loss.

Step 2: Flashes. No solution seems to work and the individual feels let down, frustrated, or depressed and wants a way out.

“The person’s not really thinking about dying,” Delisle said. “It’s more about pressing the restart button and making the obstacle go away.”

Step 3: Ideation. Suicide becomes a possible solution, and the individual considers scenarios of how it could be done.

“At this point, the person might recognize his thinking has gone too far and call a suicide hotline,” Delisle said. “The thinking is telling the person he needs help.”

Step 4: Rumination. Suicide becomes the focus, the definitive way to make the problems go away.

“The person begins to make plans,” Delisle said.

Step 5: Crystallization. The decision is made; suicide is the only viable option.

“Planning can include how and who will find him,” Delisle said. “He might call 911 to alert others [than his family or friends] where he can be found.”

Step 6: Acting out. The person carries through with plans.

Of course, nothing is 100 percent predictable, Delisle said.

“Any person can go from one step to another, skip steps, or go back steps,” he said. “That’s why it’s important to explain the steps people thinking about suicide go through.”

Don’t take blame

Recognizing the steps, however, is certainly no guarantee that the result will work to the advantage of a caring individual. Admittedly, every 911 call presents the possibility of serious injury or death, and suicide is certainly not an exception. It’s similar to any situation, Delisle said: “We can’t blame ourselves.”

The trauma of a caller threatening to and actually ending his or her life takes an emotional toll on the dispatcher on the line. Delisle took an immediate break from the phones the time his caller committed suicide while he was still on the line.

“I talked to two colleagues that I knew wouldn’t judge the way I was feeling,” he said. “I thought the next would be too difficult after what happened, but I went back to the floor anyway.”

Ultimately, the dispatcher has to decide what to do next. At some point, he said, the dispatcher has to seek relief and that can be achieved through talking to someone, exploring spiritual beliefs, and understanding the limits of intervention.

“Accept we are not superhuman,” Delisle said. “We are human. We did all we could do.” Marshall agreed.

“We never want to default to the position that there’s nothing that can be done,” he said. “But we are not God.”

Mental health influences suicide rate

Majority committing suicide have mental illness

Simon Delisle

Between 80 and 90 percent of people who commit suicide have mental illness, and the primary mental health disorders associated with higher risk of suicide are depressive disorder, bipolar disorder, schizophrenia, and anxiety disorders (post-traumatic stress disorder (PTSD), panic attacks, and phobias).1

Depressive disorder

According to the World Health Organization (WHO), globally, more than 350 million people of all ages suffer from depression.2 Not counting the effect of secondary disease states associated with depression (e.g., diabetes and cardiovascular disease), by the year 2020, unipolar depression is projected to be the second-leading cause of disability worldwide and the leading cause of disability in high-income nations.3

Bipolar disorder

People living with a bipolar mood disorder are at risk during the depressive and manic phases. During a severe depressive episode, it is unlikely that the individual can continue with social, work, or domestic activities, except to a limited extent; manic episodes involve elevated or irritable mood, over-activity, inflated self-esteem, and a decreased need for sleep.4

Between 30 and 70 percent of suicide victims suffer from major depression or bipolar disorder.5

The numbers, however, do not fully reflect the prevalence of mental health disorders. For example, two-thirds of people in the world with depression do not realize that they have a treatable illness and do not
seek treatment. Only 50 percent of people diagnosed with major depression receive any kind of treatment, and only 20 percent receive treatment consistent with current practice guidelines of the American Psychiatric Association (APA).6

Schizophrenia
Up to 40 percent of the mortality rate can be attributed to suicide; the estimated lifetime suicide risk is 4.9 percent for people with schizophrenia.7

Anxiety disorders
These types of disorders are caused by a combination of factors, including changes in the brain and environmental stress. While credible, international statistics are difficult to come by. An estimated 40 million adults in the U.S., or 18 percent, have an anxiety disorder. Most people develop symptoms of anxiety disorders before age 21. Women are 60 percent more likely to be diagnosed with an anxiety disorder than men.8

So, when a caller admits to a mental health issue, please remember that this person is more at risk, needs more empathy, and would benefit greatly from staying on the line with you.

Sources
4 See note 2.
6 American Psychiatric Association. “Practice Guideline for the Treatment of Patients with Major Depressive Disorder (3rd edition).”

To thyself be true
Suicide calls convince dispatcher to put dream job on hold

Audrey Fraizer

The black armband Ryan Dedmon wears around his upper right arm is a reminder of the profession and people he holds dearly but chose to leave—at least temporarily—for his own well-being.

Dedmon is a former dispatcher for the Anaheim Police Department (APD), Calif. In mid-November 2013, he emptied the contents of his locker and walked away after 11 years in a law enforcement career he adored.

Dedmon did not want to transfer to another position within the department and he did not want to go out on disability.

“I did not think I would be able to walk around the department with my head held high with people knowing I was transferred to another position because I was incapable of fulfilling my duties in dispatch anymore,” Dedmon posted in a segment of his four-part series detailing his career and decision on the blog Operation 10-8.

He was also determined to confront the demons—acute stress disorder and post-traumatic stress disorder (PTSD) directly related to his job—forcing his hand.

And in the past two years, he has done just that. He keeps busy but in a healthier sort of way than the workaholic habits he used to deflect his emotional imbalance while in dispatch.

Dedmon’s blog (operationt8.com) honors first responders and addresses PTSD through his personal narrative. He’s an adjunct instructor for the Criminal Justice Training Center at Golden West College in Huntington Beach, Calif. He is a volunteer for the Orange County Sheriff’s Advisory Council’s Project 999, which provides financial assistance to families of officers killed in the line of duty, and the 911 Wellness Foundation, established in 2011 by Clinical Psychologist Jim Marshall.
“Jim was a game changer for 911,” Dedmon said. “Dispatch was overlooked. We were neglected. Whether or not it was intentional, I don’t know. It’s just the way things played out.”

Although several PTSD relief organizations existed within EMS, the first link in response was not given the benefit of acknowledging stress; Marshall recognized that something needed to be done. The foundation that grew out of his concerns is devoted to the psychological and physical health of dispatchers. The nonprofit organization, governed by a board of mental health experts and career emergency communication representatives, conducts research, sponsors national forums and workshops, and—vital to Dedmon’s journey to wellness—it provides a platform for discussion and support.

As Marshall explained, the 911 Wellness Foundation is not a service organization; it was created to fill a niche that few recognized needed filling prior to his work.

“We are devoted to the wellness of telecommunicators, 24/7,” he said. “By pushing the topic, the foundation has helped bring it to the forefront.”

Dedmon is a subject matter expert for the foundation’s board, and he is a compassionate voice and face in the dispatch community.

People follow his advice: “Take care of thyself” because, “If you don’t, you’re going to reach the point where you can’t help anyone else.”

In other words, “Find your happy place,” those things you liked to do before the job ate away your life, he said. Dedmon likes to search out friendships that do not require hyper vigilance, or the assumption that he is there to save their world. He distance runs. He shares his story and has been shocked by the response.

“It’s overwhelmingly positive,” he said. “The audience relates. They thank me for being the voice, and by reading my blog or listening to me speak they can better cope knowing they’re not alone.”

Destined for the job

Dedmon was destined for public service, favoring the TV shows “Law & Order” and “Matlock” in his youth and anticipating the day he would exchange his civilian clothes for a police uniform. During his last semester in a criminal justice degree program at Biola University (California), he accepted an internship in the gang division of the APD. He met his career mentor, Officer Kathy Johnson, Background Investigator in the Personnel Division.

The police job he eventually landed at a neighboring department did not satisfy his true ambition. He wanted to be involved from the start and be part of a team that got an adrenaline kick from helping to apprehend the bad guys, getting response to the scene, and trying to keep the scene safe for police officers and bystanders. He quit the force and returned to the APD, this time in the communication center.

“I loved dispatch,” he said.

A fringe benefit he hadn’t anticipated was working alongside Johnson; the officer had transferred to dispatch when cancer and the debilitating treatment she received forced her into a less physically demanding duty. They worked well together.

“She treated me like a colleague at her peer level instead of as a mentor,” Dedmon said.

Life was good until four months into the job when he received “one of the worst phone calls imaginable.” Johnson was dead. She had committed suicide at home, leaving a note on the door giving special notification instructions for the police arriving on scene. She could no longer tolerate the illness and its effects.

“I found myself swimming in a wide range of emotions, doing my best just to stay afloat, like a dog paddling in the open ocean,” Dedmon wrote on his blog. “Her death deeply troubled me.”

He turned to what he calls “occupational therapy.”

“I did what I do best: work, work, work,” Dedmon said.

Dedmon worked so hard that in 2012 he was selected Telecommunicator of the Year for Southern California.

Overtime, volunteer commitments, and holidays skipped to cover open shifts kept his emotions at bay. He took the shootings, stabbings, rapes, robberies, assaults, and other violence in stride. But nothing prepared him for the call he answered on a Saturday afternoon in spring 2013.

“911 Emergency.”

“I need the Anaheim Police Department,” the caller said.

“This is the Anaheim Police Department. Where are you?”
“I'm at a business at 1234 N. Kraemer Pl. in Anaheim.”

“What is your emergency?”

“I am really sorry I had to call you and involve you in this. I have a handgun, and I am going to shoot myself. I will be dead by the time police get here. You will find me outside in the rear parking lot. There is a note I have written in my back pocket. The note has contact information for my family. I am so sorry. Goodbye.”

The caller was dead from a self-inflicted gunshot wound by the time police were able to reach the scene. Although Dedmon had handled other suicidal callers during the three years since Johnson, this call was different.

“Bob was my first gunshot victim,” he said.

He took off a few days from work, and once back got into the same routine; he plunged into the job. Then came a call nearly eight months later, on Halloween. A father called to report that his daughter had shot herself. She was 51 years old, and Dedmon stayed on the line for nearly a minute listening to her gasping for air over the phone the father had placed near her while he let the police in through the door.

This would be the last 911 call that Dedmon would answer and his last day working as an APD dispatcher.

He held on for three weeks, meeting with two officers from the peer support program APD had recently established. The two calls played over and over in his head, taunting his feelings of self-worth in his inability to save the victims. He wept.

Guilt plagued him. He felt responsible for his inability to save the victims. He wept. The two calls played over and over in his head, taunting his feelings of self-worth in his inability to save the victims. He wept.

“Public service is in my heart and mind,” he said. “And I was a damn good dispatcher. But what I will handle better this next time is taking care of myself.”

The Rev. Russ Myers doesn't wait for things to happen, and because of where he chooses to practice his vocation, he doesn't look forward to things that he knows are inevitable. But he's always ready to assist when he can.

“This is a job where distress happens to everyone eventually,” said Myers, the first dedicated chaplain for Allina Health EMS in St. Paul, Minn. “Our people endure a lot of stress, and Allina asked ‘What can we do to help?’”

For starters, the President of Allina Health EMS, Brian LaCroix, coaxed Myers into an on-call position in combination with a full-time chaplaincy position he then held at United Hospital, which is affiliated with the Allina Health System. In less than a year, the .2 FTE (full-time equivalent) had progressed to half time.

“I wrote the job description,” Myers said. “We agreed this would be proactive, not reactive. I'm not waiting in the office for the phone to ring.”

The primary responsibility is straightforward: build relationships.

This is the core of “chaplaincy care” and the philosophy underpins, even enables, all the other dimensions of chaplaincy care to occur, according to doctrine of the internationally recognized Association of Professional Chaplains’ Commission (APC) on Quality in Pastoral Services.

Through establishing relationships, chaplains are better able to move people along a spectrum from feeling emotionally exhausted—through stages of grief, fear, anger, and disillusionment—to an emotionally stable, less stressful place where life can eventually return to normal.

Creating that relationship does not involve proselytizing. Chaplains do not try to persuade anyone to join a religion, cause, or group. They don’t preach religion or demand belief in a higher power.

“I'm not here to convince anyone of our personal religious beliefs,” said the Rev. Albert “Al” Kleinsasser, EMS Chaplain, HealthEast, St. Paul, Minn. “This is not about religion. I am here to offer support.”

The intended recipients define a major difference between hospital (hospice, long-term, and acute care) and EMS chaplaincy. Myers and Kleinsasser concentrate support on staff and to a less extent on the patient, although the role is not mutually exclusive. Primarily, however, they develop relationships with EMS response teams.

“I go on ambulance runs,” said Kleinsasser, who stayed on part time as the Healtheast EMS chaplain when he retired in December 2014 as hospital chaplain. “I sit in back of the ambulance and [when at the scene] go off to the side while EMTs and paramedics are medically assisting the patient. I help the family if need be, but I'm primarily there to support EMS.”

Support is discreet, non-demanding, and non-judgmental.

“This is another avenue of listening by someone in a different EMS role,” Kleinsasser said. “It’s low key. It’s about being there with them, present. They will never remember verbatim what I’ve said. They will remember Chaplain Al was at their side during their time of need.”

Kleinsasser and Myers are available to meet with crew members immediately after an incident, at a debriefing, a follow-up later on, or in response to requests by supervisors in relation to situations that might require their attention. They arrange to meet in a coffee shop as easily as the employee lounge. Neither waits for formal introduction or an incident to spur contact. They do not wait for the
phone to ring, a text or email to arrive, or for a knock on the office door. They go to the places where people work. They ride with the ambulance crews. They don’t push.

“I reach out, recognizing the person might be going through a hard time,” Myers said. “But it’s up to the person to reciprocate.”

Myers emphasized their proactive attitude despite a low-key approach. By developing relationships and building trust, chaplains can respond effectively to an individual in crisis.

“We’re here to provide support emotionally and spiritually, and I don’t want to be a stranger when I show up at the time my support is needed,” he said.

He noted the intensity of dispatch from his first visit.

“I like to see myself as a layer of support for them,” he said. “I am a resource for them not only on the job but also for what’s going on in their personal lives.”

Allina Communication Director Chuck Kaufman said Myers is one of the staff; he never imposes his religion or forces counsel.

“He’s welcomed everywhere,” Kaufman said. “He’s become part of the culture. He participates, reaches out, and I don’t think he has a hard time finding something to talk about.”

Chaplains are also lightning rods for distress, and they learn not to take the emotionally driven outbursts personally. They encourage people to attend to their spirituality, which is not the same as converting to a religion.

“I never tell them where to get it,” Myers said. “I will talk about religion if they want to. I won’t bring it up.”

Kleinsasser said personal beliefs contribute to the work.

“You have to be grounded in what you believe,” he said. “It helps in relating to others, but there’s also a balance. We put our feelings aside. This is about the journey the other person is going through.”

Chaplains are ministers from a variety of faiths who offer a broad range of services that contribute to overall spiritual and emotional well-being. Chaplains are traditionally attached to nondenominational organizations, such as state or federal correctional facilities, universities, military bases, and hospitals and other long-term or acute patient care settings.

They are also highly accomplished professionals. The idea of finding retired clergy to provide chaplaincy services has been largely replaced by strict standards for education, training, and certification.

Myers and Kleinsasser are APC-certified chaplains, having completed an additional 1,600 hours of Clinical Pastoral Education (a residency within a hospital setting) beyond their bachelor’s and master’s degrees. They must complete a peer review every five years and show proof of an annual 50 hours of continuing education.

Practicing his religious vocation outside a church proper was something Myers wanted to do even before accepting the position he helped create. He is a minister for the Evangelical Lutheran Church in America and, after ordination, served as pastor of two rural congregations for 4 1/2 years. He took some time off to pursue an advanced degree, and the program he selected included visiting hospital patients.

“Then the chaplaincy bug bit,” he said.

He completed a one-year chaplaincy residency at a Level 1 trauma hospital in Minneapolis prior to becoming a chaplain with Allina in August 1993; he has been with the company for 22 years.

Kleinsasser is an American Baptist. A college job driving a hearse for a funeral home that doubled as an ambulance in an emergency was a factor in a later decision to join the ministry. In 2006, he transitioned from being a pastor at the First Baptist Church in Winona, Minn., and pursued a chaplaincy program. HealthEast asked him to develop the EMS chaplaincy position nearly four years ago. He contacted Myers and they collaborated.

Both are the first EMS chaplains at their respective agencies. They started at the ground floor and expect the position to continue well beyond their retirements. Inside the system, they are fixtures. Their visibility provides a platform. The two professions—EMS and chaplaincy—also intertwine through an underlying truth that connects them.

“The work never gets any easier,” Myers said. “It just gets more familiar.”

If you’d like more information about starting an EMS chaplaincy program at your agency, you may contact the Rev. Russell Myers at Russell.Myers@allina.com or the Rev. Albert Kleinsasser at ajkleinsasser@healtheast.org.
The Grand Island Fire Department, Nebraska, was among the first agencies outside of Utah to subscribe to the then-new world of emergency medical dispatch (EMD) when it started using the Medical Protocol in 1982. Grand Island was part and parcel to the dawn of dispatch as it had been in the adoption of the paramedic concept in 1980. Paramedic Supervisor, Larry Nelson, lauded the conversion at dispatch from “Attention. Ambulance One. Emergency! Emergency!” to the “Four basic commandments of EMD” (Case Entry Questions) because, as he put it, “Since implementing the new system, several notable changes have occurred.”

Nelson’s praise of the Medical Priority Dispatch System™ cardset—which in 1982 was in version 3—was published as an article in Fire Service Today (December 1983) and in a far-sighted conclusion, Nelson wondered if the 1980s would be as revolutionary for EMD as the 1970s were for EMS training.

Well, we know the answer to that, and during the ensuing 33 years, EMDs have become an integral part of the EMS system. Grand Island has never lost its zeal for protocol, staying a loyal user and advocate as protocol advances to version 13.0.
EMD 'coaching' saves lives

Larry Nelson, REMT-P
Paramedic Supervisor
Grand Island Fire Department, Nebraska

"Attention Ambulance One. Emergency! Emergency! 2408 West 17th, 2408 West 17th, man down, man down, 1910 hours, KRT 765."

Before the Grand Island, Nebraska, city/county 911 dispatchers were trained in Emergency Medical Dispatching (EMD), the above information usually was all they were given before making a response. Not knowing the nature of the problem meant that the fire fighter/paramedics would have to take all advanced life support (ALS) equipment to the patient, even though the equipment is oftentimes unnecessary.

This type of dispatching may be fine for a "you call, we haul, you pay, that's all" type of operation. But for any community that takes its ambulance services seriously, Dr. Jeff Clawson, medical director for the Salt Lake City Fire Department, has developed a 25-hour course that enables the dispatcher to become an integral part of the health care system (see "Strengthening the weak link, Emergency Medical Dispatch priority training," Fire Command, January 1981). The trained EMD may be able to do several important things by questioning the caller using information stored on a flip-card file.

Briefly, here's how the system works. When a call is received, one dispatcher collects basic dispatching information: name, address, problem (the phone number is not needed because of the 911 fish hook system). The dispatcher then follows the four basic commandments of EMD by asking: (1) What is the chief complaint? (2) What is the patient's age? (3) Is the patient conscious? (4) Is the patient breathing? While this information is being collected, another dispatcher dispatches the appropriate personnel for the type of problem.

Meanwhile, the receiving dispatcher continues to ask the caller predetermined questions printed on the flip-card file system developed by Dr. Clawson. The dispatcher may then go on to instruct the caller on how to treat the patient. Instructions for hemorrhage control, rescue breathing, cardiopulmonary resuscitation (CPR), childbirth, and most other emergency situations can be given over the phone. All pertinent information and the progress of pre-arrival treatment are then relayed back to the responding vehicles.

Responses reduced

Since implementing this new system, several notable changes have occurred. Because of dispatcher interrogation, the overall number of emergency responses has been reduced. Before EMD training, crews might speed through hazardous rush hour traffic — creating a danger to the public, ambulance personnel, and to more than $565,000 worth of paramedic equipment — only to arrive and find a routine ambulatory transfer patient with suitcase in hand. Neither the lights and siren response nor the ALS team was necessary.

Another benefit of this system is that it gives the dispatcher a better understanding of the patient's medical condition, information that can be more accurately relayed to the responding unit. The "man down" situation now may be relayed as: "10-78 Ambulance One. This is a 43-year-old office worker who is a known diabetic, has taken insulin this morning, and believe he has not eaten today. This victim is unconscious, however he is breathing." With this type of pre-arrival information, responding ALS teams can anticipate what equipment will be needed and they will have a better overall understanding of the type of call with which they are responding.

At the heart of this system is the Medic Dispatch Protocol, a card system outlining 31 symptoms. Each card has "key" questions, which help the dispatcher determine the seriousness of the call. Then, depending on the information received, medical self-help pre-arrival instructions are given to the caller while he is waiting for emergency personnel to arrive. These easy-to-understand instructions allow the caller to begin treating the patient. In two different instances, callers were able to open a patient's airway so that respiration resumed spontaneously before the paramedics arrived. The benefits of this system for any community are far-reaching.

Although EMD training already has proven to be "just what the doctor ordered" for Grand Island, several problems should be anticipated and dealt with prior to its implementation.

If the effort to direct CPR by phone fails, the victim is no worse off than when the dispatcher received the call.

One problem is the dispatchers' lack of emergency medical training. Instead of training EMTs or paramedics to be dispatchers, the dispatchers took a Nebraska-approved first responder course. Upon completion and after receiving state certification, they then were given the EMD training developed by the Utah State Department of Health and Dr. Clawson. In addition, all of the 911 dispatchers spent some time assisting and observing on ambulance emergency runs.

Another problem is keeping the quality of EMD skills up. In order to do this, Grand Island adopted an EMD Review Board program from the Aurora Fire Department, Colorado. The EMD Review Board meets regularly to audit the quality of the dispatchers' responses via recorded tapes of emergency calls. This board is comprised of emergency room nurses, a fire fighter/paramedic, the paramedic supervisor, the EMD supervisor, and the department's medical director, who is also the supervising emergency room physician.

Evaluations of the tapes then are shared with the dispatchers to help improve the quality of their dispatching and to give them credit for situations that were handled well. The review board is proving to be a necessity for addressing these and other problems.

Legal implications

And what about the legal implications of providing such a service? Let's say a dispatcher gives CPR instruc-
Since implementing the Medic Dispatch Protocol card system, Grand Island dispatchers (above) have reduced the overall number of emergency responses, giving paramedics more time to handle true emergencies (inset).

One wonders if the 1980s will be as revolutionary for emergency medical dispatching as the 1970s were for EMS training.

Grand Island since August 1982, one thing becomes quite clear. EMDs are an integral part of the health care team. Dispatchers always have been the nerve center for the agencies for whom they work. With EMD training, their work is now, more than ever, being taken right into the homes of the communities they serve.

One wonders if the 1980s will be as revolutionary for emergency medical dispatching as the 1970s were for EMS training.

* The entire letter and response on this topic is available upon request by contacting Jeff Clawson, M.D., 2600 Highland Drive, Salt Lake City, UT 84106, or Grand Island Fire Department, 302 South Pine, Grand Island, NE 68801.
1. Not knowing the nature of the caller’s problem meant that Grand Island firefighters and paramedics would have to:
   a. return the call for more information.
   b. send one person to the scene for further evaluation of the incident.
   c. refuse transport until more information was available.
   d. take all ALS equipment to the patient even though the equipment was oftentimes unnecessary.

2. The first of the four basic commandments of EMD is:
   a. Is the patient breathing?
   b. What is the patient’s age?
   c. What is the Chief Complaint?
   d. Is the patient conscious?

3. The second of the four basic commandments of EMD is:
   a. Is the patient breathing?
   b. What is the patient’s age?
   c. What is the Chief Complaint?
   d. Is the patient conscious?

4. The third of the four basic commandments of EMD is:
   a. Is the patient breathing?
   b. What is the patient’s age?
   c. What is the Chief Complaint?
   d. Is the patient conscious?

5. The fourth of the four basic commandments of EMD is:
   a. Is the patient breathing?
   b. What is the patient’s age?
   c. What is the Chief Complaint?
   d. Is the patient conscious?

6. The reason cited for a reduction in the overall number of emergency responses due to the introduction of the Medical Protocol is:
   a. a decrease in the number of callers asking for emergency response.
   b. dispatcher interrogation.
   c. Pre-Arrival Instructions.
   d. increased public awareness of when/why to call 911.

7. How did dispatchers’ pre-arrival information help the responding ALS teams?
   a. Responding ALS teams could anticipate what equipment would be needed.
   b. Responding ALS teams would have a better overall understanding of the type of call to which they were responding.
   c. Both a and b

8. What was at the heart of the early Medical Protocol?
   a. “You call, we haul, you pay, that’s all” type questions
   b. assurance that all advanced life support equipment would be sent no matter the patient’s complaint
   c. freelance questioning of the caller
   d. a card system outlining 31 symptoms

9. The Grand Island 911 center adopted an EMD Review Board program to:
   a. determine the characteristics of a caller willing to follow instructions.
   b. use as a disciplinary approach to protocol non-compliance.
   c. audit the quality of the dispatchers’ responses via recorded tapes of emergency calls.
   d. screen ALS response in relation to the EMD’s information.

10. There can be no liability for a good faith effort that fails, or for leaving a person better off (according to James O. Page).
   a. true
   b. false
MORE THAN JUST A PAIN
Protocol 18: Headache
Josh McFadden

Having a headache is hardly an uncommon occurrence. In fact, the World Health Organization (WHO) states that “nearly everyone has a headache occasionally.” Headaches can vary in severity and duration from a slight annoyance that lasts a matter of minutes, to a life-altering, debilitating condition that is virtually constant.

Sometimes a headache is hardly noticeable, not affecting one’s daily routine or ability to accomplish tasks or enjoy activities. Other times, however, a headache can render children and adults alike incapable of functioning at a normal level.

One type of headache is a migraine, a neurological disease that is much more than simply a bad headache. Migraines are characterized by an intense, recurring throbbing on the side of the head; about one-third of migraine episodes are accompanied by pains on both sides of the head. Migraines also cause other symptoms such as nausea, vomiting, dizziness, visual disturbances, and tingling or numbness in the face, fingers, or toes. Those suffering from migraines also can be overly sensitive to sound, light, touch, and smell.

Migraine sufferers can experience more than just physical pain. It is not rare for people with this disease to have bouts of depression, anxiety, or trouble sleeping.

The statistics
It may be surprising to some just how prevalent migraines are. If you regularly combat migraines, you are hardly alone.

In the United States, about 38 million people suffer from migraines. This amounts to more than 12 percent of the population. One in seven people on Earth experience migraines. Interestingly, migraines affect three times as many women in the U.S. than they do women in other countries (18 percent vs. 6 percent). And the chances are pretty good that plenty of people around you deal with this troubling disease: One in four U.S. households have someone that suffers from migraines.

Migraines seem to affect young adults and the middle-aged more than any other age groups, as the disease is most common...
Among those aged 25–55. The disease appears to have a connection to heredity as well. One parent with migraines has a 40 percent chance of passing on this condition to his or her children. Alarmingly, if both parents experience migraines, they have a 90 percent chance of their children suffering the same fate.4

Migraines know no bounds. These painful episodes can come to children, adults, and the elderly. In fact, migraines are more common among Americans than diabetes and asthma combined.

Migraine attacks can last anywhere from four hours to three days. For some people, living with migraine pain and discomfort is a daily struggle, as 14 million people in the U.S. have migraines every day.5

The causes

Unfortunately, scientists and medical professionals are not exactly sure what triggers migraines. One widely accepted explanation is known as the neurovascular theory. This states that “various triggers cause abnormal brain activity, which in turn causes changes in the blood vessels in the brain.”6

The Mayo Clinic has stated that migraines might be brought upon by certain things such as cheeses, salty foods, and processed foods. It’s possible that skipping meals could also be a factor in the incidences of migraines. The Mayo Clinic further reports that food additives (namely, the sweetener aspartame), alcoholic beverages, highly caffeinated drinks, stress, intense physical activity, weather changes, and use of contraceptives may contribute to migraine activity.

Additionally, the Mayo Clinic states that migraines may be caused by changes in the brain stem or imbalances in brain chemicals, such as serotonin.

Addressed in the Medical Protocol

In the Medical Priority Dispatch System™ (MPDS™) v13.0, migraines are handled on Protocol 18: Headache and are listed under the ‘Not Serious Types and Causes’ category along with cluster, sinus, and tension headaches.

Though one might not consider a migraine to be a condition meriting emergency care, consider that every 10 seconds a person in the United States goes to the emergency room with a headache or migraine.

Though one might not consider a migraine to be a condition meriting emergency care, consider that every 10 seconds a person in the United States goes to the emergency room with a headache or migraine.

For instance, Key Question 4 on Protocol 18 asks, “Was there a sudden onset of severe pain?” This question is crucial because, as Rule 1 states, “Sudden onset of a severe headache is considered to have a more serious underlying cause until proven otherwise.” Furthermore, Axiom 2 states, “Headaches that are both sudden and severe, especially when associated with movement problems (numbness or paralysis), may represent the early onset of a serious condition.”

Five “Serious Types and Causes” of headaches are identified on Protocol 18 as berry aneurysm rupture, epidural hematoma, intracerebral hemorrhage, ischemic infarction, subarachnoid hemorrhage, and subdural hematoma. In addition, hypertension, meningitis, and post-traumatic (hit head) are listed as “Possibly Serious Types and Causes.”

It is not the EMD’s responsibility to diagnose the patient’s problem but rather to follow the protocol step by step, asking each question as it is written. The associated lists of varying types and causes simply serve as a reference for the EMD.

In short, as stated in Axiom 1, “The most important objective of this protocol is to determine if the underlying cause of a headache might be a life-threatening but potentially treatable condition such as STROKE, meningitis, or other serious brain condition. Headache, in and of itself, is not a diagnosis but a very general symptom of many other low-acuity problems.”

If the EMD identifies a stroke symptom in Key Questioning, he or she then asks the new Key Question 7, “Exactly what time did these symptoms (problems) start?” If unknown, the EMD will ask about the time frame of when the patient was last seen to be normal. As explained in the Additional Information, the time of symptom onset is vital to the hospital and responders as an important part in preparing the patient’s therapy.

After inquiring about the initial onset, the EMD will then use the Stroke Diagnostic Tool to assess whether there is CLEAR, STRONG, PARTIAL, or NO test evidence of stroke. The EMD then adds the diagnostic results in the form of a suffix attached to the Determinant Code, which is factored into the correct response.
Initiating a response

Although stroke is a time-sensitive event, it is classified as a CHARLIE-level response. Rule 2 explains “STROKE must receive an immediate response that is not subject to delay. Lights-and-siren are not recommended; however, there should be a sense of urgency.” For this reason, EMDs should assign a CHARLIE-level Determinant Code to callers with any of the following complaints:

- not alert (18-C-1)
- abnormal breathing (18-C-2)
- speech problems (18-C-3)
- sudden onset of severe pain (18-C-4)
- numbness (18-C-5)
- paralysis (18-C-6)
- change in behavior in the past three hours or less (18-C-7)

If the patient's status is unknown or other codes are not applicable, the EMD should initiate an 18-B-1 response. If the caller reports that the person suffering headache symptoms is breathing normally (Key Question 2) and does not have any of the symptoms identified in the other Key Questions, the EMD should initiate an 18-A-1 response.

The EMD will use the Stroke Diagnostic Tool to assess whether there is CLEAR, STRONG, PARTIAL, or No test evidence of stroke. The EMD then adds the diagnostic results in the form of a suffix attached to the Determinant Code, which is factored into the correct response.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “More Than Just a Pain,” which starts on page 38. Take this quiz for 1.0 CDE unit.

1. In the United States, about _________ people suffer from migraines.
   a. 50 million
   b. 38 million
   c. 15 million
   d. 2 million

2. Heredity appears to be a factor in whether a person experiences migraines.
   a. true
   b. false

3. According to the Mayo Clinic, which of the following beverages might trigger a migraine?
   a. highly caffeinated drinks
   b. sports drinks
   c. orange juice
   d. milk

4. Patients who call an ambulance for a headache generally have a less serious underlying cause than patients who arrive at the emergency department on their own.
   a. true
   b. false

5. The new CEI (Critical EMD Information) on Protocol 18 prompts the EMD to provide hospital staff with the Stroke Diagnostic Tool results, symptom onset time, and:
   a. the contact information of anyone who witnessed the onset.
   b. the patient’s stroke history.
   c. the patient’s family medical history.
   d. any medications the patient is currently taking.

6. The “Possibly Serious Types and Causes” of headaches listed on Protocol 18 are:
   a. berry aneurysm rupture, epidural hematoma, and intracerebral hemorrhage.
   b. ischemic infarction, subarachnoid hemorrhage, and subdural hematoma.
   c. tension, cluster, and sinus.
   d. hypertension, meningitis, and post-traumatic (hit head).

7. If, after asking Key Questions 3–6 on Protocol 18, the EMD identifies stroke symptoms in the patient, it is not necessary to ask Key Question 7.
   a. true
   b. false

8. The EMD will use the Stroke Diagnostic Tool to determine whether there is CLEAR, ________, PARTIAL, or No test evidence of stroke.
   a. STRONG
   b. WEAK
   c. UNDETECTABLE
   d. OBVIOUS

9. If it is determined the patient is having speech problems, the EMD should assign a DELTA-level Determinant Code.
   a. true
   b. false

10. If the patient is suffering migraine symptoms, is breathing normally, and does not have any other symptoms identified in the Key Questions, what is the appropriate Determinant Code?
    a. 18-C-1
    b. 18-C-7
    c. 18-B-1
    d. 18-A-1

To be considered for CDE credit, this answer sheet must be received no later than 12/31/16. 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.
PREPARATION IS EVERYTHING
Potential active assailant incident demands dispatcher vigilance

Audrey Fraizer

Listen to Melissa Alterio and Anthony Weed talk about training for an active shooter and you’d think the possibility is imminent.

And to them, even if it isn’t, you better be prepared.

“Visualize the situation, know what you’re going to do, so when it happens, you’re ready,” said Weed, a Lt. Police Officer for the Orange County Sheriff’s Department, NY. “It becomes automatic.”

Weed and Alterio, Training Supervisor, Communication Center, Orange County Sheriff’s Department, presented the “Active Shooter Incidents for Telecommunicators” session at NAVIGATOR 2015 as sort of a snapshot of the eight-hour course that Weed designed for the sheriff’s department and broadened to include dispatch responsibility at Alterio’s request.

“We’re the first to the call. We’re the first to ask questions. We’re the first to keep our officers safe.”

The program was so informative—and proactive—that Dave Warner, Priority Dispatch System™ Program Administrator—Law Enforcement, decided to attend and, from there, invited Weed to help in the development of Police Priority Dispatch System™ (PPDS™) Protocol 136: Active Assailant (Shooter).

Weed said he was honored; the Academy’s recognition was an affirmation of his dedication to a proactive response.

“We become complacent,” he said. “We don’t expect this to happen, but it does. And no matter how remote, you have to practice in the event it does.”

Alterio advised thinking ahead to determine what resources are available in case an incident occurs and to make sure the communication center is prepared to act instinctively.

“Mentally prepare,” she said. “The only way you’re going to get through that call is through training. Never stop training. You can always improve performance.”

Weed refused to believe Columbine was the first active shooter incident and his subsequent research led to incidents dating to the 18th century. On July 26, 1764, in Franklin County, Pa., four Native American warriors invaded a pioneer school, killing a teacher and nine of his 12 students. The raid was launched as part of Pontiac’s Rebellion to drive away the British soldiers and settlers.

Other active assailant incidents highlighted in the presentation include:

- Aug. 1, 1966: Charles Joseph Whitman brought multiple weapons to the University of Texas campus, killing 14 people and wounding 32 others in a mass shooting; Austin Police Officer Houston McCoy shot and killed Whitman.
- April 20, 1999: Eric Harris and Dylan Klebold killed 12 students and one teacher...
at Columbine High School, Colo; both committed suicide within five minutes of the SWAT team’s arrival.

- Dec. 14, 2012: Adam Lanza killed 20 children and six others (total of 26 people killed) at the Sandy Hook Elementary School in Newtown, Conn.; he committed suicide inside the school following the rampage.

**The active assailant**

PPDS Protocol 136 defines an active assailant as “An armed person who has used any type of weapon to inflict deadly physical force on others and continues to do so while having unrestricted access to additional victims.”

The qualifier “unrestricted access to additional victims” distinguishes the use of Protocol 136: Active Assailant (Shooter) from PPDS Protocol 106: Assault/Sexual Assault. While Protocol 106 refers to an “unlawful attack, or attempted attack, upon another person,” which may include multiple victims, Protocol 136 more specifically addresses active assailants in wide-open places offering a large number of potential victims such as shopping centers, school campuses, and movie theaters.

Prior to the mass shooting at Columbine High School, the traditional law enforcement response favored an attempt to cordon off the area and await the arrival of tactical teams, such as SWAT teams. However, this strategy resulted in time lost waiting for other units to take over and more opportunity for the active shooter to engage innocent victims and raise the level of pandemonium.

Law enforcement agencies across the country have since moved to a more aggressive response to limit the number of casualties. The first responding officer(s) conducts a “Rapid Deployment” or “Movement-to-Contact-to-Fix” military type offense. Although specific tactics vary by agency, the underlying goals are the same and favor immediate pursuit by police with the goal of containing or neutralizing the killer(s) as quickly as possible.

**Callers reporting an ACTIVE ASSAILANT (SHOOTER) should always be considered to be in imminent danger, but these incidents are best addressed on Protocol 136, as it includes specialized questions and instructions.**

Surveying the scene for hazards is the very first action a responder takes at the time of arrival to an active assailant incident. The responder cannot treat the wounded or attempt to save lives until the scene is rendered safe.

**Protocol 136**

Protocol 136: Active Assailant (Shooter) reflects this current and evolving tactical philosophy, as it provides calltaker questions and instructions that complement police procedures in response to these situations. The information calltakers gather through Key Questions can heavily influence deployment tactics used by responders and law enforcement administration, and in assisting EMS and fire agencies.

The Active Assailant (Shooter) Protocol was introduced in PPDS v4.1 and has been subsequently updated in later versions.

**How it works**

The Active Assailant (Shooter) Protocol adds another ECHO determinant to the PPDS to allow for early dispatch initiation to address specific immediate dangers and minimize the loss of life.

However, unlike most ECHO determinants, the pathway for Protocol 136 does not immediately direct the calltaker to Pre-Arrival Instructions (PAIs) from Case Entry, nor does it link to the Caller In Danger (CID) Protocol.

**Callers reporting an ACTIVE ASSAILANT (SHOOTER) should always be considered to be in imminent danger, but these incidents are best addressed on Protocol 136, as it includes specialized questions and instructions for these high-risk situations.**

For active assailant situations discovered during Case Entry, the EPD should initiate a 136-E-1 response, provide Case Entry PDI-b, and then go to Protocol 136 immediately after completing Case Entry.

The links to PAIs appear within the Key Questions section of the Active Assailant (Shooter) Protocol. This allows the EPD to first address critical responder safety questions before beginning PAI Protocol S and immediately instructing the caller on the best actions to take to save lives (either evacuation or LOCKDOWN).

**The critical role of the EPD**

Active assailant situations change rapidly and can quickly overwhelm the capacity of emergency service agencies with overloaded phone lines, limited availability of police resources, and the number of victims exceeding the capabilities of paramedic crews and emergency room space.

This places 911 in a critical role with the ability to contribute to a more positive outcome via the collection of necessary information to assist police with deployment and the EPD’s provision of lifesaving instructions to callers.

**Specialized Key Questions**

The Key Questions on Protocol 136 are specifically designed to quickly collect the information responders need to address these unique incidents, as discussed here:

- “What type of weapons are involved?”
  The risks associated to responding off site are so high that most ECHO determinants use a fixed specific number of weapons involved.
- “When was the last time you heard shots fired?”
  This question aids the calltaker in determining 1) Activity level...
of the assailant at the time of the call and 2) Callers with the most up-to-date information because of their proximity to the assailant. The National Tactical Officers Association (NTOA) cautions against a change in police response based on a time delay of when shots were reportedly last fired. The NTOA statement is provided as follows in Protocol 136:

This time delay, by itself, does not negate the need for an immediate response. The perpetrator may be using, or preparing to use, other weapons (knives, IEDs, etc.), or her/his shots may not be audible. If the threat’s location is not known, officers should begin searching or rescue wounded victims. Officers should transition to a hostage/barricade situation if necessary, based only on the totality of circumstances.

- “Does the suspect appear to be wearing a bulletproof vest or body armor?” Body armor on suspects limits the effectiveness of responders’ weapons.

Note: In PPDS v5.0, “bulletproof vest or body armor?” has been formatted in black rather than the red format associated with scene safety questions. A question formatted in black does not negate its importance to responders in formulating a tactical response to a threat. The change was made to emphasize scene safety considerations—i.e., of the highest priority.

- “Did you see the suspect carrying anything?” This question can elicit information to indicate the use of explosives, chemical or biological weapons, or other weapons that will hinder a law enforcement response.

- “Did you hear the suspect saying anything?” This question can help provide insight into the suspect’s motives, level of preparation, and intended target.

If the caller reports hostages have been taken, the EPD should stay on Protocol 136 to find out the number of hostages and where the active assailant has taken them. It is not appropriate to turn to the Hostage Taker Protocol listed separately in the PPDS, as these instructions are intended for situations in which the EPD is speaking directly to the hostage taker.

Since phone contact with callers can be lost at any time, the EPD must give PAIs early in the call to address critical responder safety questions.

The process adds another layer of precaution, said Shawn Messinger, Priority Dispatch System Program Administrator—Law Enforcement.

“We actually teach that in the unlikely event an active assailant calls in 1st party, the EPD will still use Protocol 136 and rephrase the Key Questions to account for a 1st party caller,” Messinger said.

Pre-Arrival Instructions

Since phone contact with callers can be lost at any time, the EPD must give PAIs early in the call to address critical responder safety questions, as mentioned, and to prepare callers to escape (evacuation), to move to a confined space and further safeguard themselves from the assailant(s) (LOCKDOWN), or to prepare to defend themselves if found.

These specific instructions can prevent a panicked caller from making the situation worse, as illustrated with the following Evacuation instructions:

- “Get out of the building/area even if others won’t follow. Help others escape, if possible.”

- “Take an evacuation path that’s away from the suspect.” The shortest route out of the area may not be the safest. A panicked caller might not give second thought to the potential danger associated with the shortest route without the calltaker’s cautionary instructions.

- “Do not attempt to move wounded people.” Attempting to move wounded individuals slows the evacuation and puts the caller and others at further risk.

- “Do not rush towards officers, keep your hands visible at all times, and follow all of their commands.” Panicked callers swarming responders hinders their ability to assess and address possible threats and puts victims at risk of accidentally moving into the line of fire.

Callers unable to safely evacuate should remove themselves from sight and conduct what is commonly referred to as a LOCKDOWN. The simple act of securing everyone into a room with a locking door, or a door that can be barricaded, and turning off the lights and closing the blinds gives the shooter fewer targets and makes potential targets more difficult to access. Sitting or lying on the floor right next to the wall with the door minimizes the danger from bullets fired through the door. During lockdown, everyone should silence the ringer and vibration mode of their cellphones to further prevent the assailant from discovering the location of those in hiding.

Once in a safe space, no one should leave, and no one should answer or open the door for anyone. Opening the door to a safe space may give an active assailant the opportunity to rack up the body count as quickly as possible.

An Axiom new to PPDS v5.0 adds: “A true LOCKDOWN supersedes a fire alarm unless the smoke or fire is an immediate life threat.” It is critical that callers stay in lockdown even if a fire alarm is heard, unless smoke or fire put them in danger.

Often, the suspect will hunt down victims at random, once through the initial shooting. Individuals caught in the “hunt” who cannot flee from the active assailant should be mentally prepared to fight for their lives by using weapons, throwing objects, acting aggressively, and yelling. Instructions for self-defense can help change the mindset of a caller from victim to fighter.

Sources

### POLICE CDE QUIZ

**YOU MUST BE POLICE CERTIFIED TO TAKE THIS QUIZ**

Answers to this quiz are found in the article “Preparation is Everything,” which starts on page 42. Take this quiz for 1.0 CDE unit.

1. Lt. Police Officer Anthony Weed of the Orange County Sheriff’s Department assisted in the development of which of the following PPDS protocols?
   - a. Protocol 106: Assault/Sexual Assault
   - b. Protocol 119: Harassment/Stalking/Threat
   - c. Protocol 123: Missing/Runaway/Found Person
   - d. Protocol 136: Active Assailant (Shooter)

2. Which of the following active assailants brought multiple weapons to the University of Texas campus, killing 14 people and wounding 32 others in a mass shooting?
   - a. Charles Joseph Whitman
   - b. Eric Harris
   - c. Seung-Hui Cho
   - d. Adam Lanza

3. Protocol 136 more specifically addresses active assailants in wide-open places offering a large number of potential victims such as shopping centers, school campuses, and movie theaters.
   - a. true
   - b. false

4. Underlying law enforcement goals of an active assailant incident favor:
   - a. waiting to see what happens with the goal of the assailant surrendering.
   - b. negotiating by any form of communication possible, such as a cellphone, with the goal of having the assailant put down his/her weapons.
   - c. immediate pursuit by police with the goal of containing or neutralizing the killer(s) as quickly as possible.
   - d. surrounding the area with the addition of police from neighboring jurisdictions with the goal of containing the incident.

5. Protocol 136 was introduced in which version of the PPDS?
   - a. Version 3.1
   - b. Version 4.0
   - c. Version 4.1
   - d. Version 5.0

6. For active assailant situations discovered during Case Entry, the EPD should:
   - a. initiate a 136-E-1 response.
   - b. provide Case Entry PDI-b.
   - c. go to Protocol 136 immediately after completing Case Entry.
   - d. all of the above

7. Using PAI Protocol S, the EPD instructs the caller:
   - a. to clarify the suspect(s) description and movement.
   - b. on the best actions to take to save lives (either evacuation or LOCKDOWN).
   - c. to describe the types of weapons involved.
   - d. on the urgency to provide the hostage location.

8. If the caller reports hostages have been taken, the EPD should:
   - a. stay on Protocol 136 to find out the number of hostages and where the active assailant has taken them.
   - b. move to Protocol 129 to get a better suspect and vehicle description.
   - c. move to Protocol B if the caller is the Hostage Taker/Kidnapper.
   - d. return to Case Entry for a CID response (100-E-1).

9. In the event of possible evacuation, the EPD should advise the caller to:
   - a. take the shortest route out of the area.
   - b. run in a zigzag path to avoid getting shot.
   - c. help the wounded victims on the way out.
   - d. take a path that’s away from the suspect.

10. A true LOCKDOWN supersedes a fire alarm:
    - a. at all times, no matter if smoke or fire present an immediate threat to life.
    - b. unless the smoke or fire is an immediate life threat.
    - c. until firefighters arrive on scene to extinguish the fire.
    - d. until it is known whether the suspect pulled the alarm (false alarm).

To be considered for CDE credit, this answer sheet must be received no later than **12/31/16**. 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.
Lakewood, Colo., resident Nicole Bechtle can’t thank enough the 911 dispatcher who walked her through the steps to bringing breath back to her young son.

On an otherwise routine day this past June, Bechtle had just finished feeding 3-month-old Zane when a parent’s worst nightmare occurred. Zane was turning blue and not breathing. Thank goodness a cool-headed, experienced dispatcher was on hand to help.

Bechtle reported that Zane was unconscious and not breathing. Without hesitating, Quintana followed the Medical Priority Dispatch System™ (MPDS®) Protocol and guided her through CPR.

Bechtle’s knowledge of CPR made Quintana’s job easier, and it helped give Zane a better chance of survival.

“She was able to follow the instructions and keep up because she was familiar with what to do,” Quintana said.

Two minutes into CPR, a glorious sound came from Zane’s mouth: a wailing cry. Though not normally the sound people love to hear, in this case, the crying was music to Bechtle’s ears. Quintana was relieved as well.

“It was a sweet sound to hear—the little whimpers and squeaks he started to make,” Quintana said.

Once the cries came, Quintana knew Zane was going to make it.

“I am happy for mom and the baby,” Quintana said. “I concentrated on keeping calm so I could keep her calm. It’s extremely gratifying when you’re able to make a difference, to help save a life.”

Kim was very compassionate and calm as she helped the mother with CPR instructions. Kim remained a source of strength and hope during this difficult time.

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Bechtle picked up her baby, finding him to be limp. As she described it, he was “like holding a ragdoll.” Her immediate reaction was to begin CPR, but it had no effect. So she dialed 9-1-1 and was connected with West Metro Fire dispatcher Kim Quintana.

Despite finding herself in a perilous situation with her infant son’s life in jeopardy, Bechtle was composed and cooperative. Her ability to keep her emotions in check was vital.

“She was great,” Quintana said. “She was very calm and listened.”

Bechtle reported that Zane was unconscious and not breathing. Without hesitating, Quintana followed the Medical Priority Dispatch System™ (MPDS®) Protocol and guided her through CPR.

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“I am happy for mom and the baby,” Quintana said. “I concentrated on keeping calm so I could keep her calm. It’s extremely gratifying when you’re able to make a difference, to help save a life.”

Kim was very compassionate and calm as she helped the mother with CPR instructions. Kim remained a source of strength and hope during this difficult time.

Of course, dispatchers field a multitude of calls every day—some more intense than others. But Quintana, who has been with West Metro during her entire 15-year career, strives to exhibit the same professionalism and compassion with each call, regardless of who it is or what the emergency may be.

“I like to keep my composure on all calls, whether it’s a child or an adult,” she said. “Most people only call 911 once in their lifetime, and I want that experience to be as great as I can make it and as helpful. Like everyone else at West Metro, I’m here to serve my community and to make a difference for those families that depend on us to help them when they need it most.”

NO SMALL FEAT
Dispatcher comes up big in helping revive little one

Josh McFadden

Kim was very compassionate and calm as she helped the mother with CPR instructions. Kim remained a source of strength and hope during this difficult time.
Before the big game kicked off on Super Bowl Sunday 2015, playmaker Brian Dempsey, with the assistance of two bystanders, was working to save the mayor of Toledo’s life.

On Feb. 1, Dempsey, a dispatcher with Lucas County (Ohio) EMS since 2001, was working through a snowy day that included a press conference at the public safety building at noon. Toledo Mayor D. Michael Collins and Lucas County Sheriff John Tharp discussed moving to a level-three snow emergency for the county that afternoon.

“Nobody’s allowed on the roads unless they’re absolutely essential,” Dempsey said.

Within a few hours of the press conference, a call came in for an unconscious person, which was transferred to Lucas County EMS. On her way to work, Evelyn Johnson had felt something off about the vehicle pulled over on the opposite side of the road.

What she thought was someone with car problems, turned out to be something much more serious.

“The caller basically told me there was a person that wasn’t responding in the vehicle,” Dempsey said. “She said that the vehicle was up against a pole and had hit a curb. His foot was on the pedal. She could hear it revving as we were talking.”

Dempsey knew Johnson needed to get to the driver.

“All the doors are locked, and I can’t get in without breaking the window,” Johnson told Dempsey.

He encouraged her to do so. Johnson took a hammer from her car, broke a window, and unlocked the door. With the help of another bystander (Andra Crisp) who’d stopped, they needed to get the man’s foot off the gas pedal and the vehicle in park.

“We were concerned with the car taking off,” Dempsey said.

After they turned the car off, they laid him flat on his back in the snow.

“She confirmed that no, he was not breathing,” Dempsey said.

Chest compressions began, but Dempsey knew they weren’t being administered fast enough.

“I told her she had to go faster, and she hit the rate perfectly,” he said.

One to two minutes after beginning chest compressions, first responders arrived on scene and Dempsey disconnected the call. The surprise came a little later.

“We found out shortly afterward that it was the mayor of Toledo,” he said.

Unfortunately, Collins had suffered sudden cardiac arrest and did not recover. He was taken off life support days later and passed away with his family by his side.

Dempsey knows that he did what he could with the help of the MPDS® and the bystanders on scene.

Ralph Shearn, Lucas County EMS Communications Manager, said Dempsey received a letter of commendation for handling the call well.

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Ralph Shearn, Lucas County EMS Communications Manager, said Dempsey received a letter of commendation for handling the call well.

“Brian’s display of calmness and control of the situation no doubt assisted in maintaining the respect of Evelyn Johnson, not to mention the ability to provide the critical Pre-Arrival Instructions to assist in sustaining the mayor’s life,” Shearn said.

For Dempsey, the situation helped renew his faith in humanity.

“Just the fact that in today’s society these two people still had it in their heart to stop and help somebody,” he said.

“These guys had no idea who it was—they didn’t know it was the mayor.”

Dempsey, a dispatcher since 1997 following a few years in public safety as a firefighter/EMT, experienced a career first.

“Those were the first people I’ve met,” he said. “They were the perfect caller. They were calm, not worked up. They did everything we asked them to.”

Deciding to raise public awareness about CPR, the Toledo Fire Department and the Toledo Free Press teamed up to offer the basics in free two-hour sessions on Valentine’s Day.

“There is good stuff that’s happening from it,” Dempsey said.

AFFIRMATION
Dispatcher sees positive impact even without happy ending

Heather Darata

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Brian Dempsey, Evelyn Johnson, and Andra Crisp. Toledo Free Press Photo by Christie Materni.
Craig Nimsgern spent the weekend prior to Labor Day at Great Basin National Park in east-central Nevada near the Utah border. The 77,180-acre park draws about 90,000 visitors each year, with the majority making the trip to tour Lehman Caves at the base of 13,063-foot Wheeler Peak.

Nimsgern and his buddies didn’t drive the 317 miles from their homes in Las Vegas to look at limestone caves. They came for Wheeler Peak, the second-highest peak in Nevada and the longest of 12 trails in the Great Basin National Park, extending 13.1 miles and rising more than 3,000 feet in elevation.

The last bits, along the exposed ridge, wind through loose rock, known as scree. “The hike was tough,” Nimsgern said. “No doubt about that.”

Great Basin National Park and the hike, however, provided a “great contrast” to Las Vegas Fire and Rescue where he works as a communication specialist. The company he kept for the five-day road trip was also a change from the company he keeps at the job. Don’t get him wrong. “The people I work with are the best,” he said. “We work great together.”

Yet, it’s the outdoor adventures and the chance that work won’t dominate conversation that helps the Wisconsin native de-stress from the routine of calls in Las Vegas can easily run the gamut of brawls and drunk driving to shootings, stabbings, and other sorts of mayhem.

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There are also the good calls, and after just 18 months at the center, on July 17, 2015, Nimsgern answered one of the more memorable and positive calls that anyone can anticipate during a career as an EMD. He helped a couple through the delivery of their baby boy.

The call, he said, came in at the end of his shift when about all he was looking forward to was calling it a day. The person on the other end of the line (the dad) had rushed home from work after mom notified him to say she was in labor.

“By the time he got there, it was too late to make it to the hospital,” said Nimsgern of the “amazingly calm” caller. “He was more than happy to have me give him instructions.”

Within minutes, the baby was delivered and the ambulance had arrived. Mom and baby were transported to the hospital, and the threesome—mom, dad, and baby—was doing fine.

Nimsgern said the dad and mom were fabulous. Dad listened to the Pre-Arrival Instructions and followed them without question, and mom apparently remained remarkably calm, considering the situation. There was little background noise except for the sound that gave Nimsgern a huge sense of relief.

“I heard the baby cry,” he said. “That was so amazing.”

Nimsgern said he really didn’t know what he was getting into when applying for the communication specialist opening. He had moved to Las Vegas from the Midwest to complete his degree at the University of Nevada–Las Vegas. He has a master’s degree in emergency medicine and for a time worked as a supervisor in security at a Las Vegas casino.

“I was ready to find something else, saw the ad for communication, and the next thing I know, I had an interview,” he said. “I sat in on a few calls to see if this was what I wanted to do. It was intense.”

The intensity and his ability to perceive a situation and adjust his voice accordingly are part of the challenge, like hiking Wheeler Peak in an afternoon.

“The baby call was the best,” he said. “The outcome was great, and it’s the kind of call that makes everything worthwhile.”

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

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

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

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


2. Request a copy of the Public Safety Telecommunicator Checklist for Missing Children.

3. Apply to attend NCMEC’s CEO Overview Course in Alexandria, Virginia.

CEO Overview Course

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

For more information, visit www.missingkids.com/911 or email 911@ncmec.org
According to the World Health Organization (WHO), every year more than 815,000 people take their own life, and there are many more people who attempt suicide.\(^1\)

Canada's suicide rate is 11.1 deaths per 100,000 people. Canada's suicide rate was higher than that of the U.S. from 1970 to 2003. This has now reversed. The current suicide rate for the U.S. is 12.0 per 100,000.\(^2\)

Men generally have a higher suicide rate than women, although that can vary by country. In Canada, of those who died by suicide in 2011, the rate among men was 16.3 (per 100,000), compared to the rate among women at 5.4 (per 100,000).\(^3\) In the U.S., of those who died by suicide in 2013, men had a suicide rate of 20.2, and women had a rate of 5.5.\(^4\)

While the link between suicide and mental disorders (in particular, depression and alcohol use) is well established, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship breakups, or chronic pain and illness.\(^5\)

Evidence from Australia, Canada, Japan, New Zealand, the U.S., and a number of European countries reveals that limiting access to methods used to commit suicide (such as firearms and pesticides) can help prevent suicide. Establishing plans of actions by national governments are also shown to be effective, although only 28 countries are known to have national suicide prevention strategies.\(^6\)

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**Sources**

- See note 5.
PUT ON YOUR THINKING CAP
National Telecommunicators Week is coming up fast

Audrey Fraizer

Snow might be falling and the New Year ringing in, but it’s never too early to begin planning for your center’s annual National Public Safety Telecommunicators Week celebrations.

And what better way to mark the occasion than a clay modeling project that can relieve stress while, also, providing a bit of competition among a room full of Type A personalities?

That’s the magic behind Charlotte County Sheriff’s Office (CCSO) 911 center’s successful event in 2015, and it’s no secret that they borrowed the idea from a dispatcher who sculpts 911 protocols to ease the daily tension.

“We try a creative project every year at this time, and we liked what Kathy McCarty did,” said Cathy Singleton, CCSO, EMD-Q®. “We figured we’d give it a try.”

McCarty’s work in clay was chronicled in the March/April 2013 issue of the Journal. What started as a request to mold a clay lapel to recognize the great work of dispatchers at the New Hampshire Bureau of Emergency Communications morphed into a personal hobby.

In the months following her first “release” of the lapel pin, McCarty extended her artistry in clay to 33 action figures, each depicting a medical condition related to the Medical Priority Dispatch System™ (MPDS®). Her preferred “sculpting medium” is the polymer clay she finds ideal for the detail work each protocol model requires. She buys the clay in the multi-color packages and bakes the sculpture in an oven until it hardens.

Singleton read the story and brought the idea to CCSO Administrator Melanie Bailey, and she passed along the project to the supervisors.

The supervisors adopted and adapted the idea. Instead of polymer clay—a type of malleable plastic—they used commercial Play-Doh, the kids’ craft project medium composed of flour, water, salt, boric acid, and mineral oil. They also lowered their expectations, from one person sculpting every MPDS Protocol to picking and choosing by the center’s four squads of dispatchers.

They were given a week to turn in a maximum of five sculptures per squad. The results were amazing, said Carolyn Turner, Squad Supervisor, CCSO 911 center.

“They really got their creative juices going,” she said.

The 30 figures created included the most visual of the MPDS v12.2 Protocols, such as Protocol 14: Drowning (Near)/Diving/Scuba Accident (which received first place), Protocol F: Childbirth–Delivery (fourth place), and Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites) (in this case a snakebite coming in fifth).

The fun, however, wasn’t only in the making or judging.

Turner and Singleton got a kick out of watching the process and the creative ways the different squads tried to find out what the others were doing. The ribbons awarded gave “bragging rights,” Turner said, within the center and the CCSO.

“We put them on display,” said Turner, whose squad produced the highest number of sculptures. “Everyone came to see them.”

The figures are now shrunken in history. When left out of an airtight container, it’s only a matter of hours until unattended dough is no longer fun to mold. After a day, the air-dry models were shrinking and cracking, they are preserved through photographs and future reminiscing.

Bailey doubts the project will be repeated in 2016 since they prefer something new to spring on dispatchers.

“It’s a learning experience that we try to make as fun as possible,” said Bailey, who suggested the project.

“We try to shake things up each year.”

The modeling also had the benefit of relieving stress through the focus required in planning and creating and the dispatchers’ ability to put a conscious divide between their artwork and the daily work of being a 911 dispatcher.

“They were able to separate from the incident,” Bailey said. “And it turned out to be a good way for them to relax.”

National Public Safety Telecommunicators Week was born from an idea conceived in 1981 by Patricia Anderson of the Contra Costa County Sheriff’s Office, Calif., to set aside time to publicly recognize 911 professionals. It is now held during the second full week of April, which in 2016 will be April 10–16.
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