Much more than just a dispatcher
Dispatchers are placing greater emphasis on promoting their careers and generating interest in people entering the workforce.
Mary is with the Washington State Patrol where, for the past 10-plus years, she has worked as a dispatcher, chief training officer, supervisor, and training program supervisor. She is certified by the International Association of Chiefs of Police as a Leadership in Police Organizations instructor. She is also a certified instructor for the Washington Criminal Justice Training Commission.

Ryan is the Communications Specialist for the 911 Wellness Foundation, a nonprofit working to optimize the overall health and well-being of emergency dispatchers. Ryan is a former Police Communications Operator and currently serves as an Adjunct Instructor at the Golden West College Criminal Justice Training Center in Southern California.

Art 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.

Patrick is the Public Information Officer for the City of Corvallis, Ore. With a background in journalism and government communications, he manages the city’s official communications, from press outreach, to emergency communications, to social media.

Sherri is the training and operations manager for Waukesha County Communications, Wis., a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.
If we had to sum up all the great new content in the November/December issue of the Journal into two words, we couldn’t. But if we were to pull out some of the predominant themes, I’d have to say they would include promoting emergency dispatch as a career and bringing more international flair—here’s looking at you, Canada—to our Journal coverage.

The final Journal edition of 2016 kicks off with a tremendous feature by Managing Editor Audrey Fraizer about the changing landscape of emergency dispatch as a career focus rather than simply being the fallback position when candidates fail the firefighter physical, for example. Now, more than ever, young people entering the workforce are looking at emergency communications as a destination rather than a detour.

There’s a terrific Medical CDE by Senior Editor Josh McFadden that takes a look at MPDS® Protocol 11: Choking by presenting several scenarios in which children are the patients. You can also read a Fire CDE by Audrey about how recent American national fire standards are reconfirming the importance and effectiveness of the FPDS® Protocol.

In a Canadian twin bill, we have a Center Piece on the communications center in Red Deer, Alberta, Canada, and an ACE Achiever piece on Urgences-Santé in Montreal, Canada, which also debuted its state-of-the-art new facility earlier this year.

We’ve got some cool new Your Space stories, including one about a Corvallis, Ore., USA, EMD who uses the MPDS’ hands-on-chest compression PAs to help a wife and her two sons save her husband and their father. From the dispatcher, to the family, to the state of the EMS process did its job to save a life.

Finally, there’s also a great new FAQ coming your way, some interesting findings about the Stroke Diagnostic Tool in Academy Research, an insightful Technically Speaking about the ProQA® override feature by Art Braunschweiger, and, as always, plenty of great columns from our experienced contributors. Check out the new issue—in print and online (at iaedjournal.org for bonus content)—and let us know your thoughts. As always, pass along stories ideas to editor@emergencydispatch.org.
DEAR READER

WHEN PANIC SETS IN
Someone is there
Heather Darata

It felt like Friday the 13th. A strange, unwanted experience haunted me that Friday morning in July. I was moving quickly to catch my usual morning train, and in my haste I ticked off the driver of the Chevy Silverado pickup truck with the out-of-state plates not moving my speed in my neighborhood.

Passing him when he got to the final speed bump on our way out of the complex didn’t sit well with him. When he honked, I figured that would be his only way of showing his displeasure. It was far from it.

About a minute later, I saw him passing me on the two-lane secondary road I was gunning down. I was alarmed when he swerved back over in front of me and slammed on his brakes. I almost didn’t stop in time, but I managed to avoid hitting him. When he didn’t move and we both sat there just before the intersection we were going toward (I'm pretty sure he did that intentionally to upset me), I decided to cut through the retail development to get to the main road.

As I made an abrupt right turn and drove away from the truck, I hoped to never see him again. Unfortunately, that wasn’t the case. He passed me on the main road just as I was about to turn out of the parking lot onto the main road. Snap! The look on his face was killer. I could only hope we could put the whole incident behind us now.

Nope. As I passed him in the middle lane, he stretched his arm out his window to flip me off. Then he switched lanes so he could pull up behind me. I glanced in my rearview mirror and noticed a wedding ring and a woman in the passenger seat. I wonder if she hoped that she could become invisible as she looked down.

For the next mile, he was never too far from me. When we merged with another lane a few signals later, I got a break. Then I switched lanes again and made a U-turn. To my half astonishment and happy surprise, he didn’t follow me. I kept a close eye as I swung into the train parking lot, parked, and ran to make my train. He wasn’t in sight. It was finally over.

It dawned on me that as panic set in while I experienced the worst road rage incident I’ve been involved in, my brain sent up a flare with the help I needed. My brain told me not to pull over or park if Mr. Road Rage was still following me. I’ve heard some scary reports of people being beaten or shot after pulling over—sometimes after getting out of their vehicle.

I also had it in my mind to call 911 if he kept following me or engaged in other dangerous behavior. And that’s where you and the protocol would have come into play. I wouldn’t need to rely on myself any longer to know what to do in that situation because you would walk me through it while sending help my way. That’s just what someone needs when fear and panic set in—a calm voice that cares. ●
YOUR BRAIN ON DISPATCH
Roller coaster can tip the scale of efficiency
Mary Ransier

Research shows that the oldest part of the brain, known as the reptilian brain, is where most of the functions of the autonomic nervous system take place—the actions that keep you alive without you needing to think about them consciously, like breathing or regulating heartbeat. It is where the autonomic nervous system breaks down into the sympathetic and parasympathetic nervous systems, the yin and yang creating balance in your body.

The sympathetic nervous system allocates resources and energy; it dumps a cocktail of adrenaline, cortisol, and other hormones into the bloodstream to ready the body for challenge. Although the sympathetic nervous system and stress response were tools saving our ancestors from dangers like big saber-toothed tigers, the tools can have an adverse effect in today’s world. Humans can actually think themselves into the stress response.

The parasympathetic nervous system helps the body recuperate once the perceived “danger” is passed. Recuperation can depend upon the amount of chemicals and hormones dumped into the bloodstream. The response can range from shutdown for maintenance to jitters and the urge to exercise to burn off the residual adrenaline.

Because dispatch involves constant emergency, the body and brain lack the time for scheduled maintenance and rest, and, in turn, the continuous cycling and surges in adrenaline and other hormones have detrimental effects to health and well-being.

When the brain shuts down, dispatchers can experience tunnel vision and a phenomenon called “auditory exclusion.” This sensory breakdown can alter the individual’s ability to multitask and/or perform all the job functions needed during a critical incident. The autonomic, reptilian part of the brain prepares for possible blood loss to limbs by shunting blood away from those areas and to important organs. In a process called vasoconstriction, the blood moves away from the surface and extremities, which includes draining blood from the neocortex, where rational thought occurs.

The sedentary nature of a dispatcher’s job combined with the inability to fight, flight, or freeze and burn off the chemical cocktail can lead to high levels of exhaustion.

According to retired U.S. Army Lt. Col. Dave Grossman, whose current work specializes in the psychology of killing and ways to reduce violence in society, “The midbrain is in charge, and you’ll do what you’ve trained to do—no more, no less. You will do what you’ve been programmed to do—no more, no less.”

If a dispatcher gets to this point and lacks adequate training, there’s a high probability of the stress response taking over and causing the dispatcher to either freeze up or physically push away from the console.

How are we as trainers, supervisors, managers, peers, and organizations, going to deal with the physical reaction to stress? Do we tell our employees to “Suck it up buttercup” and hope they can weather the storm? Or do we shed light on this cockroach known as stress and watch it skitter away into the dark by equipping our dispatchers with what they need?

Being a good dispatcher is not an absence of fear. Rather it is the ability to control fear and learn effective ways to cope. Coming into this field and knowing how the brain works and the physiological outcomes under stress can help prevent crippling self-doubt, freezing, or fear from taking over in the moment. According to Grossman, “We can educate people after the event, to help them understand and heal, but it’s much better to do it beforehand. We want a vaccine, not penicillin. Forewarned is forearmed. If you are warned that these things will happen to you [your body] they won’t blindside you.”

Sources
3. See note 2.
The Academy’s release of a new feature in protocol is the beginning of yet another avenue for further research. Take the Stroke Diagnostic Tool (SDxT) in Medical Priority Dispatch System™ (MPDS®) Protocol 28 (Stroke [CVA]/Transient Ischemic Attack [TIA]), for example.

Research specific to the SDxT, conducted by the Academy’s research team, analyzed stroke data from three sources collected using MPDS v12.2 in the software engine ProQA®. The study was conducted to assess the SDxT’s effectiveness, with the ultimate goal being to identify strokes promptly and accurately. The SDxT also provides pertinent information that comm. centers could use, according to local policy, for early notification of an incoming stroke patient to stroke center personnel for timely treatment and administration of tissue plasminogen activator—a drug designed to work by dissolving the clot responsible for the stroke and improving blood flow to the part of the brain being deprived of oxygen.

The three sources released data from the point of dispatch, allowing the Academy’s research team to determine the sensitivity, specificity, and predictive values of the SDxT. Study results were generated by comparing SDxT findings with both the EMS responder findings on scene and final hospital discharge diagnosis.

Specifically, the study matched hospital-confirmed stroke cases with EMS-identified strokes and dispatch records cases collected between January 2011 and December 2013 and dispatch records between June 2012 and December 2013 (the SDxT was released in 2012). Of the 830 stroke cases identified during the overlapping time periods, 603 (72.7 percent) had dispatch records that matched EMS findings on arrival. Slightly more than 50 percent (304 out of the 603 recorded) had been handled using MPDS Protocol 28.

According to study results, the SDxT had an 86.4 percent ability to effectively identify strokes among all the hospital-confirmed cases (sensitivity), and a 26.6 percent ability to effectively identify non-strokes among all the hospital-confirmed non-stroke cases (specificity).

There were also a number of strokes, identified in EMS, where the SDxT was not used. For example, while stroke might be the underlying cause of other situations or conditions, the EMD’s immediate attention would focus on a protocol other than Protocol 28 to stabilize the patient for transport. However, the high sensitivity of the SDxT could make it ideal for identifying potential stroke patients coded using Protocol 26: Sick Person or Protocol 17: Falls due to reported stroke-like symptoms.

An EMD can start the SDxT in response to patient answers to six symptoms listed in Key Question 3 in Protocol 28, which the EMD selects for the conscious and breathing patient and when the caller initially reports “stroke” or the sudden onset of one or more of the symptoms. Once the tool is activated, the EMD asks the patient (or, more likely, a second-party caller) to perform three actions in a quick test to identify CLEAR, STRONG, PARTIAL, or No evidence of a stroke, as quantified by the patient’s ability to perform the three tasks on SDxT (smile, raise both arms above head, and say, “The early bird catches the worm”).

The numerical value indicating level or absence of stroke can be sent automatically to EMS responders or directly to hospitals as units begin response. The SDxT automatically presents on the computer screen during the questioning sequence of Protocol 28. The EMD has the option of manually selecting the SDxT when using a protocol other than 28, although, in the data analyzed, the option is rarely exercised.

The study led to two interesting and mutually inclusive results. First, findings showed that the SDxT has a high sensitivity in identifying strokes, confirming its value for early recognition strokes and providing early hospital notification. Second, research determined that expanding dispatcher use of the SDxT to include cases within Sick Person and Falls would likely improve its sensitivity even more.
As a child, did you always dream of becoming a 911 dispatcher? Not me! For the longest time, I wanted to be a veterinarian. Then a hairdresser. Then a cop. I became a cop, then figured out I was much more effective on the other side of the radio—safe inside the climate-controlled environment of dispatch. I grew to love it. It became my calling.

It’s probably safe to say that most of you, when youngsters, never really thought about pursuing a public safety dispatch career. Many of us sort of “fell” into this dispatching thing. Some of us may have seen an ad in the newspaper or on a bulletin board that piqued our interest. Others may have had some exposure to the dispatch profession because of involvement in other public safety professions. That’s OK. We’re here now, and we have a unique opportunity to introduce public safety communications as a profession, as a special “calling” that motivates us to reach out to the younger generation.

So how can we support this growth? Consider the following acronym and use these ideas to help ADVANCE our profession!

 Advocate training, standards, and protocols. Join groups, write about your experience, and offer to help educate your agency partners.

 Dedicate your time and talents to help make a difference.

 Start a Vocation foundation to promote dispatching by starting a “sit-in” program. Create an interest in the dispatch profession among high school students and other career-seekers by taking a lesson from the police and fire department explorer post programs across the nation.

 Focus on Attitude and adjust if necessary. One negative attitude can be a cancer to the entire staff. Adopt a “believe or leave” philosophy. Mission, vision, and values are critical; make sure you identify and document those in your own center.

 Nurture the new employees in your organization. Successful trainees often make tremendous contributions by spreading the word that your organization is a great one to work for.

 Focus on a Community education team. If your agency doesn’t have one, get started. Put a display together and purchase items to give away at safety fairs, schools, nursing homes, service organization meetings, national night outs, and pancake breakfasts. Teach people about 911 and emergency medical, fire, and police dispatching.

 Excellence is something to strive for. Plan for it. Train to it. Always.

 Recently, we hosted special visitors in our dispatch center. Eliza and Sadie Grace are nieces to Alison Lesch, who works in our center. We gave them a tour, introduced them to the dispatchers, gave them treats, and watched as they listened in awe to the radio traffic in the background. They were all smiles.

 Their interest brought an immense joy to the dispatchers. It was clear that they were as impressed as young children could ever be, but we never knew the incredible impact the visit had on them until the next week when Alison reported that her sister said the girls were absolutely driving her crazy with constant requests to “play dispatcher.”

 Inspired by their enthusiasm, we found two headsets beyond fixing and sent them home with Alison for the girls. The picture above is a result of that simple gift.

 I’m glad our path has led us here. I am proud to serve and support the public safety family. We share a unique responsibility and purpose as we seek to promote and advance this incredibly important profession. Let’s continue to ignite the sparks of interest we see in our younger generation, like those we have seen lit in the eyes of children like Sadie and Eliza. They are our promise and our future.
For nearly 10 years, I worked in a police dispatch communication center answering 911 emergency calls. I have heard it all. It came to a point when nothing callers would say surprised me. But then again, just when I thought I had heard it all, a caller would request police assistance for the most absurd reasons that my creative imagination could not even begin to fathom. I could not make this stuff up if I tried.

As a result, many of my friends (outside of law enforcement) thought it was really cool when I ran in their social circles. They would introduce me to their friends saying something like, “This is my friend Ryan, and you’ll never guess what his job is!” The game would begin with them thinking of the most bizarre profession I might have: Do you work with tigers at the zoo? Are you a gigolo? You do movie stunts? Are you in Blue Man Group? Are you with the FBI or CIA? You could tell us but then you’d have to kill us? Backup singer for Justin Bieber?

Many were amused when I said I worked as a 911 dispatcher. They had never met a “real-life” dispatcher before, and they would ask me this: “What do you love most about being a 911 dispatcher?”

Interesting question, especially coming from people who seconds earlier thought I might be an undercover spy posing as a gigolo who trained tigers for movie stunts starring Blue Man Group while moonlighting as a backup vocalist on the Bieber “Fever” tour. My answer to them: “people.”

And I loved it most when I got to interact with people in person, not over the phone. I always jumped at the opportunity to be involved in community events. National Night Out, school assemblies, Tip-A-Cop, giving tours and explaining operations of the communication center, presenting at the citizen’s academy, and the annual Project 999 Memorial Ride were the best times of my career. I didn’t want awards. I didn’t want a promotion. I wanted to meet people and represent my agency because I took pride in the work we did.

I loved talking to people, telling them all about my job, explaining the 911 emergency system to them, and educating them with information I believed might improve their quality of life.

I saw priceless smiles on the faces of children as McGruff the Crime Dog danced in a school auditorium teaching them about when to call 911. I met the parents and families of several children we publicly recognized as “911 Heroes” with official awards. I met a homeless Vietnam War veteran in a wheelchair who recognized my name on my uniform after he called 911 from a payphone in the rain because he had nowhere to stay. A partner and I played pivotal roles in the investigation and arrests of several suspects who intentionally and maliciously misused the 911 emergency system to harass dispatchers and drain police resources for unfounded reports.

As a dispatcher, I was a critical component of the community-oriented and problem-solving policing philosophies that were the foundation to the mission of my agency. Never did I feel like I was “just a dispatcher,” good only for talking on a phone and typing on a computer. I had a problem-solving, life-changing, working dispatcher’s Ph.D.

It was people who kept me coming back to the job. Sure, I have exciting stories, but they don’t compare to the satisfaction and enjoyment of meeting and talking to people, hoping to show them that dispatchers and police officers are ordinary people who do extraordinary things to serve others.

What did I love most about being a 911 dispatcher? My answer remains, “people.”

Editor’s Note: This article was originally published at http://operation108.com/loved-911-dispatcher/ on Ryan’s blog, “Operation 10-8.”
GREEN VS. YELLOW

The override feature in ProQA

Art Braunschweiger

In ProQA®, the Send screen appears when enough Key Questions have been answered to identify the appropriate Determinant Code. That code is highlighted in green. Selecting a code highlighted in yellow, if available, allows the calltaker to override to a higher Determinant Level. When not on the Send screen, an override code is available anytime the up/down arrows on the Reconfigure Response button appear in yellow. This button will bring the calltaker back to the Send screen where an override can be selected.

In ProQA training classes for Priority Dispatch®, I typically ask the dispatchers attending whether their agency policy permits them to do this. The answer is invariably “no,” often accompanied by a look that suggests I’ve proposed something heretical.

Many agencies aren’t comfortable giving their dispatchers the ability to override and require the calltaker to send the code that ProQA presents. Common rationale is that taking the subjectivity out of the decision is one of the reasons that they’ve adopted ProQA in the first place. But there’s an important point that needs to be clarified. As International Academies of Emergency Dispatch® (IAED™) then-Board of Accreditation Chair Brian Dale noted in a session at NAVIGATOR 2014 in Orlando, Fla., “ProQA does not recommend anything. ProQA presents the most likely Determinant Code based on the Key Question answers that have been selected.” That may seem like mere semantics, but it’s not. ProQA can’t recommend who or what should respond to your call, because it can’t possibly know your local resources and their capabilities. For that reason, the override feature in ProQA is only intended to be used when the calltaker does not believe the resources dispatched will be adequate to assess or care for the patient. Such a decision might be based on the patient’s condition or the circumstances surrounding the call. This capability ensures that the needs of the patient will be met, even if a determining factor exists that ProQA doesn’t capture.

Given ProQA’s proven accuracy in coding, overrides should be far and few between. They can be further limited by an agency and its medical director taking steps to ensure the appropriate resources are matched to each Determinant Code. Authority to override the ProQA code highlighted in green must be approved and defined by agency policy and medical control. To have override authority, calltakers should have in-depth knowledge of local resources and their capabilities.

Calltakers should be required to document the reason for overriding, and overridden calls should be reviewed by the Quality Improvement Unit and, if necessary, the medical director. (The Determinant Code resulting from an override can be readily identified by a zero as the final number, as in 10-C-0.) Protocols are based only on probabilities, and nothing can replace the human brain. Unusual circumstances do occur from time to time when an override might be appropriate. Therefore, overrides shouldn’t be automatically consigned to the “forbidden zone” but rather given due consideration for approval within very specific guidelines. You never know, it just might save a life.

Source
PROTOCOL 4 AND WEAPONS

Does Assault Protocol apply to Taser use?

Brett Patterson

Brett:

If law enforcement uses a Taser on a patient, does the call have to be coded under Medical Priority Dispatch System™ (MPDS®) v13.0, Protocol 4: Assault/Sexual Assault/Stun Gun?  
Lt. Audrey V. Boyd, RPL  
Communications Coordinator  
Greenville County EMS  
Greenville, S.C., USA

Hi Audrey:

The short answer is yes, and here’s why.

Note that in v13.0, the word “Concurrent” was removed from all “Problem Suffixes” sections of Additional Information Cards.

In an early version of the MPDS, the suffixes were limited to situations concurrent to the primary Chief Complaint Protocol. However, as the MPDS evolved, the suffixes expanded to include additional complaints, often not directly associated with the primary title of the protocol. For instance, while the “I = Injection administered ...” or “M = Medication administered ...” suffixes of Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites) are concurrent, meaning they are associated with allergies, the “E = Explosion” suffix of Protocol 7: Burns (Scalds)/Explosion (Blast) may serve as a Chief Complaint not associated with burns, and serves to note a specific complaint on this protocol. These are two of several examples in the MPDS.

So while the “T = Stun gun” suffix resides on Protocol 4, it may or may not be associated with an assault. Note that the title of Protocol 4 includes Stun gun, which may serve as a primary complaint not associated with an actual assault. Note that there is a separate suffix for assault. This is important for responders to know, as the code does not imply that an officer assaulted anyone; it simply notes that a Stun gun injury is associated with the Chief Complaint.

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

Good morning Brett:

I’m a nurse, and I work at an emergency dispatch center of the Lombardy Region, Italy. We have a great center that serves 25 million residents with a volume of about 400–500 ambulance responses a day. I consider your Academy among the best in the profession, and I would like you to answer the following question:

The dispatch system provides variability in the symptom “nausea/vomiting” to assess how crucial the
symptom’s role is in diagnosing myocardial infarction (MI) (e.g., chest pain score) in the corollary of patients where MI is suspected.

I did a search, and among the most significant documents I found was a systematic review of the literature (Panju AA, Hemmelgarn BR, Guyatt GH, Simel DL. “Is this patient having a myocardial infarction?” JAMA. 1998; 280 (14): 1256–1263). The study compared the association between clinical data and diagnosis of acute myocardial infarction expressed statistically in terms of the most powerful features that increase the probability of MI, and their associated likelihood ratios.

What is your opinion?

Umberto Piccolo
118 Soccorso Sanitario
Lombardy Region, Italy

Ciao, Umberto:
The standard MPDS does not contain a nausea/vomiting question or response code in the Chest Pain Protocol. However, this question, and associated code, was added to the U.K. version of the MPDS as an approved, cultural variation at the request of the National Health Service there. We have collected cardiac arrest frequency data on this code for several years and have not found this symptom to be a significant acuity indicator in the dispatch environment. Therefore, we have not added it to the standard MPDS, and we have recommended its removal in the U.K. version. For example, a recent sample of 4,105 chest pain calls coded with this symptom contained only one cardiac arrest (Cardiac Arrest Quotient [CAQ] = .02 percent), versus the Chest Pain Not alert code which has a CAQ of 2.4 percent.

Thank you for your interest in the MPDS and for reading our professional Journal. You may also be interested in our peer-reviewed journal, Annals of Emergency Dispatch & Response. Visit aedjournal.org to get more information.

Brett

Hi Brett:
I have a question regarding a fairly unique call.

The caller was a pilot operating an aircraft for a sky diving school. One of his tandem teams had just exited the aircraft for decent. Upon deplaning, the pack of the tandem jumpers snagged and caught on the bottom of the aircraft, holding them in place without the ability to release the chute nor detach from the craft.

In this scenario, my EFD training tells me this would be considered an aircraft emergency; however, within EMD, how would we code this event? Would it fall under the 22 card as entrapment or would it fall under a 29-D-5a, pinned and aircraft involved? The outcome of this call was positive, as the jumpers did free themselves and landed uninjured.

Looking for some guidance on this one.

Thanks, as always.

Darren de Boer
Emergency Communications Officer
Central Communications Centre
Edmonton, Alberta, Canada

Darren:
Wow! That IS a unique call.
At first blush, Protocol 22: Inaccessible Incident/Other

Entrapments (Non-Traffic) seems appropriate in the Medical Protocol, as it really doesn’t fit what we would normally consider an aircraft accident. However, this call is more about resources when considering an emergency landing, and 29-D-1a may have a more appropriate response assigned locally. Either way, this is a tough call for the EMD to make on the spot. Let’s see what my firefighter/paramedic friend, PDC™ consultant, and ED-Q™ expert has to say.

Ross?

Brett

Darren:
Very interesting. This is an EFD call because you really have no patient as long as they are in the air. So if you dispatched resources to a landing spot, EFD would be the first choice for resources based on the size of the aircraft and how many other people are inside still (did all of the other jumpers get out?) because this would seem like a difficult landing if they were to try. If all you had were EMD Protocols, then a 29-D-1 would best fit the scenario.

Ross Rutschman
Who will answer the first call and, when the call is answered, will all systems be a go? Those were the questions posed in a three-minute, 36-second video produced to mark the opening of the Urgences-santé new emergency communication center in Montréal, Québec, Canada. Staff walk through new doors and step into an unfamiliar but inviting new environment. Supervisors, dispatchers, and administrators stand poised on the floor of the center watching and waiting for the first call to come in.

At 4:18 a.m. on Feb. 16, 2016, EMD Bénédicte Lévesque-Royer answers what they were anticipating, reaching the major milestone they had anxiously anticipated. “The call represents a historic moment,” said Vincent Brouillard, Supervisor of Operations, Urgences-santé, during a later interview. “The milestone was reached during our live transfer of operations from the old to the new center.”

Lévesque-Royer, an EMD of one year in June 2016, said she was surprised to take the first call, their first day, and when so many other people were on duty. Even more amazing, she said, is the “beautiful” center, the camaraderie, and her good fortune at finding what she likes to do and plans to do far into the future. “I love the callers,” Lévesque-Royer said. “They are all amazing people. They all have different ways of communicating. Some are sad, some are stressed out, and some are calm. I like their emotions and being able to help them.”

The call Lévesque-Royer answered that memorable early morning was from an 85-year-old woman who could not move because of generalized pain. Lévesque-Royer coded the call 26-A-08 and forwarded it to dispatch. The woman will most likely never know the role she played in history.

The calltakers in the video are ecstatic, clapping hands, giving high-fives, and smiling. The video ends on a happy note: The launch was successful, without skipping a beat.

The process completed over a six-hour period resulted in the safe and reliable transfer of calltaking and dispatching operations without interruption of service to patients, Brouillard said, and was supported by a huge team effort. The organization knew ahead of time to coordinate the move and the transfer of services. The logistics of moving people and making sure the new setting met its requirements was not an easy task.

Moving was more than packing boxes. A master plan and calendars were prepared to facilitate the “live transfer,” keeping staff informed in advance about any alterations to the plan. The move didn’t stop at the “live transfer” date. For the employees, it meant changes in radio technology, telephone console configuration, adaptation to a new environment, and revisions in their transportation and routes to and from work.

And no matter how busy or stressed, the team kept the high spirits going. “This was a major project and a big deal for our organization,” Brouillard said. “And it’s all been good. Everyone came together to make the transition as smooth as possible.”

Urgences-santé implemented the Medical Priority Dispatch System™ (MPDS®) in 1991 and was among the Academy’s first Accredited Centers of Excellence (April 1995). IAED™ Consultant Marie Leroux, RN, was a supervisor-instructor in Montréal’s EMS communications system, when, in 1997, she was inducted into the Academy’s College of Fellows for reasons including her involvement in bringing MPDS to the attention of Québec’s Ministry of Health.

The move to a larger, modern center was a huge occasion, said Leroux, who along with IAED General Counsel Brent Hawkins attended an Urgences-santé event held on May 24 during Canadian EMS Week, among
an enthusiastic crowd (of “who’s who”) in Québec’s health care system.

“They are passionate about the work they do and the services they provide,” Leroux said. “The new center reflects how deeply they care about the people of Québec.”

Hawkins was impressed by the culture built around use of the MPDS.

“It’s institutionalized, part of their way of thinking in an emergency,” he said. “They are big fans of the Academy and applauded Marie and me during the formal presentation. This was great to experience on such a large scale.”

The center replaces the former space at Urgences-santé headquarters where they had been since 1993 and could no longer accommodate either an anticipated increase in personnel or changes in technology. The 5,802-square-foot interior accommodates 35 workstations (28 operational at opening) for the 105 employees scheduled on three shifts. Each day, an average of 50–55 EMDs are assisted by Interfacility Transport Agents (ITAs).

EMDs and ITAs are complemented by a team of clinical online support to paramedics, trainers responsible for quality assurance and EMD continuing medical education. Supervisor of operations on all shifts oversees all staff and a battalion chief supervises the chain of prehospital response.

**Urgences-santé**

Urgences-santé is the sole public organization of prehospital emergency services in the province of Quebec for the islands of Montréal and Laval. Urgences-santé covers 2.4 million people, and handles an annual average of 375,000 calls, which represents more than a third of all Quebec medical emergency calls.

The Urgences-santé fleet of 154 ambulances and specialized units are deployed from two centers in Montréal and one in Laval. During peak hours, there are more than 100 ambulances on the road.

Urgences-santé falls under the direction of Quebec’s Ministry of Health and Social Services and is the largest of 10 communication centers serving the province.

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**Sources**

HAPPENING CENTER

Red Deer ramps up for the future

Audrey Fraizer

Cindy Sparrow will be the first to tell you. She looks forward to walking across the stage during the Opening Session at NAVIGATOR 2017 in recognition of receiving approval for the Accredited Center of Excellence Twenty Point application and bringing the ACE certificate back to the City of Red Deer 911 Emergency Communications Centre in Alberta, Canada.

“ACE is a true reflection of the work we do,” said Sparrow, the center’s director. “It’s symbolic of our achievement. So, yes, this is a big deal.”

Sparrow and her staff of 34 cross-trained dispatchers and calltakers will celebrate, the framed certificate will go on the wall, and they will continue answering 911 calls and sending response. Depending on the Red Deer City Council’s decision, the ACE certificate could be among the first things hung on the walls of a new stand-alone building that combines the 911 center with an Emergency Operations Center (EOC).

If approved, the move could take place sometime in late 2017, taking into account construction schedules. Once ready for occupants, communication center staff will vacate quarters in Fire Station 3, which houses multiple EMS departments, and City Hall will absorb the space of the exiting EOC in its building for its growing staff.

The consolidated EOC and 911 center would be a boon to staff and the public, Sparrow said. “We need the space,” she said. “Our room is pretty full. We recently added three pods and that immediately took up the space we had.”

Spacing requirements goes along with the Alberta Health Service’s (AHS) selection of Red Deer as an EMS satellite “borderless” dispatch center in the province. Red Deer was the first of three centers selected to go live in January 2016, followed by implementations in Lethbridge, Alberta, and Fort McMurray, Alberta.

Satellite dispatching software makes it easier for EMDs to coordinate location and time. They can see where the ambulances are, vehicles available for the particular trip, and whether responders are on schedule or running behind due to traffic, weather, and related time-draining conditions. The software makes it possible to transmit electronic messages between the EMD and driver.

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According to the AHS program finalized in 2009, an EMS call placed anywhere in Alberta is transferred to the respective regional satellite
PSAP, which in Red Deer involves 70 communities and counties throughout central and southern Alberta; police and fire calls remain in the control of the local communication center.

CAD-to-CAD interfacing is available for co-response (an incident that requires fire and medical attention) and to share event-related information instantly over network connections between linked communication centers.

Satellite dispatching does not increase call volume for Red Deer, since it has always answered EMS calls. The system does, however, require additional pods to accommodate the AHS-funded satellite dispatching software.

“The technology is separate,” Sparrow said. “Everyone is cross-trained, but they are not using the same CAD system [for the assigned EMS or fire dispatch].”

As Sparrow explained, the transition was more than a click of a switch.

“That’s where it all begins,” she said. “There was still a lot ahead of us.”

That wasn’t the only project moving forward in Red Deer.

In August, the Red Deer City Council approved a radio system upgrade capital project to complete the migration of all emergency service radios to the Alberta First Responders Radio Communications System (AFRRCs). Launched on July 1, the province-wide, networked radio system will connect more than 700 emergency responders and government agencies during serious incidents or natural disasters.

The willingness to accommodate projects that benefit the larger system mirrors Sparrow’s approach to ACE.

Sparrow and Bart Rowland, Deputy Chief of Support Services for Red Deer Emergency Services, plunged into the Twenty Points of Accreditation in fall 2015. They divided the points into graduated categories; from those they could easily pull together (center size and dispatch certifications) to multi-step projects (quality improvement and quality assurance processes).

Sparrow said their first step in QI/QA involved Q courses for everyone at the center, including refresher courses for current Qs, to bolster the existing Quality Improvement Unit.

If ACE and issues related to space aren’t enough to fill Sparrow’s schedule, there’s also the pressure of future telecommunications. In March, the Canadian Radio-television and Telecommunications Commission distributed an in-depth 12-question survey to PSAPs (deadline April 29) regarding the creation of a regulatory framework for Next Generation 911 services in Canada.

“There’s never a dull moment,” said Sparrow, who started as a dispatcher at the Slave Lake communication center in northern Alberta (now part of the Northwest Regional Communication Center serving northwestern Alberta.

“Each morning is hit the ground running.”

As a whole, the same applies to Red Deer; the city doesn’t slow down.

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“ACE is a true reflection of the work we do. It’s symbolic of our achievement. So, yes, this is a big deal.”

The century-old city, starting as a mix of homesteads and trading posts on the vast Alberta prairie, boasts a thriving business and commercial hub. The city’s six key industries are expected to add more than a combined 9,800 jobs during the next five years. It is the third most populous city in the province. Red Deer commemorated the 100,000-population mark in 2015 with a plaque and naming of the city’s 100,000th resident.

The tourist season is year-round, with people from all over the province and Canada taking advantage of Red Deer’s 301 acres of protected land within the city and proximity to Banff National Park and the Red Deer River Basin.

Before packing your bags and heading toward Canada, consider the single possibly bad thing about Red Deer and Alberta in general. Winters are harsh, with deep-freeze temperatures and continuous snow and wind. But take comfort because as any natives will say, “We don’t feel it; the air’s bone dry here.” And, if luck has it, you could score tickets for the Canada Winter Games Red Deer hosts in 2019. •
Scottish symposium embraces dispatch in OHCA survival

Audrey Fraizer

The recipient of the inaugural dispatcher award at the Scottish Cardiac Arrest Symposium for emergency communication had less to say in her acceptance on stage than the presenters. That’s because Gillian Ferguson is accustomed to staying out of the eyes of the public and, quite honestly, she definitely prefers it that way.

“I’m a shy person,” Ferguson said after she received the award on June 24. “I’m not one for stages. That’s not the nature of our job. We’re in the background.”

Talking to Ferguson, it’s easy to understand why her team at the Scottish Ambulance Control Centre (ACC) nominated her. A dispatcher for 13 years, and a calltaker for one year before that, she sounds genuinely enthusiastic and conscientious about what she does.

“I am very happy at the job,” she said. “We make a difference. I can go away from my shift knowing I helped a patient and the family, and when the crew says ‘we’re glad we have you today,’ that’s nice. It’s a good thing.”

The Academy Award, as it’s named, is a joint sponsorship between the Resuscitation Research Group at the University of Edinburgh, Scotland, and the International Academies of Emergency Dispatch® (IAED™), in Salt Lake City, Utah. It was established in recognition of the emergency dispatch profession and partnership forged between the two organizations.

“The partnership is incredibly important to the Academy,” said Jerry Overton, IAED Accreditation Board Chair, who with Dr. Jim Ward, Medical Director, Scottish Ambulance Service, presented the award.

“This is the first partnership of this type for the Academy and with an award that acknowledges our joint dedication to increasing the survival from out-of-hospital cardiac arrest (OHCA).”

Ferguson was among five nominated from the Scottish Ambulance Service control centers. The service has three centers in Scotland (Edinburgh, Glasgow, and Inverness), and each uses the Academy’s Medical Priority Dispatch System® (MPDS®). She had been notified about the nomination, and, on the day of the symposium, she was told she would be going on stage to accept the award.

“I was quite shocked,” she said. “You don’t do this job because of the recognition. We are the first contact but, for the most part, the public doesn’t know what we do.”

Facebook posts congratulating Ferguson prompted her to thank everyone in return:

“Can I just say a massive thank you to everyone for all your kind messages today, I’m really honored. As the saying goes, There is no I in Team, so a special big thanks to all my teammates for their support today and every day in ACC and also the nominations! Go team!”

According to her nomination: “Gillian is an outstanding dispatcher and her whole team would love to see her get the recognition she most definitely deserves. [She is] very attentive when dealing with OHCA. Understands the process and need for allocating appropriate resources and does everything she can for the patient and crews attending. Gillian always puts patients first and goes out of her way to ensure they are getting the best possible response. She is a very active member of the team, supporting them when necessary, especially during major incidents. She is sure to check on a patient’s condition once the crew has cleared from the incident as she is genuinely concerned for their welfare. She is also conscientious to check on the welfare of her crews when dealing with difficult incidents and is well known by the staff across all east divisions as being incredibly helpful, friendly, and professional.”

Overton acknowledged the critical link that every EMD automatically assumes in the chain of emergency response.
“There is no one real winner of the award,” Overton said. “Every dispatcher is a winner. This is an incredibly stressful job just like it is stressful for those in the field delivering the care. EMS is a team approach, and your careful use of the Protocol has saved countless lives.”

Ward echoed Overton’s remarks before naming the two runners-up and first-place awardee Ferguson.

“You guys do an amazing job,” he said. “You’re not generally visible on the front line but absolutely critical to the chain of survival and the successful outcomes of patients.”

Overton said their role couldn’t be stated too strongly, particularly in association with four primary factors in early recognition and treatment of OHCA: early recognition that a cardiac arrest is happening early CPR to buy time; early defibrillation to restart the heart; and early prehospital Advanced Life Support (ALS).

Overton said call handlers and dispatch participate in each phase and, as part of the process, the relatively unspoken responsibility of ALS deploying and redeploying.

“I was told about one dispatcher handling five cardiac arrests on one shift,” he said. “The dispatcher had to deploy ambulances and redeploy the remaining ambulances to make sure response times were met.”

Scottish Ambulance Service runners-up for the award included Robert Pearson, an ACC Supervisor, and Caroline Shand, an Emergency Call Handler. Rounding out the exceptional group of nominees were Linda Burns and Alistair Strachan, who are both call handlers.

A second major honoree, Fiona Laing, received the Newton Award, established by Gregor and Judy Newton to recognize the outstanding work of EMS in Scotland.

In April 2014, 43-year-old Gregor Newton went into cardiac arrest in East Lothian, Scotland, and survived due to several people and factors in place, including his wife, Judy Newton, initiating CPR; their two children going for help; bystander assistance; call handlers coordinating and gathering information; community first responders providing defibrillation; and the paramedics arriving on scene.

Gregor, who spoke at the symposium, lauded Scotland’s EMS community.

“I didn’t realize until later how lucky I was, and the first thing that struck us was the number of people involved in saving my life,” said Gregor, who was accompanied by his wife and their children on stage. “There were probably 14 people, which is really humbling.”

Laing is Community First Responder Coordinator, Pirnmill, Isle of Arran, Scotland. The community first responders are trained volunteers responding to medical emergencies while the ambulance is on its way and alerted through the communication center.

The symposium’s theme, SHIFT Happens, refers to the changes happening in the way OHCA patients across Scotland are resuscitated. Approximately 3500 people in Scotland each year undergo attempted resuscitation after OHCA, but currently only around 1–20 survive to hospital discharge. The OHCA strategy for Scotland includes:

- An increase in survival rates after OHCA by 10 percent across the country, and saving a total of 1000 additional lives by 2020.
- An increase in the number of individuals learning CPR, with a projection of adding another 500,000 people with CPR skills by 2020.

According to the report outlining Scotland’s strategy, “The ACC is the center of the coordination of all the resources involved in the prehospital care of out-of-hospital cardiac arrests,” and call handlers must be effectively trained and supported to then reliably use the triage tools available.”

This was the fourth annual Scottish Cardiac Arrest Symposium hosted by its sponsoring agency, the Resuscitation Research Group at the University of Edinburgh. The 19 speakers and award presenters featured at the one-day symposium included EMS physicians, paramedics, community first responders, educators, and representatives from Save a Life for Scotland.

Lisa Macinnes, National Program Manager, Save a Life for Scotland, and Lead Research Nurse, Emergency Medicine Research Group of Edinburgh, said gratitude shown to emergency dispatch at international summits, such as the symposium, is indicative of the respect the profession holds in the OHCA Chain of Survival.

“They are vital people who never see a cardiac arrest as part of their work,” Macinnes said. “But they hear it in the fear of every word the caller says. They’re crucial, and their work has saved countless lives.”
EMERGENCY DISPATCH BOOT CAMP

Veterans offered fighting chance at dispatch

Audrey Fraizer

Presenting professional opportunities for veterans who served in wars in Iraq, Afghanistan, and other areas of the Middle East are another step toward lowering unemployment rates through a program co-sponsored by the International Academies of Emergency Dispatch® (IAED™), Priority Dispatch Corp.™ (PDC™), and Troops to Firefighters. The program also offers benefits to communication centers.

The program teams veterans who served as active duty personnel in the U.S. armed forces since September 2001 with Academy instructors to complete five emergency communications certifications during a three-week emergency dispatch boot camp.

It’s basic training to prepare vets for a career when transitioning or separated from active duty military, said Dave Harris, Troops to Firefighters Co-founder and Retired Chief, Lockheed Martin Aeronautics, Marietta, Ga.

“We owe it to our vets,” said Harris, who was with U.S. Air Force fire protection for 30 years prior to his civilian job for Lockheed Martin. “We must give vets the opportunity to be self-sufficient through gainful employment.”

Harris and Troops to Firefighter Co-Founder Winston Minor, Retired Chief, Atlanta Fire Department (Ga.), recruit candidates at job fairs and military bases. They mentor the vets, coordinate the classes, collate certifications, post job openings, and simulate job interviews.

“Getting the job is up to the vet,” Minor said. “They make the decision.”

Although not meant as a cookie-cutter approach, Harris and Minor believe emergency dispatch is an effective and promising career choice for transitioning military personnel, particularly for vets wounded in action. But they don’t sugarcoat the reality of working in often-tight quarters coordinating emergency response for typically distressed callers. They don’t pretend everyone leaves the military at equal emotional levels.

“Not everyone’s cut out for dispatch,” Harris said. “We know that. But for the right person, it offers a chance to continue public service through their community.”

Opportunity for vets wounded in action grabbed Shawn Messinger’s attention when asked to coordinate the PDC side of the program.

“This is quite unique to our wounded warriors who want to work in public service but, because of their injuries, require training in a different capacity,” said Messinger,
This is quite unique to our wounded warriors who want to work in public service but, because of their injuries, require training in a different capacity. This program provides an opening in a great public service career.”
I DON’T THINK SO

Kim Rigden describes the dispatch profession. Phones ringing, calls piling up, using every approach at customer service, and a huge dollop of luck to get through the shift. Providing Pre-Arrival Instructions (PAIs) to assist a son giving CPR to his father. Calming the mother whose child is missing. Urging scared shoppers to safety while an armed assailant wields his automatic weapon against a frenzied crowd.

“Nothing compares to having your A-team on, answering 911 calls, and talking to crews all while your fingers are flying across the keyboard recording the information,” said Rigden, Commander, Communications Education and Quality Improvement, Toronto Paramedic Services, Toronto, Ontario, Canada. “Emergency dispatch is like being part of a room full of superheroes that no one knows is there.”

I AM JUST A DISPATCHER

Audrey Fraizer
And that’s the problem: Few people know what dispatchers do.

Utah high school students in a CPR study sponsored by the International Academies of Emergency Dispatch® (IAED™) were ambivalent about a career in emergency dispatch. They wanted the speed and adrenaline rush of a paramedic, firefighter, or police officer rushing to the scene. After all, dispatch was only a desk job. They want to be part of the action.

“People don’t go through high school saying ’I want to be a 911 dispatcher,’” said Karen Lord, Communications Officer, City of Biddeford Emergency Communications Division, Maine. “It just doesn’t happen. Unless you have a relative in the public safety community, you are really unaware of who we are and what we do.”

In a job that the U.S. Bureau of Labor Statistics calls good because “the stressful nature of the job results in many workers leaving this occupation,”1 does lack of interest and uninformed perception forecast the shape of things to come in the emergency dispatch profession?

Presumptive, maybe, but how can a public service communication agency attract quality and dedicated individuals and encourage emergency dispatch as a career in a mindset swirling with misconceptions and partiality?

“You know, that’s the million-dollar question,” said Deanna Mateo-Mih, IAED ED-Q™ Board of Curriculum Chair, National Q Advisor, and Quality Improvement Consultant. “Once you get a position as a dispatcher, how do you ensure longevity in the profession and avoid burnout or, from an agency’s perspective, avoid high turnover rates?”

Figuring that out is the ticket.

“We need to have our faces out there and not just our voices on the other end of the line,” Lord said.

**Dispatch is a profession**

A profession is a vocation requiring specialized educational training with oversight by a recognized governing body. A person entering a profession generally must pass an exam to be considered qualified. Training and education continue

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**WE ARE DISPATCH PROFESSIONALS**

That “just a dispatcher” quote seems to be quite common. At NAVIGATOR this year, I was talking to a couple of gentlemen and when I introduced myself, they said they were “just dispatchers.” That’s very sad to think they feel that way.

We are not just Lily Thompson as Ernestine [the nosy and condescending phone operator Thompson debuted on “Rowan and Martin’s Laugh-In”] answering the phone with one ringy dingy, two ringy dingys. I know the public’s perception is sometimes that the role of the dispatcher is that of a phone operator, but we shouldn’t feel that way about ourselves. The dispatcher is such an important component of the entire emergency process, but so often not recognized.

Oren E. Rae

Here I am, a dispatcher, at one of the largest 911 centers in the United States, looking back at what it means to be “just a dispatcher.” To me, it means 21 years of continually moving forward, watching an industry change with me, learning a new technology at least yearly. It means years and years of education on so many different subjects where stress and stress management always seems to be a bullet point in the lesson. It means sleepless nights AND sleepless days. It means going home with that sense that I accomplished something, be it saving someone’s life, helping a small child find their momma, or teaching a colleague a new way of performing their job so that it’s easier for them. It means heartache and a sense of pride like no other. For the past 10 years, I have been assigned to our Training Section, which has taught me that there is a whole other side to this dispatch thing. The education that goes into dispatch and 911 now is light years ahead of where it was. Two decades ago, training consisted of two weeks in a room looking over general orders and then a sink-or-swim mentality. Now, it’s academic training, structured on-the-job training, remedial training, and continuing education daily. It amazes me every day to watch the eyes of new dispatchers and calltakers glimmer when they realize that what they are signing up to do REALLY impacts others.

So, are we just dispatchers? No way! We are educated and trained professionals doing a job that not everyone is cut out to do.

Angela VanDyke

Dispatchers are hero coordinators, waiting patiently to answer a cry for help. They soothe pain with the sound of a calm voice, instill confidence in those who feel helpless, and make seconds count with every compression, chemical, or conflict. They have no pause, only purpose and action. There is no scene size-up, no huddle or pre-plan; they must be ready with every scream or whisper knowing both carry a unique challenge. They are a hero’s hero.

Anthony Guido
throughout the lifetime of a career for reasons that include developing expertise and proficiency, and potential advancement.

Dr. Jeff Clawson, co-founder of the IAED, recognized the important link of emergency dispatch in the EMS chain of response nearly 40 years ago when starting his own profession in emergency medicine. But it was more than simply the protocols Dr. Clawson invented putting emergency dispatch on a career path.

“Protocols provide an exact script emergency dispatchers follow when assisting a caller; however, they are only part of the process,” Dr. Clawson said. “Along with the protocols, we have established a system that provides a best practices approach that elevates emergency dispatch to the level of professionalism.”

True to the definition of profession, the IAED requires certification through passing an exam tailored to the particular discipline (fire, medical, police, or emergency communication nurse), quality assurance resulting in quality improvement, continuing dispatch education to renew certification, and ongoing training. The quality assurance component keeps the process and the dispatcher on track.

If that doesn’t convince you about the job’s career potential, check out the partial list of requirements from MetCom 911 in Centennial, Colo.:

- Retrieves information from callers and transmits information to fire/emergency service personnel. Follows prescribed protocols to provide emergency medical instruction to callers during high risk situations until appropriate field units arrive on scene.
- Monitors and maintains the location and status of fire, emergency medical, and other agency units in the field.
- Operates various automated and/or communications equipment including computer assisted dispatch terminal; enters and retrieves data.
- Monitors and operates TDD/TTY to communicate with hearing impaired callers.
- Participates in the administration of the Communications Center through the development, implementation, and review of procedures, policies, and training programs.

There’s also the less tangible traits that go into defining a career, said Sherri Stigler, Training and Operations Manager, Waukesha County Communications, Waukesha, Wis.

“Professional agencies invest in their dispatchers,” Stigler said. “They support physical and mental health initiatives and encourage continual growth and development. They promote a team spirit within the organization and encourage their dispatchers to work hard for a cause that’s relevant to both.”

**Start in the classroom**

Marco Pizana believes students should be given the opportunity to practice what teachers preach in the classroom.

“We’ve probably all heard kids ask ‘What’s the point in learning algebra; what’s the point of learning geometry?’” said Pizana, a criminal justice instructor at Hays High School in Buda, Texas. “The point is to apply what you are learning to your future endeavors.”

Hays is among several public schools in Texas offering the Emergency Telecommunicator Course (ETC) developed by the IAED. The course, introduced nearly 15 years ago to supplement Academy certification courses, has since expanded its reach to schools offering hands-on career and technical training.

ETC fits into public safety career tracks, and similar to other technical programs, gives students the opportunity to try a career before graduating and, also, provides a jump start into a profession straight out of high school.

“Kids are looking for certification,” said Larry Latimer, ETC Instructor. “They can take their ETC certification to a center and get in the door. A good percentage stay.”

The ETC class at Hays High School takes students through 13 chapters of the ETC manual and the hands-on practice of 911 emergency call-answering techniques using simulators. Students are eligible for ETC certification through the IAED once they finish the course. The Texas Public Safety Teacher Association offers ETC for teachers to go back to teach their students.

Latimer likes to emphasize the thinking part of dispatch. He runs scenarios by students, asking the "what-if" and “what-
to-do” questions. For example, “what if” grandpa suffers an out-of-hospital cardiac arrest. How much time could it take from the time the call to 911 is made before response arrives?

“If nobody does anything but wait, what will happen?” Latimer might ask. “Grandpa has much less of a chance if the emergency dispatcher doesn’t do her job right. At that moment, you are the most important person he will never know, because you have the instructions that can save him.”

Latimer was an instructional designer and the IAED Director of Curriculum Design during his 14-year tenure with the organization. He now works part-time teaching the Academy’s ETC certification courses.

Brett Patterson, IAED Academics, Standards & Research Division, emphasizes the importance of communications as a prerequisite for a public safety career. He was a paramedic early in his EMS career and part of a system that required paramedic certification to dispatch calls, which he did for another eight years.

“While this strategy was locally touted as a clinical advantage to the public, the real advantage was the personnel that emerged,” Patterson said. “Indeed, when I look at my colleagues today, some 30 years later, most are leaders who got their start in communications. Whether one chooses to manage responders and the scene on-line as a calltaker/dispatcher, or begin with this, and then move up the ladder into administration, communications experience is generally regarded as a prerequisite for a public safety career.”

Dispelling misconceptions

Helicopter paramedics attempting to rescue a bus load of children stranded in a flood, police stopping a home intruder attempting to kill a father and his son, firefighters rescuing babies and a babysitter from an inferno at an apartment complex, and highway patrol vehicles in a high-speed chase to stop a suicidal person driving head-on into traffic—these are the scenes from the popular series “Rescue 911” that continue to influence generations of TV viewers through reruns and DVDs. We know, because Dr. Clawson was the show’s medical advisor.

Who wants to be “just” a dispatcher at a “desk job” that borders on the tedious when there are helicopters to fly, ambulances to navigate, and speeding vehicles to chase? The real first responders (emergency dispatchers) are every bit as essential and multifaceted as the roles of paramedic/firefighter/police officer during an emergency.

A story told at a seminar Oren Rae attended shows that one new recruit knew exactly what he was taking on.

“A police captain told us about a class of new recruits and asked what they felt was their most effective weapon,” said Rae, Continuous Quality Improvement Manager, San Francisco Department of Emergency Management/Division of Emergency Communications, San Francisco, Calif. “Many responded with their guns, batons, or mace. One recruit, a little smaller in stature than the rest, held up his portable radio. When asked why, his response was, “Because with one of these, I can get four or five of you to help me.”

Who is on the other end of that radio ensuring he gets that help? The emergency dispatcher.

“Dispatch is not something that you ‘just do’ if you can’t get hired as one of the other three,” Rigden said. “Each segment of police, fire, and medical response is vital to the whole, yet requires very different skill sets. The conversation needs to be about which career fits the person and particular skill set. You want to flourish in your chosen career path.”

As an emergency dispatcher will tell you, the first link in emergency response provides every bit the adrenaline rush, combined with the spirit of altruism, as EMS does in the field.

“Before I started, I was told not everyone can do this job,” said Muskogee County EMS Communication Center (Oklahoma) EMD Kandis Crespy, who was presented a Stars of Life Award from the Oklahoma Ambulance Association, honoring her dedication to emergency dispatch. “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.”

Lord loves her job. Sure there are drawbacks, she admits, but name a profession that comes without quirks.

“Many times people will say, ‘But don’t you miss working Monday through Friday?’ and I say that I do not know, as I have never in my life had a Monday through Friday job,” she said. “If you are a strong-minded person and want fun and excitement but don’t want to run into burning buildings or get shot at, this is the job for you. It can be rewarding, challenging—but stressful at the same time.”

Mentor

A transfer into training at Fayette County 911 gave Tonya Warr greater insight into new hire issues and reasons many left the profession after two to three years. The day-to-day stress can be incredibly difficult, she said, and even her background in a public service family didn’t prepare her for everything the job requires.

“Nothing can compare to, or prepare you for, a career in emergency dispatch,” said Warr, an emergency dispatcher in Georgia for 12 years, including as a dispatch trainer at Fayette County 911, Fayetteville, Ga.

Equipped with insight from working closely with new hires, she realized the agency could do more to support an individual in a way that wasn’t connected to job performance. She hit upon the idea of mentoring, which she knew was successful in introducing new people to a corporate or other public safety landscape.

“A mentor provides an introduction,” Warr said. “The mentor can be a cheerleader and adviser to a beginner but without the political strings attached. There are no ties to employment or advancement.”

The two-tier program Warr conceived assigns, in the first tier, a new-hire-in-training to a full-fledged dispatcher relatively new to the floor. The mentor acts as a sounding board for the apprentice who might want
to discuss an issue occurring outside of work affecting performance. The second tier involves pairing a more experienced dispatcher as the mentor to a novice who might want to know where to go from here. Is the skill set relevant for advancement? Is there a future in emergency dispatch?

Mentoring allows the training to concentrate on performance and provides an entry for the apprentice into the center’s culture.

“There’s almost immediate buy-in,” Warr said. “Mentoring motivates. New people feel that the agency cares about them. They matter to the organization.”

Before embarking on a mentoring program, Warr highly recommends formalizing a plan and cultivating mentors.

“Make sure your mentors know exactly what to do,” she said. “The program is there to encourage but not in any way change the way the job is performed.”

Promote value

“The public always hears of a firefighter or police officer doing something heroic, but they don’t see the voice behind the scene,” Lord said. “Does anyone ask what has happened prior to their arrival? Does anyone know what the emergency dispatcher did to make it possible for the firefighter or police officer to have a positive outcome instead of the other way?”

EMD Jessica Greguski, Northwell Health Center for EMS, Syosset, N.Y., had taken a back seat in the eyes of her children compared to her husband’s paramedic career. So, she brought her daughters, 10 and 6, into the communication center on the national “Take Your Child to Work Day,” which this year Northwell Health held on June 6.

“I wanted them to see what I do,” Greguski said.

Gaguski didn’t know what to expect, but she wanted to give her children a sense of what their mom does and the impact emergency dispatch has on the community. She was favorably impressed by their response.

“They loved it,” Greguski said. “My older daughter was very excited. She was fascinated over everything going on: the calls, the radio, how busy we are. They saw a different picture than they had anticipated and asked so many great questions.”

Gaguski transferred from the ambulance into the communication center 12 years ago. She wanted to learn a new skill set, despite suggestions from a few former co-workers that she would not find excitement within the walls of the communication center.

“They think we sit around, our feet up on a table, snacking, and watching TV,” she said. “Nothing could be further from the truth. There is so much to learn: protocols, Pre-Arrival Instructions, and the psychology of DLS. We have GPS tracking and multiple screens to watch. We need to feel for the caller and stay composed no matter what happens. We have to rein them back in, act as their security blanket. Believe me, there’s nothing easy about emergency dispatch.”

Maybe the best possible motivation is internal to the individual, said Marie Leroux, registered nurse, PDC™ protocol systems implementations expert, La Minerve, Québec, Canada.

“Too many times, I see high-performance individuals in the field of emergency dispatch that don’t realize their value,” she said. “Think about what you do. Take the time to sit down; review what you have done. You are certified. You are trained. You have an expert protocol. Maybe you motivate colleagues and help create a positive atmosphere. You even sometimes save lives. All this has tremendous value. Don’t forget it, and use it in the most appropriate way to support your own career.”

See for yourself

Warr had planned to continue a career in public safety until an opening at her daughter’s elementary school offered her the opportunity to return to teaching.

The decision was difficult, she said. “Dispatch is a wonderful profession,” she said. “I loved being the person taking care of others—the guardian of guardians. It’s a very validating profession for the right person.”

Who’s the right person, and how do you find one?

Sources


Even if you think emergency dispatch has been left behind in national standards, you can’t disregard the full-speed-ahead drive to catch up.

NAVIGATOR presentations over the past several years have emphasized the inclusion and expanding role of dispatch in national regulations and proposed standards. The National Fire Protection Association (NFPA), the National Fire Incident Reporting System (NFIRS), Fire Suppression Rating Schedule of the Insurance Services Office (ISO), and the new kid on the block, the National Fire Operations Reporting System (NFORS), impact every level of emergency dispatch, from job description to the time stamp of when call processing ends.

**NFPA**

Founded in 1896, the NFPA develops the codes, standards, research, training, and education for the fire service internationally and has 70,000 members worldwide. The NFPA emergency dispatch regulations apply to all disciplines (fire, police, EMS, and critical incident management).

**NFPA 1061, Professional Qualifications for Public Safety Telecommunications Personnel**

NFPA 1061 was introduced in 1996 and has been updated three times since, for the 2002 edition, the 2007 edition, and the 2014 edition, which was extensively revised to recognize the expanded roles of 911 communication centers. The standard also addresses the qualifications recommended for this quickly evolving technology-based industry.

The 2014 edition defines nine essential positions and the associated duties of 911 center personnel. The nine positions are further divided into the knowledge and skills necessary to satisfy the duties that fall under each position. For example, Chapter 10 details the knowledge and skills required for QA/QI personnel to perform several tasks, including call review, feedback, remediation, data management, continuing education, and maintaining certification. The training coordinator must have the knowledge and skills to manage training, develop and modify curriculum, create remediation strategies, schedule and document training, evaluate the effect of training, and construct a performance-based instructor evaluation plan.

IAED® Fire Program Administrator Jay Dornseif said the positions...
Fire Priority Dispatch System
by the numbers

Languages 8

Users 400+

Fire ACEs 27

Languages: North American English, United Kingdom English, United States Spanish, German, French, Dutch, Brazilian Portuguese, and Malay.

standard has been repeatedly updated and revised since its introduction. Not so parallel, however, are the longevities of the two standards. NFPA 1221 was introduced in 1898 as part of a general standards on signaling systems and has gone through 31 revisions during the past 100-plus years. The 1999 revision was a particularly arduous task. The committee chaired by Evan E. Stauffer Jr., then of the Naval Facilities Engineer Command, Pennsylvania, completely rewrote the standard to reflect dramatic changes in emergency communication: “emergence of joint communication centers, the increase in technology-based information systems that assist users in both the communication center and the field of operations, and the role communication plays in emergency scene operations within the Incident Command System.”

In the 2015 revision, the NFPA 1221 technical committee modified alarm processing times in response to comments from dispatchers and calltakers about the additional time required (above the existing standard) to gather information. The 2016 edition revisited alarm processing times and definitions in several sections of Standard 1221.

Chapter 3 defines emergency alarm processing/dispatching as a process “by which an alarm answered at the communication center creates a call for service and is transmitted to emergency response facilities (ERFs) or emergency response units (ERUs) in the field.” The term includes “caller interrogation and resource selection [determination of which emergency response unit (ERU) will respond], up to the start of the emergency response facilities’ (ERFs’) notification process.”

The definition means the emergency dispatch process stops when the dispatcher starts the notification process, Dornseif said. “You’ve done your due diligence,” he said. “You’ve started notifying responders that they have an emergency, and that’s where your time stamp stops.”

The NFPA standard for Call Answering was revised to 95 percent of alarms received on emergency lines shall be answered within 15 seconds, and 99 percent of alarms shall be answered within 40 seconds (NFPA 1221-7.4.1).

The NFPA Standard for Call Processing (NFPA 1221-7.4.2) states that alarm processing time is the time it takes to initiate dispatch of FIRE apparatus and personnel or the time it takes to transfer a fire alarm to another PSAP and, with the exception of the call types identified in 7.4.2.2 (listed below), 90 percent of [fire] alarm processing shall be completed within 64 seconds and 95 percent of [fire] alarm processing shall be completed within 106 seconds. The exceptions are:

- Calls requiring emergency medical dispatch questioning and pre-arrival medical instructions
- Calls requiring language translation
- Calls requiring the use of a TTY/TDD device or audio/video relay services
- Calls of criminal activity that require information vital to emergency responder safety prior to dispatching units
- Hazardous materials incidents
- Technical rescue
- Calls that require determining the location of the alarm due to insufficient information (new for 2016)
- Calls received by text message (new for 2016)
Processing times for calls not on the list are 90 percent within 64 seconds and 95 percent within 106 seconds.

The NFPA list, however, is a recommendation, Dornseif said.

“It’s up to your agency to decide what constitutes an emergency,” he said. “If it’s not on your agency’s list, it will not count against the performance requirements of NFPA 1221-7.4.2. You can process this call until the cows come home.”

Structure fire calls, he said, should always be on the list of every fire department communication center due to the potential and actual loss of life involved.

“Speed this one out the door and make sure you’re sending out the right stuff,” said Dornseif, a 20-year veteran of the fire service. “Everything else can wait.”

According to the NFPA, U.S. fire departments responded to 494,000 structure fires during 2014, resulting in 3,275 civilian fire deaths, 15,775 civilian fire injuries, and $9.8 billion in property damage. The NFPA has released other facts about structure fires including:

- One structure fire was reported every 64 seconds.
- 92 percent of all structure fire deaths resulted from home fires.
- On average, seven people die in U.S. home fires per day.

Finally, new standards in 2016 recommend a minimum of two telecommunicators on duty and present in the communication center at all times (NFPA 1221-7.3.1) and enhanced telecommunicator support during critical incidents such as a Mayday.

Dornseif lauded the two-per-shift recommendation, saying, “It’s time to have two people on duty at all times. Period.”

Fire Priority Dispatch System™ (FPDS®) v6.1 reinforces the urgency of response to structure fires. It includes the addition of ECHO-level determinants on Case Entry for REPORTED BUILDING/STRUCTURE FIRE. The revisions allow an earlier response for all structure fire incidents with a spontaneous report of smoke or flames while also allowing for differentiated responses and resource allocation for ECHO- and DELTA-level incidents.

The National Fire Operations Reporting System

NFORS (pronounced in-fours) is a supplemental tool created to optimize fire operations for structural fires and reduce firefighter and civilian injuries and deaths through local and collaborative efforts.

The NFORS software evaluates several variables generated at data entry to help determine the most effective and efficient resource allocation available and whether the resources dispatched ultimately managed the incident. NFORS can benchmark between user agencies to identify and promote best practices.

Launched in late 2015, NFORS complements the existing NFIRS. NFIRS was designed as an incident-specific system to describe and measure the cause, origin, and severity of fires nationally. NFORS is focused on describing and measuring a fire department’s availability, capability, and operational effectiveness on the outcome of a fire event.

The systems work together, Dornseif said.

“The systems drill down to effectively fight structure fires,” he said. “We know how well we did and what we’re capable of doing.”

In addition to real-time analysis and operational application, agencies can enter data identifying new infrastructure important to fire response, including water resources and street configurations.

Several national fire associations support NFORS, including the Urban Fire Forum and the Metropolitan Fire Chiefs, which released a joint statement in September 2015 that advocates adding NFORS to any NFPA standards involving fire data.

NFORS development was funded through the AFG Fire Prevention and Safety grant program. The IAED was among 25 organizations serving in an NFORS advisory capacity.

Sources
CDE Quiz Mail-In Answer Sheet

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

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

Clip and mail your completed answer sheet along with the $5 USD (U.S. currency) NON-REFUNDABLE processing fee to:

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Attn: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

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  ☐ Comm. Center Supervisor/Manager
  ☐ Training/Unit Coordinator
  ☐ Instructor
  ☐ Comm. Center Director/Chief
  ☐ Medical Director
  ☐ Commercial Vendor/Consultant
  ☐ Other

ANSWER SHEET □ FIRE

Nov/Dec 2016 Journal “Link in Fire Chain”

Please mark your answers in the appropriate box below.

1. A B C D

2. A B C D

3. A B C D

4. A B C D

5. A B C D

6. A B C D

7. A B C D

8. A B C D

9. A B C D

10. A B C D

Expires 12/31/17

YOU MUST BE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Link in Fire Chain,” which starts on page 27. Take this quiz for 1.0 CDE unit.

1. This organization develops the codes, standards, research, training, and education for the fire service internationally and has 70,000 members worldwide.
   a. Metropolitan Fire Chiefs
   b. National Fire Protection Association
   c. ISO
   d. U.S. Fire Administration

2. If you wanted information about Professional Qualifications for Public Safety Telecommunications Personnel, which one of the following standards would provide the information?
   a. NFPA 1001
   b. NFPA 1006
   c. NFPA 1061
   d. NFPA 1072

3. What is the number of essential positions in the communication center, according to NFPA standards?
   a. three
   b. six
   c. nine
   d. twelve

4. In the 2015 revision, the NFPA 1221 technical committee modified alarm processing times in response to comments from dispatchers and calltakers about:
   a. the additional time required (above the existing standard) to gather information.
   b. the lack of acceptable reasons for time delays in the standard.
   c. the one-size-fits-all application of time standards.
   d. categorizing the types of alarm processing in reference to maximum and minimum time allocations.

5. Technically speaking, emergency alarm processing/dispatching is a process that involves:
   a. the incident, from the time of the call to the resolution of the emergency (i.e., fire is extinguished and all crew members are accounted for).
   b. the time of the call to the arrival of fire units at the scene.
   c. the initiation of response to the resolution of the emergency.
   d. from caller interrogation and resource selection up to the start of the emergency response facilities’ notification process.

6. The NFPA standard for Call Answering (NFPA 1221-7.4.1) was revised to:
   a. 80% within 6 secs. for all alarms received on emergency lines, and 69% answered within 10 secs.
   b. 85% within 9 secs. for all alarms received on emergency lines, and 79% answered within 20 secs.
   c. 90% within 12 secs. for all alarms received on emergency lines, and 89% answered within 30 secs.
   d. 95% within 15 secs. for all alarms received on emergency lines, and 95% answered within 40 secs.

7. According to NFPA statistics, what is the percentage of death resulting from home fires compared to other types of structure fires?
   a. 45 percent
   b. 68 percent
   c. 92 percent
   d. 100 percent

8. What is the minimum number of telecommunicators that should be in the comm. center at all times, according to NFPA standards released in 2016?
   a. two
   b. three
   c. four
   d. six

9. NFORS is a(n):
   a. required tool created to establish national data for wildfires.
   b. supplemental tool created to optimize fire operations for structural fires and reduce firefighter and civilian injuries and deaths through local and collaborative efforts.
   c. software package created to schedule and allocate resources.
   d. incident-specific system to describe and measure the cause, origin, and severity of fires nationally.

10. NFIRS was designed as a(n):
    a. required tool created to establish national data for wildfires.
    b. supplemental tool created to optimize fire operations for structural fires and reduce firefighter and civilian injuries and deaths through local and collaborative efforts.
    c. software package created to schedule and allocate resources.
    d. incident-specific system to describe and measure the cause, origin, and severity of fires nationally.

To be considered for CDE credit, this answer sheet must be received no later than 12/31/17. 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.
MAKE THE RIGHT CALL

Different choking scenarios require different actions

Josh McFadden

In March 2016, every caregiver’s worst nightmare came true for Sonia Melendez. Minutes after leaving a Chicago, Ill., mall, Melendez noticed that her 18-month-old granddaughter, Aureliana Colon, was choking. Melendez immediately pulled her car to the side of road and frantically called 911. However, the grandmother was too hysterical to speak, so she handed the phone to a bystander who had pulled over to lend a hand.

Handling the call

The good Samaritan spoke with a dispatcher and waited on the phone until paramedics arrived. Fortunately, the child survived and was out of the hospital in a few days. Of course, when it comes to a choking call, there are many possible challenges to address. Let’s examine a few turns this call could have taken and how you would handle each scenario.

Scenario 1

In Case Entry, the caller reports that the child was sitting in her car seat, choking. The 18-month-old girl had been sucking on her pacifier when the choking began. The caller also states that the girl’s eyes have rolled back into her head and she appears unconscious. She is not breathing or coughing at all. The caller says the grandmother told him the child was choking on some candy.

Steps to follow

Based on the information you have, you know the Determinant Code should be 11:E–1C, COMPLETE obstruction/INEFFECTIVE BREATHING. Axiom 1 on Protocol 11: Choking, helps you make this choice. The Axiom reads, “Victims of COMPLETE airway obstruction are unable to speak, breathe, or cough.” You dispatch the call appropriately and then give Post-Dispatch Instructions: “I’m sending the paramedics to help you now. Stay on the line and I’ll tell you exactly what to do next. Do not slap her on the back.” Having all other necessary information, you must move to the appropriate Pre-Arrival Instructions. Your choice will depend on the patient’s age and whether she is conscious. Because the caller reported the patient is not conscious, you can eliminate the use of Protocol D: Choking (Conscious) – Adult/Child/Infant/Neonate. Also, because you are working with an unconscious 18-month-old, you must use Protocol B: Airway/Arrest/Choking (Unconscious) – Child 1–7 yrs.

This protocol has 18 panels. The panels you cover and the instructions you give are contingent on the answers the caller provides. For example, Panel B-2 has you instruct the caller to “Lay her flat on her back on the floor/ground and remove any pillows” and then to “Kneel next to her and look in the mouth for food or vomit.” You will then ask a
critical question: “Is there anything in the mouth?” If the answer is yes, you move to Panel B-13, where you tell the caller how to clear the airway by cleaning out the child’s mouth and nose. At this point, because the baby obviously is not breathing, you'll go to Panel B-3 without giving instructions; Panel B-3 will then send you to Panel B-5 to begin compressions and then go back to mouth-to-mouth instructions after CPR is administered.

Scenario 2
Suppose the only information you have from the third-party caller is that a woman had pulled her car over on the highway because a baby inside was choking.

Steps to follow
After obtaining the location of the caller/patient, you must ask Case Entry Question 3c: “Is she breathing or not?” If the caller isn’t sure, instruct him to check and find out. If the caller reports that the patient is breathing, you know it is a PARTIAL obstruction. It is essential here to instruct him not to slap the baby on the back, because, as Axiom 2 on Protocol 11: Choking states, “PARTIAL obstruction can be made more life-threatening by attempted intervention in the breathing patient.”

Case Entry Question 4 asks, “How old is she?” In this scenario, let’s say the caller asks the grandmother and reports that the baby is 6 months old. The first two Key Questions to ask here are, “Is she completely alert?” and “Is she breathing normally?” Assuming the answers to these Key Questions are “no” and “yes” respectively, the calltaker would skip Key Question 3 “Is she able to cry?” since it is only asked if the patient is alert and breathing normally and would move on to Key Question 4 “What did she choke on?” If the caller isn’t sure what the baby is choking on, you will select Determinant Code 11-D-20, Not alert.

Next, give your Post-Dispatch Instructions and appropriate Pre-Arrival Instructions. In this scenario, you would use Protocol D since the baby, although not alert, is conscious.

11-E-JU. You have provided Post-Dispatch Instructions and go to Protocol N: Airway/Airway/Choking (Unconscious) – Newborn/Neonate < 30 days. If you determine from Panel N-2 questioning that there is nothing in the baby’s mouth, how would you handle this situation?

Steps to follow
After determining that nothing is in the baby’s mouth, you would go from Panel N-2 to Panel N-5, giving instructions and moving past Panel N-4. However, if there was something in the baby’s mouth, the correct panel flow would be N-1, N-2, N-13, N-3, and then to N-5. Once in N-5, this panel instructs you to tell the caller, “Listen carefully and I’ll tell you how to do chest compressions. Make sure the baby is flat on its back on the ground. Place 2 fingers on the breastbone, right between the nipples.” Next, move to Panel N-6 where you will tell the grandmother how to give the compressions to her newborn granddaughter. After clearly giving the instructions, ask, “Do you understand me so far?” If the grandmother says that she does not, give clarification and reassurance. If she understood your directions, you would head back to Panel N-4 and instruct her to give the baby five puffs of air. Next, you would go on to Panel N-8 and continue CPR and mouth-to-mouth.

From this point, follow Protocol N until emergency responders have arrived on the scene.

Customer service
As with other Chief Complaints, when dealing with a choking call, you’ll often be talking to frantic, panicked callers whose loved one is in a life-or-death struggle. Even third-party callers will experience a great deal of stress as you instruct them on how to assist in the emergency. Thus, it’s vital that you provide excellent customer service by reassuring the caller, clarifying instructions, speaking calmly and directly, and behaving in a professional way.

Here are some ways in which you can help callers make it through this difficult
situation and provide patients the help they need:

• Use repetitive persistence.
• Repeat phrases verbatim with a steady tone of voice.
• Say, “Listen to me carefully so we’re sure to do it right.”
• Use the caller’s name if possible.
• Give reassurance by telling the caller that if the patient can talk or cough, the airway is open and enough oxygen should be getting to the brain.
• Use a positive tone.
• Do not alter the wording from the protocols.
• Never use an offensive command.
• Refrain from inappropriate behaviors such as ignoring the caller’s concerns or demeaning, judging, or insulting the caller.
• Don’t use offensive or confrontational language.

It is essential that you maintain control of the call. Callers will look to you to take charge and tell them exactly what to do. Recognize that in moments of extreme stress, some callers may lose control of their emotions and say hurtful things to you. Never take these things personally. Keep your own emotions in check and commit to complete professionalism.

The data
The holiday season brings family and friends together for parties, celebrations, and festivities. Where there are groups assembling for social events, there is often food and drink. While we look forward to these happy times, there’s always the risk of choking. When you picture a full room of people talking and laughing, all while eating their favorite meal or downing their favorite beverage, it’s easy to see why choking is a common hazard.

The American Academy of Pediatrics reports that hot dogs top the list of foods that cause the most choking incidents. One person every five days dies from choking on this popular food. Hot dogs are the leading cause of choking deaths for children 14 and under. Apples, and grapes are good for you, but they are second, third, and fourth, respectively, when it comes to choking hazards. Nuts, peanut butter, marshmallows, gum and hard candy, and popcorn round out the top nine. Other foods to watch out for are chips, cheese, pretzels, raisins, and ice cubes.

Food is hardly the only culprit when it comes to choking. Deflated balloons, batteries, bolts, coins, crayons, jewelry, doll accessories, toys with small parts, small office supplies, and bottle caps are other common sources for choking.

Children are especially susceptible to choking. One reason could be that children have airways one-third the size of an adult’s. Between 2001 and 2009, an average of 12,435 children 14 and younger were treated annually in U.S. emergency rooms for choking problems.

Another study, this one published in the journal Pediatrics, revealed that 34 children per day are admitted to the ER due to choking issues. In Canada, choking and suffocation are blamed for nearly 40 percent of all unintentional deaths among babies under the age of 1. In Europe, an estimated 2,000 children 14 and younger choke on a toy each year, and 50,000 children in this age range have some sort of choking episode annually.

The elderly also are prone to succumbing to choking hazards, largely because of dentures or difficulty swallowing. In 2016, the National Safety Council reported that 4,684 people died from choking in 2013. Of this total, 2,751 were older than 75.

Sources
4. See note 3.
5. See note 3.
6. See note 3.
CDE Quiz Mail-In Answer Sheet

Answer the test questions on this form. (A photocopied answer sheet is acceptable, but your answers must be original.)

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

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☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other

ANSWER SHEET + MEDICAL

Nov/Dec 2016 Journal “Make the Right Call”

Please mark your answers in the appropriate box below.

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

YOU MUST BE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Make the Right Call,” which starts on page 31. Take this quiz for 1.0 CDE unit.

1. What does Axiom 1 say about victims with COMPLETE airway obstructions?
   a. Victims can breathe but not speak.
   b. Victims should be encouraged to continue coughing.
   c. Victims will faint.
   d. Victims are unable to speak, breathe, or cough.

2. If the victim is 18 months old and unconscious, what PALS should you give?
   a. Protocol N
   b. Protocol A
   c. Protocol B
   d. Protocol C

3. To help dislodge obstructions, dispatchers should instruct callers to slap the patient on the back.
   a. true
   b. false

4. If the victim is not completely alert and breathing normally, and it is not known what she is choking on, the call should be coded as:
   a. TI-E-1U.
   b. TI-D-1U.
   c. TI-D-2U.
   d. TI-A-1U.

5. Using Protocol N, how would you instruct the caller to begin performing chest compressions?
   a. Make sure the baby is flat on its back and place two fingers on the breastbone, right between the nipples.
   b. Lay the baby flat on its back and gently place the heel of one hand under the breastbone.
   c. Lay the baby flat on its back, place the heel of one hand under the breastbone, and place the other hand on top.

6. On Protocol N, if the caller does not understand your instructions on Panel N-6: Compressions, you should:
   a. move on to Panel N-7.
   b. go to Panel N-4.
   c. clarify or reassure.
   d. tell the caller to calm down and listen.

7. It’s misleading and falsely reassuring to tell the caller that if the patient can talk or cough, he or she is getting enough oxygen to the brain.
   a. true
   b. false

8. Usually, callers are looking to you to ____________________________.
   a. listen to what they have to say.
   b. quickly give them information and then get off the line.
   c. let them control where the call goes.
   d. take charge and tell them exactly what to do.

9. Hot dogs are the food most likely to cause choking. What food is the second-most likely?
   a. carrots
   b. apples
   c. grapes
   d. marshmallows

10. Each year __________ children in Europe ages 14 and younger have some type of choking incident.
   a. 2,751
   b. 4,684
   c. 12,435
   d. 50,000

To be considered for CDE credit, this answer sheet must be received no later than 12/31/17. 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.
TOOLS TO MEDICAL SUCCESS FOR LAW ENFORCEMENT

SCA survival takes more than buying an AED for police

Jeff Clawson, M.D.

Who’s often first on the scene in an emergency? Law enforcement.

Police officers, sheriff’s deputies, highway patrol, and specialty police (such as search and rescue and SWAT) are often on scene before firefighters and EMTs/Paramedics arrive for reasons including proximity, safety, and availability. So, it only makes sense that these same people carry tools proven effective in medical emergencies, particularly automated external defibrillators (AEDs) to give a second chance to patients of sudden cardiac arrest (SCA).

Arriving with an AED, however, is actually down the list of actions necessary to success. Strengthening the Chain of Survival requires more than purchasing AEDs, placing them in squad cars, and training officers how to use them. After all, would the Lone Ranger prove effective in uncharted territory without his astute companion Tonto providing direction?

As the Academy — and its founder Jeff Clawson, M.D., has long asserted: dispatch is a critical component in an AED program. It’s essential that response agencies coordinate their protocols, and continue to fine-tune procedures once officers with AEDs are being deployed. Survival rates suffer without coordinated response to cardiac emergency calls and timely hand-off to medical professionals who can provide advanced life support.

EMDs trained and certified in the use of the Medical Priority Dispatch System™ (MPDS®) are an essential first step to better ensure efficient and rapid deployment of AED-equipped officers. Tied to that step is the working relationship between the communication center and law enforcement field response. EMDs are vital partners in managing the types of calls that AED-equipped officers respond to, and, at a minimum, dispatch protocols should be specific and clearly identify medical problems that will trigger an AED response from an agency.

This was an issue that led to the Academy’s development of the Cardiac Arrest Quotient (CAQ), as described in the accompanying article. The CAQ is the number of SCAs
found at scene within a particular determinant descriptor divided by the total number of responses generated by that code. The formula delineated stronger indicators, heralded the addition of several new, richer CAQs, and stimulated continuing research into establishing associations between patient outcomes and MPDS priority levels and specific determinant codes.

Outcomes, however, are not universal in application of a single CAQ system. Outcomes depend on data submitted to the Academy and analyzed according to specific study parameters and individual agencies taking advantage of the CAQ concept to establish local AED programs. 

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**Manhunt! Improve AED Response**

Helping Police Enrich “The Cardiac Arrest Quotient”

Discharge is often overlooked as a crucial component of a successful AED program. Some law enforcement AED programs find themselves responding to a high number of calls for an AED that don’t actually require a device. To effectively add early defibrillation to its mission, law enforcement must be able to reliably collect data. The solution to this challenge? Learn from the experience of others by collecting and analyzing dispatch data.

The National Academies of Emergency Dispatch (NAED) was asked to help a prominent metropolitan dispatch center resolve a major discrepancy between their “dispatched as” vs. “outcome” findings. The agency’s governing council purchased 1,400 AEDs and deployed them on police squad cars in their jurisdiction. Cardiologists and EMS physicians subjectively selected 33 of the 250 dispatch protocol determinant codes thought most likely to detect an at-scene finding of a cardiac arrest. AED-equipped police squad cars were then assigned a co-response based on these specific codes. To their great frustration, initial data showed that less than 10% of the responses resulted in at-scene findings of cardiac arrest. How could dispatch better identify those calls that might benefit from the rapid response of an AED-equipped officer?

The Chain of Survival cites early access as the first link in the chain of events that determines whether a patient

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**Figure 1: Cardiac Arrest Quotient “Richness” Comparisons**

- **Emergency Response**
  - 6-9-1 Severe Respiratory 78 1,433 5.44%
  - 6-9-2 Breathing problems/Not alert 52 1,948 0.88%
  - 10-9-1 Severe Respiratory 1 356 0.08%
  - 10-9-2 Chest Pain/Not alert 53 442 12.26%
  - 10-9-3 Severe Respiratory 50 6,936 0.70%

- **Community**
  - 6-9-1 Severe Respiratory 78 1,433 5.44%
  - 6-9-2 Breathing problems/Not alert 52 1,948 0.88%
  - 10-9-1 Severe Respiratory 2 356 0.08%
  - 10-9-2 Chest Pain/Not alert 53 442 12.26%
  - 10-9-3 Severe Respiratory 50 6,936 0.70%

Initial data showed that less than 10% of the responses resulted in at-scene findings of cardiac arrest. How could dispatch better identify those calls that might benefit from the rapid response of an AED-equipped officer?

The Chain of Survival cites early access as the first link in the chain of events that determines whether a patient

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**The Cardiac Arrest Quotient**

Communication centers using the NAED’s Unified EMR Protocol codes collect comparable data, allowing the Academy to review a vast amount of information. To answer the challenge presented by this department, we studied outcome data from a variety of similarly sized cities. In doing so, we created the Cardiac Arrest Quotient (CAQ). The CAQ is simply the number of at-scene at-scene arrests. We modified the initial 33 subjectively selected by adding many work CAQ codes and adding several new, richer ones. The results predicted at-scene arrest findings went from under 10% to nearly 27%. This agency can now control its AED response by using the CAQ to their benefit.

**Conclusion**

The one employer of EMDs in the United States is not ambulance service, hospitals, or fire departments, but law enforcement communications centers. It is critical that employees receive early training in selecting and correctly using standardized dispatch protocol as well as establishing a sound dispatch quality assurance program.

The EMS community and law enforcement-based AED programs can improve their effectiveness by taking greater advantage of the data available from their dispatch centers. Use of the CAQ concept using comparable dispatch data from other systems should be an essential part of any defibrillator deployment program.
SPOKES IN A WHEEL

EMS is survivor’s Circle of Life

Patrick W. Rollens

On a mild, cloudy afternoon, in the comfort of his living room and surrounded by his family, Dave Smith looked back on the remarkable confluence of events that saved his life back this past April after he went into cardiac arrest while watching TV.

The evening started uneventfully, with Dave and his wife Karen watching TV. But at 10:30 p.m., Dave’s head pitched back and his breathing became labored. Karen knew something was terribly wrong.

Karen’s 911 call reached David Scott, a dispatcher at the Corvallis (Ore.) Regional Communications Center with 10 years of experience on the job. Within seconds, David was gathering information and delivering critical instructions over the phone using the center’s new ProQA® dispatch system, which had been adopted just a few weeks prior. Karen was joined by two of her teenage sons, and together they were able to get Dave onto the floor and flat on his back.

Then the real work began. “Instructions are only as good as the person on the other end of the line,” Scott said. “You have to have somebody on the other end willing to follow through with what you’re asking.”

Scott instructed Karen and her sons to begin CPR. It’s a physically demanding technique that leaves even the sturdiest firefighters winded after just a few minutes.

The success of CPR depends on one critical tenet: Once you start CPR, you don’t stop until a medical professional relieves you. Karen and her sons didn’t stop. They handed the phone back and forth, staying in constant communication with Scott as he passed along instructions to them while other dispatchers relayed information to the first responders who were en route.

“The dispatcher was very calm, very reassuring,” Karen recalled. “He told me where to push on the chest, and he told me to count out loud. If I stopped, he’d say, ‘I can’t hear you counting. Are you counting?’”

Scott stayed on the phone as the quick response team from the Monroe Rural Fire Protection District showed up, along with two deputies from the Benton County Sheriff’s Office. He stayed on the phone as they unpacked their gear and made their way into the house. Only when the emergency responders were at Dave’s side and ready to take over chest compressions did Scott allow Karen to hang up.

The quick response team used a defibrillator to shock Dave’s heart back into action. It took five shocks to get him to the point where they could transport him to Good Samaritan Regional Medical Center in Corvallis. Dave survived.

Reflecting upon the situation, 911 Manager Scott Haberkorn noted that there was no margin for error; each component of the entire emergency response had to function perfectly to save Dave’s life.

“The system worked,” Haberkorn said. “From the dispatcher, to the family, to the Monroe quick response team, to the ambulance that transported the patient to the hospital in Corvallis, everything worked just right.”

Scott points to the family as the critical component. “If the callers don’t stay with me, if they don’t at least stay calm and coherent enough to follow instructions, it’s difficult to help them,” Scott said. “The family made the difference in this case.”

The city of Corvallis operates the Corvallis Regional Communications Center, which provides 911 dispatch services for 10 Benton County emergency service providers. Go to tocorvallisoregon.gov/911 for more information on the Corvallis Regional Communications Center.

AS THEY OFTEN DO, RAW NUMBERS TELL THE REMARKABLE STORY.

- 10%: the amount by which the survival rate of an unresponsive person in cardiac arrest drops for each minute that goes by without CPR.
- 600: the approximate number of CPR chest compressions delivered by Karen and her teenage sons as Dave lay unresponsive on their living room floor.
- 10 minutes, 32 seconds: the amount of time the dispatcher from the Corvallis Regional Communications Center stayed on the phone, carefully and calmly guiding Karen and her sons through the life-sustaining techniques that helped save Dave’s life.
- 5: the number of shocks administered to Dave by emergency responders when they arrived on the scene.
GOOD LUCK COMES IN THREES

New Hampshire EMD delivers

Audrey Fraizer

A n iPhone cable has more uses than simply plugging it in a socket to recharge a battery. At least, that’s what a caller discovered when EMD Daniel Redin got to the part in protocol about tying off a newborn’s umbilical cord.

“Listen carefully and I’ll tell you exactly what to do next,” Redin said, reading the scripted Childbirth-Delivery Pre-Arrival Instructions (PAIs). “We’re going to watch the baby closely for three minutes, then tie the cord with a string (shoelace).”

There was a pause. Dad, who was the caller, watched the baby. Everything was fine, except for a minor detail.

Dad was wearing slip-on shoes, and mom was wearing slippers. There were no spare shoelaces or balls of string in the car, and dad couldn’t leave the car to flag down a motorist in hopes of borrowing a stranger’s shoelace.

The caller had no other choice but to improvise.

“He [dad] looked around the car and all he could find was the phone cord,” Redin said.

The PAIs went on as scripted. Dad tied the phone cord around the umbilical cord. Again, following the PAIs, dad was told not to cut the umbilical cord.

The cord was wrapped in place and tied when paramedics arrived on scene to whisk mom and baby to the hospital in an ambulance.

There’s no telling what responders thought of the innovative use of a phone cable, although cutting the umbilical cord is a job best left to the professionals. Cutting the cord can expose the baby to infection, and babies continue to get oxygen through the umbilical cord for five to 10 minutes after birth. About one-third of the baby’s blood is still in the placenta. The oxygen stored in the blood and fed to the baby through the umbilical cord can be lifesaving if the baby isn’t breathing independently and medics have yet to arrive on scene.

While the phone cord is most likely a unique way to tie things up, handling a baby delivery is something the New Hampshire Bureau of Emergency Communications EMD has done over the phone and in person. Redin switched to emergency communications four years ago. Prior to dispatch, he was an EMT for 10 years.

Assisting in a birth is not uncommon for an EMT. In emergency dispatch, however, it’s unlikely to have Redin’s
track record. He assisted in three deliveries in two months during the past summer.

The first delivery, in May 2016, was complicated by distance. The mother lived in a small town served by a volunteer ambulance service that was not close to her home, and baby was not willing to give them the extra arrival time required.

“Mom was in labor, and I went through the complete delivery,” Redin said.

The second baby, similar to the third, was born roadside while mom was in transit to the hospital.

All babies and mothers were none worse for the wear.

“They were all fine,” he said.

On Aug. 19, 2016, Redin and three fellow EMDs from the Bureau of Emergency Communications in Concord were recognized for their efforts to help deliver babies using EMD Protocol. As is the tradition for the event, the four EMDs were officially inducted into the 911 Stork Club. They each received a “Stork Club” certificate and a stork pin.

Redin was recognized for the baby girl delivered on July 1, 2016; Cheryl Dubord helped deliver a baby girl on July 20; Eric Cleverly helped deliver a baby girl on July 23; Allison Reopel helped deliver a baby girl on Aug. 7.

Redin is grateful for the outcomes, of course, and credits the successful deliveries to the cornerstones of his profession.

“My job is to pay attention to callers, listen to what they have to say, and do everything right using the protocol,” he said. “We ask questions, give instructions, and stay on the line until response gets there. We generally don’t meet the people.”

Redin, however, also beats the odds in that category.

In November 2013, sudden cardiac arrest survivor Tom LaFortune repeatedly thanked Redin in person during an emotional visit to the dispatch center. The 74-year-old LaFortune had experienced breathing problems while eating dinner with his two children, prompting them to call 911. Redin guided LaFortune’s son, Denis, through CPR while his daughter, Laura, watched for the ambulance to arrive.

LaFortune thanked everyone involved in saving his life, saying he owes them all of his tomorrows yet to come. “I don’t know how to put it into words except thank you,” he said. “Thank you very, very, very much.”

Redin received press coverage and a commendation from the New Hampshire Division of Emergency Services and Communications for the “difficulty breathing” call.

The first two recent baby deliveries didn’t make it to the news, and although the third delivery did, Redin’s name was not stated in the coverage.

That doesn’t bother him; in fact, he prefers it that way.

“I saw the story in the newspaper, which was fine that it didn’t mention me,” Redin said. “I like to stay in the background. You trust your protocol and everything goes the way it’s going to go.”

It’s likely that Redin and fellow EMDs will be called upon to assist in childbirth sometime in the future. Although the vast majority of all births (98.7 percent, according to 2011 statistics) in the United States are delivered in hospitals, that leaves the balance to out-of-hospital events; the 1.3 percent (in 2011) represented nearly 50,000 births and of these, 66.2 percent (33,043) occurred in residences.

New Hampshire has two PSAPs—one in Concord and one in Laconia. They receive a combined average of 2,000 calls to 911 each day. Police and fire requests are transferred to the appropriate dispatch center.

Sources
PROOF IS IN EMILY
Immediate CPR leads to girl’s survival

Audrey Fraizer

A 911 call Kim Rigden answered 10 years ago, and its consequences, still resonates with the longtime protocol devotee and strengthened the resolve of her future career.

The date was July 11, 2006, and Rigden was answering 911 calls during the morning at the British Columbia Ambulance Service (BCAS). She was a certified Emergency Medical Dispatcher (EMD), but for the last year she’d usually worked as an ED-Q™ assessing 911 calls. After 11 years as a BCAS paramedic and seven years in dispatch, she figured she was ready for anything coming in over the phones.

This call was different, and Rigden knew it was incredibly serious from the first words the caller, Cynthia Cox, said to her.

“My granddaughter has had an electrical shock,” Cynthia said. “She’s not conscious.”

Rigden jumped into Pre-Arrival Instructions for CPR Dispatch Life Support (DLS) while BCAS EMD Dan McCleod dispatched the paramedic crew and launched a helicopter.

Cynthia’s granddaughter, 7-year-old Emily Cox, was electrocuted when she stuck a metal file into an open extension cord plugged into a circuit conductor. The bolt of electricity traveled up her right arm, across her heart, and exited out her left armpit. She was in cardiac arrest for 28 minutes.

Cynthia had never administered CPR to anyone. But she had something else on her side bigger than experience in CPR: Cynthia had raised four children, and in an emergency, she could react in a way the situation demanded.

“Everything else fades,” she said. “I can focus on what needs to be done.”

And that’s exactly what Cynthia did for the next eight minutes as Rigden coached her through lifesaving CPR while waiting for response to arrive.

Rigden remembers literally putting her finger on each panel of the Medical Priority Dispatch System™ (MPDS®) card set to follow the script verbatim.

Cynthia remembers trying to get one message across to her granddaughter. She kept repeating, “Emily, don’t you dare die on me. Emily, don’t you die on me,” while providing the compressions and breaths.

When paramedics arrived, Cynthia put the phone down and turned her attention to them. Rigden could hear her explaining to the paramedics what had happened, and Rigden disconnected the call, not knowing whether Emily would live or die.

BCAS transported Emily to Peace Arch Hospital in White Rock, B.C., and from there, thanks to McCleod’s foresight, airlifted her by medical helicopter to B.C. Children’s Hospital, a medical facility that specializes in care for the most seriously ill or injured children.

Emily’s mother, Lianne Cox, and father, James Cox, recall everything about the day. Both were at work when called and told about an injured “family member.” James persisted in questioning the caller for more information and was
asked to pull over his car en route to the hospital when told the family member was his daughter. Lianne wasn’t sure what to expect.

“I knew it was Emily, but I did not know the severity of her injury,” Lianne said. “It was a very trying 30-minute drive to the hospital.”

Emily’s heart was restarted twice. She was put in a drug-induced coma for two days. She stayed in the Intensive Care Unit (ICU) for three days and then spent another seven days in the children’s burn ward. Lianne and James spent days never leaving the hospital, stationed at their daughter’s bedside, watching Emily shiver on a chill blanket (used to reduce body temperature and prevent brain injury) for two days and holding their breath, awaiting results of successive brain scans.

“At first, it was wait and see,” James said. “No one knew. After the fact, I heard that they thought she wouldn’t make it through the night. It wasn’t until she woke up and recognized things that I was willing to accept that she was going to make it.”

Lianne and James were in the room when Emily opened her eyes on day two to see a familiar figure standing at the edge of her bed.

“Grandma,” Emily said. “What are you doing here?”

By day three, Emily was sitting up in bed and eating a bowl of Jell-O.

Emily doesn’t remember any of the events of the day she was electrocuted, and little from her hospital stay. She doesn’t remember greeting her grandma. She does recall a play date in the afternoon with a friend two days before the accident occurred.

“I know what people have told me,” she said. “My grandpa heard a yelp, and they took me into the bedroom and called 911.”

Emily bears the scar on her left armpit as a reminder of that day and the fragility of life. She likes talking about the accident when asked about the scar, and she likes getting the story out to raise awareness of electrical danger. She’s a senior in high school, and once graduated plans to pursue college degrees in business and photography. Her portfolio of nature photos shares a view few take the time to observe.

“I get down to bug level and take pictures in the grass,” she said. “They give a different perspective of what you look at every day.”

As far as the accident goes, “It’s something that happened,” she said. Lianne and James said the accident remains fresh in their memory. They still tear up and choke back words when describing the day referred to as Emily’s “second” birthday.

“This made me realize you can’t always hold on to what you love,” Lianne said. “You start looking at life as the way you want it to be, not what you expect it to be.”

James said it’s a reminder of how life depends on the help of others.

“Emily and James said the accident arrives. A helicopter takes her to the B.C. Children’s Hospital. She is still here because of everything happening the way it did.”

Emily and her younger sister, Ashli, live a 15-minute drive from their grandparents, and Cynthia can probably count on one hand the number of weeks either has failed to visit.

“They come on different days once a week so I can give each one all my attention,” she said. “I feel very close to them. They are like an extension of my own children.”

Ten years to the day after the accident, on July 11, 2016, Lianne posted a LinkedIn message to Rigden:

“Hi Kim, thanks to you I have a beautiful and healthy 17-year-old daughter. It was 10 years ago today that you came into my life in a big way. I can never thank the powers that be enough that you were the one who took Cynthia’s call that day. Thank you for all you did and know that you will always be in our hearts.”

Rigden was thrilled and, at the same time, humbled.

“I can’t even explain how wonderful it was to receive this message,” she said. “The call was a gift, something very stressful but also a privilege to be there and give guidance in saving Emily. What we do matters ... a lot, but I don’t think we realize how much it continues to matter to the people we help.”

Electrocution calls involving adults are rare, Rigden said, but the possibility of receiving an accidental electrocution call involving a child is practically unprecedented.

Cynthia credits Rigden for preventing what could have been an extraordinary loss.

“It was Kim who saved Emily,” she said. “If Kim hadn’t been there, I couldn’t have done what I needed to do.”

BCAS honored Cynthia in August 2008 for performing CPR that saved a life.
A white police officer’s shooting of an unarmed African-American man on April 7, 2001, in Over-the-Rhine, a neighborhood in Cincinnati, Ohio, sparked three nights of rioting and some of the worst racial violence since the 1968 assassination of the Rev. Martin Luther King Jr.

A month later, when a grand jury handed down a misdemeanor indictment against Police Officer Stephan Roach, activists, accompanied by clergy, most notably Black United Front President the Rev. Damon Lynch III, again took to the streets of what was at the time the eighth-most segregated city in America.1

“Stephan Roach, you can’t hide; we charge you with genocide,”2 marchers chanted in protest of charges deemed prejudiced and merely a slap on the officer’s wrist.

Roach, 27, was a firefighter and police dispatcher in Oxford, Ohio, before becoming a Cincinnati police officer in 1997. Roach shot and killed 19-year-old Timothy Thomas while trying to arrest him on 14 outstanding misdemeanor charges. He thought Thomas was reaching for a gun in a pursuit that took them down a dark alley. He shot Thomas in the chest.

Roach faced up to nine months in jail if convicted on charges of negligent homicide and obstructing official business. Municipal Judge Ralph E. Winkler acquitted Roach of both charges after hearing the trial without jury, pronouncing that the shooting was a “split-second reaction to a very dangerous situation created by Timothy Thomas.”3 The trial had commenced less than two weeks after the terrorist bombings of the Twin Towers in New York City, N.Y.

Roach, who did not testify during the trial, left the courtroom holding hands with his wife, Erin. “Unfortunately, this is a tragedy for everybody involved,” he said. “I would give anything to change the outcome of what happened that night, but unfortunately I can’t.”4

Jump ahead 13 years, and Roach still carries the weight of the incidents. For a long time, he took responsibility for the three days of total chaos on the streets, and he resents the media for his portrayal as a careless police officer exhibiting reckless behavior. As of 2014, he had yet to talk to his children about the incident.

“It’s kind of a hard thing to tell your kids,” said Roach, who left the Cincinnati Police Department in January 2002 for the Evendale Police Department (Ohio). “The incident changed the course of my life, and someday I have to tell them before they find out from someone else.”

Roach was among nearly a dozen police officers and behavioral experts interviewed in the documentary “Officer Involved,”
written and produced by Patrick Shaver, a police officer in Georgia, and his wife, Carla Shaver. The couple traveled more than 30,000 miles in two years filming and creating the resulting two-hour, 40-minute movie that since April 2016 has been shown through private screenings in theaters across the country.

On July 21, the Shavers brought their film to an audience of nearly 150 people in Salt Lake City, Utah. The event was sponsored by the Unified Police Department of Greater Salt Lake City, Salt Lake Valley Law Enforcement Association, and the Utah Transit Authority Police Department.

Patrick Shaver said the idea grew exponentially from a conversation. A friend wanted his view of why police officers tend to use deadly force during a potentially violent confrontation, rather than shooting to simply injure or immobilize the suspect.

“Police are always asked that question,” Patrick Shaver said. “Why can’t officers shoot the tires off a car or aim their gun at an arm or a leg? So much more goes into the situation, and there was nothing I could find that adequately explained what police officers go through. They are looking at making a judgment to save their life, their partner’s life, or a citizen’s life in a moment.”

“Officer Involved” documents the emotional, psychological, and social aftermath of officers who have been part of a deadly force incident but without fully describing the situation prompting the action (the Roach story was an exception). More than 150 officers contacted the Shavers in response to a posting about the project and a volunteer request on their “Officer Involved” Facebook page.

“We didn’t want to get into the why,” Patrick Shaver said. “The film does not pass judgment. We have tried to show the process even when things go bad as they did in Cincinnati. People can finally see he has emotion, that he [Roach] did struggle after the incident and is still trying to make peace with himself.”

The film is divided into sections, including how do you tell your spouse/children about the incident, public perception following media coverage, emotional issues of dealing with the incident, and the way officers are treated within their departments after an incident. The film explains why an officer seldom shoots to wound (training, movement dynamics, ballistics, tactics, and the challenges officers face on the street).

Wilmington (N.C.) Police Officer Ian Lovell talked about a police confrontation in 2014 with a young woman who was alone in her parked SUV. The woman’s boyfriend had called police after she sent him messages about harming herself. When police arrived on scene, Lovell saw the woman raise the gun up from her lap toward him and his partner with her hand on the trigger. He shot her, perceiving that his life and that of a fellow officer were in grave and imminent danger. She later died from the wound. The officers were cleared of any charges.

“There’s not a day that goes by without me seeing her face and wanting to help her,” Lovell said. “That girl wanted to die. That thing I walked away with was my life. Everything else was a loss.”

Riverdale (Ill.) Police Detective Sgt. Dan Dempsey talked about losing his partner, Detective William Rolniak Jr., in 2004. Dempsey and Rolniak had been questioning a suspect before the Cook County state attorney’s office approved charges of aggravated kidnapping, attempted first-degree murder, and home invasion. The suspect took Rolniak hostage and shot him in the head before Dempsey could reach them.

Rolniak was Riverdale’s first officer killed in the line of duty.

“The services were numbing,” Dempsey said. “I don’t remember a lot of it. Everything about the incident revolves around my life. It’s very difficult to process my partner’s death and the anger and guilt I felt afterward.”

The use of lethal force is life changing, said Police Psychologist Lawrence Blum, who has spent nearly 30 years evaluating and treating police stress.

“The incident pierces an officer’s callouses,” he said. “It’s an infection of the mind, soul, and heart.”

Carla Shaver said the experience of making the film affected her perspective.

“Every time [Patrick] leaves, I think about what could happen and then put it away,” she said. “Even as a police spouse, I didn’t understand what [Patrick] goes through, but hearing what can potentially happen time and time again integrates the reality. It has made me respect the profession even more.”

For Patrick Shaver, the adventure into filmmaking enforced what he already knew about the profession.

“Police work is dangerous in every aspect, and there’s a lot more we should be doing to prepare police officers for what happens afterward,” he said.

Editor’s Note: Go to officerinvolvedproject.com/officer-involved/ for more information about the “Officer Involved” project and film.

Sources


4. See note 3.

Join us at NAVIGATOR 2017 in New Orleans, Louisiana, USA, for the inaugural Emergency Dispatch Research Workshop, hosted in partnership with the UCLA Center for Prehospital Care.

This workshop promotes a hands-on approach to learning about research. Participants work in small groups to identify a research question, decide on methods, and craft their abstracts. Statisticians, programmers, and editors are on-site to immediately provide step-by-step support, assisting participants in obtaining data, performing a statistical analysis, and constructing an abstract ready for submission or presentation.

Bring your question—we’ll help you find the answers!

- Introduction to Research
- Data Analysis
- Small-Group Project and Literature Review
- Creation and Mock Presentation of an Abstract

Email researchhelpdesk@emergencydispatch.org for more information and to register for the workshop.

* No prior research experience required.

You’re invited to submit research abstracts for the poster presentation exhibit that will be displayed at NAVIGATOR 2017 in New Orleans, Louisiana, USA, April 12–14!

Topics include any subject relevant to dispatch research in any discipline—published or unpublished. Abstract submissions must be received by Feb. 17, 2017. Submissions will be reviewed by the IAED’s Research & Informatics Division. Accepted abstracts will be announced no later than Feb. 28, 2017. PDFs of the accepted posters are due by March 10, 2017.

Go to https://www.aedrjournal.org/cfpp/ to submit your Research Poster Abstracts.

*SOMETHING INCRECIBLE IS WAITING TO BE KNOWN.*

–Carl Sagan