Never Forgotten.
Monuments honor victims of 9/11

Breathing Problem.
Academy looks at new ways to triage

Good Times.
Conference combines fun and education

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The following U.S. patents may apply to portions of the MPDS depicted in this book: 5,857,966; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,428,301. 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.
Perhaps you can blame Rich Saalsaa’s case of the swine flu (H1N1) on chance, a mere twist of fate considering the amount of time he spends cooped up in airplanes. Or maybe, the real problem has surfaced: Saalsaa puts too much of himself into the job.

The former California-based firefighter and paramedic joined Priority Dispatch Corp. (PDC) 20 years ago when it was known as Medical Priority Consultants Inc. He moved from Sacramento (which averages 16 days below freezing) to Salt Lake City (with an average of 122 days below freezing) for the challenge to automate the medical priority card set months prior to the establishment of the National Academies of Emergency Dispatch* (NAED*). He was a fellow in concept before there was an NAED College of Fellows, designing protocol, implementing protocol, and, basically, serving as protocol’s chief architect during two decades of tremendous company growth.

Saalsaa, PDC executive vice president and Priority Solutions Inc. chief technology officer, never looked back. He really enjoys his work and the area near downtown Salt Lake City where he calls home. But a diagnosis of swine flu while Saalsaa was working behind the scenes as chief architect of Protocol 36 (Pandemic/Epidemic Outbreaks)? That’s just crazy.

“I had it coming,” said Saalsaa, on the day he returned to the office after spending 10 days quarantined at home. “I had been traveling to a lot of countries on business, spending a lot of time with lots of people holed up on airplanes.”

A sore throat was Saalsaa’s first sign of trouble. From there it was a fever he noticed at the office while working among a skeletal staff during the Utah-specific July 24th holiday (commemorating the arrival of Mormon pioneers to the Salt Lake Valley on July 24, 1847). His physician gave a diagnosis of influenza, later confirmed through a culture (with an average of 16 days below freezing) for the challenges of numerous countries on business, spending a lot of time with lots of people holed up on airplanes.

The Journal of Emergency Dispatch - The Journal of Emergency Dispatch...
A recent trip back east only confirmed what everyone had anticipated: We are dedicated to commemorating the events of Sept. 11, 2001, or—more accurately—the people whose lives were tragically ended on the day commercial jetliners crashed into the World Trade Center (WTC), the Pentagon, and a field near rural Shanksville, Pa.

The signs of our honor are everywhere. A little over a year ago, the Pentagon dedicated its memorial consisting of stainless steel benches set in a granite arch above reflecting pools. There is one memorial space for each of the 184 victims killed at the Pentagon, arranged by birth year, starting with three-year-old Dana Falkenberg and ending with 71-year-old John Yannicky.

The newest museum in Washington, D.C., called the NEWSEUM—since it provides five centuries of print and electronic media history—features first-person accounts, footage of collapsing towers, and a documentary that provides a journalism perspective from that day. Front pages from Sept. 11, 2001, form the background to a mangled 360-foot antenna mast from the WTC North Tower. Earlier in the year, representatives of three national 9/11 memorial organizations gathered outside this same museum to sign the first, among many, steel beams that will be used in building the WTC Memorial and Museum. The ceremony was the kickoff to a nationwide awareness tour during which the public will be invited to add their names.

The WTC Memorial and Museum in Manhattan is well on its way to open Sept. 11, 2011, the 10th anniversary of 9/11. Workers are shaping steel and concrete into the Memorial Museum’s reflective pools and below ground level exhibit space. Those eager to keep up with the project can visit the preview site, adjacent to the WTC site, to view models and renderings and—get this—real-time images of the construction. During August and September 2009, the first two months the preview site was open, an estimated 100,000 visitors from around the world had already stopped in, some recording their 9/11 stories for inclusion in the museum’s exhibitions. The “Last Column,” a key feature of the exhibit pounded into the bedrock, shows the inscriptions, missing posters, and mementos placed everywhere—on phone booths, streetlights, and the walls of subway stations throughout the nine-month rescue and recovery effort. The National September 11 Memorial & Museum foundation has launched the online program called “Make History” for those with photos, videos, and stories to upload.

The Flight 93 National Memorial, encompassing the final resting place of the 40 passengers and crew members, is on track to be dedicated Sept. 11, 2011. Volunteers raised $1.1 million for the exhibit that will include a Tower of Voices, 40 memorial groves, a field of honor, a western overlook, and a visitor center. The more than 30,000 tributes placed at the site, and archived by the National Park Service, will be rotated through the permanent exhibit. Flight 93 was nearing Cleveland, Ohio, en route to San Francisco, Calif., when it suddenly changed course heading southeast in the direction of Washington, D.C., before it crashed into a remote field in Pennsylvania.

In total, the attacks on 9/11 caused 2,996 deaths, including the 19 hijackers (excluded from the memorials) and 2,976 victims. The victims were distributed as follows: 246 on the four planes (from which there were no survivors), 2,605 in New York City in the towers and on the ground, and 125 at the Pentagon—including 55 military personnel. The number of first responders killed totals 343 firefighters and paramedics, 23 New York Police Department officers, and 37 Port Authority police officers. Many first responders still suffer from severe respiratory ailments years after the event. For the first time, at the sixth annual 9/11 observance held in New York City, those rushing to Ground Zero, rather than away from it, read the names of those who had died.

I don’t know the lessons you learned from 9/11; lessons learned as most of us, stunned and horrified, watched the events unfold on televisions at our homes and offices hundreds or more miles away from the tragic chaos. No one went away able to deny the vulnerability—terrorism is a fact of life everywhere—or the way the day drew us together to mourn and comfort. The day also boasted of American spirit, our willingness to come together at another’s time of need. At times like these, we truly are a nation undivided.
Worthy of a Call. Scale emergency response to urgency of situation

Jeff Clawson, M.D.

Note: This editorial reflects the opinion of Jeff Clawson, M.D., creator of the Medical Priority Dispatch System™, Fire Priority Dispatch System™, and Police Priority Dispatch System™ protocols used throughout the world. It does not necessarily reflect the views of the National Academies of Emergency Dispatch®.

A national story CNN broadcast on its website (http://money.cnn.com/2009/08/24/news/economy/healthcare_911_abuse/index.htm?cnn=yes) did mention a 20 percent figure into a statement of 9-1-1 abuse. This is an inaccurate application of the statistic.

Specifically, Kavilanz wrote: “The National Fire Protection Association, which tracks 9-1-1 call volume annually, said fire departments nationwide responded to about 15.7 million total medical aid calls in 2008. Using that data, the National Academies of Emergency Dispatch® (NAED™), said about 20 percent of the calls are classified as non-life threatening and don’t require a paramedic.”

This is neither what I said, nor even remotely suggested during our 30-minute phone interview. These are true emergencies to the people calling and they do require assistance. My point: we need to handle these calls better.

First, the 20 percent is not simply “non-Life Support personnel). However, they do require basic emergency evaluation and care and then transport by EMTs (Basic Life Support personnel)—the minimal amount of training needed to be on an ambulance or first responder unit.

I also told Kavilanz that the number of these calls has gone up—but only proportionately to all calls to 9-1-1, which began to rise significantly both locally and nationally around 1990. In other words, the 20 percent today is the same 20 percent then, but of a larger overall number of 9-1-1 calls due to the increasing number of calls made to 9-1-1. People are not abusing the system more now than in the past, and true intentional abuse to 9-1-1 for medical help is quite low.

There is another medical 9-1-1 code level that, to date, has been basically overlooked within the United States, called the OMEGA tier. It is a smaller subset of the ALPHA calls that truly do not need emergency response and transport—this constitutes about 6 percent of all 9-1-1 calls, leaving the remaining 13 percent ALPHA calls for non-emergent transport. This special protocol is used universally in the U.K. and in several places in Canada and Australia. Currently, only Richmond, Va., has a fully functioning OMEGA system in the United States. The OMEGA system requires careful evaluation and a referral to a more appropriate healthcare entity: nurse advice lines, poison control centers, suicide help lines, scheduled doctors appointments, and other health/social agencies. In no case is the caller told, “This is not an emergency; we’re not coming, have a nice day.”

While the 9-1-1 systems in the United States talk the talk of too many “non-emergency” calls, they do virtually nothing to really provide any alternative, much less a safe and reliable alternate care path, for these myriad people who have a real need, even though it is not ultimately life threatening nor requiring an ambulance transport to the most expensive healthcare place on earth—the emergency room. Most 9-1-1 system administrators still believe it is “un-American” not to respond, and, more than not, continue to over respond (too many vehicles and personnel). Most still respond lights-and-siren to even clearly minor cases, placing the driving public (and tragically themselves) at great risk (15,000 to 20,000 emergency medical vehicle accidents occur each year in the United States). Now that’s not exactly helping healthcare in America today.

Let me provide you with some examples of these ALPHA-level cases, and you judge for yourself whether a call to 9-1-1 might be appropriate:

Burns to less than 18 percent of the body; chest pain under age 35 (breathing normally); just choked—but is not apparently still choking; post-seizure, now unconscious (breathing effectively); drowning, but now alert and breathing normally; moderate eye injuries; fainting episode and alert (under 35—with cardiac history); broken knee; sick with new onset of immobility (some of these are actually strokes); fall with a broken shoulder; focal seizures (alert); non-trauma-caused back pain (can’t get up due to pain).

Another continuing public safety myth is the misunderstanding of address-
ing 9-1-1 abuse by chastising the public through media articles or advertising campaigns “to only call for emergencies.” The approach just doesn’t work. You cannot reeducate the entire American public to change their emergency reaction habits learned over a lifetime—especially when their only real-life practice tries are the one to two (average) times a citizen calls 9-1-1 in his or her lifetime (the ubiquitous cell phone is likely changing that figure). As a matter of fact, most people who are 45 years old or younger have been told since childhood to call 9-1-1 “if you or mommy needs help.” Kids and most of the lay public don’t know exactly what an emergency is (nor can they), but they know when they need “help” and that’s when they call—exactly as trained, mind you.

In the early 1980s, Detroit, having just hung its 9-1-1 shingle out, felt it was being overwhelmed with 9-1-1 calls. The city allocated $3.5 million for a public ad blitz that included TV ads, radio spots, and billboards, advising basically, “Don’t call unless it is a real emergency.” After the three million plus bucks were gone, on review, calls to 9-1-1 went up nearly six percent! Remember that famous Gary Larson cartoon that shows what dogs really hear? It was to the effect of, first panel: “Don’t eat the food.” Second panel: “Blank, blank, blank, FOOD.” The individual so targeted never thinks he or she is the one abusing 9-1-1 as the advertising states.

We need safe and efficient processes in the 9-1-1 center that accept all calls, whatever they may be (within reason), but then direct the callers to the most appropriate mobile or non-mobile healthcare or “helpcare” entity—without just sending an ambulance or paramedics in a knee-jerk reaction.

You cannot reeducate the entire American public to change their emergency reaction habits learned over a lifetime.

**CONTRIBUTORS**

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Brett Patterson is an Academics and Standards associate for the NAED™. His role primarily involves training, curriculum, protocol standards, quality improvement, and research. He is a senior EMD instructor and a member of the NAED College of Fellows, Standards Council, and Rules Committee. Patterson became a paramedic in 1981 and began a career in EMS communications in 1987. Prior to accepting a position with the NAED, he spent 10 years working in a public utility model EMS system in Pinellas County, Fla.

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**QUALITY ASSURANCE PAGE 8**

**FAQ PAGE 11**
Best Practices

Customer Service. You have it or you should

By Michael Spath

Thomas Schafer was sitting upright in bed, listening to the sounds of his wife working in the kitchen a short distance away. He was not yet accustomed to the new house, the closeness of it, but the stairs in the old house had simply been too much in recent years. Closing up the cabinets as she finished putting the dishes away, Margaret was humming a familiar melody to herself, singing an occasional “la, la, la,” slightly off-key.

Thomas smiled to himself, warming as he thought about this long-standing habit of hers. She had done this for as long as he’d known her, 50 years now; their anniversary was just weeks away. She always had a song in her heart, even during recent struggles. He thought momentarily of their two children and six grandchildren, all living nearby and all in good health. He had so much to be thankful for. Life seemed pretty good, all things considered.

While he adjusted his legs to a more comfortable position, Margaret walked into the bedroom, her powder blue nightgown billowing playfully over her slippers. Without warning, her foot caught the edge of the dresser and she abruptly fell to the floor, crying out in surprise and throwing her arms out in front of her. She shrieked in pain as her right wrist snapped upon hitting the floor. Rolling to her side, she howled in agony.

“No, no, no,” she muttered, tears streaming down her face.

Thomas rolled over to the side of the bed and then fell to the floor, his ineffective legs thumping loudly on the carpet. Turning onto his side, he tried to push himself up, thinking he could hold her in his lap.

“I’m here, Marg,” he reassured her, his face just inches from hers.

“Call for help, honey,” she told him, her breathing heavy. “Call 9-1-1.”

After a moment’s hesitation, he started pulling himself toward the nightstand on the far side of the bed. For Thomas, the crawl was long. A stroke two years ago, at age 81, had left him barely able to move. Rehabilitation had helped restore some movement to his arms and one leg, but he was not prepared for this. He’d never had to call 9-1-1, and he’d hoped he would never have to. Digging his fingers into the ivory-colored shag carpet, he dragged himself first to the corner of the bed, then over to the nightstand. All the while, Margaret cried softly behind him. Pulling on the telephone cord, Thomas yanked the phone to the floor and dialed 9-1-1.

Resting on his side and breathing heavily, Thomas grabbed the handset and held it to his ear. He listened to it ring once, then twice. He grew frustrated when it rang a third time but was relieved to hear someone a second later.
“9-1-1, what is the address of your emergency?”
“Thank you,” Thomas said. “We need an ambulance. My wife fell. Can’t help her up.”
“I understand. We’re going to send you some help. I need to know your address.”
Thomas gave the address of the home he had lived in for the last 40 years.
There was a pause, and then the dispatcher asked, “Can you repeat that address so I’m sure I’ve got that right?”
As Thomas was about to repeat the address, he realized what he had done. “Oh, I’m sorry. We just moved last month…” He gave their new address.
“Thank you. Can you verify the telephone number you’re calling from in case we get disconnected?”
“No, I can’t. I don’t know it. I just need help,” he cried, feeling tears and anger beginning to rise.
“We’re going to help you. I understand your wife has fallen. Tell me exactly what happened.”
“I don’t know, I think she just tripped. She thinks her arm is broken.”
“Are you with your wife now?”
“Yes, I am. She’s over by the door.”
“How old is your wife?”
“Eighty-three. We’re both eighty-three,” he answered.
“Is she awake?”
“Yes.”
“Is she breathing?”
“Yes, she’s breathing. She’s fallen.”
“When did this happen?”
“Just now. I can’t lift her up. I’m paralyzed.”
“We are going to send help. What’s your name, sir?”
“Thomas. Thomas Schafer.”
“Mr. Schafer, we’re going to get through this together. How far did she fall?”
“I don’t know. She was walking. Fell to the floor.”
“Is there any serious bleeding?”
“I didn’t see any blood. Marg, honey, are you bleeding?” Thomas paused, listening to Margaret’s answer. “No, she’s not bleeding. She says her arm is broken. I heard it snap when she fell.”
“Okay, this is very important. Is she completely alert?”
“Yes.”
“You mentioned her arm. Is there any other part of her body that’s injured?”
“No, I don’t think so.”
“Can you ask her?”
“Marg, are you hurt anywhere else?” After a few seconds, Thomas answered, “She’s having a really hard time. Can you please hurry?”
“We’re going to get there as quickly as we can, Mr. Schafer. Is any other part of her body hurt?”
“No that I know of.”
“Is she still on the floor?”
“Yes. I can’t lift her myself. My legs are paralyzed, well, mostly paralyzed. I need help.”
“I’m sending the paramedics to help you now. I want you to stay on the line and I’m going to tell you exactly what to do next.”
“Okay. I’m going to move back over to her. I need to help her.”
“You are helping her, and you are doing a great job. Can you take the phone with you when you go to her?”
“I don’t think so. I can’t hold it while I’m crawling.”
“I understand. Let me give you a few instructions, then you can leave the phone off the hook, okay?”
“Yes.”
“Do not move her unless she’s in danger. Do not splint any injuries.”
“Yes.”
“Stay by her and reassure her that help is on the way. Just tell her to be still and wait for help to arrive. Do you understand me so far?”
“Yes, no moving her, reassure her, keep her still.”
“That’s right. I want you to watch her very closely. If she becomes less awake and vomits, quickly turn her on her side.”
“On her side. Got it.”
“Is the door unlocked?”
“I doubt it, but there’s a key under the mat in the planter box.”
“Okay, Mr. Schafer. Thank you for your help. Please leave the phone off the hook. If she gets worse in any way before we get there, tell me immediately.”
Aside from a few specifics, the general parameters of this call are fairly standard for emergency dispatchers. It’s a routine fall assessment, with the additional twist that the caller is paralyzed and not able to provide as much help as he would like. While it is a mostly routine call for the emergency dispatcher, it remains incumbent upon him or her to recognize those subtle differences and address them when appropriate to do so. There are so many other things the dispatcher could have done: answer the phone with an exasperated “9-1-1,” as if s/he was being interrupted in the middle of something much more important; admonish the caller for not knowing his address (“Sir, that address is not what I show on my screen. Don’t you know your own address?”); or, instead of offering reassurance, say, “Sir, I have to ask you these questions so I can send you help.”
Check for understanding throughout the call. Incorporate the more specific relationship between the caller and the patient into the assessment (“Are you with your wife now?”). Offer reassurance early and often. Customer service techniques can play a very important role in every call. While not strictly written into the protocol, these techniques can make a huge difference in the caller’s perception of the entire response. Who does he think he’s on the telephone with—a bored government employee who hates his or her job or a caring, compassionate human being who is doing everything he or she can to help him? If Thomas was your father or grandfather, which would you want him to get?
As the first, first responder, dispatch is an integral part of every response. It’s the first contact for the caller and it gives him or her a first impression of the entire response. Training to the expectation that the customer service techniques demonstrated in this case are used on even the most routine of calls ensures Thomas will get the help he expects and deserves when he has to call 9-1-1. What really sets this call apart is the personal side of the story—that little glimpse of life before 9-1-1 started to ring. In this case, it’s partly a work of fiction, but it is based on information the caller said in his actual 9-1-1 call. That background piece is what’s missing for the emergency dispatcher, yet every call taken has a personal side. It may be routine for the caller, but it is not routine for the first-time caller looking at his beloved wife cradling her broken arm, unable to help her, with the emotional strain clearly audible in the tremble of his voice.
Every 9-1-1 caller would be better served by calltakers in the habit of using these techniques, of going beyond the routine protocol, when appropriate to do so without having to think about it. That requires practice and reinforcement of customer service techniques. Though it is hard work to change old habits and form new ones, ultimately, it makes the job of the emergency dispatcher easier than ever before.
Push Comes to Shove.
Major incidents spark policy changes

By Audrey Fraizer

Gas leak

An unusual sight greeted drivers in cars lined bumper to bumper along 1300 East, a major inner-city street in Salt Lake City in March 2009: teachers and administrators from a daycare center pushing kids in multiple cribs along the sidewalk. Behind them, and from the same center, was a line of older children holding hands and singing in procession.

Mid-afternoon on Tuesday, March 24, 2009, was a curious time for a field trip along a busy street, but the story made up for the occasion would keep the children calm when a gas leak near the daycare forced the evacuation of a two-mile area in and around the University of Utah.

At first it was pretty crazy, one of the teachers told a news reporter on the scene. But once they were settled in, there was nothing but praise and thumbs up for moving the children quickly out of harm’s way.1

The leak, which occurred when a contractor using boring equipment pierced a 6-inch plastic line, spread natural gas everywhere. The gas bubbled up under the road and escaped from the hole dug into the roadway. Pedestrians and motorists fled, wary of the strong odor of gas at the corner of 1500 East and 500 South, just blocks south from the university campus.

“A huge amount of gas is leaking out; you can smell it,” a caller told a dispatcher at the Salt Lake City Fire Department (SLCFD) Communications Center. “I recommend you get someone there quickly. We just drove by and drove out because we didn’t want to get blown up.”

The police and fire communications centers were swamped with calls, according to David Brinton, a SLCFD firefighter/paramedic and speaker at Navigator 2009. But no matter how hard they tried keeping up with the deluge, the lack of coordination between the university and public services almost caused the system to implode.

“Patients in their rooms at the [University of Utah Medical Center] hospital received the same notice [as the daycare],” he said. “They were taken out of beds and attached to mobile IV poles. It was a comedy of errors. A lesson in the making.”

Dispatchers were taking calls about the leak for the nearly five hours it took for city crews to repair the leak. As instructed by the people in charge, dispatchers told callers in the evacuation zone to find their way to either a high school about a mile from the leak or to a stadium on the University of Utah campus. Cars backed up for miles while the Utah Transit Authority debated plans for sending in buses to transport patients from the Veterans Affairs Medical Center, south of the university campus.

“I wanted to light my hair on fire,” said EMD Lisa Burnette, SLCFD Communications Center dispatch supervisor. “It was totally frustrating. Officials kept changing the boundaries of the evacuation area, from two blocks to two miles. Communications were not coordinated.”

If there was anything good about the event—aside from zero fatalities—it was the lessons learned in the event of another mass evacuation, Brinton said. For starters, there are plans for a coordinated Wide Area Network (WAN), so users and computers in one location [such as the university] can communicate with users and computers in other locations [the communications center, for example]. There were also lessons prompting better evacuation plans, setting up a chain of command, and getting crews to the scene for directing traffic and otherwise assisting the communities affected.

“News teams were there before the fire department arrived,” Brinton said. “I’m willing to bet that won’t happen next time.”

Continental Airlines Flight 1404

Similar lessons were learned when Continental Airlines Flight 1404 crashed while taking off from Denver International Airport (DIA) on Dec. 20, 2008. The 737-524 aircraft veered off the runway and caught fire after crashing into a 40-foot-deep ravine. Flight attendants initiated evacuation and hustled passengers out of the burning plane.

No one was killed, although 38 passengers among the 115 on board were injured, two critically. The National Safety Transportation Board (NSTB) never discovered a cause for the crash, the most serious incident in the airport’s 13-year history.

Despite what has been called the miraculous survival of all on board, the Denver Health emergency response team “took it on the chin” for its poor response, according to Denver 9-1-1 Assistant Chief James Azuero, a speaker at Navigator 2009. Denver’s 9-1-1 emergency medical response system and the Denver Health Paramedic Division are part of the Rocky Mountain Region’s Level 1 Denver Health Medical Center.

“Passengers walked to a nearby fire station,” Azuero said. “The airport fire truck responding went in the wrong direction.
Seventeen fire trucks from every corner of the city arrived in less than five minutes. The first confirmed call came into EMS more than 5 minutes after the crash. The response showed a true lack of coordination and a true lack of preparation.¹

According to a Channel 7 news investigation, it took 33 minutes for the first ambulance to respond and it was sent Code 9, the non-emergency designation that requires the ambulance to maintain normal speeds and not use lights or siren. It took 40 minutes for three ambulances to arrive at DIA, and there were only five ambulances at the scene 50 minutes after the accident. It took a full hour for 10 ambulances to arrive. The average response was 17 minutes for each ambulance to arrive after it was dispatched.²

Denver Health has since implemented a policy requiring at least four ambulances to be sent to a red alert for a plane crash. In the event of a major crash, ambulances will run Code 10, the emergency response with lights and siren. Medical helicopters will respond, which was not the case for December's accident, and there is now a Denver Health ambulance stationed at the airport. The communications center instituted the use of the Medical Priority Dispatch System™ (MPDS™) and went live with ProQA® in April 2009. Universal calltaking was established, and the DIA communications center now interfaces with Denver Health’s system.

“The plane crash tested Denver’s emergency system and pointed out the flaws,” Azuero said. “The public wants to know it’s safe and we’ve been working to make things right. We’re out to improve our system and the public’s perception.”

a separate and specific response for these 26-C-2 patients.

The chest pain question was altered to become non-leading. While the council wanted even “discovered” chest pain patients to be handled on Protocol 10, Chest Pain (Non-Traumatic), because of the genuine risk of heart attack associated with this symptom, the new question eliminates at least some of the over-triage associated with leading questions.

As noted, the new pain question was changed to be non-leading, but was retained to uncover the priority symptom of chest pain. If the caller does not tell the EMD where the pain is when asked this question, which they normally do, the EMD may clarify. However, no shunt is necessary unless the caller offers “Chest Pain” as an answer to this purposefully open-ended question. If non-priority complaints such as back or abdominal pain are not offered during Case Entry questions, but are incidentally “discovered” on Protocol 26, no shunt is made from Protocol 26 unless the priority symptoms of chest pain or hemorrhage are discovered. When the patient complains of pain other than chest pain, the ALPHA Determinant Descriptor for “Other Pain” should be used, provided no higher descriptors are appropriate.

The bottom line is that patients with “discovered” pain or abnormal breathing (not part of the initial Chief Complaint) are not as likely to have a problem related to that symptom as patients with that same primary complaint. With that said, there is certainly the possibility of identifying a specific condition that is clearly “hunted” by the protocol, i.e., heart attack or stroke symptoms, where a move to another protocol is appropriate. For instance, if during Sick Person (Specific Diagnosis) Key Questions, the EMD learns that this “other pain” is actually a dull ache in the left arm and jaw, a move to Protocol 10, Chest Pain (Non-Traumatic), is appropriate. If the EMD learns that the patient had sudden, unilateral weakness, a move to Protocol 28, Stroke (CVA), is appropriate. These “discovered” signs or symptoms are clearly defined and listed in the protocol to ensure that they are not missed.

The “discovery” of pain that was not part of the initial Chief Complaint should still be handled on Protocol 26—with the exception of chest pain, which should be shunted to Protocol 10. Exceptions to this rule should only include specific protocol directives, in which “discovered” symptoms may relate to a specific diagnosis such as heart attack or stroke, as defined by protocol.

I hope this explanation helps your EMDs to select the most appropriate Chief Complaint. As Dr. Clawson is famous for saying: “If you want to be on the right train, buy the right ticket.”

Brett A. Patterson
Academics & Standards Associate
NAED

Brett:
The EMD takes a call on an unstable, unconscious overdose patient; the EMD tells the caller that she will stay on the line with the caller until the paramedics arrive. The police arrive before the paramedics; the caller tells the EMD, “The police are here now;” the EMD says OK and disconnects the line.

Knowing that the police officers are CPR-certified, is it appropriate for the EMD to disconnect the line upon the arrival of the police officers? Or, should the EMD wait for the medical team to arrive?

Thanks in advance.

Ginger (Virginia) Szatkowski
E-911 TC/ED-Q
Lawton/Ft. Sill/Comanche County
Emergency Communications

Ginger:
I think this is something your agency should discuss with the police departments you work with to provide some consistency and reasonable expectations for the officers at the scene.

Most police departments appreciate assistance from EMDs, especially when dealing with unstable patients. The unconscious overdose patient you refer to represents a potential for serious airway compromise. When the scene is secure, a word with the officer about what to do if the patient vomits can go a long way. When this is explained to the PD brass, they are generally quite receptive.

My advice is to schedule a meeting and discuss the matter. Include your medical director. Play the role of patient and officer advocate and see what their attitude is. Discuss various situations, including stable and unstable patients, and secure versus non-secure scenes. Once a decision is made, all of your EMDs will handle calls involving PD the same way, according to policy, which will be less litigious and more defendable in case an officer makes a complaint.

The bottom line is that unstable patients represent risk for all involved, including the patient. Since EMDs, officers, first responders, and ambulance personnel are all involved in the care of these patients, all should be involved in creating consistent policy that focuses on the same goal while considering the needs of each department.

Let me know what you come up with.

Brett A. Patterson
Academics & Standards Associate
NAED

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Let me know what you come up with.
A Single Call. DLS to save choking baby convinces center protocol is a hit

By Audrey Fraizer

Billed as the biggest EMD event of the year, and destined for the Snowbird Resort in Little Cottonwood Canyon near Salt Lake City, the conference featured some of the larger-than-life names in the industry. James O. Page, JD, considered the father of modern emergency services, was a keynote speaker.

Among those planning to attend was Gernot Vergeiner from Austria. An article detailing Dr. Clawson's emergency medical protocol published in the German version of the Journal of Emergency Medicine (JEMS) prompted the director of the ILL-Integrierte Landesleitstellen GmbH communications center in Innsbruck to fly halfway across the world.

"He didn't know really what to expect," said Andreas Maurer, then a dispatcher at the same center. "The protocol interested him and he wanted to learn more."

The five-day conference was a mini-version of today's extravaganza. Seminars targeting management preceded two days of breakout sessions focusing on the hot topics of crisis dispatch. The tremendous growth in Europe and the U.K. sparked the addition of eight international members to the College of Fellows.

Maybe it was the dedication of these current protocol users or, maybe, even the atmosphere of a conference always educational in nature that pushed Vergeiner to approach Dr. Clawson. Whatever it was, the Austrian director headed back home with a protocol cardset in its original language.

Vergeiner, fluent in English, brought the cardset to his office where he could study the system at that time in use in hundreds of communications centers, including 13 that had achieved certification under the recently-enacted ACE program. There were no contracts signed or agreements for translation.

Few people at the center had even heard of the Medical Priority Dispatch System™ (MPDS®). Most were taken by complete surprise the day in 1997 Vergeiner translated the protocol on the spot to save the life of a choking baby.

Maurer, who took the call, had dispatched an ambulance when Vergeiner overheard the dispatcher attempting to calm a distraught caller while waiting for help to arrive at the door. Once figuring out the problem, he grabbed the cardset and proceeded to Maurer's CAD. He translated the DLS to German and relayed the instructions over the phone. The MPDS was introduced to Austria.

"He managed to have the baby breathing by the time paramedics arrived," said Maurer, now a quality management supervisor. "They took the baby to the hospital and everything turned out just fine."

Vergeiner contacted Dr. Clawson, and they've been using the MPDS going on 13 years. Since then, there has been more life-affirming calls, including choking babies and adults, childbirth, and, as Maurer said, "the standard calls for airway control."

For five years, the family visited the center each year on the date of the save, bringing cake and coffee in celebration of the life-saving phone call. The visits stopped when the center consolidated and moved to a new location.

Maurer recalls the baby's name, Johan, but little else about the family. The part that stays with him—aside from the baby's save—was the control protocol brought to the situation.

"It was the reason the protocol was implemented," he said.
### Get a load of these 9-1-1 statistics

<table>
<thead>
<tr>
<th>The National Emergency Number Association (NENA) included these fascinating statistics on its website (<a href="http://www.nena.org">www.nena.org</a>).</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of Aug. 1, 2009, the United States has 6,181 primary and secondary PSAPs and 3,135 counties, which include parishes, independent cities, boroughs, and census areas. Based on NENA's preliminary assessment of the most recent FCC quarterly filings:</td>
</tr>
<tr>
<td>96.1 percent of 6,181 PSAPs—some Phase I</td>
</tr>
<tr>
<td>When Phase I has been implemented, the calltaker automatically receives the wireless phone number. Phase I also delivers the location of the cell tower handling the call.</td>
</tr>
<tr>
<td>93.1 percent of 6,181 PSAPs—some Phase II</td>
</tr>
<tr>
<td>Phase II allows calltakers to receive both the caller's wireless phone number and his or her location information. The call is routed to a PSAP either based on cell site/sector information or on call location information.</td>
</tr>
<tr>
<td>90.8 percent of 3,135 counties—some Phase I</td>
</tr>
<tr>
<td>86.4 percent of 3,135 counties—some Phase II</td>
</tr>
<tr>
<td>97.5 percent of the population—some Phase I</td>
</tr>
<tr>
<td>95.9 percent of the population—some Phase II</td>
</tr>
<tr>
<td>Population covered: 99 percent (at least basic 9-1-1)</td>
</tr>
<tr>
<td>Counties/parishes covered: 96 percent (at least basic 9-1-1)</td>
</tr>
<tr>
<td>An estimated 240 million calls are made to 9-1-1 in the U.S. each year. According to the FCC, one-third are wireless calls; in many communities, it’s one-half or more of all 9-1-1 calls.</td>
</tr>
</tbody>
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### Conviction further fuels cause

| The conviction of Michael Lee King doesn't mean the end to the Denise Amber Lee Foundation and the work the group is trying to accomplish to improve the national 9-1-1 system. |
| Hardly, according to Mark Lee, father of Nathan Lee, Denise's husband. |
| “We will keep doing what we have been doing all along,” Mark said. “We are in this for the long haul or until we can no longer afford it.” |
| King was convicted of murdering the 21-year-old mother of two boys after abducting her from her home in North Port, Fla. In a story circulated throughout the country, police were unable to locate King during the incident despite five calls made to 9-1-1, including a six-minute call Denise placed from her abductor's cell phone while in the back of his car. |
| Police apprehended King later that same evening and Denise's body was found buried in a shallow grave three days after he had shot her point blank in the forehead. Denise's death pointed to inadequacies in the 9-1-1 system, a cause Mark and Nathan have relentlessly pursued through the creation of the Denise Amber Lee Foundation. In 2008, Nathan and their extended families fought for legislation that would require specialized training for 9-1-1 personnel. While the measure passed, it was watered down from the foundation's original proposal, and the family went back with a proposal to make training mandatory, rather than voluntary as the current law holds. |
| “We intend to be very involved and vocal in Tallahassee,” Mark said. |
| At the same time of King's conviction and sentencing of death, the firm Targlione & Associates of Gainesville, Fla., released the report Florida 911: The State of Emergency, funded by Gulf Coast Community Foundation of Venice. The report, commissioned following Denise's death, faulted Florida's 9-1-1 system on several key points, including: |
| - No single state agency to monitor how effectively calls for emergency assistance are handled |
| - Underfunding the system on a statewide level |
| - No mandated, uniform training in the state's 258 call centers that handle 9-1-1 calls |
| - Incomplete statewide coordination of equipment used for emergency response |
| The study also presents 18 recommendations for improvement, including: |
| - Redefining 9-1-1 as a comprehensive emergency response system inclusive of all aspects of emergency service provision, from the time a call to 9-1-1 is placed to the time when help arrives |
| - Appointing a state-level position to oversee and coordinate all aspects of 9-1-1 emergency response in Florida |
| - Mandating minimum standards for training, protocol, and equipment for all call centers |
| - Establishing state-level lists of approved equipment or standards for interconnectivity among all types of devices used to access and mobilize emergency response |

### Report cites issues in collaboration

| Problems at the state level aren't the only cracks in the country's emergency communications system. A report released by the U.S. Government Accounting Office (GAO-09-604) cites emergency communications breakdowns for undermining response efforts during terrorist attacks on Sept. 11, 2001, and Hurricane Katrina in 2005. |
| “Continuity of communications, capacity, and interoperability are primary areas of vulnerability in first responder
emergency communications in communities across the country,” according to the GAO. “The destructive nature of catastrophic disasters can disrupt continuity of communications—the ability to maintain communications during and following a disaster.

“Capacity—a communication system’s ability to handle demand, provide coverage, and send different types of information—is also vulnerable in a catastrophic disaster. Lastly, vulnerabilities involving interoperability—the ability to communicate across different organizations and jurisdictions as needed and authorized—remain due to technological and human factors.”

The GAO recommends better collaboration among the agencies involved in emergency communications, establishment of a national Emergency Communications Preparedness Center, guidance in developing formal emergency communications plans, and systematic tracking of agency response to recommendations.

What’s your line?

Language is no barrier for dispatchers answering emergency calls in the Ticino Soccorso 144 communications center in Breganzona, Switzerland.

In fact, the ability to speak multiple languages is a skill the Ticino region pushes from the time a child enters the public school system.

Switzerland, bordered by Germany, France, Italy, and Austria, has four national languages—German, French, Italian, and Rumantsch. Italian is the primary language spoken in the Ticino region, followed by German because of the high number of German-speaking retirees and—during the summer months—German-speaking tourists. French and German are taught in grade school, along with English.

“All of the dispatchers speak two languages and some four or five,” said Quality Assurance Manager Christine Wägli. “English is the language for leisure and travel.”

Switching back and forth among the languages is nothing extraordinary for these dispatchers. It’s a lingual expertise they lend to other centers when no one speaks the same language as the caller.

“If Zurich gets a call in Italian and they don’t have somebody that speaks Italian, we will dispatch the call,” Wägli said.

The regional center, consolidated in the mid 1990s from many smaller centers, serves 350,000 residents and is the only center in the world that has implemented a four-language capacity ProQA® (Italian, French, German, and English). Not only does the long-time staff appreciate the software’s multilingual talents, but the same also goes for the dispatchers just entering the profession.

“They don’t have to search for words because they are provided by the system (MPDS®),” Wägli said.

RECOGNITION

Award catches dispatcher off guard

“I don’t like having a lot of attention focused on me,” she said.

Margaret Parker, NetCom operations supervisor, said every fiscal year each dispatcher has the chance to nominate four dispatchers for the award. Management reviews the nominations and selects the recipient based on the 12 characteristics of a successful NetCom employee; the points include treating people with care and respect, keeping a positive outlook, being tolerant of others, and open to different opinions and styles.

Parker said Yee goes above and beyond meeting those characteristics.

“Lisa is an extremely dedicated employee,” Parker said. “She is a very hard worker, and she’s an excellent multi-tasker. We felt like she needed to be recognized.”

Parker said Yee works well as part of a team and has helped work four major fires—three last summer and one this summer—that have been the largest fire incidents in the county in the last 20 years. Yee received a letter of recognition for her work. The chief executive officers of the Joint Powers Authority Board of Directors also presented her with a plaque commending her performance.

“We hold that title near and dear to our hearts, and we’re very proud of Lisa,” Parker said.

Yee has stayed at NetCom, a center that handled and processed 295,000 calls for service in 2008, for four years because it’s more than a job to her.

“I like my job and being able to help people,” she said.
Alexander Garza, M.D., a member of the National Academies of Emergency Dispatch® (NAED®) Chemical, Biological, Radiological, and Nuclear (CBRN) Standards Committee was recently appointed chief medical officer and assistant secretary for Health Affairs, Department of Homeland Security (DHS).

In his new position, Dr. Garza leads all DHS medical and health security matters; oversees the health aspects of contingency planning for all chemical, biological, radiological, and nuclear hazards; and leads a coordinated federal effort to ensure that DHS is prepared to respond to biological and chemical Weapons of Mass Destruction (WMD).

Prior to joining the department earlier this year, in August 2009, Dr. Garza spent 13 years as a practicing physician and medical educator. He most recently served as the director of military programs at the ER One Institute at the Washington Hospital Center and he has served as the associate medical director of emergency medical services (EMS) for the state of New Mexico and director of EMS for the Kansas City, Mo., Health Department.

Dr. Garza served in the U.S. Army Reserve and was a battalion surgeon and public health team chief during Operation Flintlock in Dakar, Senegal. He also served as a public health team chief during Operation Iraqi Freedom and as a special investigator and medical expert for Maj. Gen. Raymond Odierno.

Dr. Garza holds a medical degree from the University of Missouri—Columbia School of Medicine, a Master of Public Health from the Saint Louis University School of Public Health, and a Bachelor of Science in biology from the University of Missouri—Kansas City. Prior to earning his M.D., he served as a paramedic and an emergency medical technician. He is a fellow in the American College of Emergency Physicians and a member of the American Public Health Association. Dr. Garza is a senior editor for the Oxford Handbook in Disaster Medicine.

The NAED CBRN Standards Committee oversees the development of protocol associated with potential disasters. In 2008, anticipating a potential avian flu outbreak, the NAED had begun work on several updates for both ProQA and card-set users. When the swine flu hit in April 2009, the CBRN Fast Track Committee formally requested an immediate release of all materials relevant to the situation with modifications specific to the swine flu. The materials were finalized, tested, and translated into five languages and posted on the NAED and PDC websites within 48 hours.

Accolades don’t get much better than a Governor’s Sterling Award (GSA) for best business practices, at least in Florida.

Dispatcher focused on calming caller

South Summit Central Dispatch EMD Cindy Sullivan knew something was wrong, really wrong, the second she picked up the phone. On the other end, was an obviously distraught caller shouting his address into the phone and, without waiting for her reply, telling Sullivan his son had been shot. He was bleeding from a bullet wound in his chest.

Sullivan’s coworkers dispatched first responders and while waiting for them to arrive on scene, she provided reassurance to the father, letting him know help was on the way. She told him to take a deep, calming breath and gave him instructions for tilting his son’s head to keep the airway clear. First responders took over once they arrived on scene.

The shooting call—Sullivan’s first in her three years of dispatching for South Summit Central Dispatch—hit home to the mother of four.

“It was heartbreaking to listen to him,” she said. “The two thoughts running in my head was keeping this guy calm and finding out where the weapon is.”

The father’s agony stuck with Sullivan; she followed up, and found out the son had lived through the incident. Karen Gregorcic, dispatch manager, took Sullivan’s call to her boss.

“I believe she deserved special recognition,” Gregorcic said. “This is probably the most hysterical caller she’s ever had and she kept her cool.”

The Green City (Ohio) Council presented Sullivan with a letter of recognition from the mayor and personal thanks from council members.

“The quick actions of Cindy and the first responders saved this man’s life,” Gregorcic said.

Police apprehended the assailant shortly after the shooting in what appears to be related to an attempted robbery; the man’s son had been caught in the crossfire.

South Summit Central Dispatch dispatches fire and EMS calls and serves a population of 60,000 spread throughout four communities (Springfield Township, Green, Coventry, and Lakemore) in a semi-rural area.
among the hundreds of public and private agencies competing for the recognition.

“We are the first EMS agency in the state to receive the award,” said Ron Shiner, EMT-P, EMD-Q, paramedic, and communications training officer for Sunstar Paramedic’s 35 paramedic calltakers. “It’s quite an honor.”

Sunstar is among only 62 organizations to receive the GSA during the past 17 years the award has been offered. A 40-member Board of Directors from organizations across all sectors governs the process, which includes a 50-page application scored against seven categories and a five-to-six-day site visit. Final selection is based on meeting the GSA criteria and the organization’s role-model setting example.

Sunstar Paramedics

Sunstar Paramedics provides dispatch services and emergency medical services operations for emergency and non-emergency patients in Pinellas County, Fla. It is an NAED Accredited Center of Excellence (ACE). According to the GSA announcement, Sunstar Paramedics has achieved the following outstanding results in 2008:

- 100 percent stroke alerts called appropriately
- 97 percent patient satisfaction rating
- 25 percent increased employee engagement
- 100 percent EMS authority key contract requirements met
- 99.8 percent EMS calls without critical failures
- Implemented more efficient and cost-effective processes

Falls rank high for causes of injury

Have you or someone you know answered a 9-1-1 call regarding a fall with injuries during the past decade?

If the answer is “yes,” you’re not alone and if you haven’t, your time is coming.

Falls (Protocol 17) were the leading external cause of injury for every year from 1997 through 2007, accounting for more than a third (38 percent) of episodes in 2007 and most of them (44 percent), for the 10-year period studied, occurred around the injured person’s home.

The statistics, part of a report recently released by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), also show women are more likely to suffer injuries from a fall, compared to males, particularly among women ages 75 and older. The falls most often happened inside the home with sprains, strains, and contusions leading the types of injuries suffered. Rates of injury resulting from falls were 55 percent higher for females, compared to males, during the years 2004–2007.

Working at a paid job seemed to be a major problem for males included in the study. For every period from 1997–2007, working was the most common activity for males at the time of an injury due to over-exertion. About 80 percent of the injuries fell in the category of sprain or strain.

For dispatchers, a majority of those injured—or someone else at the scene—contacted 9-1-1 for assistance. Fifty-six percent of injury episodes resulted in at least a visit to an emergency room or use of an emergency vehicle.

Other high-ranking causes of injury in the United States during the 11-year period include transportation accidents (Protocol 29: Traffic/Transportation Accidents), poisoning (Protocol 23: Overdose/Poisoning (Ingestion)), and injury from a cutting or piercing instrument (Protocol 21: Hemorrhage/Lacerations).

The statistics are taken from the National Health Interview Survey (NHIS), which covers medically-attended nonfatal injuries regardless of place of treatment.

American Medical Association’s (AMA) Disaster Medicine and Public Health Preparedness journal, Hurricane Katrina resulted in a three-fold increase in the number of heart attacks among survivors. The extreme weather wasn’t the direct cause, of course, but rather the physical, psychological, and emotional burden the hurricane placed on the overall health of the New Orleans community.

For the study, investigators reviewed patient records from Tulane University Hospital two years before Katrina and two years after the hospital reopened. Their findings follow.

In the post-Katrina group, there were 264 heart attack admissions, out of a total of 11,282 patients (two percent), as compared to 150 admissions out of a total of 21,229 (0.7 percent) patients in the pre-Katrina group.

The post-Katrina group had significantly higher prevalence of unemployment, lack of insurance, medication noncompliance, and substance abuse than the pre-Katrina group. They were also likely to be local New Orleans residents (83 percent as compared to 70 percent) and living in temporary housing.

Lead author William Lanier, M.D., professor of anesthesiology, Mayo Clinic, Rochester, Minn., said the data is part of a larger body of evidence suggesting stress is a contributor to cardiovascular disease. And, similar to preventive measures suggested for others recovering from a heart attack brought on by stress, he recommends a healthy diet and exercise to help keep the pump running smoothly.

Heart attack is the No. 1 cause of death for both men and women in the United States, accounting for about 460,000 fatalities each year. Factors substantially increasing the chance of survival include bystander CPR.

Add hurricanes to list of factors causing heart attacks

Everyone knows cigarette smoking or a diet heavy in saturated fats can lead to a heart attack, but when was the last time your doctor told you to stay away from hurricanes for the same reason?

According to a study published in the

Hurricanes, Heart Attacks One causes the other.
The success stories of Forrest Gump and his friend Bubba, quasi-government agents dressed in black suits, and conspiracy theories aren’t the sort of subjects you’d expect to find at a professional conference, unless your members include the likes of Christopher Bradford and Jim Lanier.

“The idea came to us on the fly,” said Bradford, a firefighter and medic for the Villages Public Safety Department in Florida. “We were coming home from a Q course in North Carolina and started talking about different ways we could present our classes. We took it to the extreme and it worked.”

Their idea, made into movies shown at Navigator, turned the two 9-1-1 communication specialists into movie stars, grabbing dual lead roles in two much-abbreviated versions of the popular motion pictures used to make their point about protocol. Lanier, ECC division manager at Manatee County Public Safety, Bradenton, Fla., played Forrest and Agent Kay (from *Men in Black*); Bradford played Bubba and Agent Jay. Jeff Clawson, M.D., protocol’s creator, made a cameo appearance in both films screened at Navigator conferences held back to back in 2003 and 2004.

The less than 30-minute movies were instant sensations.

“They were a hit,” Bradford said. “People were laughing out loud. They asked us to send them copies.”

The movies did what Bradford and Lanier set out to do: they introduced the lighter side of Navigator to a conference that doesn’t mean leaving fun at the door.

“People leave with stories to tell,” said Peter Hamilton, the International Academies of Emergency Dispatch® (IAED™) Australasian regional representative. “That’s the great thing about Navigator. I’ve been lucky enough to attend most Navigator conferences over the past 10 or so years, and each one has given me memories that make me smile.”

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**By Audrey Fraizer**

**Navigator through the years.**

Never skips a beat
Early days

Former National Academies of Emergency Dispatch® (NAED™) Executive Director Rob Martin says talking about early dispatch conferences brings him back to a former life, although one that easily rivals the frenzied pace of his former consulting job in Washington, D.C., and his current position with Octo Telematics in sunny California.

Navigator and laid back were never part of the same sentence, according to Martin. “We’d be on to the next [conference] before we were through with the one we were holding,” he said. “At the same time, we’d be working behind the scenes to make sure things were going smoothly.”

The first NAED conference—before it was known as Navigator—was a relative snap to organize compared to those held in the later years, at least in terms of numbers. The concept of standardized dispatch and the use of scripted protocol were closing in on their first decade, and training and certification were the focus of the inaugural event held in Salt Lake City, the protocol’s hometown.

Martin, who was new to the Academy in 1988 when this first-ever conference was held at the Red Lion Hotel in downtown Salt Lake City, handed out EMD certificates to the 100 attendees gathered specifically for that reason.

“We had hired someone to do the calligraphy,” Martin said. “Each certificate was done by hand for a professional look because that’s the message we wanted to convey. You could hang these on the wall; it wasn’t something you’d stuff in a drawer.”

The second conference held over two days (Dec. 4 and 5, 1989) in Orlando, Fla., was publicized as an international conference for the EMD community. Featured guests included William Shatner and Arnold Shapiro, star and producer of the popular CBS television program "Rescue 911". Henry Heimlich, M.D., demonstrated his famous resuscitation technique, and certificates of merit were presented to outstanding dispatchers during a gala hosted at the Altamount Springs Hilton and Towers.

A third conference held in San Diego heralded the Dawn of the Dispatch Era. Sessions were geared to “tools they can use” in the field, ranging from how to fund a communications center to the challenges faced in providing EMS dispatch during the San Francisco earthquake and Hurricane Hugo.

Priority Dispatch Corp. Senior Consultant Bill Kinch compares them to the atmosphere you might find at an annual class reunion.

“Everyone knew each other by name just about,” Kinch said. “We had the same people in front of the classes until someone had the great idea of opening it up to all our users.”

Growing pains put a hold on a fourth conference for the next six years. Efforts shifted to developing the National Academy, at that time in its second year; formalizing the College of Fellows; expanding certification and quality assurance courses; and moving to a larger office space to accommodate a staff soon to exceed the eight people, including Dr. Clawson, running the organization.

“We needed to put our energy in other places,” Martin said.

Navigator is born

Martin was looking for a project for his master’s thesis in organizational communication when the idea to reinvent the EMD conference took hold. NAED membership had grown tenfold—from 1,500 to 15,000—in the decade since the conference held in San Diego. Protocol had long entered the computer phase, maturing from cardset form to ProQA software. The list of Accredited Centers of Excellence (ACE) was up to six, with the addition of Urgences Sante de la Region de Montreal Metropolitana’s conference, in Quebec, Canada.

Attendance would emphasize inclusiveness—everyone from all levels of the 9-1-1 community was welcome—and courses would emphasize protocol use in daily operations.

“People were starved for information,” said Kinch, who had been the “Q and A” product expert at the earlier conferences. “The demand was definitely there, and we needed to open it to the rest of the states and the world.”

Former Academy Marketing Director Mike Smith suggested the name “Navigator” to embody the image they hoped to create. Conference planners held their breath, Kinch said.

“It was a risk,” he said. “You never really know what’s going to happen.”

The re-engineered conference, held in 1998 at Snowbird Resort in Little Cottonwood Canyon near Salt Lake City, drew 300 people to sessions covering leadership training, EMD case review, quality assurance, and disaster management.

At the 1999 Navigator, held in San Antonio, Texas, conference goers were introduced to changes in version 11 of the Medical Priority Dispatch System™ (MPDS®). They had 57 sessions to choose from. Kevin Garcia, dispatcher during the Columbine High School (Colo.) shooting that occurred on April 20, 1999, was honored at the opening ceremony with a special Meritorious Service Award.

Former NAED Board of Trustees Chairman Keith Griffiths said the new format struck a cord with participants.

“It was more accessible and comprehensive,” he said. “Navigator became the best opportunity for all members of the emergency medical dispatch team.”

Opening the flood gates

The welcome mat approach led to what Navigator represents today: a forum for all levels of the international emergency dispatch community; it’s a place for the exchange of information, business cards, and camaraderie and a full year project for Communications Director Kris Berg and her crew of writers and designers.

Navigator is now held at sites alternating east and west of the Rockies and an attendance growing each year comes as no surprise to Martin.

“Nothing can compete with an event specific to an industry, (cont. on page 22)
The static over the phone line barely conceals the emotion in Jill (Stevens) Shepherd’s voice. She is tired, pensive, and in Chicago waiting for her flight back home to Salt Lake City, Utah.

It’s been a whirlwind, no-frills, 10-day trip for the former member of the Utah National Guard, honorably discharged in March 2009.

“We had a lot of buckets to fill,” said Shepherd, Miss Utah 2007. “There are some very scary situations over there.” The “over there” is Afghanistan and Kuwait, and the 12 stops Shepherd and six other Miss America state and national pageant winners made in October were part of their goodwill mission to boost morale. They visited remote Forward Operation Bases (FOBs), including FOB Keating where eight soldiers were killed on Oct. 5, 2009, in fighting so fierce that U.S. forces had to fall back as attackers breached the perimeter of their base, according to CNN news sources.

“The soldiers were emotionally drained,” Shepherd said. “You could tell we were needed.”

The former sergeant for the 1st Battalion, 211th Aviation Regiment of the Utah National Guard, has yet to leave the military experience behind. Not only was her 18-month deployment to Afghanistan (November 2003 to April 2005) a chance to serve her country but, also, one among a series of quests in a life always going for the gold.

So, don’t be surprised when Shepherd brings that same “can do” and her “we’re all in this together” attitude to the stage of Navigator 2010 as the keynote speaker or, in this case, a princess in combat boots. The noted motivational speaker personifies the ability to reach dreams, despite the odds. She goes after life and, as the saying goes, grabs it by the tail.

The former Miss Utah (2007) will appear on stage, ready to embrace an audience that has risen through the ranks, to a place where Once Upon a Time opens a story that truly ends happily for professionals now considered the first, first responders. Future possibilities thrive.

Take her decision to trade fatigues and combat boots for evening wear and five-inch heels, for example. The state and national pageants were goals, representing challenge, adventure, and a chance to show other women it’s OK to try despite odds others say you can’t beat.

Shepherd took voice lessons to hone a song-and-dance routine since an act resembling an M16 blindfolded might not capture the heart and soul of her audience. She practiced walking in heels to music blasting inside a dance studio.

“It was the same as training for the military,” Shepherd said. “I was getting ready for a different kind of combat zone.”

The journey to Miss America 2008 ended for “GI Jill Stevens” at the Planet Hollywood Resort and Casino in Las Vegas. Though she had one of the largest cheering sections—one full of soldiers from the Utah National Guard and U.S. Army Reserves—and the People’s Choice vote, they weren’t enough for her to capture the crown.

But that’s OK, Shepherd said. While the title might have been an exciting check on the list of things accomplished, Shepherd left the spotlight without any hard feelings. She was able to exalt the “All-American” woman she wanted to represent. The combat soldier dedicated to nursing, education, and sports, had achieved a seemingly impossible feat.

Shepherd’s personal Once Upon a Time tale continues to add chapters, much the same as for those working “in the trenches” at communications centers worldwide. Maybe it’s a tough stretch comparing combat boots to protocol, but the journey to reach new highs holds true for any earnest adventure.

“It’s all about trying new things,” Shepherd said. “Helping others at the same time is the icing on the cake.”

GI Jill Stevens  Former Miss Utah won the hearts of a nation during her tour of duty.
one pulling people together on stage in front of peers,” he said.

The pre-conference and conference schedule fills six days, punctuated by keynote speakers, awards, and special announcements. Navigator creates a deadline for unveiling changes to protocol and answering the questions related to the most recent releases of the fire, police, and medical protocols.

Entertainment continues to weigh in on a larger purpose. An event held poolside means networking, exhibits introduce users to vendors, and field trips offsite showcase the local communications centers. Even the comical films Bradford and Lanier produced highlighted the importance of doing the dispatch job right.

Excursions outside of conference hours are part and parcel to the Navigator experience, as long as the sightseers are willing to accept the attendant risk. NAED Associate Director Carlynn Page and Salt Lake City Fire Dept. Deputy Chief Brian Dale discovered the value of umbrellas during their tour of a Revolutionary War battlefield located near the Baltimore, Md., conference site.

“We walked around in pouring rain and got drenched,” she said. “What a blast!”

The opportunity to network is a hot sell, and it’s for that reason so many people return year after year.

“Not only can you attend sessions held by some of the most engaging and knowledgeable experts in the emergency services industry, but the opportunity to mingle with so many other like-minds is of equal value and importance,” said Hamilton, who flies 24 hours on average to attend the conference from his home in Australia. “Plus, you get to meet the Academy people that you may only ever deal with via phone or e-mail.”

And there’s always the chance to meet a superstar, at least that’s the way Page views her first glimpse of protocol’s creator.

“My first Navigator conference was in Valley Forge (Pa.) and Dr. Clawson was on my flight,” she said. “I felt like I was in the presence of a celebrity.”

The lighter moments are every bit as memorable and, in many cases, turn into learning experiences. Take, for example, the time a Navigator speaker popular among dispatch audiences stole the show, so to say. His session overflowed, leaving other lesser-known speakers at a loss for attendees. At the next conference, he was scheduled for several sessions throughout the event to help balance the numbers.

Expect the unexpected

Those attending the Navigator conference held in Pinellas County, Fla., still talk about the power outage at the convention hall during an evening banquet. People had an absolute blast anyway, Kinch said, “narrow, dark stairs and all.” There’s also the time when Brett Patterson, NAED Academics and Standards associate, spent a night in the hotel lobby because of a malfunctioning door locking him out of his reserved space.

“No other rooms were available,” said Patterson, one of Navigator’s featured speakers. “The conference had the hotel all sold out.”

Navigator never skips a beat, and the same promises to hold true for Navigator 2010 in Orlando, Fla.

The unexpected will always happen, said Claire Colborn, Navigator coordinator extraordinaire. “That’s something you can count on.”
TUESDAY, APRIL 27

GALA RECEPTION IN EXHIBIT HALL

WEDNESDAY, APRIL 28

OPENING SESSION
DISPATCHER OF THE YEAR AWARD

OPENING KEYNOTE
JILL SHEPHERD

Tea and Coffee Break

Exclusive Exhibit Hall Hours and Box Lunch

<table>
<thead>
<tr>
<th>EXHIBIT HALL</th>
<th>LEADERSHIP</th>
<th>MANAGEMENT AND OPERATIONS</th>
<th>SPECIAL INTEREST</th>
<th>MEDICAL</th>
<th>FIRE</th>
<th>POLICE</th>
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<tr>
<td>10:30AM–12:30PM</td>
<td>Controlling the Call</td>
<td>Stress Disorders in the</td>
<td>IAED Data Studies</td>
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<td>How to Talk to Your</td>
<td>Tactical Dispatching</td>
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<td>Trevor Creekmore</td>
<td>Communications Center</td>
<td>Dr. Clawson, Brett Patterson, Tacey Barron, Chris Oloka, Ph.D.</td>
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<td>Fire Chief About EFD</td>
<td>Robert Pastula, Ric Focht</td>
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<td>Jason Sharrer</td>
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<td>Jamie Young</td>
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<td>12:30PM–1:00PM</td>
<td>Politics! Yuck or Yay?</td>
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<td>Line of Duty Death (LODD)</td>
<td>Lisa Kalmbach, Brian Kalmbach</td>
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<td>Jim Carrier, Sharon Carrier</td>
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<td>Angeli Williams, Coline Bachewich</td>
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<td>1:00PM–2:30PM</td>
<td>Adult Learning—</td>
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<td>Ross Girapone</td>
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<td>2:45PM–3:00PM</td>
<td>ABC’s of Communications Center Management</td>
<td>From O to Z</td>
<td>The Pandemic</td>
<td>Line of Duty Death (LODD)</td>
<td>Lisa Kalmbach, Brian Kalmbach</td>
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<td>Rayo Two Bulls, John Ferraro</td>
<td>Tammy Spath</td>
<td>Fly Experience</td>
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<td>3:00PM–4:00PM</td>
<td>Rewiring Your Brain</td>
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<td>Michael Spath</td>
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<td>4:15PM–5:15PM</td>
<td>Maine’s Statewide Implementation</td>
<td>You Just NEVER Know</td>
<td>One Call Away</td>
<td>I Hear Dead People</td>
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<td>Stephan Bunker</td>
<td>Kevin Willard</td>
<td>Grant Rinaudo, Nadine Boulanger, Lori Daubert</td>
<td>Tracy Barron, Kim Rignen-Briscola, Louise Ganley</td>
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<td>Why People Die in Fires</td>
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THURSDAY, APRIL 29

TYPHOON LAGOON

THURSDAY, APRIL 29

ACE PRESENTATION
& CCM GRADUATION

PROTOCOL IN ACTION
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>6:00PM–8:00PM</td>
<td>GALA RECEPTION IN EXHIBIT HALL</td>
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<td>8:00AM–9:00AM</td>
<td>LEADERSHIP</td>
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<td>9:15AM–10:15AM</td>
<td>MANAGEMENT AND OPERATIONS</td>
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<td>10:00AM–10:15AM</td>
<td>SPECIAL INTEREST</td>
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<td>10:15AM–11:15AM</td>
<td>QUALITY ASSURANCE</td>
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<td>11:15AM–12:30PM</td>
<td>TECHNOLOGY</td>
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<td>10:15AM–11:15AM</td>
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<td>11:30AM–12:30PM</td>
<td>Tea and Coffee Break</td>
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**FRIDAY, APRIL 30**

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**Closing Lunch**

**Dr. Jeff Clawson Leadership Award**
CONFERENCE REGISTRATION OPTIONS
APRIL 28–30, 2010 (WEDNESDAY–FRIDAY)

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

☐ Conference Passport

DISCOUNTS (CHECK ONLY ONE, AS ONLY ONE APPLIES)

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<td>or Accredited Center</td>
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☐ 1-day (Price per day, Wednesday–Friday, check below)

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<tr>
<td>April 28</td>
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☐ Spouse/Guest Admission (Name: ______________________) $50

☐ Closing and Awards Luncheon, April 30 (Friday) $25

☐ Disney’s Typhoon Lagoon, April 28 (Wednesday) $30

PRE-CONFERENCE PROGRAM SUMMARY
APRIL 25–27, 2010 (SUNDAY–TUESDAY)

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

3 DAYS, SUN–TUE, APRIL 25–27, 8:30 AM–5:30 PM

☐ EMD: Emergency MEDICAL Dispatch Certification Course $295
☐ EFD: Emergency FIRE Dispatch Certification Course $295
☐ EPD: Emergency POLICE Dispatch Certification Course $295
☐ ETC: Emergency Telecommunicator Instructor Course $475

2 DAYS, SUN–MON, APRIL 25–26, 8:30 AM–5:30 PM

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

2 DAYS, MON–TUE, APRIL 26–27, 8:30 AM–5:30 PM

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

1 DAY, MONDAY, APRIL 26, 8:30 AM–5:30 PM

☐ EQ: Recertification Course $250

NENA, NAED, PSTC, & NCMEC SPECIAL TOPIC WORKSHOPS
1 DAY, MONDAY, APRIL 26, 8:30 AM–5:30 PM

☐ Conflict Resolution $190
☐ NENA: Introduction to Converging 9-1-1 Technologies $190
☐ NENA: Training the 9-1-1 Trainer $190
☐ PSTC: People First Management $190

1 DAY, TUESDAY, APRIL 27, 8:30 AM–5:30 PM

☐ NENA: Leadership in the 9-1-1 Center $190
☐ NENA: Continuity of Operations Plans for PSAPs $190
☐ PSTC: You Just Never Know $190
☐ NCMEC: Time to Act: The 9-1-1 Center and Missing Kids Comm. Course $0

½ DAY, TUESDAY, APRIL 27, 8:00 AM–12:30 PM

☐ NAED: Executive Workshop $95
☐ NAED: Data Mining 101 $95

½ DAY, TUESDAY, APRIL 27, 1:30 PM–5:30 PM

☐ NAED: Accreditation Workshop $95
☐ NAED: Data Mining 201 $95

Workshop Subtotal $285

☐ 9th Annual Navigator Golf Tournament Tuesday, April 27, 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 ’10 conference T-shirt at check-in. (See details on the Web.)

NAME ________________________________________

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Two weeks that will change your life

without the diet

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September 12-17, 2010 • November 7-12, 2010

“I’ve been involved in this profession for almost 20 years. During that time I’ve attended multiple National and State APCO and NENA Conferences. The CCM course was hands down the BEST learning experience that I have ever experienced. I recommend attending, in fact I plan on having every one of my management staff attend the class.”

— Tom Ling, Johnson County Central Dispatch

Online applications for the 2010 course to be held in Kansas City, MO will begin January 5, 2010. Go to www.emergencydispatch.org or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.

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

Conference keeps on giving

By Audrey Fraizer

A taste of Navigator has turned into a full plate for the United Kingdom version of the ever-popular conference now closing in on its first decade transatlantic.

This year’s conference, which took place in York, treated its nearly 100 attendees to a three-day smorgasbord featuring topics universal to the emergency dispatch profession, with slight exceptions catering to the British experience.

For starters, the Welcoming Reception, held on Sept. 21, highlighted the awards given to the U.K. Dispatcher of the Year, Teresa Ross, and the Accredited Center of Excellence (ACE) achievers.

Scott Freitag, International and National Academies of Emergency Dispatch® (IAED™/NAED™) president, started the introductions from the stage, leading to an evening of networking among peers from 17 National Health Service (NHS) trusts.

The event is the sort of reunion Freitag said he looks forward to each year, especially when it comes to meeting the people behind the new faces added to the mix as word of the conference continues to gain momentum—and for good reason.

Scheduling was on high gear in York. Fourteen sessions offered during the two days following the opening reception covered an array of concerns, from protocol and quality assurance issues to the more personal side of dispatching. According to the numbers, sessions calling attention to the suicidal caller, customer service, and cardiac arrest remained high on the “must attend” list.

Coursework was the order for the final day of the conference. The MPDS Mentor Course, introduced last year, brought attendees together for a full day of learning how to create a nonjudgmental environment in the emergency dispatch workplace while, at the same time, improving protocol compliance. The National Instructor Course and the EMD-Q Course brought the experienced MPDS user into the advanced realms of teaching and quality assurance.

A closing dinner—actually held the night before the intensive daylong workshops—gave attendees the chance to relax and the opportunity to exchange information in preparation for the coming year’s challenges.

And last, but not least, were the after-hour attractions.

The famous York Castle Museum gave sightseers a look at everyday life over the centuries through recreations of homes and public places. The Ghost Hunt of York provided tales of ancient betrayal and persecution in the city the Ghost Research Foundation International named the most haunted city in the world. The York Minster offered a feast of eye-catching glass and stone as one of the great cathedrals of the world.

The educational and networking experience just keeps getting better every year, Freitag said.

“Everyone tells me they leave ready to take on whatever comes next,” he said.
EMD Teresa Ross received the UKNavigator EMD 2009 award that, in her case, puts the spotlight on the unusually high volume of emergency childbirth calls she has taken since she began working at the command center.

“It was almost as if these mothers knew I was on duty,” said Ross, who started at the Welsh Ambulance Service NHS Trust in April 2008. Considering her track record, it came as little surprise when Ross answered an early morning call in July 2009 to assist a woman in labor. But this was not going to be like any other childbirth call Ross had handled in her short career. Instead of giving instructions to another adult in the room, Ross began relaying the Pre-Arrival Instructions (PAIs) to the woman’s six-year-old daughter, Keira.

“What was so amazing was that the little girl was so calm,” Ross said. “In fact, she seemed to really understand what we were talking about.”

ROSS came to the Welsh Ambulance Service after replying to an ad on the Internet for an EMD position. At one time she thought about the ambulance service, but the queasy feelings she has at the site of an accident made that choice unlikely. Luckily, the ambulance service was hiring for positions in the control center as EMDs.

The job is a perfect fit. Ross has always had an interest in helping people. For as long as she can remember, Ross has always had the time to dedicate to her friends, listening and caring for them, providing counseling, and offering advice at their times of crisis. When it came to finding a new career, the former account manager for a commercial venture wanted a job that would let her continue helping others.

Ross said she is grateful to Helen DiFranco, AMPDS facilitator, for nominating her. DiFranco said Ross told her that “helping people is award enough,” and “that this recognition was just a bonus.”

Ross had one other choice. She asked the girl to hand the phone to her mother, 30-year-old Sarah Leismeier. She complied and not only did mom deliver her own baby but also provided CPR to the newborn during the last eight minutes of the 38-minute wait for the ambulance. The baby, delivered four days past his due date, arrived not breathing and unconscious, and mom had the stamina to administer infant CPR while the baby was still attached to her through the umbilical cord. Paramedics transported mom and baby Jacob to the hospital; according to later reports, both were doing fine.

Ross was every bit as awed at the mom as she was the daughter.

“She [the mom] was obviously upset, but remained very calm,” Ross said. “She was very courageous. I’m not sure if she was more upset about the early delivery or that the father wasn’t there to help.”

Ross had her reservations. She wasn’t altogether comfortable with giving instructions to a child barely entering grade school. Would the birth traumatize the girl? What happened if the baby required intensive pre-arrival care? The rural setting would mean a longer time for paramedics to arrive. She decided a switch was necessary. Dad, a railway engineer, was at work.

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Dad was also taken by surprise—a son weighing 7 pounds and 9 ounces born on the living room floor.

“I’m just glad they’re both OK,” Ross said. “I was doing my job. It was mom who had the hard job and we all were able to keep it together.”

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of baseline observations, including blood pressure and cardiac monitoring. Hall assisted, applying the blood pressure cuff and handing Fox the equipment inline with the procedures. An ambulance was on the way.

It was while putting in an IV that something happened to Hall. The patient’s husband asked “is your mate all right” and the next thing Fox remembers is watching Hall nearly lose her balance while walking out the bedroom door.

Fox called her name. She didn’t respond. Hall walked toward the staircase and he again called her name. No answer. His attempt to grab her arm from over the top of the banister failed.

“I could see what was going to happen but, unfortunately, I could not reach her,” Fox said. “She appeared to pass out and fall in a forward motion down the stairs head first to the bottom.”

In the time it took Fox to run down the stairs, Hall had recovered consciousness. She was alert and able to tell Fox the correct day and date and the reason they were at the home. Hall mentioned numbness—pins and needle sensations—running down her left side. She had no feeling in her left leg. Tests at the hospital later confirmed Fox’s immediate suspicions: Hall had suffered a spinal injury.

Since the accident, Hall has had major surgery to remove a crushed disc and spent months in recovery. In May 2009, she returned to her job as an EMD call assessor. The use of crutches and a wheelchair augment her mobility. Tests have not determined the reason for her momentary blackout.

The accident affected people at all levels at the center. Coworkers sent text messages, cards, and a Christmas gift of chocolates and flowers. Fox told the story countless times and offered peer crisis counseling. He often visited Hall and was part of the team taking her to various medical and therapy appointments.

Despite the help Fox has given since the fall, he cannot shake the feeling of doing more—something, anything—to have prevented the accident. He has flashbacks, watching her fall in slow motion.

“I feel useless and inadequate that I was able to do nothing to prevent this from happening,” he said.

Hall doesn’t slight Fox’s actions in the least bit. Fault has probably never crossed her mind. Rather, she credits Fox and the other responders for saving her life.

“I’m proud to say of you all, that your help and professionalism that day spoke volumes for me, my partner, and my family,” she wrote in a memo distributed upon her return to work. “Please don’t underestimate what you do and the support you give to each other.”

Teresa Beresford, WMAS Emergency Operations Center supervisor, said their nominations as U.K. Dispatchers of the Year 2009 flows from the dramatic effect the event had on their center.

“Anyone is lucky to meet someone selfless maybe once in a lifetime,” she said. “But to have met two is truly amazing.”
Tudy Benson doesn’t mince words. EuroNavigator was the best time the PDC Director of European Operations has had since the seminal event was held for the first time last year.

Well, maybe that is a bit of a stretch, considering Benson did attend the U.S.-based Navigator conference held in April, between the two EuroNavigators, and she does have a life outside of coordinating European operations from her office in Salt Lake City.

But she did enjoy herself and the company of others during the event held Sept. 16-19.

“It’s always a reunion in Europe,” said Benson, who was at PDC when the first German-speaking center—Dispatch Centre in Tirol's Kufstein district, Austria—adopted the Medical Priority Dispatch System™ (MPDS®) in 1996. “We’ve developed into a close community.”

Held in Vienna, Austria, this year’s EuroNavigator conference threw calltakers, dispatchers, and communications center management into two days packed with 15 educational sessions, ranging from software updates and the science behind protocol to stress management and overcoming peer pressure.

On either side of the class schedule there were introductions, presentations, and a constant flow of networking.

Scott Freitag, president, International Academies of Emergency Dispatch® (IAED™) and the National Academies of Emergency Dispatch® (NAED™), gave opening remarks, translated into German, welcoming the 80-plus attendees to Vienna.

144 NOTRUF NÖ, in Lower Austria, was acknowledged for becoming the first and only IAED Accredited Center of Excellence (ACE) in continental Europe (see accompanying story). The communications center is the largest medical communications center in Europe, handling more than 2.8 million calls per year. MA70-Vienna, the conference’s hosting communications center, escorted attendees on a full tour of the facility.

Jeff Clawson, M.D., co-founder of the NAED/IAED, grabbed the audience’s attention when he took the stage with the dispatch bible in hand.

“That’s what they call it,” said Benson, describing the excitement over a German translation of the Principles of Emergency Medical Dispatch. “Last year, the cry was for a version of the bible in German. We made it a point to have it ready for this year.”

The translation was a priority back in the states, with Benson and PDC translator Nadine Schick working down to the wire to make sure the book would be fully translated, edited, printed, proofed and, finally, bound and shipped within the year deadline.

Their haste was well worth it, considering the audience’s reception at
Gernot Vergeiner’s acceptance of the first German edition. Vergeiner is director of the Tirol dispatch center and member of the NAED/IAED College of Fellows.

The room didn’t exactly explode with applause but, rather, the room was eclipsed with the silence that generally accompanies the unexpected. “They were astounded,” Benson said. “But they asked, so that’s what we did.”

Benson calls the book a work in progress. Data gathered from centers in the German-speaking countries (Austria, Germany, and Switzerland) will in next editions replace the data collected from centers in the United States. The same goes for the cases and photos used to illustrate the protocol systems.

“This will truly be their book, focused on their centers,” Benson said.

Don’t think the conference was all work and presentation without play. True to conference style, no matter which you attend— EuroNavigator, UKNavigator, or Navigator—the evening trips following conference shut down for the day highlighted the local cultural attractions. An evening spent at Wiener Prater, a large public amusement park in Vienna’s second district, had dispatchers clamoring for rides on the world-famous 200-foot-tall Riesenrad (Giant Ferris Wheel) and a simulated trip in an airplane capturing the beauty of Vienna. A dinner featuring Vienna cuisine followed.

Benson is already looking forward to next year’s EuroNavigator.

“Every year, we’re making progress with more and more centers implementing the protocol,” she said. “Yet, we’re still just scratching the surface.”

There are 19 German-speaking communications centers using MPDS, of which four also use the Fire Priority Dispatch System™ (FPDS™).

Two ACE Firsts. Lower Austrian center achieves first in language, first in area

Earning a distinction pointing to how good you are certainly does something positive for self-image. Some people may puff their chests in a self-satisfied kind of way. Others may trade former friends for new high-power acquaintances bearing surnames necessary to drop during casual conversation.

Yet, that’s not everybody. Take NOTRUF NÖ 144 in St. Pölten, Niederösterreich (Lower Austria). Sure, those at the communications center may be walking a little taller for becoming the first German-speaking Accredited Center of Excellence (ACE) and, sure, it’s something to shout about when Gov. Representative Wolfgang Sobotka sends his sincere regards in relation to the center achieving the first ACE in continental Europe.

But that’s not where it’s at for NOTRUF NÖ 144 managing directors Mag. (FH) Thomas Pöchacker and Ing. Christof Constantin Chwojka. For them, it’s all about their people and the public they serve 24/7.

“We are incredibly proud of our staff,” Pöchacker said. “The accreditation shows that not only are we at the top when it comes to answering the public, but from a quality standpoint we also belong to the best.”

Sobotka, a regular visitor to NOTRUF NÖ 144, knows of the work staff members put into the achievement. He’s quick to talk about the quality improvement team that was organized and how the members hold feedback discussions upon request and when needed. They introduced the use of protocol to colleagues from the Red Cross, Arbeitersamariterbund (ASB), Christophorus Flight Rescue, and other similar agencies.

The QI team evaluated thousands of calls and designed training classes tailored to resolve any issues the audited calls revealed. They were the center’s cheerleaders, promoting protocol and praising individual accomplishments. The ACE award required at least 95 percent compliance, a score Sobotka is confident the high-performing center will continue, “on behalf of Lower Austria, particularly on behalf of all the patients who are now receiving exemplary care.”

Chwojka said protocol never ceases to help the public, even if most are unaware of what takes place when they call.

For example, CPR instructions given over the phone are credited for helping to save the life of a 65-year-old male, clinically dead while suffering from cardiac arrest at the time a calltaker answered the emergency call. Responders arriving 15 minutes later opened the door to a patient already breathing on his own. He spent several days in the hospital, reportedly leaving without any damage to his health from the attack.

NOTRUF NÖ 144 serves an area of 7,403 square miles (19,174 km²) in northeast Austria. There are 573 municipalities within the agriculturally rich province, and it is also a center of highly-developed industry and tourism.

The ACE certificate was presented on stage during EuroNavigator. Watch for the full story about NOTRUF NÖ 144 in the next issue of The Journal.
144 Notruf NÖ was recognized as the first Accredited Center of Excellence (ACE) in continental Europe at the second annual EuroNavigator held in Vienna, Austria. 144 Notruf NÖ is led by Chief Executive Officer Ing. Christof Constantin Chwojka. The communications center is the largest medical communications center in Europe, handling more than 2.8 million calls per year. The center employs 120 EMDs and serves a population of more than four million people.

At the opening reception for EuroNavigator, the communications center and its employees were recognized for their great achievement. Jeff Clawson, M.D., and IAED President Scott Freitag presented the ACE plague to Chwojka and his staff. About 40 EMDs from the communications center were present to receive the ACE recognition and celebrate their accomplishments. It was a wonderful event—one that won’t soon be forgotten.

The next day I [Scott Freitag] sat down with Chwojka and interviewed him about the process of becoming an ACE.

**When was the decision made to begin the ACE process?**
I made the announcement in Berlin at EuroNavigator last year. The announcement was that our center would be accredited by the next EuroNavigator in Vienna.

**How did your employees react to your announcement and the very quick timeline?**
Some laughed, some didn’t believe that it could happen so fast, others didn’t think that I was serious.

**When did you start the process?**
As soon as we left Berlin and got back to the center. We had little time to get this done in time for the next EuroNavigator.

**What expectations did you give to your staff?**
First, was to make it clear to the staff that this was really going to happen and that everyone needed to participate. Second, we had to fix the problem that existed between the CAD and ProQA. At the time, the two were not working well together, which meant that we were not using ProQA. It is evident that the technical problems needed to get fixed first. We needed to use ProQA 100 percent.

**What were the reasons for wanting to become accredited?**
It is about investing in our own people, the people we serve, and in the company. I wanted to have a way that could measure our effectiveness as an organization. I wanted to be sure that we were properly assigning codes and that the EMDs were giving the best quality. Being accredited also helps the company to make money. To be accredited and have a high percentage of compliance, we can reduce ALS level units responding to calls. Historically, Austria has a high percentage of helicopter calls, which is very expensive. Because of financial pressures, the company needed to reduce helicopter and ALS responses. To illustrate, an ALS car is $600 per event and a BLS car is $120 per event. A helicopter call is $90 per minute. By correctly coding calls, we have a high degree of confidence that an ALPHA call is an ALPHA call and a DELTA call is a DELTA call. That means that we can reasonably predict what type of response is needed to send to call, thus reducing the need to send so many helicopter calls and ALS cars, which in turn significantly reduces costs.

It also helps us in reducing the overall responses of ambulances. For example, we are beginning to no longer send an ambulance on ALPHA calls. Now we can just send the medical doctor in a car or advise the caller to go to his or her own doctor. In order to make these drastic changes we needed to know that we were 100 percent compliant.

**What was your biggest challenge in becoming accredited?**
Having enough qualified and certified EMD-Qs in the center. In order to adequately review enough calls it takes between 9 and 11 Qs in the center. We also had to purchase a new call recording program. Both of these investments were very expensive, but were necessary and well worth the investment.

**What motivates your people to continue to stay accredited in the future?**
That you know that you are on the safe side. My people feel great. The people identify 100 percent with this and they are proud to be the first. You can show them the quality of their work.

**What policy do you have that others may not know about?**
Less than 100 percent customer service is unacceptable. You will be fired. You can make a mistake and be nice but you can never be rude. Do your best, we will help you, but never be rude. There is no excuse for that type of behavior.
Violence is a widespread reality in our culture. Twenty years ago, we occasionally heard about vicious attacks, but in recent years we seem to hear almost every day about some brutal or savage assault unimaginable to the average person. Incidents with this level of violence include Virginia Polytechnic Institute and State University (Virginia Tech) and Beslan, Russia, in 2007; Montreal, Quebec, in 2006; and Columbine High School, Colo., in 1999.

According to the U.S. Secret Service, in 1998 alone there were 35 children and young adults murdered in acts of school violence, and a quarter of a million were seriously injured. These shocking incidents often involve one person committing multiple homicides in what police refer to as active assailant incidents. Before we go any further, the basic definitions are as follows:

- **Active shooter** is defined as “an armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims” or “Suspect(s) activity is immediately causing death and serious bodily injury. The activity is not contained and there is immediate risk of death or serious injury to..."
potential victims.” Active shooter events are primarily dynamic. The situation is evolving very rapidly along with the suspect’s action (i.e., shooting and moving). Delayed response will result in injury or death to innocent people. Pre-incident signs existed in school incidents, and tactical intervention was too late. The event is usually short in duration, and the suspect is usually not bent on escape. In fact, 90 percent of the time, the situation ends when the suspect commits suicide or is neutralized by police, usually in a very short time frame. Even if the subject is not engaged in active shooting, the response will be the same for an active assailant (see below).

• **Active assailant** is often a more appropriate term, as an active shooter is using a gun as his or her weapon of choice, while an assailant could be using a variety of weapons, including explosives. The tragedy at Columbine High School could have been far worse had the assailants’ makeshift bombs exploded in the school cafeteria, as they had planned.

• **Barricaded suspect** is defined as a “suspect who is in a position of advantage, usually barricaded in a room or a building, and is armed and has displayed violence.” The suspect may or may not be holding hostages, and there is no indication that the suspect’s activity is immediately causing death or serious bodily injury. Barricaded suspect events are primarily static. The situation is not evolving or in motion; suspect actions appear to be contained (i.e., suspect is barricaded in a room). These events are usually long term, and the suspect usually has an escape plan. Police negotiations resolve the situation 95 percent of the time.

• **Lockdown** is an emergency protocol put in place by a school or business to control movement of the people. The concept is to lead as many people to safety as possible in the event of a dynamic event such as an active assailant/shooter. Organizations have different protocols assigning the authority to lockdown, but in the school setting, it will most likely be the school principal or a member of the administration office. In the most basic terms, the intent is to shelter as many people as possible in locked rooms, making it difficult for the intruder to locate and assault them.

• **Partial lockdowns or lockouts** are set in motion to protect people inside a facility from a dangerous external event. The exterior doors of the facility are locked to keep others from entering or exiting. The facility must have the ability to limit exits so occupants do not go out into harm’s way.

Police respond to a lockdown similarly to an in-progress call. Entrance into the facility is usually via the front doors and further action depends upon whether the suspect’s location is known.

• **Known suspect location.** Police will go directly to the last known location of the suspect.

• **Unknown suspect location.** Police will clear the building systematically to locate the suspect.

Police will either attempt confrontation with the suspect or barricade the area to confine the suspect. Once the incident shifts from dynamic to static, the police will treat the facility as a crime scene and remove the facility’s occupants while identifying possible witnesses and securing evidence.

Ron Borsch’s research into active assailant/shooter incidents has helped shape the tactical knowledge of the assailant, as follows:

- 98 percent of active killers act alone.
- 80 percent have long guns, 75 percent have multiple weapons (about 3 per incident), and several hundreds of extra rounds of ammunition may be brought to the scene.
- Despite such heavy armaments and an obsession with murder at close range, the assailant has an average hit rate of less than 50 percent.
- The assailant goes after stunned, defenseless innocents via surprise ambush; on a level playing field, the typical active killer would be a non-contest against people reasonably capable of defending themselves.
- The purpose is not to wound, but to kill until choosing to stop or stopped: “They do not take hostages, do not negotiate.”
- The assailant avoids police, does not hide or lie in wait for officers, and “typically folds quickly” upon armed confrontation.

• 90 percent commit suicide on-site: “Surrender or escape attempts are unlikely.”

Data indicates that active assailant incidents are high-intensity occurrences, with time acting as the principle opponent (aside from the actual assailant). The arrival of cell phones has greatly increased the number of 9-1-1 calls coming into communications centers, often jamming the phone systems both during and after the incident.

The Virginia Tech Review Panel Report to the governor of Virginia reported that 96 percent of students at Virginia Tech carry cellular devices, and many students placed calls or sent text messages the day in April 2007 when Seung-Hui Cho killed 32 people in two separate incidents. The sending of text messages has had its impact on Next Generation 9-1-1 (NG9-1-1) planning.

The active assailant event is something many schools and companies are addressing through mock incidents and contingency and evacuation plans. It is imperative victims call 9-1-1 as soon as possible and, when possible, have someone meet the police when they arrive. Callers need to collect information without endangering themselves. The victims need to isolate and/or evacuate as soon as safely possible and allow the police first responders to make contact.

What is dispatch doing? The emergency dispatcher, as we all know, is part of the emergency response. We are the first, first responders. What are we to do when our caller is a librarian in a locked-down classroom cradling a student bleeding from a gunshot wound to the neck? The National Academy of Emergency Police Dispatch (NAEPD™) does have an interrogation for active assailant/shooter incidents, but when you look at the Police Priority Dispatch System™ (PPDS™), there is no protocol titled “Active Assailant.”

The reason relates to one of the most basic principles of any structured call-taking protocol: safety first. Our priorities are to understand exactly what is happening in an incident and collect the most precise, effective information to ensure caller and bystander safety while
providing accurate information for police responders.

Let’s have a look at how the PPDS accomplishes the task. During the initial interrogation of Case Entry, “Tell me exactly what happened” is the fourth question, following questions regarding address, phone number, and caller’s name. From question four, the protocol directs the EPD to the most accurate Chief Complaint Protocol for interrogation.

The following are scenarios to help you understand how the PPDS protocols facilitate interrogation:

- If someone from a school or business complex calls reporting lockdown for a weapons incident, the correct Chief Complaint Protocol would be Protocol 135, Weapons/Firearms. Lockdown means there is an immediate threat to the school population.
- If it is reported that someone is attempting to abduct a child (possibly a custody dispute or a stranger) and someone has been shot during the incident, Protocol 101, Abduction (Kidnapping), is the correct Chief Complaint Protocol to address the situation.
- If a school or business calls with an active assailant shooting in the hallways, Protocol 106, Assault/Sexual Assault, is the correct Chief Complaint Protocol to use as it best describes “exactly what happened.”
- If during any of the above situations, a full lockdown is initiated, a calltaker must know how to navigate through the Caller In Danger (CID) Protocol. A full lockdown indicates that the people inside are in danger and have been directed to stay inside their room until cleared by police; the answer to the first safety question, “Are you in immediate danger?” is “Yes.” The answer to “Are you able to get yourself to safety?” in Panel 1 of the CID Protocol should be “No.” A full lockdown indicates no safe escape route, and the lockdown procedures require that victims stay in their secured location until police clear the venue. Next, the EPD should deliver the appropriate Post-Dispatch Instructions (PDIs). Even if directed to return to the Key Question sequence of the Chief Complaint, the EPD should give PDIs on the Caller In Danger Protocol consequential to the caller’s safety.

Dynamic violent incidents like active assailant events are possible in any community. When considering these low-frequency/high-acuity events, it is reassuring that we have the tools in place to competently and effectively process these calls. It is also imperative that we practice for when they occur. “When personnel are stressed and overwhelmed, they will fall back on prior training and experience. Only those equipment and protocols that they are accustomed to during day-to-day operations will be used.”

In our business, as in any, we use only those tools we’re accustomed to using during day-to-day operations. But unlike other businesses, we don’t have the luxury of “do-overs.” We need to be on top of a situation; delivering excellence is expected.

Writer Jaci Fox is a regular contributor to The Journal. Sgt. Gordon Stull, of the Medicine Hat Police Service, and Michael Spath, administrative senior public safety dispatcher (Sunnyvale DPS), made contributions to this article.

3. National Tactical Officers Association. Response to Active Shooters. www.muni.r.i.net/middletown/vendor/ag1.ppt
4. Ron Borsch is the manager and lead trainer at the post-graduate SEALE Regional Training Academy in Bedford Ohio. He also has extensive experience with the US Army; he is a semi-retired 30-year patrol officer, SWAT team operator-trainer, and he has specialized in teaching tactics to police first responder counter-measures for the active killer.
CDE-Quiz Police

To be considered for CDE credit, in order to receive credit for this quiz you must be certified in the specific discipline it is designated for.

Please mark your responses on the answer sheet located to the right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.

Answers to the CDE quiz are found in the article “Safety First,” which starts on page 34.

1. What percentage of active killers act alone?
   a. 28 percent
   b. 58 percent
   c. 78 percent
   d. 98 percent

2. Which PPDS protocol best addresses the active assailant incident?
   a. Whichever incident best addresses “exactly what happened” at the specific location.
   b. Protocol 135, Weapons/Firearms
   c. Protocol 106, Assault/Sexual Assault
   d. Protocol 101, Abduction (Kidnapping)

3. What is the definition of an active assailant/shooter as defined in the article?
   a. Someone who is actively hurting someone.
   b. An armed person who has actively hurt or injured someone and has been charged more than once.
   c. An armed person who has used deadly physical force on other persons and continues to do so while having unrestricted access to additional victims.
   d. An accused that has already been dealt with by police and is on the dangerous offender list.

4. Active assailant incidents are:
   a. generally over very quickly.
   b. dynamic.
   c. an event that can happen in any city or town.
   d. all of the above

5. Heavily-armed suspects who are obsessed with murder in active assailant incidents do not have precise accuracy while killing people.
   a. true
   b. false

6. The Columbine High School shooting occurred in what year?
   a. 2009
   b. 2005
   c. 2001
   d. 1999

7. How are most active assailant incidents resolved?
   a. The suspect is negotiated out 90 percent of the time.
   b. The suspect is negotiated out 50 percent of the time.
   c. The suspect commits suicide or is neutralized by police 90 percent of the time.
   d. There is no consistent data on the outcome.

8. A barricaded suspect:
   a. is the same as an active assailant.
   b. is different from an active assailant.
   c. has some similarities to and differences from an active assailant.
   d. is defined as a suspect whose activity is immediately causing death and serious bodily injury.

9. The use of cell phones in an active shooter event can:
   a. provide valuable information in these events.
   b. jam the phone system.
   c. have little impact on the event.
   d. a and b

10. Which of the following is true about the Caller In Danger Protocol?
    a. Any PDIs that are applicable and available must be given. This includes the PDIs on the CID Protocol.
    b. Once you are directed back to Key Questions, it is only necessary to give the PDIs on the protocol that you have returned to.
    c. No PDIs are needed because you have used the Caller In Danger Protocol.
    d. all of the above

In order to receive credit for this quiz you must be certified in the specific discipline it is designated for. To be considered for CDE credit, this answer sheet must be received no later than 12/31/10. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located to the right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
A breathing problem is one of the most common medical complaints coming into the communications center. In fact, call records collected from major cities around the world show that breathing problems represent 12 percent to 16 percent of all calls—that means roughly out of every six emergency calls, one of them is likely to be a patient with a breathing problem. In at least one of those centers, a breathing problem was the single most common complaint of all.

Not only do breathing problems make up a large percentage of emergency calls, they also make up a significant portion of the less than favorable, or poor, outcomes. Let’s describe “poor outcomes” the same way Jeff Clawson, M.D., and associates did in an extensive study of breathing problems they conducted using data from the London Ambulance Service (LAS), the largest communications center in the world. A poor outcome is one of two things: (1) high-acuity cases where the paramedics pre-alert the hospital for the patient’s arrival (also called “blue-ins” in the U.K.) or (2) cases that end with the patient in cardiac arrest.

The data from the LAS indicates that out of 1,000 patients with breathing problems, 78 will be high-acuity cases and four will end up in cardiac arrest. The same data indicates that out of all high-acuity cases, breathing problems accounted for 21 percent of them. Out of all calls resulting in cardiac arrest, breathing problems accounted for nearly 11 percent. Moreover, the single Determinant Code 6-D-1 (SEVERE RESPIRATORY DISTRESS) had the highest number of high-acuity and cardiac arrest cases in the entire Medical Priority Dispatch System™ (MPDS®) using version 11.3.

So, compared to most other complaints, chances are pretty good that a report of breathing problems will be a critical emergency. It’s no wonder that difficulty breathing is considered one of the four Priority Symptoms and that Protocol 6 remains the only Chief Complaint Protocol with no response level below CHARLIE. Because of the potential for serious underlying problems, advanced life support (ALS) providers are always recommended for response to breathing problems.

Unfortunately, it’s also true that many breathing problems turn out to be incidents that don’t require ALS responders. Even though about 78 out of a thousand patients with breathing problems turn out to be high-acuity patients, that still leaves about 922 patients who may not need ALS responders. And even though 6-D-1 has more poor outcomes than any code in v11.3 of the MPDS, it also happens to capture a higher number of total cases than any other code. This also suggests that many patients are getting ALS responders in lights-and-siren mode when it’s not necessary, which can strain the resources of the entire system.
The challenge now lies in figuring out a way to triage those incidents with a reasonable degree of accuracy over the phone. How can we structure interrogation to help us distinguish between critical breathing problems and not-so-critical breathing problems?

Dr. Clawson and his team of researchers at the Academy are wrestling with that issue in a series of studies designed to give us more information about breathing problems. The first study has already been mentioned—a survey of breathing problems cases from the London Ambulance Service.

The next in this series of studies began at the East Midlands Ambulance Trust, an Accredited Center of Excellence (ACE) in Nottingham, U.K. This time, the Academy wanted to break down the breathing problems cases to see which symptoms actually correspond to high-acuity or cardiac arrest cases. To do this, they tracked the answers to four Key Questions in the MPDS:

- Does s/he have difficulty speaking between breaths?
- Is s/he changing color?
- Is s/he completely awake?
- Is s/he clammy (cold sweats)?

Like before, the data showed that Determinant Code 6-D-1 (SEVERE RESPIRATORY DISTRESS) had a high number of calls (10 percent of the entire call volume), a large portion of the poor outcomes (16 percent), and an even larger portion of noncritical outcomes (45 percent of these calls were not even transported to the hospital). And as before, this is both good and bad. It's good because this code is very sensitive in finding the sickest patients. It's bad because it's also not very specific—it also finds a lot of patients who are not very sick at all.

This leads to the most important finding of all. Looking at the call outcomes, the researchers found that the vast majority of patients categorized as 6-D-1 did not meet the determinant description—so the patient was not, in fact, in severe respiratory distress.

Remember that SEVERE RESPIRATORY DISTRESS, as defined in MPDS versions 11.3 and older, included either of two symptoms: difficulty speaking between breaths and changing color. Anytime a caller answered yes to “Does s/he have difficulty speaking between breaths?” or “Is s/he changing color?” he or she got a code of 6-D-1. The hard part, before this study was undertaken, was figuring out which of those two symptoms really identified sick patients, and how often.

Now we have our answer. By far, the most patients were identified by callers as having difficulty speaking between breaths, more than double those with changing color. And since we know that most patients who fall in this category do not actually meet the description, we can make a general assumption that most patients do not, in fact, have difficulty speaking between breaths. This was backed up by the EMDs who took the calls, who generally felt that the callers weren’t identifying this symptom correctly. Difficulty speaking between breaths is a sign that trained medical professionals can use with a high degree of accuracy in identifying sick patients, but we’ve now learned that lay persons calling 9-1-1 just aren’t that accurate with this symptom.
So what's the result of all this? What's the impact on the EMD?

Several important things have come out of these studies. First, compliance to protocol is absolutely key. Knowing that callers aren't accurate at identifying difficulty speaking between breaths, you might be tempted to use your personal judgment to decide whether the call is serious. That would be a big mistake for two reasons. The most obvious reason is that, as we know, the caller may be right. Judging the accuracy of the caller's statements would put you in a serious dispatch danger zone. The other reason is that protocol compliance is the very thing that allows us to find and correct these kinds of problems. Without reliable data, we could not have identified this problem with any degree of confidence in the first place.

Another result is something you might already know about—the splitting of SEVERE RESPIRATORY DISTRESS, that big old 6-D-1 code in older versions of the protocol, into two more specific descriptors: DIFFICULTY SPEAKING BETWEEN BREATHS and CHANGING COLOR. This will make it much easier to gather more data on how many sick patients are falling into each category.

Finally, these studies have allowed researchers at the Academy to identify the next step in their drive to figure out how to better triage patients with breathing problems.

The next study will use the Breathing Detector Diagnostic tool to count the breaths of all breathing problems patients. This diagnostic tool is already in use to help identify patients with agonal breathing. Now, in two large communications centers in the U.K., it will be used to help figure out the relative seriousness of all breathing problems patients.

You start the Breathing Detector by clicking on a button in the toolbar in ProQA®. Using a simple interface, you click on the Start Now button to begin timing the breaths. When the caller indicates the patient has taken the first breath, you click the 1st Breath button. Every time the caller says the patient takes a breath after that, you click on Next Breath. The number of seconds between each breath is recorded and used to calculate the number of breaths per minute. The software then analyzes the pattern and makes a recommendation of the effectiveness of the breathing, such as normal, above normal, abnormal, slow, ineffective, and agonal.

We are now beginning to see how the science of the protocol relates to the actual care EMDs give. The primary concern of EMDs used to be the provision of Pre-Arrival Instructions, and that's still important. However, with the current spread of the H1N1 “swine flu” virus and the resulting stress on available resources, we need to be even more careful in what we send to calls for help. With the scientific studies being conducted by researchers at the Academy, we are defining which response codes represent the sickest patients, so we can get them the right response without depleting system resources.

This makes protocol compliance and participation in the ACE program more important than ever. Through strict adherence to protocol, EMDs are not only helping people in whatever crisis is at hand, but they are also aiding the process of protocol refinement, which in turn continues to improve the care provided to every future patient accessing the system.

References
1. Breathing problems represent what percent of all calls?
   a. 10 percent
   b. 12 percent to 16 percent
   c. 11 percent to 21 percent
   d. 45 percent

2. This article defined poor outcomes as one of two things:
   a. cases requiring ALS responders in lights-and-siren mode.
   b. cases that end with the patient in cardiac arrest.
   c. high-acuity cases where the paramedics pre-alert the hospital for the patient’s arrival.
   d. both a and b.
   e. both b and c.
   f. both a and c.

3. Out of a thousand patients with breathing problems, how many turn out to be high-acuity patients?
   a. 1
   b. 4
   c. 78
   d. 922

4. Protocol 6 remains the only Chief Complaint Protocol with no response level below DELTA.
   a. true
   b. false

5. What kind of response is always recommended for response to breathing problems?
   a. advanced life support
   b. basic life support
   c. Pre-Arrival Instructions
   d. transfer to a nurse advice line

6. A study at the East Midlands Ambulance Trust showed that Determinant Code 6-D-1 had:
   a. a high number of calls.
   b. a large portion of the poor outcomes.
   c. an even larger portion of noncritical outcomes.
   d. all of the above.

7. Determinant Code 6-D-1 is not very specific because:
   a. it finds a lot of patients who are not very sick at all.
   b. it had the highest number of high-acuity and cardiac arrest cases in the entire MPDS.
   c. its Determinant Descriptor is vague.
   d. most patients did not meet the description.

8. SEVERE RESPIRATORY DISTRESS, as defined in MPDS versions 11.3 and older, included either of two symptoms:
   a. agonal breathing and swine flu.
   b. breathing problems and cardiac arrest.
   c. difficulty speaking between breaths and changing color.
   d. difficulty speaking between breaths and cold sweats.

9. The Breathing Detector Diagnostic tool is already in use to help identify patients with agonal breathing.
   a. true
   b. false

10. Adherence to protocol helps improve the care provided to every future patient accessing the system.
    a. true
    b. false
Self Assured. Constant training gives EMD assurance at critical moment

By Cynthia Harmon

EMD Melissa Gill of Charleston County, S.C., felt confident her constant training had prepared her to handle any emergency. Yet she could not predict how essential that assurance would be when she received a desperate call Oct. 20, 2008, from Bob Schaible.

Bob and his wife Christine, 64, had been watching television when, at 9 p.m., Bob decided to switch over to some football. Christine fell from her chair, hitting her head on the coffee table before reaching the floor. But it wasn’t in anticipation of the game.

Quickly at her side, Bob noticed she had cut her nose and chipped a tooth, but more importantly, she wasn’t breathing.

A call to 9-1-1 led Bob to Gill who, without hesitation, began giving instructions for CPR to sustain Christine’s life. Bob kicked the coffee table aside, laid Christine on her back, and followed Gill’s instruction, “You pump, I’ll count.”

As Bob began compressions, he watched Christine take in some air and paused, but Gill reminded him, “Don’t stop—you’ve got to keep going.” The reassurance was vital. “Tell them to hurry,” he pleaded.

Within six minutes, the paramedics arrived and administered two rounds of defibrillator shock before transporting Christine to the hospital. Yet even after stabilization, the doctors informed Bob that they were not sure Christine would live.

“They told me, ‘I’m not getting any response from lifting her eyelids. I can’t tell you anything, but we’ll do what we can,’” Bob said.

Remarkably, Christine did make a full recovery, beating the odds of a condition with death written in the name: Sudden Arrhythmia Death Syndrome (SADS). The disease tends to strike fit, healthy people with no sign of illness; up to five percent, similar to Christine, have no anatomic abnormality. Although she remembers nothing of her close call, Christine knows just how easily her life could have ended that day considering the 300,000 fatalities SADS claims each year.*

“I’m extremely lucky,” Christine said. “It’s incredible, but I did survive it. It really is all due to my husband and Melissa Gill. No question.”

While still at the hospital, Bob called the supervisor at the Charleston County Consolidated Dispatch Center to arrange to meet and thank Gill personally. “I think if it hadn’t been for her, I would have been a widower. With me not knowing what to do, and her lying there and not breathing, it could have all been over,” he said.

When the couple finally met Gill, they brought flowers and thanked Gill for the gift of each day they still have together. Just listening to the tape of the 9-1-1 call gives Christine a surreal feeling to think her life was quite literally on the line. “What a brilliant young woman to do what she does,” she said. “I wonder if people in her line of work realize what a marvelous job they do.”

Life has resumed where it left off for Bob and Christine, hitting the golf course four to five times a week and playing couples golf on Sundays. As Bob tells his wife, “That defibrillator made you a bionic woman.”

For Gill, the emotional reunion was a great opportunity to see the outcome of a job she does every day. “I was excited to meet Mr. and Mrs. Schaible, just to get to see that I had been a positive influence on someone’s life,” Gill said.
Barbara Lanoue, Sunstar Paramedics, Florida

Holidays and Barbara Lanoue went together. The former emergency medical dispatcher (EMD) and trainer for Sunstar Paramedics/Pinellas County Emergency Medical Services, Fla., probably spent about the same amount of time at the center as she did in her kitchen preparing foods to match the occasion.

“We knew she’d be bringing in something great, especially around the holidays,” said Jim Lanier, former director at Sunstar and now ECC division manager at Manatee County Public Safety, Bradenton, Fla. “She was passionate about everything she did. She took a lot of pride in whatever she did.”

Barbara died unexpectedly on Aug. 18, 2009. She was 58 years old and had retired in February 2009 from a 21-year emergency services career. Her path in emergency services began in ambulance working as a paramedic, moved to dispatch training paramedics and EMTs in emergency communications, and—during her last years—turned to EMD-Q.

Barbara was the essence of her EMD-Q role, said Ron Shiner, Sunstar communications training officer. She knew her protocol backwards and forwards and was never one to shy from a good debate over the nuances.

“What’s conscious and alert, and what’s not, ask Barb,” Shiner said. “She was a focal point. She wasn’t afraid to say how she saw things.”

Barbara’s tenacity was a hallmark of her personality, whether she was providing life-saving Pre-Arrival Instructions or being a wonderful co-worker and great friend, said Stephan Glatstein, NREMT-P/NAEMD-Q, Sunstar director of communications.

“She will be missed unconditionally, though each of us is better for having the opportunity to know and work with her,” Glatstein said.

Barbara was enjoying retirement, trying to decide where to apply her energy next, said Lanier, who kept in touch with his former employee. She and her husband Bob traveled in a fifth-wheel they considered a second home. They owned and operated a catering business, specializing in Southern style cooking and her fabulous baking.

“Bob’s having a real hard time,” Shiner said. “We all are. They were soul mates.”

Joni Michiko Kobayashi Craig, Kaua‘i Police Department, Hawaii

Birthdays were Joni Craig’s favorite excuse for having fun, and it was just her style to bring balloons and a cardboard crown to work on the day she knew someone should be celebrating. For some, she planned special surprises.

“Not knowing what it was that I saw in the rear view mirror on my way to a major accident, I pulled to the side of the road, got out of my patrol car, and saw streamers over 20 feet long coming from under my patrol car,” said her good friend Lt. Michael Conrades, who gave the eulogy at her funeral. “I quickly pulled them off my car and later called Joni to ‘thank’ her. She laughed and laughed.”

Joni died July 31, 2009, from pneumonia. She’d been a dispatcher for 14 years and had recently been selected Employee of the Month for her conscientious work and good attitude. The award highlighted a call Joni answered in March 2009 from a distraught caller contemplating suicide. She kept him on the line, and with the help of the department’s mapping system, police arrived on the scene before the caller was able to carry out his intentions.

Joni’s sense of humor rubbed off on her daughter Tori, who could come head-to-head with her mom when it came to pranks and practical jokes, Lt. Conrades said. When Tori was three years old she covered her sleeping mom with baby powder. Another time, Joni woke up with a complete facial makeover, also compliments of Tori.

Dispatch Supervisor Kathy Langtad said Joni loved her job, and the people she worked with enjoyed her sense of fair play and humor. She was professional, and she treated her callers with respect, regardless of the incident.

“She will be hard to replace,” Langtad said. “She was an excellent dispatcher and a very good friend to everyone here.”
EMD Troy O’Neil never would have guessed the problem, at least not from the voice of the person at the other end of the 9-1-1 call.

“She had a very calm voice,” said O’Neil, a dispatcher from Cumberland County 9-1-1 (Pa.). “Someone in the background sounded frantic, but she was maybe a little nervous, if anything.”

The woman calling needed help FAST for a child—her one-year-old grandson—found face down in the water of a decorative pond at their home in rural southwestern Fulton County. The closest ambulance service could never get a crew through the sprawling landscape in time. The child was not breathing. He was turning blue.

O’Neil initiated the call as a cardiac arrest, giving the grandmother CPR instructions who, then, relayed them to a second person. The grandmother provided O’Neil with up-to-the-second updates of the child’s current condition.

“The child started to open his eyes,” O’Neil said. “A little water came out, and he was starting to pink up. Once she said he was starting to look around, I thought ‘this is cool. This child’s going to make it.’"

Without O’Neil’s instructions, there’s no telling what may have happened to the toddler. Maryland State Police Trooper 5 was on the scene within 14 minutes of the initial time of the call. The closest available MedEvac was 17 minutes away, and it landed in the family’s backyard at about the same time O’Neil heard the child start to cry—really loudly.

“That was the last thing I heard,” O’Neil said. “I ended the call with a real good feeling.”

The child survived.

The boy’s crying, however, was not the last O’Neil heard about the call he answered on July 19, 2009. During the next month, he and his team collected honors from both the Fulton County and Cumberland County Board of Commissioners. In addition to formal citations, the Cumberland commissioners presented O’Neil with a Life Saver pin for giving Pre-Arrival Instructions (PAIs) that saved the boy’s life. He also received a Life Saver pin from Fulton County, which for the past 10 years has relied on the Cumberland County communications center for EMS and fire calls.

“He had a next-to-nothing chance of survival,” said Gary Dressler, Cumberland County 9-1-1 dispatch supervisor. “I’ve been in this business a long time, and we’ve had very good success with this program [Medical Priority Dispatch System™].”

According to national health statistics, fatal drowning remains the second-leading cause of unintentional injury-related death for children ages 1 to 14 years (Centers for Disease Control and Prevention, 2005). For each drowning death, one to four nonfatal submersions are serious enough to result in hospitalization. Children still requiring CPR at the time they arrive at the emergency department have a poor prognosis, with at least half of survivors suffering significant neurological impairment (American Academy of Pediatrics).

O’Neil, a volunteer firefighter for the past 21 years, was a laid-off database manager when he contacted Cumberland County about the job in dispatch. He took the test, and one month later was sitting at his first training class. He works longer shifts for less pay than in his “previous life,” but that’s “OK,” he said.

“This is the job I always wanted but didn’t want to take,” O’Neil said. “I guess things happen for a reason. I’m passionate about what I do.”

O’Neil is among several dispatchers receiving a Life Saver pin for giving PAIs resulting in positive outcomes for their callers. The pin, designed by former dispatcher Claudia Garner, was Dressler’s idea to accentuate the positive work that dispatchers do.

“All you hear about are the times they make mistakes,” he said. “This shows the good they do.”

“Once she said he was starting to look around, I thought ‘this is cool. This child’s going to make it.’”

-Troy O’Neil
The following Cumberland County EMDs also recently received a Life Saver award:

- EMD Kris Kaminski provided CPR instructions to a caller reporting that his girlfriend had stopped breathing. EMS transported the woman to a local hospital emergency room and, later that day, transferred her to a room on the floor. During that same night, Kaminski also assisted in the delivery of a baby using PALS for childbirth and delivery.

- EMD Scott Disbrow provided CPR instructions to a caller reporting a patient who was not breathing. The patient was released from the hospital several days later after heart catheterization, and several weeks after that she called Disbrow to say thank you.

- EMD Duane Ruth provided CPR instructions to an elderly caller whose wife had stopped breathing. The patient was released from the hospital several days later after heart catheterization, and several weeks after that she called Disbrow to say thank you.

- EMD Steve Overmiller took a call regarding an unconscious patient who went into cardiac arrest moments into the call. The patient survived and personally thanked Overmiller and the other members of his team at a ceremony held several weeks after the event.

- EMD Chris Zeigler provided CPR instructions for a patient in cardiac arrest who was breathing again on his own by the time EMS transported him to the hospital.

My wife has spent the past decade answering calls from citizens contacting 9-1-1, so I know firsthand just how crucial her role in public safety and service is. It’s not an easy job.

When picking up a call, my wife can assume the caller may not be having the best day. Oh, it doesn’t really mean a bad day. For some, a stubbed toe or a headache prompts the call. At other times, the caller is reporting a person conducting some suspicious-sounding business door-to-door or to ask if it’s OK to borrow a big ladder truck for trimming the dying poplar tree that’s grown taller than the home. Some people are lonely. The caller may yell or swear at my wife and other dispatchers because they haven’t the time to listen. There’s nothing she can do but politely get off the line, reminding the caller that 9-1-1 is not the number to call to chitchat.

Calltakers and dispatchers are the public’s guardian during an emergency. The public sometimes forgets the primary focus of 9-1-1 or, when in a crisis, treats the telecommunicator poorly because of the agitated state and urgency to receive assistance. They need you, no matter the emergency, every bit as much as the officer frantically shouting “Officer Needs Assistance” into his radio or the fire captain arriving at a fully involved house fire.

Once the call ends, another one comes in. As a dispatcher, you don’t often have the opportunity to talk about the trauma. You’re on to the next ringing line, sending help for the next person in distress. Maybe, this time, you spend eight minutes on the phone with the mother of a 12-year-old boy found dead at home that morning. You wait on the phone hearing a sobbing mother praying this is not really happening. You can’t say, “Everything will be okay,” because it never will. Things will never, ever be the same again. Firefighters arrive. You hang up and take the next call, never knowing what the next call will bring.

When my wife comes home distant because of a child’s death or a firefighter injured, I know she’s trying to make the transition from work to home. Her work problems I can’t fix; I can only try to listen. She needs the break silence can provide.

Breaks, in any shape or form, are not a given. Not only during the workday but, also, any time of the year. Family holidays become a thing of the past. Some years, I spend Christmas and Thanksgiving with my wife and kids; other years it’s one of the holidays or none of them at all. We celebrate birthdays and anniversaries a day or week late, depending on scheduling. Friends and extended family make plans with the caveat that a call-in-sick or a lack of staffing may force us to cancel. For my wife, a large wildfire might mean an entire week interrupted. Home schedules are rearranged, social events are cancelled, and fast food becomes a staple.

Is it any wonder few succeed at the job despite the many who try? Every day is an emotional rollercoaster rarely punctuated by an acknowledgement. Sacrifice, patience, and dedication are the names for the profession.

Six months out of the year, I sleep alone while she works the 6 p.m. to 6 a.m. shift. I hate those nights, but I am truly grateful for the profession she has chosen. Maybe she takes my, “Thank you for working to serve our citizens” as a joke. But it’s not. I appreciate the sacrifices made in service to others. She is the first contact in an emergency and a Godsend to those dialing 9-1-1. On behalf of citizens and spouses everywhere—I thank you.
RetroSpace

Graphic Tales. Gruesome newspaper reporting left little to the imagination

By Audrey Fraizer

Newspaper reporting of accidental deaths and emergency services during the past century was not for the faint-hearted to read, at least not until the advent of photography and television to better dramatize these unfortunate events. Perhaps journalists of days long past believed it was their job to fill in the blanks created by imagination. Or, maybe, it’s the sensational the reading public demanded and newspaper publishers were more than eager to deliver.

For example, take a look at this report of a traffic accident found in the Aug. 31, 1920, edition of the Box Elder News (Utah): When a short distance north of Beck’s Hot Springs, the party met a Ford Truck driven by Byron Haslam, a young man from Salt Lake and the two cars came together head on with the result that the sedan was turned over and lay on the paved road, headed north. Underneath it lay Mr. Mack [passenger in an Oakland Sedan driven by a Mr. Fishburn] whose [sic] head was terribly crushed. Mr. Fishburn suffered a badly bruised leg and was dazed by being thrown about in the car as it turned over. Mr. Anderson was unhurt except for bruises and scratches. Young Haslam was cut in several places about his face and otherwise bruised but not seriously injured.

Further down in the story, the reader learns that Mr. Mack was “conscious until the last, almost, despite the terribly mangled condition of his head.” Mr. Fishburn and Mr. Anderson were home later that day and very little worse for the experience, except for a “mental depression as a result of the tragic outcome.”

In other words, one person died and three were injured, which is more or less how modern newspapers would report the incident if the story made it to print at all.

A traffic story published four months later in the same newspaper (dated Dec. 7, 1920) described the ill-fated demise of a Mrs. Delone Wilson Johnson. She died from injuries suffered from “fracture of the skull which she sustained by being knocked down by an automobile about 8 o’clock in the evening.”

The police reporter expressed his condolences to the surviving members of the Johnson family who were “all but prostrated
by the sudden taking of her life.” The writer included an eyewitness report from two bystanders, who hailed a passing automobile to rush the victim to the nearest hospital. She died in the car.

George Mayfield died in 1918, his entire left side “ground to a pulp” when the switchman was accidentally thrown beneath the wheels of a moving freight train. Dewey Hansen died in 1925, his lungs filling with water in a fatal drowning, despite police application of a pulmotor—an early respiratory apparatus for pumping oxygen in and out of lungs. An accident killing Frederick Reed Smith made him the 56th person to die from traffic-related injuries in Utah during 1946.

The people treated in these accidents had nearly the same chances of survival as those that didn’t make it home again. Few municipalities in Utah, or anywhere else in the United States, owned an ambulance for emergency transportation of accident victims. In many places, an ambulance ride to the hospital was a service offered by the local funeral home.

After WWII, medical training received in the military transferred into civilian rescue squads at home. In 1948, South Davis County (Utah) residents were asked to donate toward the purchase of an ambulance, which under a leasing contract, charged people transported to the hospital a 50-cent donation toward the upkeep of the service. An editorial in the Davis County Clipper urged people to fund the project or face the reality of “lessening the chances for recovery of a loved one by crowding them in the back seat of your car.”

The model subsequently purchased clearly exceeded earlier versions of the once popular Electric Winton ambulance, which did 20 miles per hour and featured a pedal gong the driver pressed to the metal to clear traffic.

Prior to 1965, drivers received no formal medical training, nor were they required to have any. Any medical knowledge they possessed was received on the job. According to the history of Hennepin County Medical Center Ambulance Service (Minn.), Herman Logan was working in a garage back in 1912 when he agreed to fill in for an ambulance employee at City Hospital. The man he substituted for never returned and Logan stayed for 39 years. At the time, he was the only driver employed and worked 24 hours a day, seven days a week, with two evenings off; he lived at the hospital.

In 1966, the National Academy of Sciences report Accidental Death and Disability: The Neglected Disease of Modern Society quantified the magnitude of traffic-related death and disability and described the deficiencies in pre-hospital care in the United States. During that same year, the U.S. Department of Transporta-

Emergency medical services have come a long way in the past decades. Just ask Scott Freitag, president, National Academies of Emergency Dispatch® (NAED™).

Freitag remembers rushing through the front door of a privately owned ambulance company in central Illinois nearly a quarter century ago, elated at beginning his EMT job. Now his first run made that evening leaves him shaking his head. Lights and siren and full speed only to find the 9-1-1 call was made to recruit help in lifting an elderly man out from his bed and onto a chair. Speed was essential, Freitag said. No matter the call coming through, the ambulance was going to get there fast.

As most users of protocol know, the Medical Priority Dispatch System™, Fire Priority Dispatch System™, and Police Priority Dispatch System™ were designed with the emergency responder forefront. They give dispatchers the tools to help in all types of emergencies through relaying Pre-Arrival Instructions. By asking the right questions, dispatchers also give responders along the chain of command a much clearer idea of the response necessary.

Maybe it was too late for either Mr. Mack or Mr. Mayfield, both critically injured in accidents, but maybe not for Frederick Smith or Dewey Hansen. Mrs. Johnson may have survived the bumpy trip to the hospital. There would be no scintillating telling of her fate; Pre-Arrival Instructions may have stabilized her while waiting for the ambulance to arrive. Perhaps that story—like others—would be ones never to reach print.

Few municipalities owned an ambulance for the emergency transportation of accident victims. In many places, an ambulance ride to the hospital was a service offered by the local funeral home.