CONCUSSIONS MAKE YOUR BRAIN HURT
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#IAEDJOURNAL
Scientists and doctors are learning more about traumatic brain injuries. The rate at which these occur in sports is increasingly troubling.

Orlando, Fla., dispatchers spoke directly with the perpetrator during June’s Pulse Nightclub shootings.
Art Braunschweiger is a software instructor and IAED™-certified ED-Q™ instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 18 years and works at Union County Regional Communications in Westfield, N.J. Art has been involved in 911 telecommunicator training and medical quality assurance since 1999.

Nancy McGinnis has been a member of the emergency medical services community for over 30 years, now employing her freelance writing and photography skills in her small business creative enterprise, communicado!
FALL IS ALMOST UPON US

Athletes are gearing up for the season

Heather Darata

Speaking of sports, have you ever gotten a bump on the head while participating in your favorite activity? Have you wondered if it might be a concussion? Do you know the symptoms of this injury? Add to your knowledge by checking out our feature about Traumatic Brain Injuries, specifically concussions; it delves into causes and effects of concussions.

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X3 - Stay on Line (= unstable) – 2nd Party

I'll stay on the line with you as long as I can.

Watch him very closely and look for any changes.

(Conscious) If he becomes less awake or starts getting...

(Unconscious) If his breathing changes in any way,

* Determine now if the patient is breathing effectively.

If any question exists, use the AGONAL BREATHING Diagnostic.

Tell me when the paramedics (EMTs) are are...
DOUBLE SQUIGGLY LINES
What’s the meaning behind the symbol?

Jeff Clawson, M.D.

Irena:
  Ross [Rutschman] called me with a question I couldn’t answer for sure. He asked what the meaning of the double line is in the headers of panels X-2/3. Does this mean as it does mathematically, approximately equal to?

  Thanks,
  Brett Patterson
  Academics and Standards Associate
  Medical Council of Standards Chair

Brett:
  Those squiggly lines have been in the protocol forever, way before I came to work for PDC™, and I have no idea what they mean, if anything. If I had to guess, I’d say someone thought they looked good aesthetically. If you ever find out the real answer, I’d like to know it myself.

  Irena Weight
  Protocol, Translation, Curriculum & Instructional Design Director

OK Doc:
  The ball is in your court; you’re perhaps the only person on the planet that knows this one ...

  Brett

Irena, Ross, and Brett:
  Thanks for an easy question for a change! This symbol is widely used in medicine and is a variation of the equal sign that means approximately or “close to.” I recall when we did it, way back when (the change from v10.3 to 11.0), to clarify that unstable is not exact science and to encourage staying on the line, if questioning the patient’s stability. This was when we moved the “stay on the line” stuff from individual PDIs to the X-card as a common exit process.

  That’s my story, and I’m stickin’ to it!!

  … Doc

Doc:
  Thanks so much! When I was asked the question, I looked at it while thinking of all the protocol questions they could ask they ask this, and I can’t give them a good answer.

  Ross Rutschman
  PDC Program Administrator–Fire & Medical

APPROXIMATELY EQUAL SYMBOL
Ever since I wrote an article in the Journal last year about issues related to the difficulties of pinpointing a cellphone caller’s whereabouts, I’ve been unable to stop thinking about this considerable, yet seemingly not insurmountable, problem of caller location.

Almost weekly, we hear news reports about patients that died or fire and police responders that were unnecessarily delayed because emergency telecommunicators didn’t have the resources to locate the caller. I can’t even begin to imagine the stress and frustration for the caller and the calltaker in a scenario where neither is able to identify where that help is needed.

The U.S. Federal Communications Commission (FCC) is working on the issue and has estimated that improved location accuracy could save more than 10,000 American lives annually. Moreover, it has mandated that by 2021, wireless carriers in the USA deliver a usable location for callers 80 percent of the time. But that means that in six years, communication centers hypothetically may still be unable to locate one in every five callers. As comedian John Oliver, host of HBO’s “Last Week Tonight,” succinctly pointed out in his May 16 segment on the topic, “That’s not good enough!”

Yet the silver lining in all of this may be that the root of the problem—technology—may also be its solution. Rapid advances in technology created a 21st century smartphone society that no longer adheres to the old rules where landlines have corresponding physical addresses available to calltakers. But what if that same wave of cutting-edge technology development resulted in some innovative options to crack the caller location enigma?

Recently, I’ve found some private sector smartphone apps that may be able to help a communication center determine a caller’s location more accurately than wireless carriers and cellphone towers. Patronus (patronusapp.com), free and downloadable on iOS and Android phones, uses the sensors in your phone to get an instant read on your location and routes it directly to an emergency communication center. Patronus Places turns your smartphone into a virtual landline by adding up to 20 unique places where emergency dispatch instantly sees your name, address, and GPS coordinates on its existing system. Similar apps include RapidSOS’ Haven (rapidsos.com/) and Apple Watch’s watchOS 3.

Granted, this cellphone app approach is not a system-wide, inclusive fix available to everyone, everywhere, particularly for those who do not own a smartphone. These apps would only benefit individual mobile device users on an opt-in basis.

But wouldn’t it be cool if these free-market technology solutions lead in the near future to the development of a universal location system that comes standard on all new carrier cellphones, negating the need for communication centers to acquire costly new caller location systems and hardware?

Again, I know I’ve oversimplified the problem. But access to effective and affordable locator app technologies for smartphones could be a step in the right direction of providing accurate emergency dispatch caller location service to everyone.
INVASION OF THE SNOWBIRDS
Project links golf course access to emergency medical services (EMS)

Tracey Barron

An abstract published in the Annals of Emergency Dispatch & Response (AEDR), the IAED’s™ peer-reviewed scientific journal, gives insight and provides a solution to a geographic problem applicable in places experiencing similar situations.

Lee County is the No. 1 perch in Florida, ahead of Palm Beach, Miami-Dade, Polk, Pinellas, and Sarasota counties. Statewide, snowbirds swell Florida’s population anywhere from 20 to 30 percent, depending on who’s counting.

Lee County is home to 108 golf courses and, as of 2013, Lee County had the seventh-highest number of golf course holes per capita in the United States, with 393 people per hole, according to the National Golf Foundation.

Snowbird season increases local revenue but, at the same time, puts increasing pressure on the delivery of EMS due to the number of older golfers on the courses (statewide, the average age of a snowbird is 69.7). Common medical emergencies include stroke, cardiac arrest, fractures, back injuries, stings, and heat exhaustion.

EMS response meeting the increased incidence is challenging and doubly so relative to finding the golfer experiencing a medical emergency. Golfers can only see the terraces and backs of houses—not street addresses—and overall unfamiliarity with the area can rob valuable time away from EMS responders. Emergency crews typically report to the clubhouse address to seek help in finding the patient.

At least that was the case until April 2011 when Lee County Public Safety Emergency Dispatch Center collaborated with Shadow Wood Golf and Country Club and the Estero Fire District to develop a series of geographic information system (GIS) maps. In 2014, the successful pilot led to making the service available countywide, and the Lee County GIS Department spent more than 800 hours producing maps of every public and private golf course.

The maps label each tee, fairway, and green to let Lee County Public Safety responders know the precise locations of emergencies. Additionally, each location has a corresponding access point for the EMS units. All of the data points are linked in a large matrix.

Medics and firefighters inspected sites for unimpeded access through the backyard of the given address. The matrix of more than 8,000 coordinates was entered into a computer-aided dispatch (CAD) system as a commonplace database. The EMD can verify the emergency’s XY-coordinates and location, enter the commonplace name, and obtain the corresponding street address to use for Automatic Vehicle Location (AVL) route mapping for the EMS responders.

All golf courses were contacted seeking their participation by displaying provided posters and were asked to encourage golfers if they have an emergency on the course to dial 911 on a cellphone rather than call the clubhouse. Calling the clubhouse only delays the critical response.

According to the study’s conclusion, the county is considering a similar implementation for waterways and beach locations based on the success on the golf course.

Sources
Is it possible to accidentally delete your AQUA® and/or ProQA® Paramount database? Anything is possible, but you would have to power through a couple of strategically placed “DO YOU REALLY WANT TO DO THIS?” warnings embedded in our software. Even then, there are default backups and hidden recycle bins that will save you in the event you did have a temporary OCD (Obsessive Compulsion to Delete) moment. This only counts if you’re happily deleting from an AQUA and/or Paramount workstation.

If you’re on the server, it’s much easier to accidentally delete. There are just two folders. That’s why server access is very limited and usually only available for IT types because the majority possess a non-delete gene. They’ll rename, move, and/or archive but are loath to delete data files.

I worked with an agency that thought it had lost an entire year’s worth of AQUA case data. There were hundreds of completed call reviews in two separate case lists. They wanted to run their ACE reports on these for re-accreditation purposes. The QI manager had been performing some house cleaning and accidentally deleted them. They were understandably in a high state of angst and needed help.

The first warning you’ll get when you select “DELETE” on a case list is: “MARK CURRENT RECORD FOR DELETION?” If you select “YES” it marks it for deletion but doesn’t actually delete it. Instead, it disappears from the interface and is put in the AQUA recycle bin. They had done this part.

To delete cases forever in AQUA, you must then purge in a separate function. It will ask you if you’re really sure about this. If you agree, you won’t be able to recover the cases, so it asks if you are really no-kidding-cross-your-heart-and-hope-to-die-sure? Those aren’t the exact words, but you get the idea. They had not gone this far. Even if they had, there’s still an internal backup on the server that runs by default at 1 a.m. every day. I remoted in, showed them all of this, and then recovered those cases. They were elated.

ProQA Paramount also has a strict deletion gauntlet. You must be a Paramount Administrator with the rights to delete cases. It makes you create a file to export to, just in case. You must then separately delete and purge. You’ll see warnings every step of the way that could be interpreted as: “LOOK ME DEAD IN THE EYE AND TELL ME YOU REALLY WANT TO PURGE THESE CASES.”

If you still managed to get through all of that and realized that you didn’t mean it, you can import the cases right back into the database from the file you were required to make in the very beginning. But, if you had gone to that file and deleted and removed it from your Windows recycle bin then I guess you really meant to delete those cases!

Back to the original question. Is it possible to accidentally delete data? Not really. You’d need to overcome the warnings (saying “oops” every time) and then deliberately search and destroy the backups. Deliberate is the opposite of accidental!
This week I did ProQA® and AQUA® training for a dispatch center in the Pacific Northwest. At one point, a dispatcher in the class said, “The nursing care center in our area isn’t going to be happy about having to answer more questions. They’re impatient enough as it is.” I’ve heard that before, and dispatchers never seem to be happy about dealing with long-term care (LTC) facilities over the phone. Yet we still have to get certain information and ensure the patient receives the proper care prior to EMS arrival.

My dispatch center has a number of LTC and specialty care facilities within the county, and I take calls from at least one each day. I sympathize with the frustrations I hear. There are a few techniques, though, that help make these calls go smoother.

First, understand that staff members on the other end of the phone are often as frustrated with you as you are with them. In their mind, they expect to be able to request an ambulance and be done with it. They don’t understand why you’re asking “all these questions,” as a caller put it to me once. Put simply, there’s a conflict of expectations. To combat this, many dispatch centers have had great success with on-site visits to the facilities they serve. Educating the staff on what questions will be asked (knowing what to expect) and why (how it benefits the patient and them) can go a long way in gaining their cooperation.

Understand, too, that the staff member calling you—especially if he or she is a nurse—is probably very busy. Many of these facilities are understaffed. When they perceive the process of requesting EMS is taking too long, they’re quick to let their impatience show. Deal with that by acknowledging their needs, not defending yours. As soon as the caller has told you what happened and/or what he needs from you, acknowledge his need to get back to what he’s doing: “We’ll get them right out to you. I have just a couple of quick questions and then I’ll let you go.”

Medical professionals dislike being treated like laypersons. When we ask Awake and Breathing, sometimes we can almost hear the eyes rolling on the other end of the phone. Yet we have to ask, because we can’t see the patient and don’t know to what level, if any, our caller has been trained. So be up front about that. “I just need to confirm: Is she awake?” [Caller answers] “Is she breathing?” This sends the message that you trust in his ability, but have to check. (And it’s an enhancement to the protocols, not freelancing.)

Another key to minimizing impatience is to avoid gaps and work quickly. It helps if your caller senses that you’re making an effort to go through your procedures as quickly as possible. Partway through Key Questions (KQs) I’ll acknowledge the caller’s cooperation by saying, “I appreciate the help; all this information is going to the EMTs so they know what to expect.” (In my world, that’s literally true—they’re seeing the ProQA information on the mobile device in their ambulance.)

Some dispatchers complete KQs only to leave out the Post-Dispatch Instructions (PDIs), assuming that the caller will know what to do. This is a liability issue; you cannot assume that your caller or the staff at any given time will know what to do for a medical emergency. Always initiate PDIs—and PAIs, if called for—and if the caller declines, accept it and document it. Many will welcome direction, and some will need it.

In the next column: two protocols that can streamline calls from medical facilities.
NOT HAVING A GOOD TIME BREATHING

EMD questioning brings up patient’s breathing problem

Brett Patterson

Brett:

I am writing to inquire how to handle “breathing problems” on Protocol 26: Sick Person.

I received a call about a patient requesting transport to a hospital; the caller stated the patient had an infection, was shaky, unable to move, and had blood/fluid oozing from her leg. The caller stated the patient has stage 4 bone cancer, which causes pain. During Case Entry, when asked if the patient was breathing, the caller stated “She's not having a good time breathing.” My question is this: When the patient/caller is requesting transport for symptoms that obviously lead to Protocol 26, why would/should I choose Protocol 6: Breathing Problems, as my QA believes, when breathing difficulties are addressed in Protocol 26? It seemed as though they were calling with infection/transport as the KEY symptoms and breathing problems were only brought up by questioning.

If they were calling for a problem with breathing, when asked “Okay, tell me exactly what happened?” they would have said she was having difficulty breathing right from the beginning, not led to that protocol through questioning.

I appreciate your time and await your reply.

Thank you,
Garrett Schneider
Emergency Medical Dispatcher
Susquehanna County 911
Montrose, Pennsylvania, USA

Garrett:

Earlier versions of the MPDS® actually contained a shunt from P26 to P6 when breathing problems were “discovered” during Key Questioning rather than being voiced as part of the initial Chief Complaint. This was also true of P5 prior to v13.0.

However, research into patient outcomes has shown us that patients
who are ‘shunted’ to P6 when breathing problems are discovered on another Chief Complaint are typically less sick. By adding an “Abnormal” (P26) or “Difficulty breathing” (P5) code to these protocols and eliminating the shunt, the code becomes more specific to the initial Chief Complaint and also provides another response option for the agency.

Incidentally, this outcome phenomenon provides some rationale for the new Rule 2 on Protocol 26.

I think the difference of opinion with your EMD-Q is simply that the breathing issue was discovered at Case Entry and, by Rule, a Priority Symptom takes precedence in MEDICAL Chief Complaint selection. However, these Rules are not absolutes and, in this case, the breathing issue was not part of the Chief Complaint. And while I certainly would not fault an EMD for choosing P6 in your scenario, P26 is also appropriate with regard to coding and instruction. If the patient is alert, the 26-C-2 code handles the Priority Symptom well, and the code is more reflective of the Chief Complaint.

I hope this helps. Can we reprint your question and this response in our Journal for the benefit of other EMDs?

Let me know if I can be of further assistance.

Brett A. Patterson
Academics & Standards Associate
Chair, Medical Council of Standards International Academies of Emergency Dispatch

Ingrid Bucksell
Operations Manager
Office of Unified Communications (DC 911)
Washington, D.C., USA

Ingrid:

In most circumstances, the MPDS deals with multiple patients by triaging high and evaluating the scene rather than multiple, individual patients. This is illustrated on several trauma protocols with DELTA-level, Multiple Patient codes, and scene questions similar to what is asked on Protocol 29: Traffic/Transportation Incidents. However, the case of multiple births is a bit different in that it is medical in nature and rarely results in more than three patients, including mom.

This topic was discussed at our last Standards Council meeting in 2012 and an attempt at a multiple patient protocol was made. In the end, however, it was decided to leave the protocol as is. Without getting into a lot of details, “protocolizing” multiple patients is difficult at best, and all of our attempts seemed only to degrade attention to one of the patients. In the end it was decided to simply recommend creating another case for each additional patient and handle them separately. However, with regard to triage, we did create a Multiple Birth suffix (M) for Protocol 24: Pregnancy/Childbirth/Miscarriage (MPDS v13.0) so that agencies can send additional resources to these calls, if they elect to.

For educational purposes, childbirth is a patient-driven event, and the EMD has little control over the delivery process. Therefore, a good understanding of priorities is necessary so that when things progress quickly or happen suddenly, the EMD knows what is important. With all births, and multiple and/or premature births especially, the EMD needs to remember “breathing” and “warm.” If we can manage these issues well, we have a good chance of providing appropriate PAIs.

This topic is somewhat personal for me as I once took a call from an 18-year-old mother, having twins, alone at home with her screaming 3-year-old daughter. The first baby born stopped breathing as the mother was telling me the second one was coming out. Neither of the premature neonates weighed more than 2 pounds. However, I knew about “breathing” and “warm,” and although no specific pathway could guide me through this dynamic situation (mom even refused to lie down), I managed to get that first baby breathing and warm by rubbing briskly with a towel and constantly reminding mom to keep it warm. I can still remember her telling her 3-year-old to “Bring mommy the blankie.”

If you have any suggestions regarding how to handle this more appropriately in protocol, please let us know. However, we think the current instructions are detailed enough, and simply need to be delivered at the right time for each patient, optimally by two callers and two EMDs, and minimally by one EMD that can prioritize the issues and move confidently around Protocol F: Childbirth—Delivery. Because even routine childbirth is a relatively rare EMD event, this protocol should be practiced and studied routinely so that the basics become second nature and navigation in dynamic circumstances can be accomplished.

I hope that helps. Let me know if I can be of any further assistance.

Brett
PERSONAL RESPONSIBILITY
EMDs in Muskogee County take their calls to heart

Audrey Fraizer

Muskogee County EMS Communication Center staff members consider the nearly 80,000 people living in 840 square miles their personal responsibility.

Well, maybe that’s an exaggeration and on the same par as suggesting that the 13 EMDs know each person by sight if not by name.

But, again, perhaps that’s not too far from the truth.

“This is home, and this is where I want to be,” said Delsie Lewis, a lifelong resident of the county. “The same for the people working here. This is where we plan to stay.”

Muskogee County is near the eastern border of Oklahoma. The varied topography includes prairie grassland in the west and wooded Cookson Hills in the east at the fringe of the Ozark Mountains. Three Forks is the confluence of the Arkansas, Verdigris, and Neosho rivers.

Lewis never seriously considered leaving Muskogee County, and neither did she foresee a career in public service. But after a 20-year career in retail, switching to emergency dispatch was going in the right direction. She has a degree in sociology/criminal law from Northeastern State University, Oklahoma, and she is devoted to the community.

“I’m comfortable here,” said Lewis, who has been involved in numerous city boards and councils. “It’s important to be part of the community and make it a better place to live.”

Twenty-five years ago, emergency communications in Muskogee County required phone and note-taking skills and the ability to work 12-hour shifts or longer in case one of four dispatchers quit, called in sick, or took a vacation.

“We’d get an address, chief complaint, and gender, and ask if the patient was breathing and conscious,” Lewis said. “We wrote the patient’s information on a piece of paper and dispatched an ambulance. I was thrilled when my boss started looking into the MPDS.”

The Medical Priority Dispatch System™ meant they could do more for the caller, patient, and bystander, Lewis said. The arrival of ProQA® simplified their accreditation process (achieved ACE in May 2000) and, last year, ProQA coupled with the online accreditation system just about made the recertification process a snap.

ACE, Lewis said, is the sign of professionalism—the frosting on an emergency dispatch career that highlights the positive effects one person can have on another.

“I love to watch the new people come in and make this a career,” Lewis said. “They see the ton of difference they can make in a person’s life.”

The significance of dispatch in
the chain of emergency response was highlighted in April 2015 when the Oklahoma Ambulance Association (OKAMA) honored EMD Kandis Crespy with the annual Stars of Life Award. OKAMA presents the awards each year to recognize EMS employees for an outstanding save. Crespy, an EMD since 2006, is credited with providing CPR Pre-Arrival Instructions that ultimately led to the survival of two patients on two separate occasions.

“Before I started, I was told not everyone can do this job,” Crespy said. “That’s probably true, but it’s been great for me. Emergency services is a great cause. We help people, and like many in the field, there’s the adrenaline rush I enjoy.”

**Muskogee County quirks**

Muskogee County is a great place to live and work, Lewis said, but like with everything else, some parts take getting used to.

Muskogee County shares the dubious nickname “Tornado Alley.” The region from central Texas, northward to northern Iowa, and from central Kansas and Nebraska east to western Ohio is ideally situated for the formation of supercell thunderstorms, often the producers of violent (EF-2 or greater) tornadoes.

Muskogee County averages three tornadoes per year, although during the past five years there’s been a relative lull in activity. According to the National Weather Service Weather Forecast Office in Norman, Okla., five tornadoes between the years 2010 and 2015 measuring EF-1 and EF-2 have touched down in Muskogee County, causing three injuries.

The largest tornado to pummel the county, an EF-4, occurred on May 1973 and had a different impact. Five people, including four from the same family (two adults and two children), died, and the immense twister forever changed the landscape and emergency warning system.

At that time, there was no storm warning system, no centralized EMS ambulance response, no emergency 911 number, and no emergency operations centers. Volunteers in each community fanned out sounding sirens when weather was threatening. Most rural area residents depended on each other for assistance.

Lewis recalls the lack of EMS when, while in high school, she was in a car accident.

“My parents took me to the hospital,” she said. “But that’s the way it was. I later went to EMT school thinking it would be a good background to care for my parents as they aged.”

Today, there are 18 fire departments (17 are volunteer) and a consolidated emergency 911 communication center managed by Muskogee County 911 Coordinator Darryl Maggard.

The Muskogee EMS ambulance service established in 1981 staffs its 20 ambulances with nationally registered EMTs; advanced, paramedic, critical care transport paramedics; and registered nurses. In 2015, Muskogee County EMS Communication Center responded to approximately 20,000 requests for ambulance service (60 percent emergency and 40 percent non-emergency responses).

The ambulance service operates the medical side of 911, while the consolidated 911 center operates both fire and law enforcement calltaking and dispatch. The two separate emergency dispatch staffs occupy the same building, but when a major event occurs or when staffing is low, dispatchers share responsibilities on the phones and radios.

An emergency operations center (EOC) divides the building into two sections, with enough room in the reinforced concrete block mid-section for EOC Director Mark Bolding to monitor weather updates, rouse volunteer weather spotters when bad weather threatens, conduct meetings and press interviews, and meet the four major commitments of emergency planning: preparation, response, recovery, and mitigation.

“We do what we can to supplement first responders,” said Bolding, the EOC’s only full-time staff member. “And if we have a situation, we can use the center to maintain operations.”

Lewis said that hasn’t happened yet since the two staffs and EOC consolidated into one building in July 2011. The emergency dispatch center has weather protocols in place and the building was designed to withstand a Level 5 tornado (winds up to 318 mph).

“You get used to the storms,” she said. “You listen to the warnings and stay alert to your surroundings. You know where to go in an emergency.”

While Lewis has seen plenty of small tornadoes, she has yet to witness the intensity of the EF5 tornado that struck Moore, Okla., on May 20, 2013, with peak winds estimated at 210 mph. The tornado killed 24 people, including seven children taking cover inside an elementary school, and injured 37 others. Property damage was estimated in the millions.

Bolding was working in emergency services for the state when the tornado struck and, in a way, the devastation and aftermath provide the reason why he savors his second career in emergency operations following a career in software development.

“If you told me I’d have a career in emergency planning, I would have said you’re crazy,” said Bolding, who grew up in Muskogee County. “Once I got into it, I loved it. You’re standing in a road and know where you are by the address painted on the curb. Your heart breaks but you have the opportunity to help. It’s rewarding to be a part of rebuilding communities and lives.”

**Sources**

No one would say Owen Smith is an introvert.

He was a Belfast (Maine) police officer from 1973–1988. He worked his way up to general manager during the 20 years he spent with a printing business and sold cars for three years.

“I like people,” he said. “I like being around people. Yeah, you could say I’m a people person.”

In June 1994, Smith applied for an emergency dispatch job at Belfast Police Department, and that’s where he stayed until, in November 2000, he submitted his application to the newly created Waldo County Regional Communications Center. He’s been the center’s first and only director for the past 16 years.

The “people” priority was a major factor in his selection as Director of the Year by the Maine chapter of the National Emergency Number Association (NENA), and it’s why Smith was nominated in the first place.

When not at work, Smith is just as likely to schedule dinner with former co-workers as he is to participate in a community project, stop by to chat with dispatchers, or attend a Maine chapter meeting of NENA.

“He cares a lot about us,” said Elizabeth Daggett, Supervisor. “He makes sure we stay happy and healthy. He cares about what’s going on in our lives. He knows exactly what we’re going through at our jobs.”

Waldo RCC uses the Medical Priority Center director looks out for staff

Audrey Fraizer
Dispatch System™ (MPDS®), and Smith keeps his EMD certification current just like the 16 EMDs and supervisors. He takes the Journal Continuing Dispatch Education (CDE) quizzes, attends seminars, and rotates his staff through the annual state NENA conference. He is a Q. The consoles are ergo friendly, and the stand-alone dedicated PSAP has windows looking out into trees.

“I’ve always said you’ve got to walk in someone’s shoes to understand, and that’s what I’ve always tried to do,” Smith said.

The nomination goes beyond recognizing administrative acumen.

“We wanted him recognized for what he does for us at the center,” Daggett said. “We spend more time here than we do with our families at home, and he understands that. He has made us into a dispatch family.”

Daggett is keeper of the obscure holiday calendar. In May, for example, staff members celebrated Reese’s candy day while, during the same month, they were still picking up pieces of red and green glitter spilling over from Christmas. Entries into the chili cook-off or macaroni and cheese bake-off are assembled at home and reheated in the center’s toaster oven. Smith gives chargers and water bottles for National Public Safety Telecommunicators Week. A phone program instituted to check on the welfare of older residents living alone evolved into more of a buddy program at the discretion of dispatchers.

“It’s a thing we started to let people stay in their homes longer,” Smith said. “If we don’t hear from someone, we send the police to check. We’ve saved a few lives by doing this. We got started with a grant, and a couple years into it, dispatchers got the idea of making gift baskets for the Christmas holiday. We serve dinner and get to meet the families.”

The job’s not all fun and games. Waldo RCC is not immune to issues facing emergency communication centers worldwide. There are budgets, policies to enforce, and the demands of balancing 16 type-A personalities.

“Like I tell new people, the biggest part of the job is making me look good,” he said with a laugh. “I joke, but I do work hard to make it work.”

Smith said he has no plans to retire and downplays the workaholic image his schedule might imply. He’s certainly not out to impress anyone; he’s been around too long for that. The NENA award, he said, was humbling, especially coming from the people he sees day in and day out.

“It’s about dispatchers, about who we are and what we do,” Smith said. “I love the job. I love the profession. I took the opportunity and have never looked back.”
At 40 years old, Jennifer Quinlan wakes up every morning grateful to be alive and acutely aware of how she might not be if events had transpired differently on the morning of Jan. 24, 2016. It takes a village—or in this case, a system. The Maine Emergency Medical Services system: a coordinated, choreographed network of EMS providers, each with the training and skills to perform their specific roles, and bringing compassion and professionalism to their part of the collaborative effort.

It’s a story that Jennifer, a former high school English teacher, and her husband, Michael, with whom she works at their small Caribou accounting firm, now want to share with other Mainers as one way of expressing their gratitude to the EMS providers who made all the difference.

On that January morning, they had no idea that one of Jennifer’s cardiac arteries was 95 percent blocked—and that without intervention, her heart was about to shut down permanently.

Michael takes up the story, because now, looking back, his wife remembers nothing of what happened for several days before and weeks after the incident.

Before retiring the night before, Jennifer mentioned experiencing a heavy feeling in her chest—and Michael’s Google search came up with “heart attack” and “panic attack.” Concerned, he suggested they make a trip to the emergency room—but Jennifer was not enthused at the prospect, and recalled how she had resolved the same discomfort a few weeks earlier by shifting her position and turning on her left side.

Eventually they both fell asleep. But Michael awoke around 2:30 a.m., alarmed by the sound of something like deep snoring coming from Jennifer. He recalls that he had to shake her vigorously and repeatedly before she finally woke up. She got out of bed to use the bathroom, came back, and promptly went back to sleep. He walked around to her side of the bed.

“We need to go the emergency room,” he urged. “I almost couldn’t wake you!”

Soon after, she again became unresponsive. Shaken, Michael grabbed the phone and dialed 911.

“The dispatcher asked me a few questions, and then he told me, step-by-step over the phone, how to clear her airway and perform chest compressions,” he said. “I could tell he was also letting someone else know we needed to get an ambulance here to the house.”

Some 175 miles away, in Bangor (Maine), Emergency Medical Dispatcher David King was nearing the end of his overnight shift when Michael’s 911 call came in to the Penobscot Regional Communications Center.

(For cost effectiveness, Aroostook County contracts with the PRCC to answer incoming 911 calls, process the information, and relay it to the appropriate Aroostook agency to respond.)

“Following our ProQA® Emergency Medical Dispatch Protocols by asking the husband a few questions, we were able to quickly establish the location of the emergency and confirm a callback number, and determine that his wife had collapsed, had lost consciousness, and was not breathing,” King explained. “The next step was to get resuscitation going ASAP by talking Michael through CPR to try to keep Jennifer’s oxygen supply flowing while waiting for EMS response.

“In our position, since we are not there in person, we have to rely on what the individual at the scene is telling us for information,” King continued. “We need to be able to convey instructions, and have them relay what is happening as it unfolds.”

Emergency Medical Dispatch training
includes techniques that can help to de-
escalate a panicked caller.

“Understandably, under the
circumstance, people are sometimes so
upset or hysterical that we have to ask
them to find someone else to take over
on the phone,” King said. “But Michael
Quinlan was great to work with—I’m sure
he was scared and anxious, but he was able
to communicate and process information,
and to stay focused, to save his wife’s life.”

Under King’s steady, calm direction
and encouragement, Michael continued
to administer CPR, including mouth-to-
mouth resuscitation when hundreds of
chest compressions alone did not suffice.

“It felt like five years,” Michael
recalled solemnly. “But I know it was
less than 10 minutes before the first
paramedics arrived.”

He said as the sirens approached, he felt
torn about leaving Jennifer’s side even just
long enough to race to unlock the front
door to let the crew in.

The response time was actually less
than eight minutes, said Caribou Fire
and Ambulance Chief Scott Susi, citing
records documenting the dispatch call at
256 a.m., and the first Advanced Cardiac
Life Support crew’s arrival on scene at 3:03
a.m. The patient’s initial cardiac monitor
reading, time stamped 3:06 a.m., showed
ventricular fibrillation—where the heart
merely quivers instead of pumping blood.

At this point, in accordance with
their protocols, a second Caribou ACLS
crew was dispatched to respond to the
confirmed cardiac arrest.

Awakened by the commotion, the
Quinlans’ 13-year-old daughter, Alaina,
was settled into another part of the house
to be spared witnessing her mother in such
dire circumstances.

The ambulance crew members
included paramedics Corey Felix, John
Thorton, Justin LaPlante, Scott Michaud,
and Daniel Raymond and Basic EMT
Jonathan Stokely, a student who happened
to be riding on this call.

“I’m extremely proud of all of my
people,” said Susi, who emphasized how
teamwork makes all the difference. “With
no time wasted, in the end we can look
back knowing we were part of the team
that provided the full circle of treatment
that saved a life.”

Thanks to their training, each crew
member knew where to station himself
and what needed to be done. Medications
were administered intravenously (injected
directly into the bone) when it was
impossible to start an IV. CPR was restarted
and defibrillation was administered as many
as six or seven times, until ROSC (Return of
Spontaneous Circulation) was achieved.

After the patient regained a pulse, she
was transported to Cary Medical Center
for further treatment and stabilization. But
when it became apparent that Jennifer was
critically ill and needed more definitive
care, “We were called back again, because
Caribou Fire and Ambulance also runs an
air service,” Susi said.

Jennifer was loaded, with fresh crew,
ono their fixed wing aircraft and flown
to Bangor International Airport. Bangor
Fire Department EMS personnel David
Rudolph and Ryan Taylor were waiting
there to transport her by ambulance
to the Eastern Maine Medical Center
catheritization laboratory.

It was not until a debriefing, weeks
later, that Jennifer discovered that one of
the Caribou paramedics who helped to
keep her alive by defibrillating her three
times more aboard that air ambulance was
actually Adam Chartier—a former high
school student of hers. Also monitoring
Jennifer’s condition and providing care en
route were Flight Nurse Chris Zappone
and Respiratory Therapist Tammy Susi.

“I’m so thankful that everyone who
helped me that day chose to go into
emergency medical services as a line of
work,” Jennifer said. “The entire crew was
amazing, so skilled and utterly professional,
and there were so many, many people
involved—I just can’t say enough about
how thankful I am.”

Now further along in her recovery
than anyone anticipated just a few months
after her ordeal began, “In some ways I’m
even healthier than I was before the heart
attack,” Jennifer said. “And we certainly
have a renewed appreciation for each
other and those we share our lives with, for
health, and for life.”

And perhaps the best medicine of
all is gratitude—thankfulness for this
happy ending.

“After our life got back to more-or-less
normal, we were determined to go to the
fire station to meet some of the people
who made all the difference that day, and
to express our appreciation,” Michael said.
“We wanted to bring a token gift—coffee
and donuts, or something—but what do
you bring to a group of people who saved
your wife and your daughter’s mother?”

Susi assured them that their visit was
the best thing they could have done. King agreed.

“Most of the time, we don’t get to learn
how things worked out,” he said.

And everyone agrees that sadly, even
despite following procedures and everyone’s
best efforts, the outcome is not always what
one would wish for. Though he has given
CPR instructions over the phone at least 10
or 15 times in his seven years of experience
as an Emergency Medical Dispatcher, this
is the first case King knows of where the
patient has made a full recovery.

One of the pictures Jennifer will
always bear in her mind: a sobering
statement made by one of the crew
members at the informal reunion: “After
we did everything we could for you, and
handed you over to the next caregivers, it
was an unforgettable long, quiet ride for all
of us back to the station.”

From an EMS point of view, this call
ran impeccably, “like textbook Advanced
Cardiac Life Support,” according to
Drexell White, Maine EMS’ longtime
EMD Program Manager who has reviewed
many calls, and who also personally
followed up with the Quinlans after this
remarkable incident.

“Talking to Michael was an emotional
experience,” White said. “It really hit home
to hear him say that our EMS system didn’t
just save her life; it saved their world.”

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permission of the author, the Quinlan family,
and Maine EMS.
Football, or American football as it is known in many countries outside of the United States, is a wildly popular sport in the U.S. Every fall, stadiums across the country are packed with passionate fans on the professional, college, and high school levels.

In 2015, a total of 17.26 million people attended National Football League (NFL) games; National Collegiate Athletics Association (NCAA) Division I games totaled more than 43 million spectators. Fox-televised Sunday NFL games had a staggering viewership of 26.8 million per game last year.

People of all ages love watching the incredible displays of speed, strength, and athletic ability. They also love watching crushing hits, hard tackles, and the bruising battles of these powerful men.

American football is among many sports in the U.S. and across the globe that maintains a devoted following and enormous participation rate. Soccer, basketball, baseball, ice hockey, volleyball, tennis, and other sports provide thrilling entertainment for those who watch and an opportunity for those who play to do something they love.

But there's also a growing concern with each of these sports: head injuries, specifically concussions.

The signs and symptoms

While participating in sports and other activities, just about all of us have bumped our heads. It can happen by falling down the stairs, slipping on ice, falling off a bike,
or getting out from under tight spaces. But banging your head doesn’t mean you’ve suffered a concussion or any other Traumatic Brain Injury (TBI), for that matter.

The human brain is surrounded by spinal fluid inside the skull. The fluid is a sort of shock absorber for blows to the head. Concussions occur when something strikes the head and causes the brain to move rapidly inside the skull, either from side to side or forward and backward.

When should you start worrying about head injuries? How are you to know you’ve experienced a concussion and should seek medical treatment? Here are some common concussion symptoms:

- Headache or feeling pressure in the head
- Temporary loss of consciousness
- Confusion or feeling as if you’re in a fog
- Amnesia surrounding the event
- Dizziness or seeing stars
- Ringing in the ears
- Nausea, Vomiting, Slurred speech
- Delayed response to questions
- Appearing dazed
- Fatigue

The preceding symptoms usually manifest themselves immediately following the trauma that caused the concussion. However, there are other symptoms that can be delayed by hours or even days that signal you have suffered a concussion. Some of these include:

- Concentration and memory complaints
- Sensitivity to light and noise
- Sleep disturbances, disorders of taste and noise, and depression

People who have had a concussion are more prone to suffering additional concussions. That likelihood rises with every subsequent concussion. Research suggests that people who have already received one concussion are up to two times more likely to receive a second one. If they’ve had two concussions, then a third concussion is 2–4 times more likely, and if they’ve had three concussions, they are 3–9 times more likely to receive their fourth concussion.

Brett Patterson, Academies of Standards Chair with the International Academies of Emergency Dispatch®, said callers don’t always relate previous head injuries to their current level of decreased consciousness or other complaints such as cognitive issues or memory loss. Patterson also pointed out that a concussion is always diagnosed by a physician and is usually done so after the patient arrives at the hospital.

“The diagnosis and treatment are post arrival, unless there are immediate concerns related to decreased level of consciousness, namely airway control,” Patterson said. “These patients are prone to nausea, dizziness, and vomiting, so if the patient is not alert, airway control and monitoring is our primary function from a pre-arrival standpoint.”

Old problem, new recognition

Players, coaches, and officials have long recognized the need to protect players from head injuries. Leather football helmets were introduced in college football in 1893. Designs improved over the years, though helmets were not required until 1939. Meanwhile, as far back as the early 1930s, doctors were warning of the potential for football players to suffer concussions. The NCAA’s Medical Handbook stated in 1933 that, “the seriousness of [concussions] is often overlooked” and concussions “should not be regarded lightly.” The handbook advised that players suffering concussion symptoms for 48 hours should not compete for 21 days. Nevertheless, the NCAA didn’t adopt concussion guidelines until 1994, and the NFL introduced a concussion protocol in 2007, fully implementing the policy in 2009. Other major professional sports leagues have only recently introduced concussion policies. In 2007, Major League Baseball (MLB) established policies for evaluating player concussions and when to allow concussed players to return to the field. Major League Soccer (MLS) and NASCAR did so in 2011 and 2003, respectively. The National Hockey League (NHL) first introduced a concussion policy in 1997 but didn’t adopt it until 2011. The National Basketball Association (NBA) has no such policy; league officials leave the decision in the hands of individual teams regarding when players should return to action following concussions.

A turning point in professional sports leagues (particularly the NFL) recognizing the dangers of concussions, and establishing policies to protect players from them, came in 2002 when Dr. Bennet Omalu found evidence in the brain of deceased player Mike Webster of Chronic Traumatic Encephalopathy (CTE). This neurological disease had been most commonly found in boxers and describes degeneration of the brain, most likely due to repeated trauma to the head. Symptoms of CTE are thought to include difficulty with cognitive reasoning, physical problems, and emotional issues. Omalu conducted tests on other deceased former NFL players and found similar results. Though initially rejected, Omalu’s research was a catalyst in the NFL adopting strict measures to prevent concussions and properly treat players who had suffered them. Omalu’s work was depicted in the 2015 film “Concussion,” starring Will Smith.

Dr. Gregory Hawryluk, Ph.D., Director of Neurosurgical Critical Care at University of Utah Health Care in Salt Lake City, Utah, said the number of concussed patients he treats is increasing.
Physicians are seeing more and more concussed patients or those that think they may have been concussed,” he said. “I think that this reflects increased awareness more than it does an increase in concussions. The fact that more people are seeing physicians when they think that they have been concussed is exactly what we would hope for. Physician guidance is very important in the early recovery following a concussion and can help to achieve the fastest and most complete recovery possible.”

Types and causes of injuries

Aside from a concussion, other brain injuries are commonly reported and treated. Each can be very serious and requires immediate medical attention. Some of these include:

- **Hematoma:** Clotting of blood outside the blood vessels. When this occurs in the brain, pressure builds inside the skull, resulting in possible unconsciousness.
- **Hemorrhage:** When this occurs on the brain, there is bleeding around the brain or within the brain tissue.
- **Edema:** When it occurs in the head, there is swelling of the brain tissue, causing pressure and the brain to press against the skull.
- **Skull fracture:** A fracture to the skull will likely result in brain damage.

In addition, brain injuries regularly occur outside of sports. According to the Centers for Disease Control and Prevention (CDC), 14.3 percent of all TBIs occur as a result of motor vehicle traffic accidents. Another 10.7 percent are suffered from assaults.9 Falls and professional levels, concussions are commonplace. According to the organization Head Case, when it comes to high school athletes, football has the highest incidence of concussions at 47 percent. The organization reports that 64–76.8 concussions per 100,000 athletic exposures (one athlete participating in one organized high school practice competition, regardless of time played) occur in high school football.10 The second-highest rate of concussions is in boys ice hockey with 54 per 100,000; boys lacrosse ranks the third most common with a rate of 40–46.6 per 100,000.

Girls are most likely to suffer concussions playing soccer, as Head Case reports 33 concussions per 100,000 athletic exposures in that sport.11 Girls lacrosse isn’t far behind at 31–35 per 100,000.

Other concerning statistics among high school boys and girls include: 33 percent of athletes who have one sports concussion will have two or more in the same year; 1 in 5 athletes will sustain a concussion during the season; and 33 percent of all sports concussions occur in practice.12 Among boys and girls of all ages and levels, statistics are similar. The Sports Concussion Institute reports that 5 percent to 10 percent of athletes who have one concussion will have two or more in the same year; 1 in 5 athletes will sustain a concussion during the season; and 33 percent of all sports concussions occur in practice.13

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Prevalence in sports

The most common TBI in sports is a concussion. At the high school, collegiate, and professional levels, concussions are commonplace. According to the organization Head Case, when it comes to high school athletes, football has the highest incidence of concussions at 47 percent. The organization reports that 64–76.8 concussions per 100,000 athletic exposures (one athlete participating in one organized high school practice competition, regardless of time played) occur in high school football.10 The second-highest rate of concussions is in boys ice hockey with 54 per 100,000; boys lacrosse ranks the third most common with a rate of 40–46.6 per 100,000.

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Prevalence in sports

Soccer also presents a strong likelihood of head injury, where girls and women have a 50 percent chance of suffering a concussion. Though it is not clear if heading the ball causes more concussions than falls or collisions with other players, according to the Sports Concussion Institute, the impact of a player heading the ball is 70 mph.15 Some youth leagues across the U.S. have begun outlawing heading as a protective measure against concussions.

Immensely popular in the U.K., Australia, New Zealand, and in the Pacific isles, rugby has its fair share of concussions as well. Complete with full contact without the helmets and padding worn in American football, The Telegraph newspaper in the U.K. reported that concussions in the Rugby Football Union rose by 59 percent from the 2012–13 season to the 2013–14 season. The publication also states that 10.5 concussions were suffered per 1,000 player hours in 2013–14. During that same season, 13 percent of the league’s players suffered at least one concussion. The publication points out that the rise can be attributed to better awareness of concussions among league officials,
**FAST FACTS**

**SPORTS CONCUSSION STATISTICS**

- Concussions have risen by **200%** among teens ages 14 to 19 in the last decade.
- **3.8 MILLION** sports concussions were reported in 2012.
- Cumulative concussions are shown to increase catastrophic head injury leading to permanent neurologic disability by **39%**.

- **An estimated 5.3 MILLION** Americans live with a traumatic brain injury-related disability.
- **90%** of diagnosed concussions do not involve a loss of consciousness.
- The number of reported sports concussions doubled from 2002-2012.

- **15 different high school sports have a rate of at least 7 concussions per 100,000 athletic exposures.**

“The reality is, you are at risk with any activity,” he said. “You can even be concussed on a roller coaster.”

Short- and long-term consequences
Concussions and other head injuries can do much more than cause headaches and dizziness. As Omalu proposed, these injuries can be severe enough to cause long-lasting impairment of cognitive abilities and other serious disorders connected to CTE. Other researchers have proposed CTE leads to mental slowing, explosive behavior, memory loss, paranoia, pathological intoxication, jealousy, and Parkinson’s disease. Boxer Muhammad Ali, considered one of the greatest athletes in history, died on June 3, 2016. He battled Parkinson’s disease for 32 years.

Medical experts have also said multiple concussions can lead to brain swelling, permanent brain damage, long-term disabilities, and death.

In recent years, retired professional football players have reportedly suffered from similar conditions, in addition to depression and other psychological issues. Former NFL players Dave Duerson, Ray Easterling, and Junior Seau were confirmed to have had CTE, and each took his own life after retiring from the league. Duerson, who died in 2011, had left a note requesting that his brain be used for CTE research.

A recent study by Boston University researchers confirmed CTE in the brains of 87 of 91 deceased former NFL players. Other well-known deceased former players to have CTE as a result of concussions include Frank Gifford, Ken Stabler, and Bubba Smith. Additionally, there are a number of former players currently living with CTE, including Brett Favre, Bernie Kosar, Tony Dorsett, Jamal Lewis, and Jim McMahon.

More than 4,500 former professional players and their estates have filed a class-action lawsuit against the NFL for concussion-related injuries. Hawryluk is happy to report that the majority of concussions don’t lead to severe consequences.

“Fortunately, most patients make an excellent recovery from a concussion,” he said. “A small portion of patients, however, are the so-called ‘miserable minority,’ who suffer from persistent symptoms. This is referred to as post-concussion syndrome, which can be associated with a number of symptoms, including easy fatigability, disordered sleep, headache, vertigo, irritability, anxiety or depression, and personality changes.”

Precautions
Avoiding concussions and other head injuries altogether is impossible. Head injuries in sports, in particular, can be significantly minimized if participants take certain safety measures to protect themselves. Also, athletes should pay close attention to concussion symptoms and avoid playing if they have had a recent head injury. Athletes should never rush their recovery from concussions or other head injuries.

One of the easiest things athletes can do is wear the proper equipment—in games and at practice. People should also wear helmets and proper padding and mouth guards when riding skateboards, bicycles, rollerblades, and horses, and when skiing and snowboarding. Wearing a helmet in these activities can lower the risk of head injury by up to 85 percent.

“The most important thing for athletes to do is to treat their bodies and those of their fellow players with respect,” Hawryluk said. “Using proper technique and a conscious effort to avoid blows to the head are key. Don’t use your head as a battering ram. Don’t hit an opponent from behind who isn’t able to brace from the contact. Remember that although helmets help, they do not prevent concussions.”

Conclusion
Scientists and medical professionals continue to learn more about concussions and other TBIs. As this knowledge comes to light, amateur and professional athletes have a far greater awareness of the dangers of head injuries and the risks they take by participating in their sports. Children, adolescents, and adults should by no means eliminate these activities from their lives, but it is critical that people everywhere exercise caution and take appropriate measures to reduce their exposure to these potentially devastating injuries.

Sources
12. See note 11.
13. See note 11.
15. See note 4.
Omar Mateen’s calls to 911 from the Pulse nightclub in Orlando, Fla., is believed to be the first time an active assailant accessed emergency communications as the messenger in an act of terrorism.

The prevalence “will most likely increase,” said Chris Knight, PDS™ Chief of Program Management & Implementations, citing reports that the Islamic State (ISIS) encourages “lone wolf” attacks (action not directed from the core but carried out by sympathizers with no direct links to the group).

The first call reporting multiple shots fired inside the nightclub came at 2:02 a.m., and two minutes later police officers arrived on scene. Mateen called 911 about 30 minutes later, at 2:35 a.m., from the club’s bathroom, where he was holding 12 to 15 people hostage.

According to partial transcripts released by the FBI on June 20, Mateen stayed on the line with the calltaker for about 50 seconds, during which time he declared his respect for God and loyalty to ISIS!

Mateen [in Arabic]:
“In the name of God the Merciful, the beneficial.”

Orlando Emergency Dispatcher (ED):
“What?”

Mateen:
“Praise be to God and prayers as well as peace be upon the prophet of God. I let you know, I’m in Orlando and I did the shootings.”

Orlando ED:
“What’s your name?”

Mateen:
“I pledge allegiance to [omitted]. May God protect him [omitted] on behalf of [omitted].

The ED asked Mateen his name for a second time. The call ended when the ED asked Mateen where he was in Orlando. The dispatcher reported the 29-year-old Mateen, who was killed later that morning by a SWAT team responding to the attack, sounded “cool and calm” while making his suspected pledge of allegiance (Bay’ah) to the leader of ISIS, Abu Bakr al-Baghdadi.

Although Mateen’s direct affiliation with ISIS remained uncertain as of press time, his “lone wolf” approach in the attack indicates he was sympathetic to ISIS. As “soldiers of the Islamic State” lone wolves are directed to “Rise and defend your state from your place wherever you may be.” In contrast to the Paris attack, Mateen acted outside the core of command.

The motive, however, is basically irrelevant to emergency communications, said Dave Warner, PDS Program Administrator—Law Enforcement. A dispatcher does not ask motive—“Why did you do this?”—but, rather, gathers...
information about the incident to make rapid over-the-phone assessments of patients, bystanders, scene safety, and the immediate situation to determine the resources to send or not to send.

“We don’t deal with motive,” said Warnér, a former police officer for Salt Lake City, Utah. “We deal with the action and the subsequent response required.”

The newest version of the Academy’s Protocol 136: Active Assailant (Shooter), in the Police Priority Dispatch System™ (PPDS®), includes a first-party caller pathway that applies to calls in which the perpetrator is contacting emergency communications. The pathway does not assume that the caller (suspect) is saying “Please help me,” which is generally the intent of calling 911 (or emergency numbers in other countries) during a medical, fire, or police emergency.

Mateen wasn’t asking for help; he was declaring allegiance to the Islamic State. He was not looking for reassurance or Pre-Arrival Instructions.

The reason he was calling, however, did not and does not diminish the dispatcher’s role, according to Dr. Jeff Clawson, co-founder of the International Academies of Emergency Dispatch™ (IAED™) and inventor of the medical, police, and fire protocols.

“Dispatchers, in a way, are responsible for the overall flux of what’s happening in the system,” Clawson said. “They are in charge of every scene until someone else gets there. No one knows more about a call than the dispatcher because that’s the only person who has talked to someone at the scene. Once response arrives, there’s a new commander. Dispatchers have to be multitasking, fairly unfappable, and able to provide leadership and empathy to people who are in the midst of a crisis. On paper, their job is more complex than a field responder’s—not more important or harder, but more complex. They change hats a lot in what they do.”

After his initial call to 911, Mateen and crisis negotiators talked three times over the phone. The first time, at 2:48 a.m., lasted nine minutes; the second, at 3:03 a.m., lasted 16 minutes; and the third, at 3:24 a.m., lasted three minutes.

During those calls, Mateen, identifying himself as an Islamic soldier, told negotiators “to tell America to stop bombing Syria and Iraq” and alluded to the ISIS November attack in Paris ordered by ISIS command in Syria. He also claimed that vehicles outside were carrying bombs, telling the negotiators, “You people are gonna get it, and I’m gonna ignite it if they try to do anything stupid.” No explosives were found.

This was not the first time Bay’ah has been proclaimed in an attack on American soil. ISIS has made it clear that announcing Bay’ah during or after the attack is enough to turn it into an ISIS-branded mission. This is what San Bernardino shooters Tashfeen Malik and Syed Rizwan Farook were apparently trying to do when they declared support for ISIS on Facebook shortly before being killed by police.5

Less than two years earlier, in November 2014, Abu Bakr al-Baghdadi had released a statement accepting pledges of allegiance from groups abroad (outside of Iraq and Syria) and encouraged attacks against the enemies of ISIS to “erupt volcanoes of jihad everywhere.”6

The ISIS leader gave jihadists permission to “kill him [any disbeliever] in any manner or way however it may be. Do not ask for anyone’s advice and do not seek anyone’s verdict. Kill the disbeliever whether he is civilian or military, for they have the same ruling. Both of them are disbelievers. Both of them are considered to be waging war [the civilian by belonging to a state waging war against the Muslims].”7

Mateen used a handgun and AR-15-type rifle to kill 49 people and injure 53 others, some critically. The three-hour rampage and hostage siege ended shortly after 5 a.m. (EDT) when SWAT officers driving an armored vehicle smashed through a wall of the building. Mateen was shot and killed in the ensuing gun battle involving 11 officers.

Most of Mateen’s victims were male, with 18 of the 49 people killed 25 years old or younger and more than 90 percent of Hispanic background.

The PPDS Active Assailant (Shooter) Protocol was designed for rapid deployment following reports and verification of an active assailant in the act of using a deadly weapon to seriously injure and kill victims at random. It gives EDs the ability to provide lifesaving PAIs to callers and through specific caller interrogation give all responders—law enforcement, fire, and medical—vital information about what they might expect on scene.

First-party caller (suspect) interrogation is also found on Protocol 109: Bomb/CBRN/Product Contamination Threat, Protocol 121 Mental Disorder (Behavioral Problems), and Protocol 127: Suicidal Person/Attempted Suicide. ●

Sources
4. See note 1.
5. See note 3.
6. See note 3.
SPORTS INJURIES: WHICH PROTOCOLS FIT?
Serious injuries are prevalent among athletes
Josh McFadden

When autumn fills the air, so do the sights and sounds of popular sports. At the high school, college, and professional levels, American football is king in the United States. Starting in late August and continuing into early winter, football brings enormous participation. In February 2014, more than 1 million high school students participated in organized football and more than 14,000 U.S. high schools fielded teams.1

Across the U.S., other fall high school sports include soccer, tennis, and lacrosse. And while the number of participants in these individual sports doesn’t match football, the total high school participation in all sports is estimated at 7.8 million. Year round, the total number of participants aged 6 to 19 playing organized sports in the U.S. is estimated at 45 million.2

While many athletic contests occur without major injuries or incidents, a complete lack of accidents is unavoidable in any sport. In 2012, 135 million people ages 6 to 19 years old suffered sports-related injuries serious enough to send them to the Emergency Department (ED).3 Clearly, sporting incidents keep 911 dispatchers, emergency responders, and ED staff busy.

Types of injuries
Different sports present various incidences of injury. For example, a football player has a much greater chance of suffering a concussion than a tennis player does; a soccer player is more likely than a swimmer to injure an ankle. High-contact sports produce more injuries than low-contact or no-contact activities, though no sport is immune to athletes getting hurt.

Ankle injuries are the most commonly reported sports-related injuries, making up 15 percent of all such incidents. Next up are head injuries at 14 percent, followed by fingers (12 percent), knees (9 percent), and facial injuries (7 percent). Based on 2012 figures, the most common diagnoses for sports-injury ED patients are strains and sprains, with 451,480 such injuries. Fractures are second with 249,500, with contusions next up with 210,640. ED-diagnosed concussions due to playing sports were 163,670 in 2012. Lacerations and dislocations are other commonly ED-diagnosed sports injuries. A total of 11.5 percent of all female athletes seen in the ED are diagnosed with concussions; for boys, the figure for concussions is 7.2 percent.

How they occur
Depending on the sport, serious injuries take place in a number of ways. In football, collisions are common culprits of concussions and other head injuries. In gymnastics and diving, falls can result in broken bones. Heat and cold exposure for outdoor sports such as football, soccer, rugby, lacrosse, skiing, cross-country, and track and field can also cause a number of issues. Exposure to hot temperatures can cause heat cramps, heat exhaustion, and heat stroke. Exposure to extreme cold can cause frostbite and hypothermia. Some of these conditions can be life threatening.

Protocol 30: Traumatic Injuries (Specific)
Protocol 30 is used when “the caller doesn’t follow the norm and describes...
a specific injury." Generally speaking, injuries are a sub-complaint of a mechanism of injury (how the patient was hurt). However, this Protocol is commonly used for sports injuries where the injury itself is the primary complaint, rather than the mechanism.

The first Key Question of Protocol 30 is “Is there any SERIOUS bleeding (spurting or pouring)?” Note that this initial question is asked prior to the Arrest and Unconscious send points. This ensures that this information is available to the EMD, even if the Protocol dictates an early send and go to PDIs.

The DELTA-level codes are appropriate when the patient is in arrest, is unconscious or not alert, or has a chest or neck injury with difficulty breathing. A new DELTA-level code is available in MPDS® v13.0 when there is “Evidence to suggest critical injuries from high-speed/high-impact incidents ...” These cases call for a 30-D-5 Determinant Code, “HIGH VELOCITY impact/MASS injury.”

Key Question 3 and its associated subquestions are important to this Protocol because they help the EMD differentiate POSSIBLY DANGEROUS and NOT DANGEROUS body areas, which helps the EMD select the appropriate Determinant Code. The POSSIBLY DANGEROUS Body Areas are abdomen; amputation (excluding finger/toe); back; chest (breathing normally); genitilia; groin; head (alert); hip/pelvis; leg, upper (obvious deformity); and neck (breathing normally). NOT DANGEROUS Body Areas are ankle; arm, upper*; collar bone (clavicle); elbow*; finger; foot; forearm; hand; knee*; leg, lower; leg, upper (without deformity); shoulder; tailbone (coccyx); toe; and wrist.

Obviously, any of these body areas may be reported to the EMD as a sports injury. If no DELTA-level symptoms are reported, POSSIBLY DANGEROUS body areas should be coded as 30-B-1, while NOT DANGEROUS body areas warrant a 30-A-2 Determinant Code (unless a SERIOUS hemorrhage is reported, which would be coded as 30-B-2). Notable exceptions include NOT DANGEROUS body areas with the assigned asterisk, which notes that those specific body areas should be assigned a 30-A-1 Determinant Code. This allows for local response flexibility.

Two Rules on Protocol 30 could apply to sports-related fractures. First, Rule 2 states: “The head-tilt is the only recognized method of airway control in the PAI dispatch environment. When presented with a TRAUMA patient described as not alert with INEFFECTIVE BREATHING, the EMD should protect life over limb and open the airway.” When serious injuries affect a patient’s ability to breathe, the airway becomes the top priority, second only to scene safety concerns. Second, Rule 4 states: “Direct pressure on the wound should be avoided in the presence of visible fractured bone or foreign objects.”

Compound fractures also occur in organized sporting activities, and these fractures often cause minor bleeding. However, direct pressure on a fractured bone may cause more harm than good; it should not be applied unless bleeding is SERIOUS.

Protocol 20: Heat/Cold Exposure
In early August, high school and college football teams across the U.S. begin what is commonly known as “Fall Camp” to prepare for the upcoming season. A longstanding tradition of these camps is to hold the dreaded “two-a-day” practices. As the name implies, camp players are required to attend two practices held on the same day. These usually take place, sequentially, for a week or two during the month of August, with practices typically held in the morning and then again in the evening.

Two-a-day practices normally include conditioning drills of running sprints, sit-ups and push-ups, and performing various exercises designed to increase stamina and raise fitness levels. In some areas of the U.S., temperatures soar in the 90-degree range, or even into triple digits during these physically draining practices.

If players are not properly hydrated or overheat, they stand a risk of suffering heat exhaustion or even heat stroke, a potentially life-threatening condition. Even well-conditioned athletes must take precautions during intense summertime practices. Four years ago, Yahoo News reported that between 2000 and 2012, 21 college football players collapsed and died during summer conditioning workouts. The New York Times pointed out that during a 20-year period ending in 2001, 40 high school football players died from heat stroke. Six high school football players died in 2011 from practicing in the heat of August and early September.

Heat and cold exposure can threaten life, so it’s critical to treat these matters with seriousness and concern. Protocol 20: Heat/Cold Exposure handles these situations, although a word of caution is advised. Note Axiom 1: “Because a patient has a problem in a hot or cold environment does not mean the problem was caused by the environment. Heat or cold extremes may trigger other medical problems.”

Key Question 1 asks, “Does s/he have chest pain or chest discomfort?” If the caller says “yes,” Protocol 20 immediately shunts the EMD to Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic). Otherwise the Key Questions that follow on Protocol 20 are “Is s/he completely alert (responding properly)?” “Has s/he ever had a heart attack or angina (heart pains)?” “(Not 1st party) Does s/he have a change in skin color?” and “What is her/ his skin temperature?”

If the patient is not alert, you should select the 20-D-1 Determinant Code. If the patient does have a history of heart attack or angina, send 20-C-1. If there is a change in skin color, the Determinant Code is 20-B-1.

If the athlete has suffered heat stroke, he or she will have red, dry skin with a decreased level of consciousness. Heat stroke victims can have temperatures up to 108 degrees or more, which can cause serious damage to the brain and other vital organs. Heat exhaustion, which is
non-life-threatening, will present with cramping, pale skin, sweating, nausea, and vomiting. Heat exhaustion is common among athletes overexerting themselves when it’s hot and humid outside.

When the complaint is heat exposure, PDIs will advise removing the patient from heat sources, removing any outer clothing, and applying cool water to the patient's skin while fanning. The EMD should also advise the caller to turn on a nearby fan or air conditioner, if possible. EMDs should be aware that heat- and cold-related problems can rapidly lead to a decreased level of consciousness, making airway compromise a real possibility.20

While not as common as heat exposure, cold exposure may occur during winter sporting activities conducted outdoors. Hypothermia and frostbite cause as much as 20 percent of all injuries to Nordic skiers and 3-5 percent to mountaineers.11 The frostbite of extremities and systemic hypothermia are of primary concern. The symptoms of cold exposure are similar to heat exposure and involve a change of skin color and, most seriously, a change in level of consciousness. Hypothermia can occur even at 50 or 60 degrees Fahrenheit.22 Treatment includes protection from the environment and a gradual return to normal temperatures.

A notable Rule (2 on Protocol 20) involving cold exposure patients states “Unconscious, non-breathing hypothermia patients should never be considered an OBVIOUS DEATH by dispatch or on-scene personnel and should be initially coded 9-E-1.” This is because extreme cold exposure can slow the body’s metabolism so much that even trained rescuers may be fooled, as Axiom 4 explains: “Hypothermic patients can appear dead, even to trained rescuers. A person isn’t considered actually dead until they are ‘warm and dead.’”

Protocol 6: Breathing Problems

Physically demanding sports where aerobic activity is high, such as in football, basketball, soccer, ice hockey, lacrosse, rugby, cross-country, track and field, and others, can be troubling for participants who suffer from asthma and other breathing conditions. A 2004 study conducted by doctors at St. Joseph’s Hospital for Children in Philadelphia, Pa, showed that over a 7 year period, 61 confirmed asthma deaths in the U.S. occurred on the playing field. Basketball and track were the biggest culprits, but football, swimming, cheerleading, and other activities also had asthma-related fatalities.13

Not only are breathing problems common in sports-related calls to 911, but they are among the most prevalent of all public safety Chief Complaints. As an EMD, you should be aware that, according to Rule 2 of Protocol 6, “Breathing problems are potentially life-threatening until proven otherwise;” and, as Rule 3 states, “A patient having breathing problems may worsen at anytime.”

Along with asthma, emphysema and chronic bronchitis are primary causes of breathing problems. This trio of chronic lung diseases is known as Chronic Obstructive Pulmonary Disease, or COPD. The later two diseases primarily occur in older populations, but asthma affects both young and old alike, making asthma exacerbations, such as episodes of progressively worsening shortness of breath, coughing, wheezing, and chest tightness, a common complaint among young athletes who suffer from the condition. Many athletes with asthma have a prescribed inhaler or nebulizer to help them manage their disease. As such, most asthma patients self-treat prior to seeking emergency help. This fact helps explain why many asthma patients are more likely to be seriously ill by the time they decide to call for help. Rule 5 of Protocol 6 warns, “Asthma patients are usually very experienced in managing their disease. When the status of these patients is reported as ‘Can’t breathe,’ ‘Unable to breathe,’ or a similar description, this should be considered INEFFECTIVE BREATHING.”

In summary

Unfortunately, common to sporting activities are traumatic injuries, metabolic issues due to environmental extremes, and respiratory emergencies primarily due to exacerbations of asthma. Fortunately, the MPDS helps EMDs deal with all of these emergencies with regard to both prioritization and patient care. Protocol 30 classifies traumatic injuries by Priority Symptom, mechanism of injury, and body area affected, and PDIs/PAIs are available for the minor to most seriously injured patients. Protocol 20 deals with environmental extremes encountered during sporting activities and considers potential, underlying medical issues. Protocol 6 helps the EMD deal with exacerbations of asthma among athletes. Familiarity with these protocols will ensure the appropriate care of patients involved in sports-related incidents.

Sources

8. See note 4.
10. See note 4.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Sports Injuries: Which Protocols Fit?” which starts on page 28. Take this quiz for 1.0 CDE unit.

1. What is the estimated number of participants between 6 and 19 years old playing organized sports in the U.S. each year?
   a. 1.35 million
   b. 7.8 million
   c. 45 million
   d. 59 million

2. Head injuries are the most commonly reported sports-related injuries.
   a. true
   b. false

3. In MPDS v13.0, which new Determinant Code is available for high-speed/high-impact incidents on Protocol 30?
   a. 30-D-4, Chest or Neck injury (with difficulty breathing)
   b. 30-D-5, HIGH VELOCITY impact/MASS injury
   c. 30-B-1, POSSIBLY DANGEROUS body area
   d. 30-B-3, Unknown body area (remote patient location)

4. Rule 4 on Protocol 30 states, “Direct pressure on the wound should be __________ in the presence of visible fractured bone or foreign objects.”
   a. considered
   b. applied
   c. lessened
   d. avoided

5. From 2000 to 2012, how many college football players collapsed and died during summer conditioning workouts?
   a. 12
   b. 18
   c. 21
   d. 40

6. When using Protocol 20, which Determinant Code is appropriate if the patient is not alert?
   a. 20-D-1
   b. 20-D-2
   c. 20-C-1
   d. 20-B-2

7. It is impossible for hypothermia to occur at temperatures higher than 50 degrees Fahrenheit.
   a. true
   b. false

8. Unconscious, non-breathing hypothermia patients should never be considered an obvious death and should initially be coded:
   a. 9-E-1
   b. 9-D-1
   c. 20-D-1
   d. 20-B-2

9. Of the sports-related conditions detailed in this article, which is the most prevalent of all Chief Complaints?
   a. traumatic injuries
   b. heat/cold exposure
   c. breathing problems

10. Protocol 30 classifies traumatic injuries by:
    a. Priority Symptom.
    b. mechanism of injury.
    c. body area affected.
    d. all of the above

To be considered for CDE credit, this answer sheet must be received no later than 10/31/17. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
The evening of Oct. 6, 2005, the estranged husband of Lynetta Myrick grabbed the youngest of the couple’s three children from her mother’s arms, threatening to harm the girl before fleeing from their Cincinnati, Ohio, home by foot.

A neighbor hearing Myrick’s scream called 911, providing an address, description of the suspect, and a report of what she had heard in answer to the dispatcher’s questions. Myrick placed a second 911 call on her cellphone, lost the connection, and agreed to the neighbor’s offer to pursue the husband by car. She called again from inside the car, and this time, the dispatcher told her to either pull over or to return to her home and wait for police. Myrick chose the latter.

That was the last time Myrick saw her daughter alive. Two days later, 18-month-old Aliyah was found dead, a victim of blunt force trauma inflicted by her father.*

The girl’s death deeply upset William Hinkle, then-Director of the Hamilton County Department of Communications in greater Cincinnati.

“There was no reason that child should have died,” Hinkle said. “I couldn’t believe it when I listened to the call. It was absolutely the worst call I’ve ever heard.”

Hinkle jumped into action. He scheduled a meeting among staff to review every single policy and procedure affecting the welfare of children. Administrative change, however, wasn’t his incentive. He was out to change the culture of 911 calls involving children endangerment.

“If 911 does anything to excess, it should be to do everything we can to protect children,” said Hinkle, who was later appointed Executive Director of the National Center for Missing and Exploited Children (NCMEC) Call Center Project. “What could be more important?”

Best practices

Whether a family is reporting a missing child or improper contact between an adult and child, usually the first point of communication is a public safety calltaker. To make sure agencies collect all the information they need when a child is in danger, NCMEC in 2007 teamed up with several organizations, including the International Academies of Emergency Dispatch® (IAED™), to produce a guide for emergency dispatch professionals. The publication, Model Policy and Best-Practice Guide for Call-Takers When Handling Calls Pertaining to Missing and Sexually Exploited Children, was released during the summer of 2007.

The document is a reference specifically for emergency calltakers to present the missing and/or sexually exploited child response process in a logical progression from the initial call through the first response. The document
includes guidelines for reports involving abductions and abandonment, and a child who is lost, injured, or otherwise missing. For cases of possible sexual exploitation, it provides questions for a person reporting: child pornography, child sexual molestation, child victims of prostitution, online enticement of children for sexual acts, and a child who may be with an adult companion met on the Internet. (More information about the document appears at the end of this CDE.)

The guide, however, was not the first to address the problem of missing and exploited children. Communication centers using the Police Priority Dispatch System™ (PPDS®) already had guidelines in place to use, and, because of the public served by the PPDS, they go beyond reports of missing and exploited children into protocols that encompass all ages.

This does not diminish the importance of the NCMEC document since the recommended guidelines in the national standards focus on the recovery of missing children and on the consistency in the manner 911 centers handle these cases. But there is a major difference: PPDS is a structured protocol, while the document provides recommended guidelines.

**PPDS Protocols 101 and 123**

The type of emergency, and subsequent applicable protocol, is determined at Case Entry. The caller’s response to the initial questions sends the dispatcher to either Protocol 101: Abduction (Kidnapping)/Custodial Abduction/Hostage Situation or Protocol 123: Missing/Runaway/Found Person, although the actual protocol that applies can change from one to the other as the call progresses and the dispatcher collects more information about the incident.

**Protocol 101**

An abduction is the taking and carrying away of one person by another through force, fraud, or persuasion. It may involve a ransom demand.

On this type of call, the time lapse between the incident and the call is very important. Police will want to set up a perimeter around the area in an effort to keep any vehicles or victim contained, increasing the chances of finding them. That is why the dispatcher needs to find out how much time has passed since the abduction actually happened. A car traveling at 45 mph can cover 2 miles in just three minutes, and another three-quarters of a mile every minute after that. In six minutes, the car may be 4 miles away, making it difficult to set up an effective perimeter. The EPD will also ask about weapons and, if possible from information relayed by the caller, make police aware of the type(s) of weapon(s) involved or mentioned.

If police field units are setting up a perimeter, an accurate description of the car is necessary. When obtaining this description, dispatchers should follow the protocol and use the format described by the acronym CYMBALS (color, year, make/model, body style, additional descriptors, license plate, and state/province). This provides a logical, standardized format for receiving and broadcasting information relating to automobile descriptions.

The caller will also be asked to describe the suspect. Age, gender, and accent can help in identifying the suspect, while EPD questions regarding caller demeanor, background noises, and call delivery can provide vital information about the circumstances. If the suspect is known, such as in cases involving parental custody disputes, the EPD will ask the caller to write down essential information, including the suspect’s phone number and address.

In some cases, a suspected abduction may be reported as a past incident. Many of these calls actually turn out to be missing person calls where the reporting party has surmised that the victim must have been abducted when he or she did not return home on time.

When processing these calls, determining the time lapse between the event and the call will dictate the priority of most of the other actions that are taken.

**Protocol 123**

Protocol 123 identifies cases of those who are missing, without reference to age. The protocol also addresses runaways (the act of intentionally leaving without permission) and found persons (any person who has been located).

The PPDS defines a missing person as someone whose location is not known, but there is no evidence that a criminal act has taken place. Evidence of a criminal act indicates a potential kidnapping/abduction. Those who are categorized as “at-risk” missing persons include very young people, the elderly, and persons with physical or mental conditions that impair their ability to care for themselves or to make sound decisions based on circumstances presented to them. These important identifiers are listed in the Key Questions, which also address the possibility that the missing person could be a runaway.

Found persons are any persons reported to be missing who have been located. Found persons may also be at-risk persons who are noticed by others, even though they have not been reported as missing.

When someone is reported as missing, the chain of events that follows depends on the situation and age of the missing person.

A 3-year-old who has been missing from home for 15 minutes will bring an army of searchers to an area, while a 17-year-old who disappeared after dinner with a suitcase and a $100 bill may be seen as a runaway case.

A 70-year-old Alzheimer’s patient who has been missing for an hour from a nursing home will bring an immediate search, while a husband who hasn’t come home from work by 9 p.m. may not generate such an urgent response. Agency policy, procedure, and protocol will dictate the response to each situation.

A found person call may involve a very young person, an elderly person, or a mentally ill person. These can be difficult calls because the person who has been found may not be able to tell the police where he or she belongs. The EPD may need to contact other agencies, such as social service agencies. Recent missing person reports should also be consulted for cross-reference.
When reporting missing persons, callers should be instructed to find a recent photograph of the person and also to make a list of friends, including addresses and phone numbers, and to write down the person’s favorite places. Callers should also be asked to try to locate the person by looking under the beds, in closets, and other hiding places and to call back if the person is located. For found persons, callers should be instructed to try to keep the person there until officers arrive.

**Missing and exploited children**

Similar to the goals the IAED emphasizes in its training and certification courses, the NCMEC standards document stresses the methodical collection of pertinent information (incident location, callback, and contact information) through systematic inquiry. The document recommends entering all information into an electronic format that can be sent to law enforcement in conjunction with on-air broadcasts.

In a breakdown of the procedures expected of communications personnel, the calltaker is asked to make a preliminary assessment about the level of risk to the missing child based on the questioning. It is also the recommended responsibility of the calltaker to obtain sufficient information from the reporting party to broadcast a radio message that alerts other officers and agencies, if necessary, about the circumstances of the child’s disappearance. Information should include the child’s height, weight, hair and eye color, and clothing, as well as the location where the child was last seen. Most importantly, the radio alert should contain any information known about a possible abductor with special emphasis on the description of the suspect and vehicle used as well as direction of travel.

The calltaker is also asked to search agency records for related information (data mining) to let responding officers know if the child or family had been subject to previous reports that might have bearing on the incident. Calltakers should also gain access to the Sex Offender Registry list to determine whether individuals designated as sexual predators reside, work, or might otherwise be associated with the area.

The guidelines do not replace the AMBER (America’s Missing: Broadcast Emergency Response) Alert program; rather they are meant to help in gathering the information necessary for an appropriate response consistent with agency policy. AMBER Alerts are emergency messages that are broadcast when law enforcement determines that a child has been abducted and is in imminent danger. The broadcasts include information about the child and the abductor, such as physical descriptions, as well as information about the abductor’s vehicle, which could lead to the child’s recovery and the apprehension of the suspect.

**Federal law and missing children**

Federal law requires police to report each case of a missing child under age 21 reported to them to the National Crime Information Center (NCIC). Federal law prohibits police from establishing or maintaining a waiting period before accepting a missing child or unidentified person report. The National Child Search Assistance Act also mandates agencies to:

- Enter, without delay, reports of missing children under age 21 into the state law enforcement system and NCIC and make it available to the state’s Missing Children Information Clearinghouse or other agency designated to get such reports
- Update identifying information on each case in NCIC within 60 days
- Pursue proper investigative and search action
- Maintain a close liaison with NCMEC for the exchange of information and technical assistance in appropriate cases (42 USC §§ 5779 and 5780).

*In a 2–1 decision, an intermediate Ohio appeals court ruled that a city and its 911 dispatcher were not liable for negligence in advising a mother to stop following her estranged husband after he had kidnapped their 18-month old daughter, who he subsequently murdered. The dispatcher did not engage in willful and wanton misconduct in advising the mother to either pull over or to return to her home and wait for police to provide assistance. The city and dispatcher were therefore entitled to governmental immunity.*

**Source:**

Answers to this quiz are found in the article “Staying in the Right Hands,” which starts on page 32. Take this quiz for 1.0 CDE unit.

1. The Model Policy and Best-Practice Guide for Call-Takers When Handling Calls Pertaining to Missing and Sexually Exploited Children provides:
   a. specific, scripted protocol to follow when handling these types of calls.
   b. case studies detailing reports of missing and exploited children.
   c. a reference specifically for emergency calltakers to present the missing and/or sexually exploited child response process in a logical progression from the initial call through the first response.

2. The caller’s response to which section of the PPDS Protocol sends the dispatcher to either Protocol 101 or Protocol 123?
   a. Case Entry
   b. Key Questions
   c. Description Essentials
   d. Determinant Descriptors

3. An abduction is defined as:
   a. a situation in which the location of a person is not known, but there is no evidence that a criminal act has taken place.
   b. the taking and carrying away of one person by another through force, fraud, or persuasion.
   c. situations involving children or an at-risk person unattended and lost.
   d. a request for assistance in an event that is life threatening in nature or where the assistance must be rendered immediately.

4. CYMBALS is an acronym used to provide police with an accurate description of the:
   a. suspect’s characteristics.
   b. victim’s characteristics.
   c. type of weapon involved.
   d. suspect’s vehicle.

5. When processing calls using Protocol 101, which one of the following elements dictates the priority of most of the other actions that are taken?
   a. whether a weapon is involved
   b. contents of ransom note
   c. time lapse between the event and the call
   d. suspect’s vehicle.

6. Very young people, the elderly, and persons with physical or mental conditions that impair their ability to care for themselves or to make sound decisions based on circumstances presented to them are classified under what definition in the PPDS?
   a. "at risk" missing person
   b. special needs individual
   c. runaway
   d. hostage

7. When someone is reported as missing (Protocol 123), the chain of events that follows depends on:
   a. time lapse between the event and the call.
   b. whether a weapon is involved.
   c. the court order in place.
   d. situation and the age of the missing person.

8. For found persons, callers should be instructed to:
   a. tell the person to go home.
   b. notify the closest family member to pick up the individual.
   c. try to keep the person there until officers arrive.
   d. drive the person to public transportation.

9. AMBER Alerts are:
   a. emergency messages that are broadcast when law enforcement determines that a child has been abducted and is in imminent danger.
   b. determined by local policy in the event of ongoing custodial battles.
   c. information relayed to law enforcement when a missing “at risk” individual is sighted by a caller from the general public.
   d. warnings provided by law enforcement when a convicted sex offender has moved into a neighborhood.

10. Federal law allows police to establish or maintain a waiting period before accepting a missing child or unidentified person report.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 10/31/17. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
The memo, composed nearly 35 years ago, supported a hard-fought concept we now take for granted in the state of Utah but have yet to realize across the country and world.

Historically, the process in Utah began with the development of the Medical Priority Dispatch Card System at the Salt Lake City Fire Department, followed by the state-level Emergency Medical Dispatcher training course. While the courses became quite popular at the individual dispatcher level, required training for all dispatchers was adopted initially by only the Salt Lake City Fire Department, Davis County Sheriff’s Office, and Gold Cross Ambulance.

In 1981, we approached the Utah Paramedic Association with a rough plan for statewide standards. With the initial blessing and expertise of Richard L. Warburton, Director, Utah State EMS Bureau, and Jan Buttrey, the Associate Director, a draft of EMD regulations was prepared.

In an early Paramedic Advisory Committee meeting, it was decided that the standards should include all medical dispatchers in Utah, in both ALS and BLS agencies. While only modest resistance came from municipal departments providing ALS, rural law enforcement agencies were incensed. The need was questioned, the economics decried, and the safety of Pre-Arrival Instructions doubted. Dr. Clawson was quickly flown by the EMS Bureau to St. George, Utah, to address the Utah Chief’s of Police Association in a very tense meeting, in which the tide was swayed based on the obvious need to provide pre-arrival instructions statewide.
The State Bureau of EMS held two public hearings, and after a number of administrative delays and political meetings, a compromise version was reached. The regulations then read, “Dispatchers serving medical providers are not required to be certified as EMDs, but are encouraged to voluntarily seek training and certification through a department-approved course” (effective July 1, 1983).

The EMS Regulatory Committee also established an Emergency Medical Dispatch Advisory Board to make recommendations concerning dispatch protocols, training, curriculum, instructor programs, as well as to review all new selective dispatch protocols now required by the regulations.

Over the past three decades, the regulation has gone through several modifications and now (as of July 1, 2016) requires certification, provision of Pre-Arrival Instructions, and ongoing continuing medical education programs and appropriate review and evaluation (Rule R426-2. Emergency Medical Services Provider Designations for Pre-Hospital Providers, Critical Incident Stress Management and Quality Assurance Reviews).

The early phase of the process was one of the most taxing and political struggles that has ever occurred in Utah EMS, and we are grateful for the support of the Utah State EMS Bureau, the Utah Paramedic Association, and prime public service figures at the time such as forward-thinking Salt Lake City Fire Department Chief Peter O. Pederson.

The process is obviously not yet over. The Academy continues to put up the good fight in states, provinces, regions, and entire countries that lack requirements essential to an effective (Academy-worthy) Emergency Medical Dispatch program. Join us in making training, certification, continuing dispatch education, and quality assurance an international reality as we approach the 40th anniversary of Protocol.
COFFEE TO GO, PLEASE
Baby makes debut in coffee shop parking lot

Audrey Fraizer

A stop for a fresh cup of coffee wasn’t part of the schedule for a soon-to-be grandmother and her daughter but, at least, they stopped at a most accommodating shop for the birth of baby Dominick.

The grandmother, Kristie Cardona, and her daughter, Marina Cardona, were driving along a business strip on April 7, 2016, when Kristie Cardona chose the only reasonable action considering the circumstances. She pulled the car off the road and into the parking lot of a Starbucks coffee shop and immediately turned her attention to her daughter in active labor on the passenger side.

“She’s broke her water, and she’s having contractions every minute, so I’m afraid I’m not going to make it there,” Kristie Cardona told Reba Rose, using her cellphone to call 911. “Like, she’s going to pop this baby out.”

Rose is an EMD for the Denver (Colo.) 911 Communication Center. Ever try straddling the console of a car, balancing a cellphone between your shoulder and ear, and, at the same time, positioning yourself for a baby delivery? Fortunately, the potentially awkward scenario was turned around by Starbucks’ barista Rebecca Frisk. Midway through the call, Frisk came to the car, took the phone, and relayed Pre-Arrival Instructions (PAIs) from Rose to Kristie Cardona.

“They did great,” Rose said. “Mom pushed one time really hard and the baby was out.”

Frisk grabbed a clean towel from inside the shop to wrap the baby at about the same time lights-and-siren announced the arrival of paramedics. Mom and baby were transported to the intended destination (St. Joseph’s Hospital) where the new father was waiting.

“He had been there all alone,” Rose said. “The paramedics let him cut the umbilical cord.”

Five weeks after the call, the best was yet to come for Denver 911 Communication Center. Grandmother, mom, and baby were coming for a baby shower, which is a center tradition for babies beginning their entry into the world with a call to 911. As part of that tradition, Dominick and mom received unique keepsakes to support bragging rights to a story they will tell in the years to come: a copy of the 911 call and a “We make special deliveries” blue baby blanket.

“It was quite a celebration,” said Rose, an emergency dispatcher for a little more than 15 years, “They were really happy to meet us. They were grateful I answered the call.”

Rose was awarded the coveted Stork Award for her adherence to the EMD Protocol during Dominick’s birth, earning her a stork pin that she wears proudly on her lanyard, a certificate, a baby blanket, and an engraved name plate on the Stork plaque hanging in the center.

“It’s cool to be on the receiving end,” Rose said. “This shows we make a difference.”

Calls involving children, she said, are among the most memorable and the ones that can test her nerves of steel and ultimately prove the value of the Medical Priority Dispatch System™ (MPDS) in a crisis. Rose has helped deliver three babies since the center went live with protocol four years ago, and, in one of her most memorable calls, she helped save a 3-year-old boy choking on a rubber ball the size of a 25-cent machine gumball.

“The ball wasn’t coming out,” Rose said. “His breathing had stopped.”

Rose initiated PAIs for a child choking. A firefighter arriving on scene moments later reached down the boy’s throat and dislodged the ball. He was intubated and rushed by ambulance to the hospital. Rose visited, giving him a stuffed animal.

“The parents thanked me for saving their child’s life,” she said. “I said it wasn’t me. They followed the instructions. They did what I told them. They saved his life.”
CAREER THAT MEANS SOMETHING
Bright lining comes in helping children and families

Audrey Fraizer

Your questions better be in line and ready to go when talking to Seleta Walker. Boom. Boom. Boom.
She answers one right after the other, barely hesitating to take a breath and, most likely, checking her email alerts while talking on the phone. After giving so many interviews over the years, she can anticipate what the next question will be.

“We are 24/7, four shifts, and we have two offices,” she says. “I’m in the Virginia office but fly to Florida every month. We talk. I take them to lunch. We go over what’s new.”

The 31 years since Walker applied at the National Center for Missing and Exploited Children (NCMEC) in Alexandria, Va., has never put her at a loss for a challenge, a topic for discussion, or a dearth of applicants vying for job openings at NCMEC. The international nonprofit organization was designated by Congress in 1984 in the aftermath of Adam Walsh’s disappearance from a shopping mall in south Florida on July 27, 1981.

Through the untiring efforts of his parents to champion unsolved crimes, the murdered six-year-old became the face for helping to keep children safe and out of the hands of predators, and Walker was keen on becoming involved.

“I wanted a job that meant something,” Walker said.
Walker was fresh out of college when hired in November 1985 as a call center specialist. NCMEC was a year old.
She’s risen through the ranks, eventually becoming the center’s director. Walker seldom has a spare minute.

“I worked Sunday,” she says on a Monday morning before 7 a.m. “Always lots to do.”

Walker directs 24 calltakers in the Virginia office and five more in the Florida office. The second call center was planned as a backup, in case of an emergency that interrupts power in the office outside the capital city. A missed hour in the communication center can translate into 20 missed calls from anxious parents, people providing tips that could bring a child home, and reports of cyber sites sexually exploiting infants, toddlers, pre-teens, and teens.

“We get 500 calls at a minimum each day,” Walker said.
Calltakers use a first response call intake checklist to identify all the information that needs to be obtained. The information is entered into a database using forms relevant to the situation—such as a missing child—that are filled out, prioritized, and placed into the NCMEC network. Each case is numbered, catalogued, followed up on, and remains active until resolution. They never give up searching for anyone.

Walker receives up to 400 applicants for each opening. She chooses candidates based on education (college degree required), proficiency in speaking a foreign language (not required but highly desired), and her sense of the candidate’s resiliency. She meets one-on-one with select candidates to get a sense of a “tough mind,” a professional who can listen and emotionally handle the potentially harrowing calls and persevere during six weeks of intensive training, no matter how similarly related to previous job experience.

“We need to have someone fresh—someone who will learn our system,” she said. “We can’t afford a mistake.”
Walker said they hear plenty of devastating stories, but there’s also the bright linings of the children and families they help. While she’s been party to many successful outcomes, the day Carlina “Netty” White went missing—Aug. 4, 1987—stands most firmly in her memory.

“She was a newborn when she was abducted from a New York hospital, and I had just had a baby, too,” Walker wrote on NCMEC’s Facebook page in celebration of her 30th year at NCMEC. “I couldn’t imagine her parents’ pain. We took so many leads, and nothing panned out … until the day we got the call from a young woman who believed she was a missing child named Carlina White. Once DNA testing confirmed that the girl was Carlina, it was one of the happiest days of my career. And the second happiest was when Carlina came to visit NCMEC and I got to meet her! She is an inspiration.

“If you can help one single person each day, it is rewarding to come to work,” Walker wrote in the same post. “After 30 years, I look forward to more recoveries and reunifications. That’s what keeps me going.”
LEAVE THOSE GHOSTS ALONE
Supernatural lays claim to gold mining history

Audrey Fraizer

There are a few things about the Cripple Creek Police Department you don’t need to see to believe. The two-story police department once housed a grocery store on the first floor and a brothel on the second. The brick building, dating back to the turn of the 20th century, can be unsettling, particularly at night, when it’s dark, and the quiet amplifies sounds that might go undetected during the day.

“When you are here by yourself at night, things happen,” ED-Q™ Jesse Avery said. “We hear chairs moving across the floor upstairs. We hear voices. Phones dial themselves.”

Dispatch Supervisor Diann Pritchard said they hear someone coming down the hall toward the communication center, look to see who it is, and don’t see anyone there. The water runs from the faucets no matter how many times they turn them off.

“It’s more than just being an old building,” Pritchard said. “But I figure if they don’t bother me, I’m not going to bother them.”

Dispatch Supervisor Diann Pritchard said they hear someone coming down the hall toward the communication center, look to see who it is, and don’t see anyone there. The water runs from the faucets no matter how many times they turn them off.

Ghosts have good reason to stay in Cripple Creek, a town 45 miles west of Colorado Springs on the eastern slope of Pikes Peak. There is still gold in those hills. In 2014, surface-mining operations at Cripple Creek produced 210,921 ounces of gold.

Geological origins of the mined gold is up to speculation. History shows a big strike was made, word spread, and the gold fever took hold. From 1890 to 1910, 22.4 million ounces of gold were produced in Cripple Creek and made millionaires out of 30 prospectors.

Things changed after World War II. Gold prices fell, and the industry died, turning Cripple Creek into a ghost town haunted by its well-heeled and raucous past. Mining was left to a new sort of prospector. In 1948, Wayne and Dorothy Mackin took over Cripple Creek’s once-famous Imperial Hotel and turned it into a tourist destination.3 George Long, the hotel’s owner at the turn of the 20th century, is said to appear in spectral fashion to flirt with female guests.

The Cripple Creek Police Department and the Imperial Hotel, however, aren’t the sole proprietors of the past. The Fairley Brothers and Lampman Building at 300 East Bennett Ave. houses a casino and restaurant, and customers have sworn they’ve heard the clicking tap of high-heeled boots echoing on the wood floors of the turn of the century establishment. Maggie, as she’s called, is consistently seen wearing a shirtwaist and skirt complementing the era of the boots with her hair piled on top of her head. She leaves behind a scent of rose perfume.

Stinky at Hotel St. Nicholas is not so sweet smelling. He lurks at a back staircase leading into the former hospital, psychiatric ward, and convent, trailed by a distinctive smell of sewage.

The ghosts of Cripple Creek lore place the town among the country’s most haunted paranormal destinations. Travel Channel’s Ghost Adventures televised a paranormal search at two sites in Cripple Creek, and Mountain Peak Paranormal Investigations detected paranormal activity at the museum once serving as the territorial jail.

The reason to stay in Cripple Creek, however, is more than the gold rush history, ghosts, and even the spectacular scenery in the mountains at the base of Pikes Peak. Pritchard’s not a “city girl,” never wanted to be one, and wouldn’t know what to do if she were one.

“We know our neighbors,” Pritchard said. “We have a small town goodness about us.”

Editor’s Note: Read the serious side of the Cripple Creek Police Department communication center and its ACE achievement in the November/December issue of the Journal.

Sources
4. See note 3.
5. See note 3.
What could be more important than protecting our children?

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

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

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

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


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

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

CEO Overview Course

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

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