Stack the blocks: CDE assigns order to police calls

The National Academies of Emergency Dispatch

THE JOURNAL
OF EMERGENCY DISPATCH

November/December 2008

Help is only a call away

Life Is Good!
Dispatch career hits a high note at EuroNavigator
Quickly sending the RIGHT on-scene information to responding officers and updating it in real-time can help save lives. That’s what the Police Priority Dispatch Protocol System® does better than any other. When your team takes a 9-1-1 call using ProQA® dispatch software, you can be confident that both your new and veteran dispatchers are doing it RIGHT and that responding officers are receiving the information they need to protect themselves and the citizens around them.

We agree with what master mathematician Claude Shannon said in 1963:
“Information is the reduction of uncertainty”
ProQA® Dispatch Software—reducing uncertainty for over 29 years

ask the right question. get the right answers. send the right information.
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The following U.S. patents may apply to portions of the MPDS depicted in this book: 5,852,966; 5,989,187; 6,004,266; 6,020,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,428,301. FPDS and PPDS patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the NAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued.
Thirty years and counting.

A series of feature stories in this issue of The Journal kicks off our 30-year anniversary of protocol celebration. The stories we’ve included embody the value of protocol and the dispatchers trained and certified to use protocols for just about any emergency situation you can imagine—from a near drowning, helicopter crash, and tonic-clonic seizure to the unexpected arrivals of three babies in less than a week and a bear attack during the very early morning hours in Anchorage, Alaska.

Each time, protocol was there to help, sending first responders to the scene while dispatchers stayed on the line calming the often-distraught callers and gathering crucial information for responders. They were there, dispatchers armed with protocol, providing the assistance needed at those times of crisis. Jeff Clasow, M.D., co-founder, National Academies of Emergency Dispatch (NAED), started a revolution in emergency services 30 years ago in Salt Lake City when protocol was introduced to emergency communications. Before that time, dispatchers had few guidelines to follow. They seldom answered calls using questions in the logical order inherent in the Medical Priority Dispatch System® (MPDS).

Protocol standardizes the way dispatchers communicate with callers and, in turn, improves the emergency response system. The original cardset contained 29 sets of two 8-inch-by-5-inch cards. Each caller complaint was listed in alphabetical order, as they are today, and reflected either a symptom (e.g., abdominal pain, burns, cardiac/respiratory arrest) or an incident (e.g., electrocution, drowning, or traffic injury accident). The core card contained three color-coded areas: Key Questions, Pre-arrival Instructions, and dispatch priorities.

The protocol never stops evolving. The NAED now offers three distinct types of dispatch credentials (police, fire, and medical), compared to the single credential offered in 1988, in addition to certification in quality assurance and the Accredited Center of Excellence (ACE) ranking for communications center operations. More than 3,000 communications centers use the system worldwide, affecting the lives of millions of people year in and year out.

Despite the growth and recognition of protocol, there are many things that have remained consistent over the years. Most noticeable is the dedication of emergency professionals and Academy staff and the attention they give to their work. The protocol systems, now times three, have withstood the test of time and scrutiny; they remain at the cutting edge of effective and efficient emergency response.

We hope you enjoy these stories and look forward to sharing more of these types of events as they cross our desks in the years to come.
I am writing this issue’s column from Berlin, Germany, on the second day of the inaugural EuroNavigator conference that is being held primarily for German speakers. This event has been long in coming and the International Academies of Emergency Dispatch® (IAED) is very excited to have this conference hosted in Berlin. This experience takes me back to the early days of Navigator when it was held at Snowbird, Utah. In those days, there was a handful of courses and a little larger handful of attendees. Here in Berlin, there are 71 registered attendees, which is more than we had expected. In addition to the typical offerings of an EMD-Q course and IRW’s (Instructor Recertification Workshop) for both the Fire Priority Dispatch System™ (FPDS) and the Medical Priority Dispatch System® (MPDS) instructors, attendees are able to choose among some other common tracks that may be found at EuroNavigator U.K. or U.S. Navigator conferences such as: Einführung einer standardisierten Notrufabfrage (Krankentransport und Rettungsdienst) in Wien (Implementation of Structured Calltaking in Vienna), Entwicklung Neuerungen AM PDS v12.0 (Version 12.0 Overview), Finanzieller und organisatorischer Benefit durch Protokoll und QA-Fünf Jahre und eine Million Notrufgespräche nach Protokoll! (Financial and Organizational Benefits Using Protocol and Quality Assurance in a Center Over Five Years With a Million Calls per Year in Lower Austria), Vergleich strukturierte/unstrukturierte A bfrage (Structured vs. Non-Structured Medical Calltaking), and 1 Berufsfeuerwehrer, 350 freiwillige Feuerwehren, 1 Leitstelle (1 Paid, 350 Volunteer Fire Departments, 1 Control Center). In addition to these fascinating sessions, there were equally good sessions on continuing dispatch education, call processing, and personnel hiring.

While there are so many people that have had a part in the growth of the MPDS and FPDS in Germany and Austria, one person stands at the top—Tudy Benson. Tudy is responsible for all of the protocol users in these countries and acts as the international liaison between the IAED and these agencies. One only needs to be around and watch the interaction these control center managers and calltakers have with Tudy to understand just how vital she is to their acceptance and success of the protocol. Another great benefit of having Tudy work closely with these groups is that she is a native German and speaks German fluently. These attributes, along with her knowledge of the protocol and her caring demeanor, have contributed to the success the IAED has recently seen in this part of Europe. The IAED looks forward to returning next year for an even bigger and better German EuroNavigator conference.

Not to be outdone was the annual EuroNavigator U.K. held at the Thistle Hotel in Bristol from September 25-28. The theme of this year’s conference echoed that of Navigator 2008—“Power of the Protocol.” This year’s conference in Bristol included sessions in MPDS, EMD-Q certification, and a new program called the MPDS Mentor Course taught by Larry Latimer, Ross Rutschman, and Louise Ganley. The primary purpose of this new course is to help control centers better train and mentor their new employees, much like an initial dispatcher training program that would be in addition to specific protocol training. The remainder of the program included sessions on MPDS version 12.0, quality improvement, dispatcher stress, policies and procedures, and call processing. Feedback from attendees indicates that this had been another great conference with a lot of sessions to choose from and fantastic speakers.

Much like Navigator conferences held in the U.S., our vision for EuroNavigator in the U.K. and in Germany is to create an educational event relevant to all in emergency communications. The conference is designed to help attendees learn and be inspired from some of the best in the industry. It truly is our desire that conference attendees return home rejuvenated, with fresh strategies and a renewed or newfound passion to continue their quest for excellence. As you read through this issue of The Journal, look for the Navigator 2009 conference schedule and plan on joining us in Las Vegas. Be safe out there!
Don’t Compound the Problem.
Questions asked together can paint inaccurate picture of patient condition

Jeff Clawson, M.D.

Dear Dr. Clawson:

I am an EM D certified telecommunicator. My communications center has a quality assurance program. I have one question that may be could help me answer. If you don’t mind I have a small script to go along with my question:

Telecommunicator (TC): “911, what is the address of your emergency?”
Caller (C): Gives the address
TC: “What’s the phone number you’re calling from?”
C: Gives the phone number
TC: “And what is the problem? Tell me exactly what happened?”
C: “My mother is having trouble breathing.”
TC: “OK, are you with your mother now?”
C: “Yes”
TC: “How old is she?”
C: “72”
TC: “Is she conscious?”
C: “Yes”
TC: “And is she breathing?”
C: “Yes”

When I ask if the patient is conscious, the caller answers the question; I then ask “And is she breathing?” Subsequently, our EMD-Q deducts points from my score saying that this should not be asked as one question. She said the Academy would not back the way I asked the question in a legal setting. In my opinion, I didn’t ask it as one question. There was an answer to the consciousness. Breathing was asked separately and answered.

Justin Gibson

Justin:

The issue you raise deals with compound questions. If these two questions were asked together as one (without pausing to get the first answer you apparently did) that would invoke the scoring deduction. In your case, you merely inserted a bridge word, which doesn’t make any difference since each question was asked and answered separately. That is a completely valid way to do it. In this case, “and” could just as easily been “okay,” which is much more common and, coincidently, is now used in Case Entry version 12.0 to segue from phone number verification into “…tel me exactly what happened.”

The caller replies that the patient is “slipping out.” The EMD assumes the patient is breathing, without clarifying the response, and subsequently selects an inappropriate Chief Complaint. The Pre-Arrival Instructions (PAIs) are not given for this non-breathing patient.

Additionally, the caller in distress may misunderstand compound questions.

Compound questions are risky and should not be used except in special circumstances where we know they work OK.

We have examples of cases where these questions were merged into one and the caller answered with only one answer even though that was not the true situation. The correct answer to a compound question, if it is clearly understood by the caller in the first place, would have to be one of the following to be technically correct:

Yes and Yes
Yes and No
No and Yes
No and No

When single answers are given to compound questions, it leaves the EMD to wonder whether a single “no” relates to one or both of the question fragments. The same goes for “yes.” This clearly illustrates why compound questions are risky and should not be used except in special circumstances where we know they work OK.

The fact is illustrated well in a case included in the EMD certification curriculum: a paramedic call-taker asks if the patient is “conscious and breathing” as a compound question.

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Y2K Was Nothing. Challenges since then demand high level of emergency response

By Captain Robert Muller, Cecil County Dept. of Emergency Services Communications Division (Md.)

Much like many of the agencies around the country today, my agency ended the Y2K era thinking that the future would bring a lot of new challenges. In the wake of the Sept. 11, 2001, terror attacks, many of the agencies across the country began looking to become more efficient by developing a knowledgeable workforce and improving voice communications capabilities and data sharing. Along with this newfound purpose to make a difference, funding began finding its way to state and local agencies to make these changes possible and bring emergency services up to speed with the needs of our citizens.

Our agency followed the lead of many others and began looking to upgrade our services in a multi-faceted approach to address all areas of response and preparedness. The journey began to design and construct a new communications system, emergency operations center, computer-aided dispatch system, and 9-1-1 public service answering point (PSAP). A public safety facility was constructed to put the Department of Emergency Services (DES) and the sheriff’s office in the same location. DES was responsible for Fire/EMS dispatch and acting as the primary 9-1-1 PSAP, and the sheriff’s office dispatched its own units.

In late 2006, preparations were in the works for consolidating the separate dispatch centers and combining the personnel to make the most of the equipment and personnel available. One of the biggest challenges in accomplishing this goal was developing training for personnel in both centers to bring them up to speed in their own respect. The law enforcement dispatchers required training in 9-1-1 center operations and technology, while the Fire/EMS personnel had been answering 9-1-1 calls for service for years but had transferred law enforcement calls to one of the secondary PSAPs in the county for service.

During the initial phases of consolidation, the Fire/EMS personnel received training on processing law enforcement calls for service based on guidelines in place at the time and served as the primary calltakers for all disciplines. After field-testing this initial training by the calltakers, many questions arose about what questions to ask and what information they needed for the more than 300 call types that were in service at the time.

The implementation of the police protocol was essential to providing a standard level of service to the community and a constant in the training for personnel.

After years of processing medical calls using the Priority Dispatch System™, it became apparent that the calltakers needed more direction; a need for standardized call processing was apparent. The process for change was not an easy task. I contacted Adam Hinckley and Eric Parry of Priority Dispatch Corp.™ (PDC), who stepped up and provided experience, knowledge, and resources to help us develop the proposal and presentation. The presentation outlined the needs for a standardized call-processing program, included an overview of the Police Priority Dispatch System™ (PPDS), and listed key components that were already in place. The presentation was well received and we were off to search for funding and to develop a timeline for the project.

The Emergency Number Systems Board (ENSB) in Maryland is one of the best assets available to the PSAPs (Editor’s Note: See a story about the ENSB in the section Navigator Rewind). We were able to secure funding for the project through the ENSB and it provided direction. Hinckley was here again, working with us through every step of the process and providing guidance on setting up the best framework.

We established a Dispatch Steering Committee (DSC) to review the materials from PDC and the PPDS system. The DSC allowed us to bring in the allied agencies represented in the dispatch center while improving our knowledge of each other and developing a cohesive working relationship. During our review of policies and procedures related to the PPDS, it
An Important Message from the Board of Certification

Effective January 1, 2009, the fee to recertify will increase to $50. For multiple discipline recertifications, the fee will now be $85 for two disciplines, and $110 for three disciplines. This is the first increase in more than a decade and applies to a two-year period from the date of the original certification date and subsequent renewals.

Please remember, it is YOUR responsibility to know when your certification expires; the date can be found on your membership card. Recertification applications can be accepted as early as six months before expiration. A grace period may be given for a lapse of up to 90 days. A lapse of three to six months will be subject to a reinstatement fee of $15.00. A lapse of six months to one year will incur a $30.00 reinstatement fee, and the member must attend an eight hour discipline specific refresher course. With a lapse of one to two years, the member must attend two days of a discipline specific certification course and pay a $45.00 reinstatement fee. For a lapse of more than two years, the individual must take a full 3-day Academy-approved certification course and pay the standard certification fees.

Tammy Haislip was the right person in the right place at the right time.

Kevin Kesick was brought in by PDC to teach both courses, and he did a phenomenal job! Our staff was very impressed by his knowledge of the process and the experiences he shared with them. The training came alive to them and really improved their momentum in learning the new system. On behalf of the department, Assistant Chief Stephanie Reynolds presented Kesick with a Certificate of Appreciation for his efforts.

How do these computers work?

As the final weeks before our implementation date approached, PDC sent Tammy Haislip to introduce us to the “ins and outs” of the ProQA police software. She was an excellent asset and was the right person in the right place at the right time. She assisted our IT staff in coordinating with our CAD vendor, troubleshooting issues with the process, and providing background information for setting up options. All of our personnel completed ProQA training, which was valuable not only to learn the new ProQA police software but also to update everyone on changes to ProQA for medical that we were missing out on!

With all of the training completed, Implementation Specialist Bill Kinch provided feedback on our status and prepared us for implementation day. He was an excellent resource, providing guidance on the fly to our calltakers. He also coordinated efforts with Chip Hlavacek to resolve some residual “gremlins” in the computers along the way.

The implementation of the police protocol was essential to providing a standard level of service to the community and a constant in the training for personnel.

The consolidation of the center afforded the opportunity to take advantage of the ability to improve service by implementing the protocol system. But the process of implementing the system served as the best opportunity of all. It allowed the agencies involved in the newly consolidated center to work together on a common goal and develop a teamwork approach that now extends beyond the confines of this individual project.

Knows His Stuff  Kevin Kesick accepts a Certificate of Appreciation from Assistant Chief Stephanie Reynolds.

To download the formal Lapsed Certification Policy

More At www.emergencydispatch.org
Imagine working as one of 16 Emergency Medical Controllers taking calls for a service area population of 251,664 in an area where landmarks include the Bord na Móna peat processing plant, Charleville Castle, Tullamore Dew Heritage Centre, and the Grand Canal, one of the country’s greatest engineering achievements.

Sound picturesque? Going to work at the Health Service Executive (H.S.E.) National Ambulance Service (Midland Division) in Tullamore, Ireland, seems anything but boring.

The large town of Tullamore—“big hill” in Irish—is about 56 miles southwest of Dublin in the Midlands region of Ireland and is the administrative capital of County Offaly. The town is situated on the River Tullamore and is home to the Phoenix Festival—an annual celebration of the town’s coat of arms with arts and music programs and other events—and in recent times, The World Fleadh—Ireland’s largest international Traditional and Celtic music festival.

The H.S.E. National Ambulance Service (Midland Division) received accreditation from the National Academies of Emergency Dispatch® (NAED) in February 2008.

By Heather Darata
Statistically speaking

Pat Mooney, control/communications officer, who manages the control centre on behalf of the Midland Division, said there are few cities in Ireland. Rather, there are towns, in which the capital of an area is a large town. He described the control centre’s operational area of 2,548 square miles (6,599 square kilometres) as a mix of urban and rural.

“In our operational area, we provide services on a spatial basis rather than focusing on individual towns,” he said.

The control centre receives approximately 28,000 calls a year, with 14,000 to 15,000 of those being emergency or urgent calls. Mooney said some of their most frequently used protocols include back injuries (traumatic), traffic collisions, breathing problems, chest pains, and stroke. Recent population health studies have identified the age profile of the Midlands area population as higher than the national average, possibly accounting for the trends in protocol usage normally associated with older age groups.

“Our older population is increasing due to improved life expectancy,” he said. “The statistical analysis predicts that by 2020 there is going to be more people over the age of 65 than there has been in the last 20 years.”

Starting the process

Long before the Midland staff started down the road to accreditation, the thought of pursuing ACE status weighed heavily in the minds of control centre management.

“It was something that was always there in the background, in my background and in general, a goal that the wider management team aspired to,” Mooney said.

When the timing and circumstances were right, the control centre started the process of achieving accreditation; however, it didn’t happen overnight. He said the process required improving their auditing capabilities and collecting the evidence necessary to meet the 20 Points of Accreditation. Additionally, they had to develop the review and steering groups instrumental in governing the processes.

Meeting obstacles head on

Like any extensive process for achieving something meaningful, it wasn’t without its struggles. Mooney said a main obstacle was dedicating the manpower, considering the extensive work that would be involved. Ger Bergin, an emergency medical controller, was assigned to take the lead in consultation with Mooney and the broader management team under the direction of the Dispatch Steering Group.

Mooney said as part of the governance process, the Dispatch Review Group and Dispatch Steering Group met on a regular basis to monitor target dates and discuss any obstacles encountered along the way. The Midland Control Centre Training Team also played an important role.

Bergin said staff support was an important part of the overall process.

“The total support and commitment of the staff was key to the process,” Bergin said. “We worked together as a team.”

Additionally, the Dublin Fire Brigade, as well as Beverley Logan and Louise Ganley from the U.K. Bristol Offices of the International Academies of Emergency Dispatch® (IAED) and Priority Dispatch Corp.™ (PDC), offered advice for a control centre going through the accreditation process.

“We will encourage and mentor others within Ireland who are interested and willing to take that road.”

–Pat Mooney

Even with people to go to for advice and those helping hands at the control centre, it was still a daunting task.

“It was time consuming and took a sustained and focused approach by everyone involved to ensure that the centre was in compliance with each of the elements of accreditation,” Mooney said.
Staff’s perception matters
A big step in the process involved convincing staff members. Mooney said the staff was naturally concerned about the required 95 percent audit standard and the other changes the new system would mean for them. In the long run, however, they were just as dedicated as the steering groups at making this successful.

He said it didn’t take long for them to recognize that the standard of patient care could be improved and that they could bring their own competency up to an evidentially based standard of excellence.

“They were also motivated to become the first in the Irish Health Service in Ireland to acquire the Academy’s accreditation,” Mooney said.

Going the distance
Communication and feedback were key in the staff meeting and exceeding the standards required for accreditation, Mooney said.

When it came to scoring the performance of individual emergency medical controllers, feedback played a crucial role in delivering quality improvement.

“They felt very positive about the feedback,” he said. “It was constructive critique in relation to how they could improve their handling of the calls.”

Advice to those seeking accreditation
Mooney said achieving accreditation would not be possible without having the full support of both management and staff and making sure that the staff was included in the decision-making process from beginning to end.

“Partnership, from a quality improvement perspective is important,” he said. “It’s my view that securing staff buy-in at an early stage and giving them the opportunity to participate in the decision-making process is far more effective that expecting results based on managerial instruction.”

The following list acknowledges new ACEs as well as reaccredited centers since July 2008.

New Accreditations
123 Hanover Emergency Communications; Hanover, Va.

Reaccreditations – Medical
17 Fountain Police Department; Fountain, Colo.
36 Dauphin County Emergency Management Agency; Steelton, Pa.
56 Great Western Ambulance Service NHS Trust—Avon Sector; Bristol, U.K.
60 North West Ambulance Service NHS Trust Manchester Area; Manchester, U.K.
64 South Central Ambulance Service (Two Shires); Northants, U.K.
69 C.A.U.C.A.; St. Georges, Quebec, Canada
70 Bernalillo County Emergency Communications; Albuquerque, N.M.
71 American Medical Response—Miami; Miami, Fla.
73 EMC Emergency Medical Care Inc.; Dartmouth, Nova Scotia, Canada
97 San Mateo County Public Safety Communications; Redwood City, Calif.
99 Durham Emergency Communications Center; Durham, N.C.

Reaccreditations – Fire
1 Dauphin County Emergency Management Agency; Steelton, Pa.
**Frequently Asked Questions**

**Choking on Fish Bone. Does obstructed airway prevent patient from following PAI?**

Hello Brett:

One of our dispatchers asked a question that I’m sending to you for clarification. She had a 1st party caller who was choking on a fish bone. He was able to speak to her; however, the call had to be done through Language Line because his only language was Spanish. Occasionally, during the call, he would go into a coughing fit and report breathing was difficult due to the obstruction. He was home alone. She was wondering what you would do for Pre-Arrival Instructions (PAIs) when it involves a 1st party caller who has started with a partially obstructed airway, as he did, and then goes into a completely obstructed airway. Obviously, the patient would not be able to speak to us with a completely obstructed airway, but if the patient remained conscious, would the patient be able to listen to instructions and perhaps dislodge the obstruction?

What are your thoughts on this?

Please let me know. Thank you!

Tricia Hallden
EMD-QI Coordinator
New Haven Communications Center
New Haven, Conn.

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The Midlands staff and management are ready and more than willing to show others the way and assist them in the process. After all, Mooney said their control centre has been behind two significant firsts in the Irish Health Service— the first control centre to implement ProQA ® and the first H.S.E. control centre to become an Accredited Center of Excellence (ACE) earlier this year.

“This is a great achievement for us,” he said. “We look forward to continuing to maintain our accreditation status into the future and we will encourage and mentor others within Ireland who are interested and willing to take that road.”

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Tricia:

Your question really involves three circumstances, two of which have been addressed in version 12.0 of the Medical Priority Dispatch System® (MPDS).

First, if the Chief Complaint is unclear due to the EMD’s inability to understand the caller, the call should be coded 32-B-3 to avoid any delay in response while the language line is contacted. From Protocol 32, AI, Rule 4:

“If the EMD does not understand the caller’s language well enough to determine a Chief Complaint and no one on duty is able to assist, the EMD should send 32-B-4, immediately contact a language line service, if available, and reconfigure as appropriate.”

Second, victims of a PARTIAL obstruction (now defined) should be encouraged to “continue spontaneous coughing and breathing efforts” as recommended by Protocol 11, AI, Axiom 2:

“PARTIAL obstruction can be made more life-threatening by attempted intervention in the breathing patient. The best approach for PARTIAL airway obstruction is to encourage the patient to continue spontaneous coughing and breathing efforts.”

Finally, if the patient progresses to a COMPLETE obstruction (also now a defined term), or becomes unconscious, the EMD should link to ABC-1. Unfortunately, this is of little use in the rare but potential case of the 1st party caller when no one else is on scene to assist. The best the EMD can do in this situation is continued encouragement, appropriate response assignment, and relay of information to responders.

Please do not hesitate to call or e-mail me directly with any further questions or comments on this or other issues related to protocol.

Brett Patterson
NAED Academics & Standards
Ball State University (BSU) in Muncie, Ind., is moving into the curriculum phase of its 3-year, $2.5 million project to improve public safety answering point (PSAP) training.

Over the past year, since receiving the grant, BSU staff members involved with the project have been busy visiting PSAPs, talking with dispatchers, and conducting focus groups with communications center managers. A survey posted online was developed based on the cumulative research as one of the first steps taken in the project.

Robert Pritchard, an associate professor of journalism at BSU and a member of the PSAP project team, said the curriculum phase will begin after they’ve analyze the data from the survey that went online in August. The BSU team will be working with a group organized specifically for the project by the National Emergency Number Association (NENA) Public Education and PSAP Training Committee.

According to a BSU press release, Ball State’s team of faculty and staff will first create a communications DVD that will be distributed to about 3,000 9-1-1 dispatch centers for independent study awareness training. A seven- to eight-hour electronic independent study module will also be used in conjunction with on-site, hands-on training activities utilizing tabletop exercises and other techniques.

The grant is from the U.S. Department of Homeland Security through the Federal Emergency Management Agency (FEMA) and is part of the Competitive Training Grant Program (CTGP).

Survey gives dispatch demographics

A survey dedicated to dispatch and developed by the nonprofit 911Lifeline has determined the following information about dispatchers as of July 11, 2008:

- 78 percent work at a center with E9-1-1 Phase II
- 5 percent have only B9-1-1
- 4 percent are NG9-1-1
- 31 percent work in countywide dispatch centers
- 55 percent work in local or consolidated centers
- The median range of population served is 100,000-250,000
- 51 percent are dispatchers or calltakers, with 44 percent being both
- 38 percent are supervisors or above
- The average shift size is 6, with a range of 1-45
- There is a median of 10 people/supervisor with a range of 6-18

PEOPLE IN THE FIELD

Move to Ontario provides new opportunity

Kim Rigden has said her farewell to the British Columbia Ambulance Service (BCAS) after a 17-year career that included a long stretch as a primary care paramedic (1991-2004) prior to becoming a quality improvement manager in the BCAS Performance Management Division. The decision to change from active service in the BCAS communications center to training and consulting, however, was not so much a matter of choice as it was opportunity. Rigden’s husband, Father Christopher Rigden-Briscall, is a priest in the Orthodox Church and was recently selected to serve as the full-time priest at the Christ the Saviour Antiochian Orthodox Mission in the Kitchener-Waterloo area of Ontario, Canada. Rigden said the move is a major one for their family of six (four children) but it was an offer they could not turn down.

“The church was very eager to have us there,” she said. “It was hard saying good-bye to my friends in the ambulance service, but I’m sure many of us will keep in contact.”

Once settled in Waterloo following a whirlwind two-week trip to states in the Northern and Midwestern United States, Rigden embarked on a consulting business and, in her new role, she anticipates a schedule that will allow her to train dispatchers at various communications centers. Her focus will be on the positive side of emergency dispatch and she plans to incorporate the appreciative inquiry techniques she learned from David Nelson, D.Min, whose assignments as a faculty member for Fitch & Associates include the Communications Center Managers Course (CCM). She will also teach courses for the National Academies of Emergency Dispatch® (NAED).

“I have to be mindful of not trying to take on too much,” said Rigden, who also writes for The Journal of Emergency Dispatch (Emily’s story, July/August 2008). “But I do love emergency dispatch and really want to help people to reduce the stress that comes with the job.”

For more information, you can contact Rigden at krbconsulting@gmail.com.
INTERNATIONAL NEWS

Mumbai, India, Launches the Medical Priority Dispatch System®

The ambulance service in Mumbai, India, is now offering the same life-saving support the Medical Priority Dispatch System® (MPDS) and ProQA® deliver to communications centers throughout the world.

On October 8, Mumbai's 1298 Ambulance Access for All launched the MPDS for use in its network of fully equipped advanced and basic life support ambulances. The installation of ProQA software at the Mumbai communications central control room is part of the "1298 Dial for Ambulance" initiative. The program encourages Mumbai residents and visitors to dial 1298 for medical assistance in an emergency.

Since initiating the "1298 Dial for Ambulance" program in 2004, the ambulance service has attended to 35,000 plus medical transportation cases out of which 8,000 have involved life-threatening situations. Despite improvements such as digital mapping and GPS ambulance tracking, Mumbai emergency officials found that those requiring emergency assistance were still losing critical time in accessing help.

They needed an effective and efficient emergency medical dispatch (EMD) system, explained Sweta Mangal, CEO, Dial 1298 for Ambulance. They selected ProQA because of the many benefits it offers to the patient and community. "ProQA is the premier emergency medical dispatcher (EMD) software package in the world," Mangal said. "The system can collect vital information from the caller, obtain the patient’s status, choose an appropriate ambulance dispatch level and, most importantly, instruct the caller with the help of medically approved protocols."

Mangal said the new software emphasizes the benefits of calling for an ambulance during a medical emergency and helps shift the way people in Mumbai react to medical emergencies. International Academy of Emergency Medical Dispatch® trained and certified calltakers are available 24 hours a day, seven days a week at the control room at Kalina, providing assistance through the translation of the MPDS into several languages, including Marathi, Hindi, Gujarati, Tamil, and Malayalam.

Hillsborough County makes the news

Hillsborough County 9-1-1 Emergency Dispatch Center in Tampa, Fla., found itself in a swirl of publicity following three births occurring during six days in late June and early July.

The local television crew featured the center in the evening news program, and local newspapers ran several stories about the three EMDs and the babies they helped deliver using the Medical Priority Dispatch System® (MPDS) Pre-Arrival Instructions (PAIs) for childbirth and delivery (see a related story in this issue of The Journal).

Communications Supervisor Gordon Silver, who gave the PAIs for a delivery on July 4, said three deliveries in six days was unprecedented. He's been at the center for 26 years and generally receives maybe one call per year involving the birth of a baby. Seldom do the news media cover such an event.

"They usually call in the morning to ask if there were any deaths during the night," Silver said. "But they don't pick up on the good news. This was refreshing and the news reporter who came down to interview us seemed genuinely interested in what we do."

If local coverage wasn't enough, the Hillsborough County Emergency Communications Center was also chosen for an episode of the new series Call 911. The program, offered on the Investigation Discovery network, chronicles calls to emergency dispatchers from the onset of the call to on-the-scene response.

Call 911, a 20-part series, premiered July 30. The episode featuring Hillsborough showcases an at-home baby delivery and a choking incident.

There's still time to add your answers to the 911 Lifeline survey, which can be accessed at http://911lifeline.org/limesurvey/index.php?sid=93512&lang=en.

Founded in 2006, 911 Lifeline is a national membership organization that provides support and services to 9-1-1 professionals.

• There is a median of 15 people/manager or above with a range of 2-102
• 40 percent have been telecommunicators for 6-15 years
• 67 percent have been in their current position for less than 10 years
• 7 percent have been in their current position for more than 20 years
• 73 percent have been with the same agency for more than 6 years
• 7 percent have been with their agency for more than 25 years
• 56 percent have been in public safety for more than 16 years
• The median age range is 40-49 with 7 percent older than 60
• 20 percent belong to a union
The expanding use of Tasers has prompted the American Medical Association (AMA) into taking a closer look at just how much harm the electronic control devices can cause.

A policy adopted at a meeting held by the medical group in June approves a study by

### Taser use

“In most of the accident cases, people do not know what to do,” Mangal said. “That is true even for patients with cardiac problems. The protocol will help victims of an accident, sexual assault, or patients with cardiac arrest, heat stroke, a fall, amputation, headache, animal bite, pregnancy, child collapse, and other injuries.”

Worldwide, the MPDS is used in over 3,000 communications centers and translated into 15 languages and dialects, with the majority of users in the United States, Canada, United Kingdom, Ireland, Australia, Germany, Italy, Switzerland, and New Zealand. Currently, there are over 46,000 IAED-certified Emergency Medical Dispatchers taking calls today. Mumbai, formerly Bombay, is the financial capital of India. With an estimated population of 13 million, it is the most populous city in India and the second most populous city in the world. The potential for phone-directed patient care impact and ambulance response accuracy is immense in this enormous community.

### Baby makes the call

Once again it was the baby that decided when and where with the Medical Priority Dispatch System® (MPDS) providing the how in an on-the-way to the hospital birthing in West Sussex, U.K.

According to the news clip on the BBC news channel, Keeli and Ian Judge were in the car traveling to a birthing center not far from their home when their unborn baby decided that wait had ended. The dad, Ian, pulled the car over on a busy roundabout and called 9-9-9. Emergency call operator Laraine Domm, of the South East Coast Ambulance Service, brought the couple through the Childbirth Pre-Arrival Instructions (PAIs), including the part reminding dad that the baby would be slippery.

“Be careful not to drop him,” Domm says in the recorded call.

“OK,” responds dad.

Baby Samuel and mom were taken by ambulance to the hospital, although it was not the place the couple had planned to go for an anticipated water birth.

Despite the change in venue, Keeli sounded elated about the unexpected arrival, especially considering her husband’s aversion to blood.

“He can’t actually stand the sight of blood either, but they talked him through it and he was just so calm. He just took control,” she told the BBC.

Domm commended Ian’s ability to stay focused during the birth in the back seat of the family car on a busy road near the stunning Borde Hill Garden.

“He managed to stay cool, calm, and collected,” she said during the interview broadcast in July, which was taken shortly after Samuel’s arrival.

### California ups ante for making non-emergency calls to 9-1-1

Legislation signed by California Gov. Arnold Schwarzenegger takes a two-strike rule down to one strike for anyone making a call to 9-1-1 for something other than an emergency situation.

Under the new law, signed July 10, a first call to 9-1-1 for reasons other than an emergency will result in a written warning.
A second offense carries a fine of $50; a third $100; and for fourth or subsequent violations, the caller will be fined $250. The new law goes into effect Jan. 1, 2009.

Under the old law, written warnings were sent out for first and second offenses, and the maximum fine was $200.

California made the headlines for 9-1-1 emergency call abuse in February 2008 in a case that involved 27,000 non-emergency calls made by one person over an eight-month period, commencing May 2007.

The California Highway Patrol answered the first batch—17,000 calls—made during a seven-month period. The second batch—10,000 calls—was answered in January 2008 by the Hayward Police communications center. The caller was arrested after police tracked his cell signal. If convicted, he faces $1,000 in fines and jail time. The story in the San Jose Mercury News (Calif.) didn’t report any additional fines for the calls.

BC Ambulance Service rewards citizen saves

The British Columbia Ambulance Service (BCAS) keeps busy handing out awards in recognition of a citizen’s quick action in saving lives.

The awards and recipients include the BCAS Vital Link Award to Kaye Halstead, who is credited with saving her husband’s life; and the BCAS Good Samaritan Award to Erick Mackinnon and Alexander and William Thiessen, who are credited with saving the lives of their mothers in two separate incidents.

According to the BCAS press releases:

Kaye and John H halstead were having breakfast when John appeared unresponsive at the table, like he had fallen asleep.

“I called his name and shook him a little bit but he didn’t respond, so I called 9-1-1,” Kaye Halstead recalled. “The BC Ambulance Service dispatcher was very helpful; he told me to put my husband on the floor, tilt his head back, and to listen for any breathing. All I could hear was a little gurgling. The dispatcher then talked me through the steps of CPR, which I continued until the BCAS paramedics arrived.”

When Kaye called 9-1-1 she was connected with BCAS EMD Shaun Hanse, who guided her through the steps of CPR while the BCAS paramedics were enroute.

Carrie MacKinnon, a Type 1 diabetic and nurse, woke up with low blood sugar. She asked her son, Erick, to get her two juice boxes from the fridge.

Having talked to him his whole life about her diabetes, he asked his mom if her blood sugar was low and she replied, “Yes.” Erick knew right away to call 9-1-1. He explained clearly to the EMD that his mother was a diabetic and needed help. When Carrie woke up in her living room with an IV in her arm and BCAS paramedics looking after her, Erick sat calmly on the couch watching cartoons.

One morning, while home on summer school break, 8-year-old William noticed his mother Betsy Thiessen acting strangely and asked if she had tested her blood sugar.

When she didn’t make sense he alerted his older brother, 11-year-old Alexander. While Alexander tested her blood sugar, he instructed his brother to call 9-1-1. Alexander made his mother comfortable then took the phone to explain that his mother was diabetic. He told them the results of her blood sugar test. The boys remained on the phone with the dispatcher, who was able to call the boys’ father and connect them through a conference call.

The BCAS Vital Link Award is presented to individuals involved in trying to save people through administering CPR. The BCAS Good Samaritan Award is presented by the BCAS to individuals who have provided unselfish and humanitarian assistance during a medical emergency.

Commitment to EMD program brings commendation

A 28-year and counting tenure with the city of Boca Raton (Fla.) hasn’t settled into a slide of retirement complacency for Fire Rescue Department Division Chief Michael O’Neil.

That’s hardly the case, as his selection as Firefighter of the Year 2007 shows.

“It was a tremendous honor,” O’Neil said. “Certainly nothing that I had expected.”

The two-page commendation cites O’Neil for his dedication to dispatch as well as his wide-ranging application of computer skills.

On the dispatch side, the commendation states: “Michael’s leadership and commitment has encouraged and resulted in a continuous improvement in the Emergency Medical Dispatch (EMD) program. We have a half-dozen documented cases of our dispatchers providing phone instructions in CPR while our fire rescue paramedics responded and the patients were successfully revived. The Emergency Medical Dispatch System® [the Medical Priority Dispatch System®, M PDS] program, which Michael oversees, helps countless numbers of callers until our paramedics arrive on the scene.”

The commendation acknowledges O’Neil for his computer wizardry, with work that includes a computerized fire hydrant tracking database, computer software for calculating fairness in overtime, and a software-training module that maintains training records for ISO and state recertification requirements.

The computer projects, many of which O’Neil developed and debugged on his own personal time, are estimated to have saved Boca Raton more than $200,000 when compared to commercially available products and maintenance.
We Hear You. Academy responds to MPDS version 12 concerns and questions

By Benjamin H. Rose

It’s been several months now since the release of Medical Priority Dispatch System® (MPDS) version 12, and feedback has begun to trickle into the offices of the National Academies of Emergency Dispatch® (NAED). Concerns and questions have surfaced regarding five particular issues:

1. Focal seizure
2. Significant facial burns
3. Difficulty breathing with chest or neck injury
4. Positioning of unconscious pregnant patients in third trimester
5. Unconscious with effective breathing on trauma protocols

Focal seizure

Seizures are caused by abnormal electrical disturbances in the brain. When the electrical activity encompasses the entire brain, the result is a generalized seizure causing twitching or jerking movements involving the whole body. Generalized seizure is one of the most common causes of sudden unconsciousness.

On the other hand, focal seizures (also called partial seizures) involve electrical disturbances confined to a limited portion of the brain. The limited nature of the electrical disturbance makes focal seizures different from generalized seizures in two important ways. First, focal seizures cause twitching in just one part of the body. Second, patients of this rarely reported seizure usually remain awake and breathe normally throughout the event.

Focal seizures, while disconcerting and perhaps frightening to the caller, seldom constitute a prehospital emergency. They typically last less than two minutes and end naturally with no intervention. The twitching movements are usually vague and unorganized and almost never pose a danger to others.

Prior to v12, the MPDS lacked the ability to properly categorize focal seizures, often leaving the EMD with no choice but to select CONTINUOUS seizure. This resulted in the occasional over-response, leading the NAED’s Medical Council of Standards to introduce the FOCAL seizure pathway in the Convulsions/Suizures Protocol for MPDS v12. The intent is to avoid the unnecessary selection of CONTINUOUS seizure and the resultant...
DELTA response when the caller reports a less dangerous focal seizure.

EMDs should learn to recognize when the caller is describing a focal seizure on Case Entry and select FOCAL seizure only in those cases. As defined in the MPDS, FOCAL seizure is localized twitching in only one part of the body in a conscious patient.

Occasionally, a simple focal seizure may progress into a generalized, CONTINUOUS seizure. Focal seizures always require evaluation by responders. If the patient is not completely alert, it may be a sign of a more dangerous condition, and the patient’s breathing should be checked using the Agonal Breathing Diagnostic Tool. (Illustration on previous page.)

Significant facial burns

Among field responders, facial burns are traditionally linked with the potential for respiratory burns. This can be especially dangerous because the airway may become inflamed and close off the flow of air. However, the MPDS has not previously included a distinct category for facial burns because the Council of Standards had no evidence that facial burns presented a critical danger unless accompanied by difficulty breathing, which was already represented in the DELTA determinants.

Although the Council of Standards has received numerous requests for the addition of a determinant for facial burns, compelling evidence to support that request surfaced only recently. Two supporting cases submitted with a Proposal for Change for version 12 convinced the council to approve the request, with limitations established by a dispatch definition (see below).

In the first case, a woman lit up a cigarette while taking oxygen, causing a small explosion right in her face. She had no difficulty breathing at the time of the call, and the case was correctly coded as 7-A-1, “Burns <18% body area.” However, she was then transported as a full trauma team activation and transferred to a burn center for treatment of respiratory burns.

In the second case, a welding torch explosion resulted in burns to a man’s face and arms. As in the first case, the patient had no difficulty breathing during the call, and the case was coded as 7-A-1. This patient was intubated in the emergency room and flown by helicopter to a burn center.

These cases highlighted two important factors. First, the swelling of the airway and resultant breathing problems did not occur until after the caller had hung up, but they came on very rapidly. For this reason, the new determinant was placed in the CHARLIE level to provide an emergent ALS response. Second, both cases involved explosions. Hot gases that invade the airway usually cause respiratory burns. The SIGNIFICANT FACIAL Burns definition was created to account for this. Burns of significance are those caused by explosion, fire, or gases—so we’re not as concerned with spatter burns, such as might result from a hot liquid being splashed onto the face.

Difficulty breathing with chest or neck injury

Prior to version 12 of the MPDS, all trauma protocols contained a question about abnormal breathing. The presence of abnormal breathing automatically generated a CHARLIE-level response. A certain amount of over-triage was expected—consider a patient with a severely broken ankle who is breathing rapidly due to the pain—but the Council of Standards decided to err on the side of safety, considering the possibility that a traumatic injury could be the cause of the abnormal breathing.

Research conducted by the Salt Lake City Fire Department over a two-year period demonstrated that less than one percent of patients in abnormal breathing determinant cases received ALS procedures. The majority of patients were treated with an IV and pain medication, indicating that the abnormal breathing stemmed from a simple pain response rather than a traumatic source.

In response to this research, the breathing question has been qualified. It is now asked only when there is an injury to the chest or neck. Essentially, it is limited to body areas where a traumatic cause for breathing problems is likely. This will limit
Positioning of unconscious pregnant patients in third trimester

As the fetus continues to grow during the third trimester of pregnancy, the fetus and the expanding uterus displace abdominal organs and their combined weight can exert abnormal pressure on major blood vessels, particularly the inferior vena cava. This can result in the patient’s collapse as blood flow to the heart slows and blood pressure drops.

This issue was discussed in the September/October issue of The Journal of Emergency Dispatch in Brett Patterson’s article “Anatomy of a PFC.” Patterson’s article gives fascinating insight into the PFC process by following a particular PFC through the entire process. The PFC under consideration happened to be the one regarding the positioning of unconscious pregnant patients, submitted by Andy Heward of the London Ambulance Service. Patterson’s article is highly recommended. A few portions relevant to this CDE article are quoted here:

Heward provided supporting research material that shows that this sort of spontaneous hypotension occurs in about 10 percent of pregnancies. He also pointed out that pregnant patients who collapse for other reasons might be encountered lying on their backs, which exacerbates this potentially serious condition.

Heward went on to explain that the MPDS treats all unconscious patients in the supine (lying down, face up) position. He provided supportive documentation to suggest pregnant patients in their third trimester would be better off on their left side and that a tilt of even 15 degrees may be sufficient to relieve pressure on the vena cava.

The head-tilt method, which is performed with the patient in the supine position, is the preferred method of airway control in the dispatch environment because it is easily described in the non-visual environment, and it literally forces the bystander to monitor the patient’s airway and breathing status. These important considerations had to be weighed from a risk-benefit standpoint: the circulatory risks and airway benefits associated with placing an unconscious, third-trimester patient on her back, versus the circulatory benefits and airway risks associated with turning her on her side.

The difficult task of considering this dilemma was made easier because Andy included specific references to related research with his PFC. This research suggested that airway maneuvers, as well as CPR, could be performed with the pregnant patient tilted slightly to one side. The research also suggested that such maneuvers could be enhanced if the patient had a stabilizing object placed behind her to help maintain her position.

In MPDS v12, the CPR sequence in Protocol C was modified to account for the optimal positioning of these patients, and a related Rule was added on Protocol 24.

Unconscious with effective breathing on trauma protocols

Securing and maintaining an open airway presents little trouble when dealing with medical patients. Just open the airway and monitor. The MPDS has a more complicated history regarding airway control for trauma patients because of the potential for spinal injury. Recommendations in the past have included tilting the neck just a little at a time to minimize spinal injury risks and more recently using the rescuer’s hands to stabilize a breathing patient’s head and neck in the position found.

In MPDS v12, the distinction between effective and ineffective breathing has provided a new way of looking at airway control for trauma patients. It’s very simple. If breathing is ineffective, value life over limb and tilt the head back to open the airway. If breathing is effective, just leave the airway alone and let the patient breathe—even if unconscious. There is no need to go to PAIs and provide “invasive” treatment when the patient is breathing effectively, but the airway should be monitored closely in case breathing deteriorates. MPDS v12 provides a new DLS Link to X-3 for unconscious trauma patients with effective breathing. Remember the recommendation to stabilize the head and neck in the position found if you suspect a spinal injury in a breathing patient.

The NAED hopes you continue to send in feedback about your experiences and questions regarding MPDS version 12.
1. A focal seizure causes the entire body to jerk or twitch.
   a. true  
   b. false

2. Patients experiencing a focal seizure usually remain awake and breathing throughout the seizure.
   a. true  
   b. false

3. In MPDS v12, a SIGNIFICANT FACIAL Burn is defined as:
   a. a burn to the face accompanied by difficulty breathing.
   b. a burn that covers more than 18 percent of the face.
   c. a burn caused by a hot liquid being splashed onto the face.
   d. a burn to the face caused by explosion, fire, or gases.

4. SIGNIFICANT FACIAL Burns may be more dangerous than other similar burns because of the increased potential for:
   a. hypothermia  
   b. infection  
   c. respiratory burns and airway swelling  
   d. permanent disfigurement and scarring

5. Research conducted by the Salt Lake City Fire Department demonstrated that less than ______ percent of trauma patients in abnormal breathing determinant cases received ALS procedures.
   a. 1  
   b. 3  
   c. 5  
   d. 10

6. Research submitted to NAED by Andy Heward of the London Ambulance Service suggests that airway maneuvers, as well as CPR, could be performed with a pregnant patient tilted slightly to one side.
   a. true  
   b. false

7. According to the research, a tilt of even ______ degrees to the left side may be sufficient to relieve pressure on the vena cava of a collapsed, pregnant patient in her 3rd trimester.
   a. 5  
   b. 15  
   c. 25  
   d. 35

8. When a trauma patient is unconscious and demonstrating INEFFECTIVE BREATHING, MPDS v12 directs the EMD to:
   a. protect life over limb and instruct the caller to tilt the patient’s head back to open the airway.
   b. minimize spinal injury risks by instructing the caller to gently tilt the head back, a little at a time, until air goes in and the chest rises.
   c. instruct the caller to use her/his hands to stabilize the patient’s head and neck in the position found.

9. When an unconscious trauma patient is breathing effectively, MPDS v12 directs the EMD to:
   a. protect life over limb and instruct the caller to tilt the patient’s head back to open the airway.
   b. minimize spinal injury risks by instructing the caller to gently tilt the head back, a little at a time, until air goes in and the chest rises.
   c. leave the airway alone and link to X-3 for Stay on the Line instructions.

10. The NAED hopes you continue to send in feedback about your experiences and questions regarding MPDS version 12.
    a. true  
    b. false

Answers to the CDE quiz are found in the article “We Hear You,” which starts on page 17.

Take this quiz for 1.0 CDE unit.

To be considered for CDE credit, this answer sheet must be received no later than 12/31/09. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). 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 certificate to be submitted to the Academy with your application when you recertify.

Clip and mail your completed answer sheet along with the $5 processing fee to: The National Academies of Emergency Dispatch 139 East South Temple, Suite 200 Salt Lake City, UT 84111 USA (800) 960-6236 US; (801) 359-6916 Intl. Attn: CDE Processing

Please retain your CDE acknowledgement to be submitted to the Academy with your application when you recertify.

Name ____________________________
Organization ____________________________
Address ____________________________
City__________________St./Prov. ____________
Country__________________ZIP ____________

Academy Cert. # ____________________________

E-mail: ____________________________

Daytime Phone (        ) ___________________

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

November/December Journal 2008  VOL. 10 NO. 6 (We Hear You)
Building Blocks of a Police Call. Process targets information officers require

By Jaci Fox, Medicine Hat Regional 9-1-1 Communications

In order to accurately and efficiently process police calls, it is essential to maintain the principles of Structured Call Processing. The Emergency Police Dispatch Protocol® (EPD) shares the principles that Emergency Medical Protocol® (EMD) and Emergency Fire Protocol® (EFD) follow, but has a number of significant differences compared to the other two disciplines. Let us consider the anatomy of a police call, dissected into its major components, and the process that works to produce proficient and timely police information and dispatch prioritization.

Case Entry Protocol
The Case Entry Protocol provides for the initial interrogation of the incident. This interrogation includes the five W’s critical to successfully call initiation:

1) “What's the address of the emergency?” This question is scripted to solicit specific information about the location of the actual incident. This is perhaps one of the most significant pieces of information in any call. We must efficiently and precisely obtain this information quickly in order to get the appropriate response sent, when safe to do so.

2) “What's the phone number you are calling from?” Maintaining phone contact is vital during a police incident, providing that doing so does not endanger the caller.

3) “What is your name?” This question is not a mandatory question in EMD or EFD. However, in the police questioning it is important as it starts a bond with the caller immediately.

Remember, we have trained calltakers and not trained callers.

1) “What's the address of the emergency?” This question is scripted to solicit specific information about the location of the actual incident. This is perhaps one of the most significant pieces of information in any call. We must efficiently and precisely obtain this information quickly in order to get the appropriate response sent, when safe to do so.

2) “What's the phone number you are calling from?” Maintaining phone contact is vital during a police incident, providing that doing so does not endanger the caller.

3) “What is your name?” This question is not a mandatory question in EMD or EFD. However, in the police questioning it is important as it starts a bond with the caller immediately.
works effectively as a calming technique, and can be important in naming the victim or witness in a complaint.

4) "What [tell me] exactly happened?" The importance of this question cannot be underestimated. There is a significant difference between what the caller perceives the problem to be and what exactly is happening. For example, a caller may describe the problem as: "Send police my son is bleeding!" In this situation, do we truly know what has happened? Perhaps a young boy was pushed out of a tree. Perhaps a car struck a teenager, or an adult was just stabbed. You can see how important it is to understand circumstances, rather than the caller's impression of the problem alone. If you are not obtaining useful information by asking CE4 once, an enhancement proven successful is: "This is very important, TELL ME EXACTLY WHAT HAPPENED." Enhancing with "This is very important," helps us to get what we need to move ahead. In order to accurately classify the incident, we MUST have a very clear picture of what is transpiring, so that we use the correct interrogation.

5) Where are you (in relation to the incident) and when did this occur? As well as when was the accused person last seen? If the answers to these questions reveal the criteria for a cold call, then the secure past event does not require the thorough interrogation that would be needed for an in progress event.

Chief Complaint Protocols

This section includes: Key Question interrogation, the Determinant Descriptors, Post Dispatch Instructions, Critical EPD Information, and Dispatch Life Support (DLS) Links.

The Key Questions begin by addressing potential safety issues. It is imperative that the interrogation is structured to ensure the safety of the caller, officer(s), and the public. All safety-relevant interrogations follow this basic format: when an officer arrives on scene, is there gunfire or other weapons, is the officer shooting when he arrives at the incident, is anyone else being injured when police are arriving on scene? Once the safety issues have been addressed, we reach the dispatch point of the call; when it would be safe to dispatch officers to the incident. This is pre-assigned matrix includes pre-planned officer resource allocations and modes. The Determinant Descriptors are pre-assigned so that we can send the right number and type of units and officers to a call, at the right time, in the right way.

The answers provided from Key Questions enable the selection of an appropriate Determinant Descriptor. Using Post Dispatch Instructions, call takers now can assist officers with the responsibility of preserving evidence.

Critical EPD Information reminds the police dispatcher of other duties that need to be finished to resourcefully handle the call. Lastly, the DLS Links provide the call taker with a professional and an effective way of maintaining or terminating the call.

Caller in danger protocol

When dealing with dangerous situations it is essential to provide exact
instructions to offer safe alternatives for the caller. This would include instructing the caller to get to safety (if that is an option), or instructions regarding what the caller should do if they cannot safely leave the scene. This protocol also includes intuitive ways of soliciting information from the scene of the incident when the caller cannot get to safety.

Pre-Arrival Instructions
Pre-Arrival Instructions are for inherently dangerous situations that require precise direction during escalating, time-sensitive events. These instructions handle situations for Caller in Danger, Bomb or Suspicious Packages Found, Sinking Vehicles, or Hostage Situations.

Case Exit
The Case Exit protocol provides the call taker with a professional way of maintaining the caller until law enforcement arrives or terminating the call. Best practices of customer service provide efficiency for communications centers, as well as law enforcement agencies. Satisfied customers do not make unnecessary calls when their complaints or concerns have been validated and addressed.

We must also note that there are some important, interrogation differences between police calls and other public service calls. Police calls are dynamic—they may change quickly during the questioning and the call taker must be able to ask the most appropriate questions at hand. The accused may flee the scene of the incident when he or she knows police are coming. Callers may be deceptive during their interrogation. Finally, 85 percent of police calls are not in-progress events. Most of the time, law enforcement incidents are reported when the incident is over. Generally, when the public calls for EMS or fire, their calls are “go now” incidents, which is often the opposite of police calls.

We have learned that in the police world, seconds save time, but answers save lives. It is the accurate collection of information that effectively and routinely produces important details. These details provide for the safety of those involved in the call and reveal the exact nature of the incident. Functioning on fact-based information, as opposed to emotional or situational erroneous information, provides for the best possible outcome.

Quoting a study done in Birmingham, Ala., “The complaint operator, the person who receives the call made to the police department, is the citizen’s most important link to police service. The operator’s response—whether cordial, helpful, perceptive, or calming—can make a great contribution to helping a citizen before, or irrespective of, response by a police officer (in person). The dispatcher’s role is equally critical. Very often a dispatcher’s decision dictates the type of response a patrol officer makes. Dispatchers are responsible for prioritizing incoming calls.” Further quoting the study, “Most analysis of police calls suggest the emergency calls—medical emergencies, crimes in progress, disturbances—account for fewer than 15 percent of all calls.”

Protocol provides confidence
Structured, science-based protocol interrogation provides call takers and dispatchers with the confidence to produce refined, high-level call processing. The information gathered is incident-specific and not emotionally biased. The call taker is able to listen actively to the caller because he or she is not required to partially listen to the caller while simultaneously attempting to choreograph an interrogation sequence based on wit and/or previous experience. Each incident is prioritized for response with accurate information that is then sent out to responding units.

The building blocks our police calls stack up. We see many commonalities among caller interrogations and processing consistent with the EMD and EFD protocols. However, by exploring the Anatomy of a Police Call, we see that there are some distinct differences in the interrogation process of police calls.

In the next issue of The Journal, we will use a sample call and break down police protocol into distinct pieces, explain how it works, and examine the outcomes of each step in the interrogation process.

Sources
CDE Quiz Mail-In Answer Sheet

Answers to the CDE quiz are found in the article “Building Blocks,” which starts on page 21.

1. What are the 5 W’s of Case Entry?
   a. Where do you need the police to attend? Where did you come from? What is your name? What are you wearing? When were you born?
   b. Where are you calling from? Where do you need the police to attend? What is your name? What exactly happened? Where are you (in relation to the incident) and when did this occur?
   c. Where are you and when did this occur? Where were you born? What’s the suspect’s name? When did this happen? Where are you calling from?

2. “What’s your name?” is a mandatory question for EMD.
   a. true
   b. false

3. The Key Questions begin by addressing what?
   a. the description of the suspect
   b. vehicle description and direction
   c. safety issues in the event
   d. contact information for the complainant

4. After Key Questions are completed, what are we primarily responsible for?
   a. getting contact information
   b. comforting the caller when they are in distress
   c. giving the caller relevant instructions to maintain their safety
   d. encouraging the caller to catch the suspect

5. Pre-Arrival Instructions are available for what situations?
   a. caller in danger
   b. bomb or suspicious packages found
   c. sinking vehicles
   d. hostage situations
   e. all of the above

6. Police calls are standard and never change.
   a. true
   b. false

7. About what percentage of police calls are not in-progress events?
   a. 87 percent
   b. 95 percent
   c. 85 percent
   d. 81 percent

8. We have learned in the police world that answers save time, and seconds save lives!
   a. true
   b. false

9. Structured protocol interrogation offers what to each dispatcher/calltaker?
   a. the option to think about other things to ask while taking the call
   b. extra speed in taking a call
   c. the confidence that they can deviate when they choose as long as they follow the Case Exit verbatim
   d. the confidence to know they can trust this defensible, scientifically based interrogation system to produce refined, high level call processing

10. About what percentage of police calls require a hot (immediate) response?
    a. 18 percent
    b. 15 percent
    c. 10 percent
    d. 5 percent

To be considered for CDE credit, this answer sheet must be received no later than 12/31/09. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). 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 certificate to be submitted to the Academy with your application when you recertify.
Ducks in a Row. Do your homework before requesting financial help from Maryland’s Emergency Number Systems Board

By Audrey Fraizer

It’s the job of Maryland’s Emergency Number Systems Board (ENSB) to make sure county PSAPs have all their ducks in a row.

At least, that’s the case if the state’s primary public safety answering points, or PSAPs, want funding for the technology and equipment it takes to run a communications center. PSAP supervisors and coordinators responsible for filling out the applications can apply the funds toward protocol systems.

“You ask the board for a certain amount of money, so you better know how much it will take when making your case,” ENSB Executive Director Gordon Deans told his audience at the Navigator Conference held during April in Baltimore, Md.

Do the homework

In other words, it pays PSAPs to do their homework, especially since the ENSB application for funding includes several points agencies must think about when developing a project plan:

1. Describe the nature of the improvement/enhancement/replacement being requested.
2. Was this request for funding included in your agency’s “3-Year Funding Plan” requested by the board?
3. Did you meet all requirements of your county’s procurement regulations?
4. Describe your procurement process, justify sole source procurements, and attach relevant documentation.
5. Is this part of a larger program of improvement for the PSAP?
6. When do you anticipate the start and completion of your project or purchase (provide a project “timeline” from start to completion)?

Dispatchers regulated

Maryland has strict laws for its dispatchers. State code for emergency medical services requires dispatchers to complete an emergency medical dispatcher (EMD) course and they must demonstrate competence in medical protocols. In addition, dispatchers must be licensed and recognized as an EMD by a state-approved EMD program.

The Medical Priority Dispatch System® (M PD S) was recommended for use in state PSA P s from proposals submitted after the law was enacted. The EMD selection was made under the Maryland National Incident Management System (N IMS), an initiative of the U.S. Department of Homeland Security to provide consistent response during a domestic crisis.

The reasoning to select M PD S was simple, Deans said.

PSAPs had active training programs and protocols in use before the law was passed, but they were of the homegrown variety. PSA P s rarely updated the original documents and few centers were using the same training programs or methods for answering 9-1-1 calls. The Emergency Telecommunicator Course (ETC) fit their needs and its success convinced the state to try

While the county PSAP directors have the final say in which protocol system they want in their centers, they can receive funds up to the level of the Priority Dispatch Systems™ (PDC), and that includes ProQA®, AQUA™, and the cost of the computer-aided dispatch (CAD) interface.

“They can choose other systems,” Deans said. “That’s up to them, but we found that the NAED and PDC fits the scope of our project so that’s the system [PDS] we recommend.”

“It’s all about quality. Our goal is running an efficient 9-1-1 system.”

Standards across the board

The success of the EMD program prompted the ENSB to look into national standards for fire and police dispatch. Four years ago, the 15-member EN SB put together a four county pilot program to evaluate the benefits of using consistent fire and police response systems no matter the location of the incoming
emergency call. The board chose the Fire Priority Dispatch System™ (FPDS) and the Police Priority Dispatch System™ (PPDS).

The pilot proved a success and the ENSB has since developed a goal to have 80 percent of the state’s counties using the three disciplines by June 2009 (90 percent by June 2010). As of April 2008, the state was on target and Deans was optimistic about meeting the deadline.

He said there was some initial hesitancy, especially among fire officials, despite the positive findings from the pilot program. “The fire side worried about the delay in dispatch from all the questions,” he said. “We needed a lot of help from the Academy to get this through that.”

ENSB responsibilities

The ENSB is responsible for coordinating the enhancement of county 9-1-1 systems. Funds placed in the 9-1-1 trust cover the costs of technology and equipment from the 25-cent 9-1-1 surcharge applied to wireless, wired, and VoIP phone subscribers. The ENSB reimburses counties for the cost of enhancing a 9-1-1 system. A separate 75-cent 9-1-1 surcharge levied by the individual counties covers the operational costs of running the communications centers.

The county PSAPs are audited each year to make sure no money is made from the surcharge, and the governor appointed ENSB meets monthly to discuss funding and other issues related to running the state’s 24 PSAPs. Every five years, the ENSB purchases new phone systems for each center and provides the funds to train personnel.

“It’s all about quality,” Deans said. “Our goal is running an efficient 9-1-1 system.”

There are items the ENSB doesn’t fund:

- Funding that does not directly relate to answering and processing 9-1-1 calls
- Service or maintenance contracts beyond the initial warranty period
- Personnel salary or overtime costs
- CAD Systems (excluding CAD interfaces)
- Public-Safety Radio Communications Systems
- Other equipment associated with police, fire, or EMS personnel “responding” to requests for emergency service

Lessons learned

The pilot program taught lessons that Deans boiled down for those attendees at Navigator seeking funds to implement protocols. They are as follows:

1. Collect data.
   Before you implement a protocol system, check your baseline data for comparison once the system has been up and running. Deans also recommended sending surveys to callers and the public at-large asking them to evaluate 9-1-1 response both before and after switching to protocol.

2. Consider other funding sources.
   For example, the U.S. Department of Homeland Security provides funds for emergency communications. The National Emergency Communications Plan (NECP) released in July 2008 provides information for state, local, and tribal agencies and governments on federal funding available to assist with emergency communications procurement and planning. It also offers a forum for regional planning and participation.

   Identify the stakeholders and talk to them, Deans said. This includes county officials and executives, fire and police supervisors and commanders, and the public. “Let them know you plan to change things,” he said. “They need to accept that.”

4. Bring in the dispatchers.
   “Once you get the blessings of stakeholders, talk to your dispatchers,” he said. “They need to understand that this is going to happen. Discuss the benefits and what they can expect from you.”

5. Set a reasonable timeline.
   This is nothing wrong with optimism, but rushing a project against an unrealistic timeline can prove frustrating and counter-productive. “You’re not going to do this in six months like we initially thought we could do,” Deans said. “The change takes time and intensive labor.”

6. Assemble a good team.
   The project’s demands require a commitment. “You need a good team who wants to get this done,” he said.

   Appoint a liaison from the team to keep fire and police administrators in the loop, Deans said. A nonunderstanding of the system is important, as well as periodic progress reports. “They’re going to hear when things go wrong,” he said. “They need to have the information at hand to respond knowingly.”

8. Implement one protocol at a time.
   Deans cautioned against introducing the different protocols simultaneously. “Get your people comfortable with one before moving on to another,” he said. “Too much at one time can get confusing.”

9. Set up a quality assurance program.
   Deans said the quality assurance (QA) program should be in place at the same time the center begins answering calls using protocol. The problem for centers, he said, is hiring a person dedicated to QA or freeing up the time of an existing employee to manage the QA program. “QA is a continuous process,” Deans said. “Buy-in is critical.”

10. Remember the details.
    Don’t overlook the administrative side, Deans said. This might include updating the SOP manuals, obtaining interagency agreements, and scheduling continuing education courses.

11. Reward staff.
    Deans suggests a program to identify excellence such as an employee of the month award or recognition for dispatchers who meet and exceed compliance standards.

12. Contact media.
    Let the media know what you’ve done, Deans suggested. Give them stories about how protocol helps saves lives and explain how the system works. “It’s always a good idea to embrace the media,” he said. “You certainly can get a lot out of establishing a good relationship.”

    Collect data to compare against the baseline and let your stakeholders know about the improvements. “Show them how far you’ve come,” Deans said.
THE PREMIER EDUCATIONAL CONFERENCE FOR POLICE, FIRE, AND MEDICAL DISPATCH

NAVIGATOR ’09

Vegas

APRIL 29 – MAY 1

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Topics and speakers are subject to change. Visit www.emergencydispatch.org for the latest updates.
### EXHIBIT HALL

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<td>Coffee Service</td>
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<td>Registration and Continental Breakfast</td>
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**Special Issues in Version 12**

- Dr. Jeff Clawson, Brett Patterson
- **Why Do You Keep Asking Me All These Questions?**
  - Grant Rinner, Nadine Boulanger, Lori Deubert

**CDE – To Boldly Go Where no Instructor Has Gone Before**

- Tracey Barron, Louise Ganley

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**Coffee Service**

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**Picnic Lunch in the Exhibit Hall**

- **Exclusive Hours & Box Lunch**
  - 11:30 a.m. - 12:30 p.m.
- **Last Chance to Visit This Year's Exhibitors!**

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**Coffee Service**

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**Leadership Award**

- Dr. Jeff Clawson

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**Closing Keynote Lunch**

- Sponsor: EnRoute

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

CONFERENCE REGISTRATION OPTIONS
APRIL 29–MAY 1, 2009 (WEDNESDAY–FRIDAY)

Passports INCLUDE admission to all regular conference sessions, the opening reception, the exhibit hall, and two box lunches.

☐ Conference Passport $515

DISCOUNTS (CHECK ONLY ONE, AS ONLY ONE APPLIES) DISCOUNT
☐ NENA Membership (ID: ________________________) $-30
☐ NAED Membership (ID: ________________________) $-40
☐ Group Rate (3 or more from same agency, submitted at the same time) $-70
☐ Accredited Center (Current ACE) $-100

☐ 1-day (Price per day, Wednesday–Friday, Check below) $195
☐ April 29
☐ April 30
☐ May 1

☐ Spouse/Guest Admission (Name: ________________________) $50
(Admission only to exhibit hall. Includes two lunches and opening reception.)

☐ Keynote and Awards Luncheon, May 1 (Friday) $25

Pre CONFERENCE PROGRAM SUMMARY
APRIL 26–28, 2009 (SUNDAY–TUESDAY)

NAED CERTIFICATION COURSES
(Prices as marked. NAED materials and testing fees INCLUDED)
3 DAYS, SUN–TUE, APRIL 26–28, 8:30 AM–5:30 PM
☐ EMD: Emergency MEDICAL Dispatch Certification Course $295
☐ EFD: Emergency FIRE Dispatch Certification Course $295
☐ EPD: Emergency POLICE Dispatch Certification Course $295
☐ ETCI: Emergency Telecommunicator Instructor Course $475

2 DAYS, SUN–MON, APRIL 26–27, 8:30 AM–5:30 PM
☐ EMD-Q: MEDICAL Dispatch QI Certification Course (Class 1) $315
☐ EFD-Q: FIRE Dispatch QI Certification Course $315

2 DAYS, MON–TUE, APRIL 27–28, 8:30 AM–5:30 PM
☐ EMD-Q: MEDICAL Dispatch QI Certification Course (Class 2) $315
☐ EFD-Q: FIRE Dispatch QI Certification Course $315

1 DAY, TUE, APRIL 28, 8:30 AM–5:30 PM
☐ EQC: Recertification Course $250

NENA & NAED SPECIAL TOPIC WORKSHOPS
1 DAY, MONDAY, APRIL 27, 8:30 AM–5:30 PM
☐ NENA: Introduction to Next Generation 9-1-1 $190
☐ NENA: Overcoming Negativity in the Communications Center $190

1 DAY, TUESDAY, APRIL 28, 8:30 AM–5:30 PM
☐ NENA: Next Gen Employees for the Next Gen PSAP $190
☐ NENA: Preparation for PSAP Management $190
½ DAY, TUESDAY, APRIL 28, 8:30 AM–12:30 PM
☐ NAED: Accreditation Workshop $95
☐ NAED: Data Mining 101 $95
½ DAY, TUESDAY, APRIL 28, 1:30 PM–5:30 PM
☐ NAED: Executive Workshop $95
☐ NAED: Data Mining 201 $95

Workshop Subtotal

☐ 8th Annual Navigator Golf Tournament Tuesday, April 28, 8:00 AM–1:00 PM $65

FREE T-SHIRT WITH PRE-REGISTRATION
Prepay your registration fees before the conference, using a credit card or check/money order, and you will receive a free, custom-designed Navigator ‘09 conference T-shirt at check-in. (See details on the web.)

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CANCELLATION POLICY
Please provide cancellations in writing no later than March 27, 2009. Your registration fee will be refunded, minus a 5% processing fee. Thereafter, no refunds will be issued.
As all good stories begin, once upon a time there were a group of people who organized a very small but important conference. It was first held in 1989 and was planned to meet the needs of a growing group of public safety professionals—the emergency medical dispatchers or EMDs as they called today. The conference was the inspiration of the folks at the National Academy of Emergency Medical Dispatch who named it Navigator. In no time at all, or so it seems, the conference grew up to become one of the most well attended and respected emergency dispatch conferences in the United States. In 2002, the conference moved across the pond to the United Kingdom and that's where our Tale of Two Cities begins, because for the first time EuroNavigator traveled across the English Channel from this year's location in Bristol, England, to continental Europe for a conference held one week later in Berlin, Germany.

Why did we make the move, you might ask. Prior to this year, the European version of Navigator was confined to the UK. Like its U.S. counterpart, word spread and
the growing popularity begged for a conference location closer to our Germanic speaking European members in Germany, Austria, Switzerland, and Italy.

The First City

But I'm getting ahead of my tale. It was a beautiful fall week; the sun was shining and the city of Bristol sparkled from its church spires to its busy harbor. The conference at the first of the two European cities was held Sept. 25-28 and kicked-off with a registration Happy Hour on Wed., Sept. 24. Attendees enjoyed catching up on all the news with friends and peers over a pint or two. It was perfect event to meet and make evening plans for dinner, fun, and maybe a bit of sightseeing.

The conference started bright and early the next day with the opening session where the Accredited Centers of Excellence for 2007-2008 were recognized and the EuroNavigator Dispatcher of the Year award was presented (see sidebar on page 35). Scott Freitag, president, International Academies of Emergency Dispatch® (IAED), and Brian Dale, IAED Accreditation Board chair, rounded out the session with a keynote presentation introducing the theme Power of the Protocol; It Starts with You.

The conference offered a variety of topics, sessions, and workshops—32 in all—tailored to the diverse needs of the U.K. EMD community. A highlight from the conference was a special three-day workshop for EMD mentors. This was the first emergency dispatch mentoring course the Academy has offered and its trial run spawned interest for mentoring classes to be held in Europe and the U.S. In the January/February 2009 issue of The Journal, you'll get the chance to read more about the class, its core values, and curriculum. A other workshop put the medical instructors through an intensive three-day update for the new version 12 medical protocol, which the U.K. centers expect to implement after first quarter 2009.

Dominic McNabb attended the conference from Dublin Fire Brigade, Ireland, with one very big check heading his to do list: Ideas, tips, and best practices for reaccreditation.

“The process starts in January and we want to be well prepared,” he said.

McNabb attended ACE related sessions that included Processing Hints and Tips taught by Louise Ganley and Claire Ellis and Call Processing taught by Scott Freitag and Brian Dale. He also attended sessions relevant to the continuing dispatch education classes he plans to organize when he gets back home.

“I'm really pleased with how everything has gone and what I have learned and will be able to bring back to the control room,” he said.

The Dublin Fire Brigade control room is situated in the DFB headquarters in the city center.
The control room is responsible for taking fire calls for five counties and ambulance calls for the Eastern Regional Health Authority Area. Fire brigade staff answer calls for both fire and ambulance with Eastern Regional Ambulance Service staff taking emergency and non-emergency ambulance calls for their areas. The center was first accredited in September 2006, and the host agency for the 2006 EuroNavigator Conference held in Dublin.

On Sunday, the final day of conference, Scott and Brian teamed up again to moderate the Q&A session *Dealing with Your Most Difficult Calls*. All agencies in the U.K. had been invited to submit a call prior to the conference and a committee in charge of prescreening grouped them according to call characteristics. The calls were played during lunch and attendees, separated into groups, ranked them according to criteria. The call receiving the highest marks in each group earned a prize for the dispatcher. The competition was fierce and raucous cheers and groans accompanied the sights from EuroNavigator-UK. On page 32, IAED president, Scott Freitag welcomes attendees to the opening session. This page. Top left, Great Western Ambulance Service-Avon receiving Re-Accreditation as a Center of Excellence. Top right, East Of England Ambulance Service-bedfordshire and hertfordshire receiving Re-Accreditation as a Center of Excellence. Middle left, Southwestern Ambulance Service receiving Re-Accreditation as a Center of Excellence. Middle right, attendees enjoy the company and ambience during happy hour registration. Bottom, instructors discuss the MPDS v.12 protocol update during the EMD Instructor workshop.
the announcement of each winner. A top prize went to the call voted best among all participants.

The Q&A session was a fun and upbeat way to conclude a successful conference and, also, announce the new name for next year’s conference—UK Navigator—that will be held Sept. 22-24 in York, a beautiful historic city located in northern England in the county of North Yorkshire. Be sure to check the Web at www.emergencydispatch.org to request a brochure or to submit a proposal for presentation or a topic you would like covered.

The Second City

EuroNavigator made its maiden voyage across the channel in October for the first-ever German Navigator conference. The two-day conference, Oct. 2-4, was held in Berlin for an audience eager to attend educational sessions and workshops as well as events catering to networking and inspiration. There was a special pre-conference IT workshop covering ProQA® and AQUA™ that contributed to the Academy’s goal of having a self-sufficient German-speaking instructor core to teach software and protocol. The protocol certification course instructors participated in was a three-day conference/post-conference workshop.

But the exciting event wasn’t all work without play. During an opening reception,
attendees received a warm welcome and an inspirational message from the IAED president Scott Freitag (yes, his speech was translated since he’s still working on learning to speak the language). His welcome was followed by keynote speaker O berbrandidirektor Wilfried Graf "d, Berliner Feuerwehr (director of Berlin Fire Department, Wilfried Grafling).

Tudy Benson, director of European Operations, said the reception was a great experience. “The ice broke right away,” she said. “People mingled and were eager to meet one another and talk about the issues they shared.”

Highlights of the conference included presentations from the two newest members — Hamburg, Germany, and Vienna, Austria. The agency representatives talked about their communications centers and the experience of implementing the Medical Priority Dispatch System® (MPDS). Ing. Christ of Chwojka discussed the financial and organizational benefits of protocols, structured calltaking, and quality assurance. Other presentations covered MPDS version 12 changes and additions, the Fire Priority Dispatch System® (FPDS), structured calltaking, and response configuration from a medical director’s viewpoint.

Our Tale Only Begins

In the Dickens’ novel The Tale of Two Cities, the main characters travel between two cities— Paris and London at the time of the French Revolution—for the sake of principle related to a noble act of rescue. We at the IAED believe protocol is also about principle. The fire, police, and medical protocols are the national and international standards in emergency dispatch and they operate at their best only through the full commitment of everyone involved. That’s why we continue to cultivate a conference tradition started nearly 20 years ago. We are here to inspire and champion a cause through a forum that keeps our members engaged and informed about the issues, research, and techniques comprising the protocol systems. No matter where we go or the language we speak, we acknowledge the compassion our members put into their work and the reliance they place on the protocol that helps them make a major difference in every community served. We want you to be the best you can be and we’re there alongside you, every step of the way.

The Sound of Music

Baby’s cry lets EuroNavigator Dispatcher of the Year know everything is all right

A baby’s cry is beautiful music to Tom Balaam. At least, it was when the emergency medical dispatcher (EM D) heard the healthy wail near the end of a 9-9-9 childbirth call he answered at the South East Coast Ambulance Service (SECAmb) in October 2007. “I wasn’t expecting a good end to this call,” said Balaam, who works out of the U.K. Sussex Office of SECAmb. “The head was stuck but she gave it one last push and that’s when I heard the baby’s cry. It was the most amazing moment.”

The newborn boy was a breech birth delivered by a woman who was alone at home in Eastbourne and—until that morning—unaware a baby was due. “The first thing I knew was stomach pains this morning, and then his leg popped out,” she told Balaam at the start of the 5 minute and 14 second call. Balaam didn’t skip a beat. Although a bit startled by the mother’s admission, he quickly turned to the childbirth instructions for a breech birth in the ProQA® software.

“This could be a difficult delivery,” he calmly tells the 29-year-old caller. “But I will tell you exactly what to do.”

The fear in her voice at the start of the call disappeared as she focused on the Pre-Arrival Instructions (PAIs) Balaam provided. A final push and the baby was out, a huge relief for Balaam, knowing the head and arms were not showing moments earlier, as the call indicates.

“I’ve never been that relieved in my life,” Balaam said. “You forge ahead and hope for the best with any call but this one had me worried.”

The newborn boy was in the mother’s arms, wrapped in a towel, and resting on her belly when the father and paramedics came to the door. Balaam said the father apparently took the new family member in stride despite leaving in the morning without any inkling of whom he’d be meeting later that day.

“He came home for a spot of tea or to get a coat; I’m not sure,” Balaam said. “It was a shock for her but he seemed to roll with it.”

Balaam credits the mother’s acquiescence to his instructions and recent training lessons he was giving aged to reassure the patient during a very difficult and frightening time.”

Balaam received the annual IAED Dispatcher of the Year award for his superior work demonstrated by this call at the annual EuroNavigator Conference held in Bristol, U.K., during September 2008.

Tony Gilbert, SECAmb control manager, who made the nomination, said Balaam was “very calm, professional, and compassionate during the call and man—

The Tale of Two Cities

In the Dickens’ novel The Tale of Two Cities, the main characters travel between two cities— Paris and London at the time of the French Revolution—for the sake of principle related to a noble act of rescue. We at the IAED believe protocol is also about principle. The fire, police, and medical protocols are the national and international standards in emergency dispatch and they operate at their best only through the full commitment of everyone involved. That’s why we continue to cultivate a conference tradition started nearly 20 years ago. We are here to inspire and champion a cause through a forum that keeps our members engaged and informed about the issues, research, and techniques comprising the protocol systems. No matter where we go or the language we speak, we acknowledge the compassion our members put into their work and the reliance they place on the protocol that helps them make a major difference in every community served. We want you to be the best you can be and we’re there alongside you, every step of the way.
The National Academies of Emergency Dispatch® (NAED) recently released version 12.0 of the Medical Priority Dispatch System® (MPDS) in North America. First announced here in the March/April 2008 edition of The Journal, the release occurred in July 2008, exactly two years after the last protocol release, v11.3. Many of the improvements in v12.0 came directly from MPDS users across the world submitting Proposals for Change (PFCs), some of them as early as 2005—before the release of v11.3.
So why did it take two years to process PFCs and create a new version of the protocol? An explanation of the concepts behind the NAED’s process is in order first.

The NAED has a well-defined, scientific-method based process for updating the protocol. Since the NAED took control of the MPDS protocol 20 years ago, it has processed, tested, and successfully released 10 versions of the protocol with the necessary curricula, QA processes, and all other standards based on them. During this time, the Academy has had tremendous experience in developing the best possible method for creating new protocol versions.

Unified Protocol

The NAED’s process is supported by a very important principle: the Unified Protocol model. This means the Academy maintains a single protocol with no variants—introducing changes to this standard in an orderly manner, which is then provided to all users of the protocol throughout the world. This is essentially the same principle underlying the American Heart Association’s improvements for the standards of the critical processes of CPR, BLS, and ACLS.

The benefits of the Unified Protocol model are extensive. Because all communications centers everywhere use the same protocol, the amount of data that can be gathered to study a particular issue increases dramatically. In addition, the valuable experience, useful ideas, and specific research from each communications center can then be shared with all protocol users around the world via the submission of PFCs.

Begin the journey

In the early days of the Academy, it became obvious that maintaining the Unified Protocol would require a formal expert group—a council—to review the current standards of care, consider and evaluate user-submitted PFCs, and implement protocol evolutionary changes in a timely manner. This constituted the birth of the Academy’s Council of Standards.

Our journey to the MPDS v12 starts the very month after the release of v11.3. Versions 11.2 and 11.3 were prompted primarily because of the release of new standards for CPR compressions from the AHA/ILCOR. For those releases, one of the NAED’s primary goals was to incorporate the new CPR standards into the protocol. At that time, only those PFCs of an urgent nature were approved for inclusion into the protocol. So when version 11.3 was finished in July 2006, a considerable number of PFCs were waiting for the central Rules Group of the Council of Standards to examine, as more continued to pour in from around the world. The Rules Group started working through the PFCs immediately.

The Rules Group is an essential subcommittee made up of the Council of Standards chair, the Curriculum Council chair, the Research Council chair, and the Board of Certification chair. This Rules Group gives an initial rating to each PFC in light of the current standard of care, protocol philosophy, supporting data, and the potential urgency of the proposal. This rating system
helps the full council arrive at an effective decision and provides early identification of PFCs that require further research. One such PFC for v12.0 was the proposal for administering aspirin to heart attack patients, which soon became the Aspirin Diagnostic and Instruction Tool.

The initial examination by the Rules Group took place primarily during three extended conference calls during the last half of 2006.

Research and evaluation

The PFCs were then passed on to the Readers Group of the Council of Standards. The Readers Group is the council’s working committee, populated with professionals from around the world with expertise ranging from dispatch, medical practice, nursing care, quality assurance, public safety, rescue, hazmat, and NAED protocol design, logic, and instruction. The Readers Group researches and evaluates each PFC passed on by the Rules Group to determine its medical soundness, dispatch relevance, and potential for logical implementation into the MPDS. This work took place primarily during several three-day meetings between February and June of 2007.

The Readers Group considered more than 300 PFCs for potential inclusion into v12.0. While some PFCs met with nearly instantaneous approval—with perhaps some modifications—others took hours to thoroughly cover all of their potential clinical and safety ramifications.

Arranging the Readers Group meetings is a challenge in itself. The 23 members come from six different countries, including the U.K., Australia, New Zealand, Canada, Germany, and the United States, and they maintain busy professional lives. Considering the fact that they volunteer their time to the NAED, it’s quite astonishing that these mammoth meetings came together at all. Despite the challenge of coordinating this diverse group, the NAED considers the multifaceted composition of the Readers Group as absolutely essential to its mission of maintaining a Unified Protocol for all its users.

Production cycle

Soon after the second Readers Group meeting, the Research and Standards team began the production cycle for the new protocol. During the cycle, each PFC is converted into what the Research and Standards Department calls a proof sheet, which is a form giving detailed instructions for the precise changes required by the PFC and providing areas for each specialist in the production cycle to implement, test, and sign off. Proof sheets are logged into a relational database and then passed to each Research and Standards member responsible for handling the various changes required.

The PFCs accepted for version 12.0 generated 234 proof sheets, many of which involved multiple changes. The creation and logging of proof sheets began immediately after the second Readers Group meeting in June 2007. Work on the proof sheets began in early September and continued until the final days before the release.

Carrying out the changes from the proof sheets inevitably involves unforeseen problems, especially while implementing the changes into the complex logic structure of the automated protocol system, ProQA®. These challenges are resolved through continual communication with the Readers Group and at times can cause significant delays. The Research and Standards team tests the changes from each proof sheet. Any new change that

### Proposals For Change. The Academy has your back

**TROY PRING**

EDRC Chair, El Paso-Teller County 9-1-1 (Colorado)

**MARK TOMAN**

NAED Instructor and Supervisor for Toronto Emergency Medical Services

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**Pring’s request was granted.**

“When was s/he last without this problem (the last time s/he was normal)?” was revised to “Exactly what time did these symptoms (problem) start?”

According to the Academy’s rationale, the old wording was confusing for the layperson, and the EMD often had to rephrase the question. However, the difficult wording was understood from the beginning; it was used for a specific reason. The wording is designed to establish the time of symptom onset, not just when the problem was first noticed by the caller or patient, and was recommended through consult with the National Institute of Neurological Disorders. It is hoped that the new wording will accomplish the same goal, while eliminating the cumbersome nature of the previous question.

**Resolution version 12.0:**

The **Key Question** was reworded from “What’s the problem, tell me exactly what happened.” to “Okay, tell me exactly what happened.”

Mark Toman submitted the formal application in November 2005 for a change that was made in MPDS® version 12.

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3. Okay, tell me **exactly** what happened.

   - (Not obvious)
   - Are you with the patient now?
   - (Not obvious)
   - How many other people are hurt (ck)?
   - Traffic/Transportation incident ———
   - Multiple victims ———

**MPDS® v12. NAED® © 1979-2008 PDC.**

Five years earlier, the same proposal Toman submitted was turned down.

“I was surprised it was accepted this time,” said Toman, an instructor for the National Academies of

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Toman wanted the change for grammatical reasons. The original Case Entry question, which has been part of the MPDS since the beginning, can confuse callers because of the compound structure suggesting very different answers. The first part, “What’s the problem?” seeks the caller’s impression of what is wrong, while the second part, “Tell me exactly what happened,” elicits the facts of a situation.

The second part, Toman states, is of far greater value to the EMD in determining an accurate Chief Complaint.

The Academy councils obviously agreed. The Rules Group of the Medical Council of Standards stamped its approval and passed it on to the Readers of the Medical Council of Standards. The change made it to the version 12 update along with more than 300 other user-submitted Proposals for Change (PFCs).

According to the Academy’s rationale, the EMD’s primary goal is to elicit the facts and the incident history. With the old compound question, callers frequently started talking without waiting to hear the second, more useful part of the question. All of this leads to the frequent, unnecessary repetition of “Tell me exactly what happened” in order to get the correct Chief Complaint.

Brett Patterson, an Academics and Standards Associate for the NAED, said the time from submission to approval depends on several factors. It could be the number submitted, the lack of documentation, or the added experience of using the protocol over a longer period of time. A major change in a national standard takes precedence (consider the dispatch CPR protocol based on the American Heart Association’s science advisory).

Then, there’s always the chance of rejection. Not everything submitted makes it to the table for discussion, and even if it does, there’s no guarantee of approval.

LAURA LIDDELL
Paramedic and 9-1-1 Training Coordinator, Manatee County (Florida) Department of Public Safety
Received: June 2006
Request: To add the Sinking Vehicle Case Entry instructions to the MPDS, Protocol 29 (Traffic/Transportation Incidents).
Resolution version 12.0: A new Sinking Vehicle (1st Party) pullout card has been added to Protocol 29.
Laura Liddell, paramedic and 9-1-1 training coordinator for the Manatee County Department of Public Safety in Bradenton, Fla., illustrated her request with a news story about a sinking car and the subsequent death of the 19-year-old passenger that was published in the Bradenton Herald. The young man was the son of a former paramedic, someone she knew.

Liddell said there is always the possibility of that happening again in their area because of the coastal setting. “We’re surrounded by water,” she said.

She proposed the addition of the Sinking Vehicle instructions found in the Fire Priority Dispatch System™ (FPDS) and the Police Priority Dispatch System™ (PPDS); they were added to the MPDS® in a pullout card to Protocol 29. Although it was too late to save the young man who died, she said the addition has the potential to save the life of a first-party caller should this occur again.

“The person has only a few minutes to get help,” she said. “They are going to listen to what you’re saying.”

Liddell is elated by the addition. “It’s a really good enhancement,” she said. “We’re very glad they added it.”

According to the Academy’s rationale, this addition addresses the
Our dispatchers reported that at least 50 percent of their callers hung up after saying “call me back immediately,” she said. “It was fairly conclusive.”

The research they conducted to support the proposal is a part of the process Buchanan said she especially enjoyed. “The Academy doesn’t accept a proposal because it’s something you may want changed,” she said. “There has to be research to support your request.”

Brett Patterson, an Academics and Standards Associate for the NAED, said direct experience does precipitate most of the suggestions submitted, while it’s the research that can make or break further discussion among the Academy councils, also depending on the complexity of the PFC.

“Sometimes people submit relatively simple requests such as a font change and evidence isn’t necessary,” Patterson said. “Most of the time evidence is critical and we need the documentation to support the proposal.”

According to the Academy’s rationale, the old wording sounded like a closing statement. This caused some callers to prematurely hang up and occasionally caused EMDs to overlook linking to Case Exit. The new wording is a simple instruction that carries no implication that the call is over.

“In the March/April edition of the Journal of Emergency Dispatch. EM D instructors must take an early training course to transition their skills from v11.3 to v12.0. This ensures that a cadre of trained instructors is prepared to teach classes for the 3,000 agencies and nearly 50,000 members wanting to use the new protocol once it is released. The instructors had to be updated regarding any corrections and refinements that resulted from the beta testing process.

A gain, careful coordination is an essential part of this complex process.

Formal voting

Once the protocol is properly tested and determined to be complete by the Rules Group, the entire protocol is then sent to the full Council of Standards for formal voting. Each expert member of the Council of Standards is sent a confidential draft of the finished, proposed protocol along with a voting and comments form to send back to the N A E D offices. The protocol has been extensively tested by this time, so most changes proposed by the full council at this point tend to be fairly minor in nature.

Once the final protocol is approved, the manual cardset and all related materi-
Bryon Schultz has a long history with the MPDS®. The communications QI supervisor for the Eastern and Western divisions of Oklahoma’s largest EMS agency has worked with the protocol system for more than a decade. For several years, he has been a National Academies of Emergency Dispatch® (NAED) instructor and, for the past two years, a member of the NAED Curriculum Council. However, he said it’s the classroom experience that has prompted the many PFCs he and others from the agency have submitted. Most of the suggestions are relatively minor and derived from discussions with students who, new to the system, provide a fresh perspective to a system he knows well.

The recommendation to move the phone to the patient, rather than vice versa, was a change gaining momentum almost simultaneously to the increasing number of emergency calls coming in from cell phones. It was something the students noted and something Schultz and the other EMDs thought practical. “This makes it easier for the EMD,” he said.

According to the Academy’s rationale, in general, it is faster, safer, and easier to move the phone to the patient rather than bring the patient to the phone.

ANDREAS MAURER
Chair, German Cultural/Language Committee, ILL GmbH
Leistelle Tirol (Austria)

Received: January 2007
Request: To add information in the Post-Delivery Instructions (PDI) about contacting the local height rescue team to ensure appropriate response to a caller threatening to jump. (Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt)

Resolution version 12.0: The Fire Notification symbol has been added next to Determinant Code 25-B-4 “Jumper (threatening)”

The title of Panel 1 has been changed from “Patient to Phone” to “Phone to Patient.” The wording has been changed to “Get the phone as close to her/him as possible. Don’t hang up. Do it now and tell me when it’s done.”

Resolution version 12.0: The Fire Notification symbol has been added next to Determinant Code 25-B-4 “Jumper (threatening)”

Incidents with jumpers require notification of fire or technical rescue teams in order to reach and protect the patient.

New standard of care and practice
After council approval, the NAED then calls for the International Cultural Subcommittees of the Council of Standards to formally review the new protocol for all language and cultural-based variations before the protocol is formally released into Europe, Australia/New Zealand, Asia, Africa, and South America. In the end, a new standard of care and practice has been released. While receipt of a new version seems automatic and routine for most communications centers, it is anything but. It is a new incarnation of the Unified Protocol that is now MPDS version 12.0.
The Medical Priority Dispatch System® (MPDS) is reaching middle age without a comb-over hairstyle or protruding paunch. The emergency protocol system developed to help reduce patient morbidity and mortality in the prehospital care system enters its fourth decade in 2009, celebrating a honored reputation built on clinical field and dispatch research, expert consensus, and the recommendations of people who use it everyday throughout the world.

And, as anyone might envy, it’s only getting better with age.

For medical 9-1-1 emergencies, MPDS is the lifeline of care until help arrives on the scene. Dispatchers and calltakers trained in the use of MPDS are the voice of assurance on the other end of the phone, calming people during—for most callers—the worst or most frightening moments of their lives. They do this constantly, taking call after call, never knowing what will greet them when making the time-honored request: “Tell me exactly what happened.”

Over the years, the use of the Pre-Arrival Instructions (PAIs) in MPDS has helped people whose lives are threatened by sudden cardiac arrest, seizure, and stroke. The childbirth and labor PAIs describe how to use a shoelace to tie off the umbilical cord of a newborn baby and how to prepare the mother in a breech delivery. The application of MPDS and the PAIs are universal during emergencies that very seldom discriminate based on age, gender, or time of day.

But it’s not only the ones helped who are thankful for the prehospital care instructions; it’s also the dispatchers and calltakers. “Had it not been for the EMD program, I would not have done as well ‘under the gun’ as I did,” wrote dispatcher David Davis in a letter he sent to the National Academies of Emergency Dispatch® (NAED). “I learned to keep my head, gather information, and relay this information to the proper EMS units.”

The stories that follow demonstrate the protocols in action and the professional skills of the dispatchers, calltakers, and callers in getting help to the victims. They are only a sampling of what goes on daily in the 3,000 communications centers using MPDS and their affiliated communities worldwide. They are a reflection of what caring people can do when given the right tools for responding to your emergency and mine.
Near Drowning. Toddler found face down in pond recovers

A frenzied search by family and friends located toddler Evan Delk face down in a pond close to where he had been only moments earlier. He wasn’t breathing. He was in full arrest.

“They were frantic when I took the call,” said Dispatcher Laronda Baker, of MetroSafe 9-1-1 in Louisville, Ky. “He was out of their sight for such a short time. It didn’t seem something like this could happen so quickly.”

Baker jumped into the Pre-Arrival Instructions (PAIs) for CPR after getting their location and dispatching emergency vehicles to the scene. Evan’s cousin relayed the CPR PAIs to another family member and Baker, who has given the same instructions several times before, stayed on the line with them for eight long minutes. She disconnected once a sergeant from the Louisville metro police department arrived at the pond and took over the CPR.

Baker moved on to the next call without putting Evan far from her thoughts. Although the communications center rarely monitors the progress of a caller or the victim, this incident was different. Baker and her co-workers were particularly concerned because of Evan’s age (not yet a year old) and the family’s anguish.

“It was very tragic,” she said. “We wanted closure on this one. We wanted to know what happened.”

An early prognosis was bleak, said Sherrie Whitford, the center’s quality improvement and development supervisor. The hospital could not release a condition report, at least not during the first several hours following the accident.

Baker left that day on a scheduled 15-day vacation not knowing whether Evan would make it through the night but with promises from co-workers that someone would contact her once the information was available.

A few days into her leave, the call came in. The news was better than Baker could have hoped for.

“He had made a full recovery,” Baker said. “He was going home.”

Whitford called his recovery nothing short of a miracle.

“He was out of their sight for such a short time. It didn’t seem something like this could happen so quickly.”

–Laronda Baker

“It was the best news we could give anyone on a vacation,” Whitford said. A week after Baker returned to work, the family invited her over for Evan’s first birthday. The party was held at the family’s home, not far from the pond, which had been drained and the hole filled following the near tragedy.

Baker said it’s not often she gets to meet the people she talks to as part of her job, and it’s even more uncommon to receive an invitation to a family event. “They wanted to thank me for helping to save their son,” she said. “They were very grateful. We were all hugs and kisses.”

MetroSafe 9-1-1 answered 750,000 emergency calls in 2007—about one for every resident in metropolitan Louisville. They also answered 650,000 non-emergency calls, for a total of 1.4 million calls during 2007.

Baker said the phone never seems to stop ringing.

“You never know what’s going to happen,” she said. “But calls like this one really make it worthwhile.”
During a bad storm last winter a call came into the Madison County Emergency Communications Center (N.Y.) from a caller who had been in a helicopter that went down in the storm.

Rob Durfee, communicator at the Madison County center, said there were two or three people on board when it crashed.

“They said they were going along and they just came into a big whiteout,” he said.

“It was a real bad storm that day.”

Luckily, only one suffered from minor injuries. They needed to make contact so they could be found before being out in the snowstorm too long.

“They tried calling out on a cell and they couldn’t get any reception on the cell so he [the caller] had to go quite away on foot and then he finally came through,” Durfee said.

It wasn’t just a matter of being out in the snowstorm, exposed to the elements.

“They were from out of state, and he just had no idea where he was,” Durfee said.

“That’s the whole thing. That’s where that GPS came in. Helped a lot.”

GPS was initiated, and within seconds they had a good clue as to what area he was making the call from—Fenner, a city served by the Madison County Emergency Communications Center.

“It shows us what fire district that they are in,” he said. “We just alerted the fire departments for that area and they ended up locating them and took them back to the crash scene.”

The sheriff’s department stayed behind monitoring the area.

“I know the sheriff’s department was up there for close to a week probably, guarding the plane because of the crash scene,” Durfee said.

Durfee has nothing but compliments for his fellow communicators working when the call came in.

“Everybody did what he or she had to do and it all worked out all right,” he said.

Durfee isn’t new to his job of talking to people who are calling while in stressful situations. He’s worked at the Madison County communications center for 30 years.

A crash between two freight trains in March 2007 goes down as a memorable time for him.

“We had a real bad train wreck,” Durfee said. “They had hazardous stuff on board.”

Hundreds of phone calls came pouring into the center.

“That’s the busiest I’ve ever been since I’ve been here,” he said. “There were three of us working, and the phones, we just couldn’t keep up. That’s the busiest day I’ve ever had here in 30 years.”

It’s the positive things that can happen for people calling 9-1-1 in times of need that keep him going shift after shift.

“You like to hear when positive things happen you know, like if a baby stops breathing or something and they call you and tell you that the baby made it out all right,” Durfee said. “A serious accident and you find out the person’s all right.”

The Madison County Emergency Communications Center dispatches emergency services for a primarily rural area, including four villages and the city of Oneida.
Haley Latimer knew exactly what to do the evening her mother Karen would not respond to a question. She dialed 9-1-1.

The first few seconds into the call Haley sounded comparatively calm, considering the circumstances, while giving address and telephone callback information to EMD Gord Conrad, the quality improvement coordinator for British Columbia Ambulance Service (BCAS), Vancouver Island Region.

But soon into the call, the 12-year-old girl started sounding much less self-assured. She was scared. Her mother was now lying on the kitchen floor and there was no one else at home to offer any first aid assistance.

“My mom is on the ground and she’s shaking,” Haley cried. “Please send help.”

On that morning—July 6, 2007—Karen Latimer suffered a tonic-clonic seizure, often referred to as a grand mal seizure, possibly related to the effects of a previously ruptured cerebral aneurysm. The aneurysm, which ruptured in 2004, sent Karen to a hospital in Victoria, British Columbia, for nearly six months and five operations. The brain hemorrhage and subsequent surgeries put her at risk for seizures, and she had suffered five during the past three years.

“I knew something like this happened to my mom,” Haley said. “But this was the first time I was home alone with her when it did happen.”

The seizure came without warning that evening, as they usually did. There was no aura and or other sensation associated with the symptoms of a tonic-clonic seizure. Karen simply lost consciousness and Haley arrived at her side moments before her mom fell away from the sink in the midst of dinner preparations. Quick-acting Haley was able to grab a paring knife from her mother’s hand before she lost balance and stumbled into Haley’s arms.

“My mom was in a daze,” Haley said. “I asked her a question and she didn’t answer. She started spinning slowly, like she was looking for something, and I was able to catch her before she fell.”

Haley grabbed a cell phone, while gently lowering her mother to the floor, and dialed the three numbers she knew to call in the event this ever happened. Within the next nine minutes, paramedics were at the door of the family’s home in Courtenay, which is the town closest to the Mt. Washington ski resort on the east coast of Vancouver Island. Dur-

like Haley, he had picked up the phone and dialed for an ambulance (there was no 9-1-1 at that time) desperately seeking medical help.

“What did you do?” Haley asked Conrad when he related his story to her during their wait for the ambulance to arrive.

“I listened to what the paramedic dis-

patcher told me to do,” he said. “I followed his instructions.”

Haley’s willingness to follow Conrad’s Pre-Arrival Instructions (PAIs) until paramedics arrived earned her the BCAS Good Samaritan Award, which she received in March 2008. The BCAS presents the award to individuals who have provided selfless and humanitarian assistance during a medical emergency, promoting the important role the public can play during a medical emergency.

Conrad lauds Haley’s courage and he was there when she received the award.

“She was a brave girl,” he said. “This was the first time I ever got to meet someone who has called and I’ve answered probably thousands of calls. I had to pursue this one. She was absolutely amazing.”

Karen spent the next several days in the hospital recovering and undergoing more tests. Since coming home, there have been two more seizures requiring hospital stays and she is receiving services through the Vancouver Island Health Authority Brain Injury Program. The program provides the assistance people need to get back on their feet and into society.

Karen, a former nurse, was told she might never work again because of the severity of her medical condition. She, however, sees it differently.

“I want to go back to some type of work,” she said. “It’s one day at a time.”
Daily Lookout. Elderly residents receive wake-up calls

Checking on elderly community members is something dispatchers working the day shift at the Walton County Sheriff's Office (Fla.) have come to enjoy doing every morning for more than nine years.

Donna Smith, communications manager, said about 50 elderly people in the area are currently on the Elderly Calling List, which means each person receives a call in the morning, typically between 6 a.m. and 8:30 a.m., from one of the dispatchers.

“T hey look forward to us calling,” Smith said. “If we are late calling them, if we get busy or something, they’ll call us. They’ll say, ‘Hey we’re just checking on you this morning. Is everything OK over there?’”

When they sign up to be on the list, they provide the sheriff’s office with a contact person, which can be a family member, friend, or neighbor, who can be called if the elderly individual is not contacted that morning, she said.

If a call is made to an individual who has not previously notified someone at the sheriff’s office that he or she will not be home to take the call—but is, instead, at a doctor’s appointment or out grocery shopping at that time—and no one answers the phone after several attempts, the contact person will be called and a deputy will be sent out to check on the individual.

Smith said most of the elderly individuals on the list live alone but sometimes a husband and wife sign up.

“T here’s not really a certain set criteria that they have to meet; you know, you have to be this age or your medical condition has to be this,” she said. “If they call us, then we certainly put them on it.”

Some of these citizens also let the office know about their medical problems. Typically, most of them do not have family nearby to check on them so the sheriff’s office places a call daily to find out how they are doing and if they need anything.

“A lot of times we’re the only people that they hear from. A lot of them don’t even have family.” —Donna Smith

“T hey get attached to us in the same manner that we do with them,” she said. Sometimes, one of the elderly individuals will stop by the sheriff’s office bearing treats for the dispatchers. They’ve also received encouraging notes.

“We get a lot of thank-you cards from their family members that maybe live way off in other states,” Smith said.

Individuals have found out about this service through a number of ways, including word of mouth, radio ads, write-ups in the newspaper, and information on the sheriff’s Web site. Smith said the woman who does the CrimeStoppers program also passes the word along while she’s out and about.

The dispatchers don’t fly solo on this project. Walton County Sheriff Ralph Johnson supports the program, which ensures the area’s elderly population receives the attention it needs.

“Our sheriff is real good about making sure that we do check on them,” Smith said.
Coworker Care. Dispatchers eager to help coworker with bone marrow disease

When Robin Foster’s colleagues at the Rowan County 911 Telecommunications Center (N.C.) heard she was diagnosed with a rare bone marrow disease near the end of 2007, they couldn’t wait to help.

Foster, a shift supervisor at the center, took medical leave in December 2007 and underwent a bone marrow transplant in January 2008. She later found out the transplant didn’t take, so another transplant was scheduled for September.

Grayson Gusa, an assistant shift supervisor, said they began discussing doing something for Foster shortly after she was diagnosed at the end of 2007. However, when they found out the date she would no longer be working at the center, it took on a different note.

“Once we found out that the official ‘termination’ date of her position and benefits was approaching on June 30, 2008, that renewed our motivation to have this benefit for her,” Gusa said.

So the planning began by Gusa, lead shift supervisor Allen Cress, EMS supervisor John Sharp, and paramedic Heidi Hatley for a fundraiser to take place in August.

“We stayed very quiet in our initial steps in planning the event, knowing that if Robin ever got word (about it) that she would no longer be working at the center, it took on a different note. Once we found out that the official ‘termination’ date of her position and benefits was approaching on June 30, 2008, that renewed our motivation to have this benefit for her,” Gusa said.

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When a bear attacked a 15-year-old rider at night during a 24-hour biking marathon, it’s lucky that endurance cyclist Pete Basinger was not far behind.

“He did a very good job at reassuring her,” said calltaker Stephenie Wolf of the Anchorage Fire Department communications center in Anchorage, Alaska, who along with Supervisor Don Tallman stayed on the line with Basinger for the 23 minutes it took for help to arrive. “He was a great liaison for us.”

The drama started shortly before 1:30 a.m. on Sunday, June 29. Petra Davis was riding in an endurance race along the Rower’s Run trail of Far North Bicentennial Park in Anchorage when a bear apparently lunged at her, inflicting severe puncture marks and lacerations to her neck, right shoulder, torso, buttocks, and right thigh.

Basinger found Davis sitting dazed but conscious in the middle of the trail. His race ended. His focus shifted to the wounded rider.

“It was at the darkest point in the night, and in an area of heavy brush, so I couldn’t decide at first whether to go for help, just stay put, or start trying to move Petra,” Basinger said.

The possibility that the bear was still in the area forced a decision. He picked up Davis and carried the teenager down the trail in a direction opposite from the one she indicated the bear took. She handed him her cell phone. According to a story in the Anchorage Daily News (July 1, 2008), Basinger put Davis’ feet up to help her against shock, cradled her head, and dialed 9-1-1. They never saw the bear again.

The helmet she was wearing was discovered in the woods nearby, punctured with the bear’s teeth marks.

After twice failing to connect to the emergency number, Basinger called a friend, Greg Matyas, one of the race organizers, who was helping at an aid station.

Wolf called back, anticipating nothing more than troubled breathing since that was the message she received based on Davis’ call to 9-1-1 soon after the attack. Davis’ voice had been described as a desperate whisper, indicating only part of the story.

Once in contact with Basinger, attention quickly turned to the severity of the bear attack. Twenty-three minutes later, paramedics from the Anchorage Fire Department escorted by armed city police were at Davis’ side. Once bleeding was controlled, she was lashed to a backboard and carried to the waiting ambulance.

Davis spent more than a week in the hospital undergoing three surgeries, including an emergency surgery to repair a torn carotid artery.

Describing the emergency

The teen’s injuries, although serious, were not something Basinger could assess while waiting for help to arrive. He knew she was bleeding, but it was dark outside, the trail was unlit, and any source of light would be on the bicycles in the area next to the attack. Basinger didn’t know if the bear was close, and he wasn’t going to leave Davis’ side while he talked to Wolf on the other end of the 9-1-1 call.

Wolf: What’s the problem, tell me exactly what happened?
Basinger: A young girl has been mauled by a bear.
Wolf: How old is she?
Basinger: I think around 15 or 16.
Wolf: Is she conscious?
Basinger: Yes.
Wolf: Is she breathing?
Basinger: She is breathing.

Minutes into the call, Basinger began the difficult task of giving Wolf and Tallman their exact location. It wouldn’t be easy to find them. Far North Bicentennial Park is a rugged 4,000-acre park crisscrossed with trails used year-round for jogging, hiking, biking, dog mushing, and skiing. Although immensely
Bear during an endurance race held annually in Anchorage.

Waiting for help to arrive

Basinger knew that darkness and the difficulty responders could have discerning which trailhead to take from main roads running north and south would compound the crisis. None of the trails in that area are wide enough for emergency vehicles.

During the ordeal Basinger constantly assures Davis help is on the way. “You’re doing awesome,” he tells her several times during their 23-minute wait. “You’re going to be fine. Just hang in there.”

Further into the call, he again consoles Davis. “You’re doing good. It will all be over soon.”

Fifteen minutes into their wait Basinger flags down a third biker coming along the trail. That biker catches the attention of Anchorage Fire Department crews following a mad dash up the trailhead. Davis is breathing more rapidly. She has rolled to her side and Basinger notes a puncture mark to her throat. Basinger sees the medics, escorted by police, approaching the stand of trees where he had taken Davis for protection.

“The medics have arrived,” Basinger tells Wolf.

Wolf congratulates Basinger on a job well done. The call disconnects. Race organizers intercept the other bicyclists coming into the area, and the race is cancelled.

Teamwork

Wolf commended Basinger for his calm voice and the constant reassurance he gave.

“Anchorage is such a beautiful place,” Wolf said. “It’s kind of crazy. I was just there.”

Living in bear country

The attack on Davis was followed six weeks later with an attack on a runner by a sow with two cubs. The runner watched a biker head down the same trail where Davis was attacked, assumed it was safe, and was bitten on her neck and head. She also suffered a collapsed lung. Game officials later killed the sow thought to mail the runner; the DNA of the dead bear did not match what was collected from the Davis bear attack. In August, Tallman took a call from 18-year-old Devon Rees, who survived an attack near his home in Eagle River by punching and kicking the sow that lunged at him from a creek bank during the early morning hours.

The two attacks at the Far North Bicentennial Park, the attack at Eagle River, and numerous close encounters during the same summer season had residents on edge. The Alaska Fish and Game Department received nearly 600 bear complaint calls in Anchorage during the summer, and a study the department conducted in response to bear activity found that more than a dozen grizzlies frequent most of the trails in the Campbell Creek area of the city’s Far North Bicentennial Park and the adjacent Campbell Tract.

Anchorage Fire Department communications center Manager Al Tamagni said the number of attacks and complaints was unusually high, even for a city such as Anchorage where residents and bears share the state parks and wilderness trails.

“You’re going into someone else’s home, the bear’s,” he said. “You have to play by his rules.”

Basinger, who is working toward a master’s degree in outdoor education, said the incident has changed him.

“I spend most of my time outdoors alone and often at night,” he said. “In Alaska or other areas with bears, I don’t think I will be able to go out and enjoy myself so carefree like before.”

A rundown of recent bear activity in Alaska is available from the Anchorage Daily News at www.adn.com/bears/.
Unexpected Arrivals. Hillsborough dispatchers aid in delivery of three babies born just days apart.

Maybe it was the water, the weather, or the anticipation of holiday fireworks. Whatever the reason, only Mother Nature knows why three babies decided to take the fast track to delivery in Hillsborough County (Fla.) during a six-day period. All babies and moms reportedly did well at area hospitals and were home well before this story ever made it to publication.

“Yes, this is very unusual,” said Hillsborough County Emergency Dispatch Operations Manager Becky Widdoes. “I’m not sure what’s going on except that people aren’t getting to the hospital on time.”

The first baby born during the three-baby streak came as a total surprise to the mother and her coworkers attending an all-day work-related training seminar. Sarah Elliott, a 5-year employee with Hillsborough County, took the call during the normal lunch hour on Monday, June 30, and over the next eight minutes provided Pre-Arrival Instructions (PAIs) for the baby girl who arrived at 12:51 p.m. Coworkers, who were probably just as surprised as the new mother, reportedly assisted in the delivery that had ended quite successfully before the arrival of Hillsborough County paramedics.

This is the second time Elliott has delivered a baby in her dispatch career at Hillsborough County.

The second of the three babies came four days later, early on the morning of the Fourth of July holiday, making it a day far more exciting than any fireworks display for the father who delivered his fourth child on the living room floor of his home. According to a news story, mom felt cramps but dismissed the pain because the baby wasn’t due for another four weeks. She took a hot bath to relax, which obviously tried the patience of her soon-to-be born fourth son. He wanted out.

The couple had time to make it into the living room where the delivery was so fast that the baby was out by the time dad connected with 9-1-1 and received instructions for using his shoelace to tie off the umbilical cord. Paramedics arrived shortly past 3 a.m.

Communications Supervisor Gordon Silver, who had answered the early morning call, was impressed with just how unruffled the father sounded over the phone.

“He was great and so calm,” Silver said. “When I answered the call, it was like he had called to tell me his drain was plugged.”

Everything went so well that Silver met the family at a reception held at the communications center. This was a first for Silver, who has worked as a paramedic and dispatcher in Hillsborough County for the past 34 years.

“After all these years I still care a lot about the job, and this was one of those calls you want to remember forever,” Silver said.

Baby number three made his debut less than 24 hours later, at 2:43 a.m. on July 5. Mom noticed her contractions getting closer together although the baby wasn’t due for another week—so much for keeping on schedule. By the time she got out of bed for a walk to relieve the contractions, baby was ready to make his debut. With the help of dispatcher Hattie Strickland, the baby was born before mom and dad could make it out the front door.

Strickland had the longest call among the three childbirth calls recently received at the center.

“But it was nice to be able to walk them through the whole process,” she said. “The baby was wrapped and waiting by the time paramedics arrived. I talked on the phone with the mother and she told me they were naming the baby Taylor.”

“I’m not sure what’s going on except that people aren’t getting to the hospital on time.”

–Becky Widdoes
This was the second childbirth call Strickland has answered in the three years she has been with Hillsborough, although she said the first one doesn’t really count.

“I helped in a car but there was a midwife along,” she said. “She did most of the work. It wasn’t the same as this past one, so I don’t count it.”

Strickland was introduced to the family in person nearly a month after Taylor arrived so unexpectedly. She gave his parents the book “It’s Time to Call 9-1-1,” and she was genuinely pleased to have the opportunity.

“Not a lot of dispatchers get to meet the people they help,” she said. “This was a first for me. It was great.”

Not to be outdone, two other dispatchers from the crew of 30 at the Hillsborough County Emergency Dispatch Center helped in the over-the-phone deliveries of babies born in April and January. In April, the dispatcher provided PAIs to a couple on their way to the hospital. Last January, dispatcher Wanda White talked a couple through the birth of their new baby girl. The baby was born in the family’s bedroom.

The births prompted something Widdoes had planned to do for a long time. She gave the dispatchers stork pins that can be worn on their uniforms. She’s also starting a program to honor dispatchers who give CPR instructions over the phone to a patient who later leaves the hospital to go home.

But her new recognition program doesn’t end there. She’s now looking through the EMD protocol for other saves that can be worked into the shape of a pin.

“The dispatchers like the pins,” she said. “They’re proud of what they do.”

Hillsborough County has seven PSAs representing the unincorporated area, the cities of Tampa, Temple Terrace and Plant City, and the territorial enclaves of the University of South Florida, Tampa International Airport, and MacDill Air Force Base. In addition, there are three secondary PSAs located in the Hillsborough County Emergency Dispatch Center (EDC), City of Tampa Fire/Rescue Department, and the Florida Poison Information Center Network.

Reassuring Voice. Calm attitude keeps situation under control

Devon Morris had been on the job less than two years when he received a call that may have cemented his future plans.

The call was from a young woman who, from the tone of her voice, was frantically trying to save the lives of her family while deeply worried about the others still remaining in the burning apartment complex in downtown Carthage, Mo.

“She was very upset,” Morris said. “She said she had been very shook up and hysterical when she called and said [she] calmed her down.”

Morris said he tries to put himself in the shoes of those he’s talking to.

“If I present myself as someone who’s under control, it lowers the stress level of the person I’m talking to,” he said. “I’d want someone to do the same for me.”

Morris, a former customer service representative for a financial services and communications company, applied for the dispatch job from an ad he read in the local newspaper. At first, he felt a bit uneasy about all of the multitasking involved not to mention the emotional strain of answering emergency calls.

“But I’ve excelled,” he said. “This is something I really like to do.”

Morris said his experience at the dispatch center convinces him he made the right move, and it’s a move that has determined his future in the public safety sector.

Rowland, who brought Morris’ name to the Jasper County Emergency Services Board of Directors, said it’s not often dispatchers are acknowledged for what they do, and the recommendation was something he was glad to do.

“The apartment fire could have been a bad situation, and Morris did a real good job in helping keep things calm,” Rowland said. “He needed to be recognized for that.”

William “Butch” Rowland, a member of the board and a Carthage fire captain who responded to the May 5 fire, got wind of Morris’ assistance from the woman who had placed the call. She told Rowland about the “wonderful job” the dispatcher had done.

“After we got the fire out and were getting statements, she came up to me and explained what had happened,” Rowland said. “She said she had been very shook up and hysterical when she called and said [Morris] calmed her down.”

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Address Unknown. Clever approach gets emergency help to right address

What do you do when a call comes in from a sobbing 6-year-old who’s dialed 9-1-1 because his mother needs help but doesn’t know his address for you to send responders to?

You do what Melissa Eddy did. The Kenton County (K.y.) communications center dispatch supervisor took charge of the call.

“My mom’s seizing,” said Ashton Barker, a 6-year-old from Ft. Mitchell, Ky., when Eddy answered the line.

Eddy asked him for his address and that’s when the call became a little bit more difficult. Ashton wasn’t sure what his address was. As he started to get upset, Eddy offered some reassurance.

“Okay, okay, slow down for me, okay,” she said.

Ashton did, as soon as she began questioning him and later addressing him by name.

“He would concentrate on my questions and I think it kind of calmed him down a bit,” Eddy said.

She started the process of trying to locate where Ashton was calling from so responders would have a location to go to.

“Do you live in an apartment or a house?” she asked.

Ashton told her he lived in an apartment and was able to give her his apartment number. That still didn’t tell her what apartment complex or even what cross streets they were looking for.

While on the phone with Ashton, Eddy was working to find his location.

“I remember looking and seeing that it was a cell phone, of course, and that always complicates things,” she said. “I did a long/lat (longitude and latitude) on it and that’s kind of how we narrowed down where he was and it pinpointed the general area. So that’s why I started questioning him on what things looked like and what he could tell me about numbers and things like that.”

Eddy tried finding out what Ashton could see out the window, his parents’ names, a home phone number, what kind of car his mom or dad drove—vehicle color, 2-door or 4-door, if it had any stickers—what school he attended, and if he had to go up stairs to get to his apartment.

Despite his young age, Ashton was able to communicate a lot of information to Eddy during the call.

“He seemed to answer my questions pretty well—what he could understand,” she said. “I tried not to talk like an adult, like above his age. I tried to communicate with him as best I could. I feel he did a great job.”

Eddy was working with two others at the time—one dispatching police and one dispatching fire. They helped feed her ideas of what to ask Ashton.

“They did a real good job communicating to the police and the fire what to look for and yelling ideas to me here and there,” she said. “It was a group effort.”

During the call, Ashton told Eddy his mom had fallen down and was making “scary noises.” Ashton and his 3-year-old brother were home with their mom when she started seizing and blood began coming out of her mouth.

“Okay, Ashton,” Eddy said. “We’re going to get some help to you and help your mommy, okay. I want you to stay on the phone with me, all right?”

Ashton reassured his brother that the police would be there any minute.

“You’re doing real good, okay,” Eddy told Ashton as the phone call progressed.

Pinpointing the location of the cell phone helped get responders on their way.

“That got us to the general area and we knew he was in an apartment, so then the police could drive around in that apartment complex,” Eddy said.

She came up with an idea for Ashton to get the attention of the policemen looking for his apartment.

“If you see a police officer come by, I want you to start banging on the window,” Eddy said.

Ashton banged on the window several times and caught their attention, which was how they located him.

“They saw him at the window,” Eddy said. When help arrived at the apartment, it was time to disconnect the call and let responders take it from there.

“You did good buddy,” Eddy told Ashton at the end of the call.

Eddy said she believes Ashton’s mom was fine.

“From what I remember everything turned out okay with her,” she said. “If it’s something like that that we’re really involved in we always try to find out the outcome.”

Eddy said this call is one of the more memorable ones she’s taken during the 10 years she’s spent working in a communications center.

“This is definitely one of the most memorable ones just because everything thankfully worked out,” she said. “It was a good call, a good day.”
Lost and Found. Park rescue takes knowing way around

By Stephanie Ricker

Wichita, Kan.—Wednesday, March 20, 2002. It was a dark and stormy night... Well, actually it wasn't. It was a beautiful, unusually warm spring afternoon around 2 p.m. I was assigned to dispatch the West WPD channel and I had a new employee sitting with me as an observer.

I answered a 9-1-1 call from a woman on a cell phone. She was very difficult to understand; her teeth were chattering and I had the impression from her speech pattern that she might have a disability that affected her ability to communicate. She indicated her boyfriend, who was in a wheelchair, was partially submerged in water. Because of the perilous situation, he was scared and having difficulty breathing. An ambulance was needed. She kept insisting she was at 21st and Oliver, on a nature trail by the creek.

From my experience, given her description, it was impossible for her to be near that intersection. The area includes a strip mall, a church and small cemetery, a residential area, and the Wichita State University golf course. The golf course was the most likely place to find a trail and creek. However, I've played on that course; there are no trails or paths, there are ponds but no creeks, and only paying customers are allowed on the course.

Since she sounded like she might have a disability, I took the chance that she lived near 21st and Oliver at an apartment complex that serves people with disabilities. After confirming that she and her boyfriend lived at the complex, it was apparent that she was using the intersection as her only frame of reference. This made it easier to start considering where else they could be in the area, especially since they were on foot.

This incident happened prior to Phase II implementation, so all her cell phone could tell me was that she was in the northeast area of Wichita, which was consistent with that intersection and her apartment complex address. The only place in that general area with nature trails and creeks is a large park about a mile north of the apartment complex. After confirming with her that she was actually in Chisholm Creek Park, we sent EMS, fire, and police.

Narrowing down a location to start looking for them was only the beginning. That park is roughly half the size of New York City's Central Park, a mile long and half a mile wide, wooded with several creeks and trails.

While crews responded and started searching the park, she and her boyfriend were understandably becoming more panicked and time seemed to crawl by. From what I could understand, the caller was trying desperately to keep hold of her boyfriend's wheelchair before it rolled all the way into the creek. The thought kept going through my mind that the new dispatcher sitting next to me would quit for sure after listening to this call.

At one point I heard the caller telling someone in the background. Trying not to sound too desperate, I asked her to please hand him the phone. This man informed me that they were not on the trail. The patient was in a wheelchair and the wheelchair had slid off the trail into the creek. This man had arrived just in time to get the attention of the paramedics who were approaching the area.

The next day, I received a call from those paramedics giving me a more detailed picture of what had happened. The patient had been in a motorized wheelchair and the caller had been holding up the back of the wheelchair to keep the patient's head out of the water so he could breathe. She had pretty much reached her limit by the time the paramedics arrived.

It took some innovative maneuvering and all five responders to get the patient and his wheelchair out of the creek. Fortunately, they weren't injured, just cold from being in the water. Had there been a delay in sending them help by directing units to the intersection of 21st and Oliver, both may have drowned before they were found. Now I joke that although my golf game is not impressive, I can at least claim that my knowledge of the course has helped me save lives.

Sedgwick County Emergency Communications in Wichita, Kan., is separate and distinct from the agencies to which they provide services. Sedgwick County is a metropolitan area of approximately 1,000 square miles with a population of approximately half a million people. The center coordinates 9-1-1 services and radio communications for the Wichita Police and Fire, Sedgwick County Sheriff, fire and EMS departments, and a myriad of suburban public safety agencies. Dispatchers have the joint responsibility of answering 9-1-1 and non-emergency phone calls while dispatching a radio channel.
Fred A. Sorenson’s knowledge of aircraft and quick thinking gave him a second chance—both during the war and after.

The former Salt Lake City, Utah resident survived his Army Air Corps assignment as a tail gunner on a B-17 Bomber during World War II and was part of a crew that escaped capture when the bomber was crippled by ground fire and forced to land behind enemy lines in Poland.

But his good fortune didn’t end there. Sorenson, who traveled extensively as a medical service representative for 33 years after the war, was also one of 45 people who in November 1965 survived the worst commercial plane crash in the aviation history of Salt Lake City. Forty people died at the scene when the Boeing 727 burst into flames at the municipal airport; five more died from their injuries in the days following the tragedy. According to news reports at the time of the accident, all the victims had been trapped inside the aircraft, with many of the deaths attributed to smoke inhalation inside the cabin.

Sorenson, who was quoted in a story written shortly after the crash by United Press International reporter James C. Bapis, credited his survival to an automatic reaction and the miracle of fate. From his experience with aircraft, he knew how to position his body once he felt the plane going down. When the plane did hit, he was thrown from his seat to a seat in the row adjacent to an emergency exit. He and several others were able to open the door and, at the same time, lead others from the plane outside. He had escaped with few injuries—broken ribs and teeth. A phone call home from the airport terminal soon after the crash assured his family of his safety.

His daughter Sherri London, who still lives in Salt Lake City, was in high school at the time. She answered his call and quickly turned the phone over to her mother. “We luckily heard it from him before the story made it to the TV news,” she said. The incident changed his life, London said. He still had a sense of humor, though lower keyed, and he no longer enjoyed plane travel despite a job that demanded he fly. “Something like this has to change people,” London said. “It was one of the things forcing you to ask, why was I so fortunate?”

The event was so remarkable, Sorenson’s family included mention of the crash in his obituary published in the Deseret News at his death in August 2003. The luck of his fate allowed him the opportunity to watch his children prosper and to play grandpa to 12 grandchildren and great-grandpa to 15 great-grandchildren. He took up oil and watercolor painting after his retirement and was noted for his dedication.

Emergency dispatchers may say the unpredictable keeps them hooked on the job, but the decisive point is the opportunity to provide vital assistance in their role as the “Zero Minute” first, first responder.
to church, family, and friends.

London said the accident, though a tragedy, had a great deal of influence in the way he spent his remaining years. “He may have appreciated life a lot more,” she said.

He was given a second chance.

Sorenson’s second chance reflects the hopes of emergency dispatchers. Their desire to help during a crisis is central to what they do. Emergency dispatchers may say the unpredictable keeps them hooked on the job, but the decisive point is the opportunity to provide vital assistance in their role as the “Zero Minute” first, first responder. As every issue of The Journal shows, dispatchers relay police, fire, and medical information that helps people survive. EMDs give CPR instruction and guide parents through the delivery of babies born earlier or faster than anticipated. They can prescribe aspirin and give step-by-step directions for using a defibrillator. The fire protocol details response to a large or small aircraft emergency.

The protocol system in all its forms—police, fire, and medical—is designed so the emergency dispatcher can assign the appropriate unit to the location and provide the caller with necessary instruction in initiating patient care PRIOR to the arrival of field units. When Pre-Arrival Instructions (PAIs) were first formulated in Phoenix and Salt Lake City during the 1970s, they were considered a dangerous novelty. They are now the standard of care at more than 3,000 communications centers worldwide.

No one can say whether the use of the fire protocol for aircraft emergencies would have increased the number of survivors on that fateful day in November 1965. Yet, it’s good to know that the power of protocol today is only three digits and a dispatcher away from any crisis. More people like Fred A. Sorenson live to see their grandchildren and great-grandchildren grow up.

The Priority Dispatch System™ (PDS) celebrates a 30-year anniversary in 2009. Future issues of The Journal will highlight the PDS milestones. Among the benchmarks:

- June 4, 1979—The first working PDS® protocol prototype is introduced at the Alarm Office of the Salt Lake City Fire Department and goes online just hours after the first training class ends on September 14.
- Early 1980s—The MPDS protocol system spreads to Colorado, Montana, California, Maryland, Nebraska, and Arizona.

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- February 1987—The North American Emergency Dispatch software begins development to provide an online version of the MPDS protocol.
- December 1988—ProQA® emergency dispatch software begins development to provide an online version of the MPDS protocol.

- March 1989—The first Navigator Conference is held in Salt Lake City, Utah.
- February 1990—The first edition of The Journal is published.
- February 1993—The Albuquerque Fire Department becomes the first national Accredited Center of Excellence (ACE).
- Summer 2000—The NAED expands to include national fire and police protocols; there is a public release of v1 of the National Fire Protocol.
- 2001—The NAED publicly releases the National Police Protocol.
- 2004—The MPDS celebrates its 25th anniversary.

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has spent 10 years as a police call-taker and seven years as a police dispatcher. She is EMD, EFD, and EPD certified. She is also a certified quality assurance specialist. Jaci serves as the co-chairperson of the Police Council of Standards for the International Academies of Emergency Dispatch and as quality assurance coordinator for Medicine Hat Regional 9-1-1 Communications in Alberta, Canada.

KRS BERG
is Communications Director for the National Academies of Emergency Dispatch and works from the Salt Lake City, Utah headquarters. Among other duties, she chairs the Academy’s Marketing Committee and serves on the Navigator/Euro-Navigator Conference Committees.

STEPHANIE RICKER
has been a dispatcher for 19 years and most of those years have been with the Sedgwick County Emergency Communications in Wichita, Kan. She received a Certificate of Merit from the Sedgwick County Commission for handling a “very emotional and trying incident with a great deal of poise and composure to assure the crews would be taken care of” following a fire incident that killed Sedgwick Fire Department Lt. Bryon Johnnson.

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