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ART BRAUNSCHEIGER
7 | FROM THE EMD SIDE

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, New Jersey, USA. Art has been involved in 911 telecommunicator training and medical quality assurance since 1999.

SHERRI STIGLER
20 | NAVIGATOR

Sherri is the training and operations manager for Waukesha County Communications, Wisconsin, USA, 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.

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13 | CENTER PIECE

Bonnie has been a dispatcher with Waukesha County Communications, Waukesha, Wisconsin, USA, since 2010. She is an APCO-certified Communications Training Officer, a member of the center’s quality assurance team, and an IAED™ ETC instructor. She enjoys working with and sharing her knowledge and expertise with people interested in the emergency services career.

RYAN DEDMON
20 | NAVIGATOR

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.

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THE WHOLE ENCHILADA
Lots of substance served up in this issue

Heather Darata

It’s hard to believe it’s already summer. We have a lot in store for you this time around. In addition to our NAVIGATOR coverage, we have a feature that features four specific smartphone apps. Bystander CPR offers step-by-step CPR instructions and alerts users to the closest AED. GoodSAM alerts the closest volunteer responders registered with the app when there is a cardiac arrest. The volunteer responder accepting the alert gets a map with the patient’s location and the location of the closest AED and has access to the app’s tools, including a metronome and on-scene video streaming. Check out our feature to learn about the PulsePoint and FirstNet apps.

People might think summer sunshine puts suicidal thoughts at bay, but it’s just not true. Suicide is the eighth-leading cause of death in the U.S., with 30,000 people dying each year. To learn about Crisis Intervention Training in addition to how the medical and police protocols are each used to handle suicide, read the CDE articles in our OnTrack section and take the quizzes to receive credit.

If you’re in the mood for a cross-country trip, check out our Best Practices section to learn about Waukesha County Communications (WCC), Wisconsin, USA, and the Albuquerque Fire Department (AFD) in New Mexico, USA. WCC provides emergency communication services for 21 fire/EMS agencies and law enforcement agencies in the county. AFD made history by becoming the first-ever IAED™ Accredited Center of Excellence (ACE).

Your favorites are in here too—Ask Doc and FAQ. Make sure you don’t miss out on an amazing survival story in Your Space section. Miraculously, Jonathan Arteaga lived to tell the tale after a 37,000-pound mobile home fell on him. Montgomery County Hospital District (Texas, USA) communication center EMD Danielle Williams answered the call. Two days later had the chance to meet. Also inspiring is the story of Anthony Bruno from Las Vegas Fire & Rescue, Nevada, USA. On his way home after his shift had ended at 2 a.m., he came across an emergency scene. After stopping at the scene, he heard a noise. His investigation led to a person in need of help, about 100 yards away from the initial accident. Bruno has been recognized with several awards for his role in helping save the man’s life.
Here at the Academy, we spend months preparing to put on a memorable, educational, enjoyable NAVIGATOR conference each year. We expend a great deal of time, energy, and resources to ensure it’s a worthwhile week for you.

In years past, National Public Safety Telecommunicators Week (NTW) preceded NAVIGATOR. NTW gives special acknowledgement and appreciation to dispatchers and calltakers everywhere for their dedicated efforts as the first, first responders. It has been the perfect way to get ready for our annual conference. This year, however, NAVIGATOR was held a couple of weeks earlier than usual, placing it at the same time as NTW. This created some challenges on our end, as we tried to give appropriate recognition to each. It was also a unique experience to celebrate both important occasions simultaneously.

While a portion of our staff headed to New Orleans, Louisiana, USA, for NAVIGATOR, April 12–14, others remained behind to take care of other duties. I had the pleasure of promoting NTW on social media, and it was enjoyable to see how centers in the U.S. recognized the week.

Followers of our Facebook page sent us photos of themselves and their coworkers dressing up as superheroes or in crazy outfits. Others provided pictures of comm. center employees eating meals together that local restaurants or stores had provided during the week. It was obvious that you take NTW seriously and that you’re all part of a large group of like-minded, hard-working professionals.

My favorite part of promoting NTW on social media was when I posed this open-ended question: “How do you encourage someone to overcome the stress of the job and find success?” I asked our followers to tell everyone what advice they would give a struggling dispatcher/calltaker. The response was fantastic, and everyone who participated gave excellent advice. Here are some of the most insightful words of wisdom:

“Each call that we take changes a life. When a caller dials 911 it begins a chain of events that in large part is controlled by you. That call creates a ripple effect. The size of that effect is determined by you. You determine when to send a unit non-emergency or to send a battalion emergency. That is a huge responsibility. Not everyone can handle that responsibility. This is a special skill not everyone is built to do, but if you are you must find it in yourself to pick up the line and answer that call.”

— Patty Fernandez-Andres

“Don’t give up. The task of learning this job seems insurmountable, but it isn’t. Take full advantage of the time you have with your trainer and learn as much as you can from them; take the best of each dispatcher you train with and put those pieces together to be the best you can be. Most importantly, remember that we are all here for you!”

— Dawn Michele

“You will have good days and bad days—days that you feel on top of the world because you know you saved a life, and days when you just wish you could go through the phone and do something to make a difference. We all have the days when the only thing that helps is just being there, and sometimes it is just to listen and offer words of encouragement. But never doubt for one second you are not doing enough or you are not making a difference, because you are.”

— Lisa Howard

That was just a small sample of the wonderful responses we received during NTW. It is a pleasure to be involved in a small way in this profession and to hear so many inspiring stories and examples of devotion and heroism.
MEET BROCK
One victim’s legacy to the Medical Protocol

Art Braunschweiger

This column is dedicated to the young man in the photo. His name is Brock Ruether. In May of 2012 he was a talented, athletic 16-year-old living in Alberta, Canada, when he went to volleyball practice at his high school one evening. During play, Brock collapsed from sudden cardiac arrest (SCA). CPR was started within a few minutes, but it didn’t save him. Sadly, the AED that could have saved his life was brought to his side and never used.

Brock’s mom, Kim, now spends her time educating the public on SCA and the need for better AED access and awareness in schools. (75 percent of SCA deaths in children occur on school grounds.) The statistics on SCA are sobering: nine out of 10 victims die, including 7,000 to 10,000 children every year in North America. Yet the chances of survival are nearly 100 percent if the shock from an AED is administered within one minute of collapse. That shock is arguably even more important than CPR because SCA usually results from ventricular fibrillation, an erratic and ineffective beating of the heart that can only be corrected with an electrical shock from a defibrillator.

Brock’s death was the catalyst for several changes in the Medical Priority Dispatch System™ Protocol. The AED instructions have since been revised, and an AED dashboard has been added to ProQA® medical. And in Version 13.0 of the Protocol, to increase calltaker awareness of the vital need for the caller to get and use an AED, Brock’s Law was added. It simply and directly states that “The presence of an AED does not ensure its use—the EMD does.”

You might be thinking, “I know that. I always give callers the instruction to get an AED if there’s one available.” Unfortunately, there usually isn’t; at least, that’s what most of our callers say. Granted, not many people have defibrillators in their homes. But think about the places where there are defibrillators. Large stores, office complexes, movie theaters, and other high-occupancy buildings are almost certain to have an AED mounted on the wall somewhere. Next time you receive a call for a cardiac arrest from one of those places, and the caller says there’s no AED available, remember Brock. Step out of the Protocol for a moment and say “Sir, there should be a defibrillator somewhere in the building. Send someone to go look for it.” That’s not freelancing; it’s lifesaving. The caller may be in such tunnel vision because of the patient’s collapse that they’re not thinking beyond the immediate area they’re calling from. Your prompt could literally mean the difference between a positive outcome and a pronouncement of death.

But what happens if you tell ProQA there isn’t a defibrillator available, and as you’re doing compressions the caller volunteers that someone showed up with one? Would you know how to get to the AED pathway? It only takes four clicks in ProQA: one to access the Go To Specific PAIs button (“Target Tool”), one to highlight Protocol Z (AED Support), and a double-click on Panel Z4 – Place AED. And please, don’t just read this. Run a test call and try it.

Lastly, when you receive a call for a patient in their early 20s or younger who collapses with no outward cause, sudden cardiac arrest should be the first thing you consider. Remember, too, that breathing descriptions of “gasping,” “a little,” “barely,” and similar terms describe agonal respirations—not effective breathing. And remember Brock. Defibrillation is critical to survival. Get that AED to the patient’s side and make sure it’s used without delay.
Perhaps the most influential agents of change for the MPDS are the actual users. From Proposals for Change (PFC) to rapid input regarding the newest beta version, users provide the real-life feedback so necessary for quality protocol evolution.

Case in point: MPDS v13.0 contained changes to the ECHO-related, INEFFECTIVE BREATHING section of Case Entry. These changes were inspired by PFCs that detailed actual cases where EMDs did not select an ECHO code because the caller’s description did not EXACTLY match the quoted phrases in this section of the Protocol. In other words, the patient was actually in dire straits but, because the description did not match the Protocol phrase exactly, the EMD did not code the call as ECHO.

In reality, these phrases were taken from actual calls, which is why they are placed as quotations. However, they were never meant to be exact or absolutes. So, after considering the related PFCs, the Council of Standards voted to make a couple of changes to clear things up. First, the phrase “...or reasonable equivalents...” was added to the directive at the beginning of the section, and this has worked out very well. Additionally, to more directly address one of the PFCs, the phrase “Can’t breathe at all” was changed to read “Can’t breathe (at all).”

But while the intent of the later change was actually to allow more discrepancy on the part of the EMD, it has apparently opened the gates a little too wide. Several high-volume agencies have reported spikes in the number of ECHO-level calls and have provided data that links the complaint of “Can’t breathe” alone to the volume increase. Additionally, there is field data to suggest that most of these patients are not as sick as the “Can’t breathe at all” group. In fact, many of them are reported to be 1st party callers speaking in full sentences, while stating, “I can’t breathe.”

In response to this excellent feedback, the Academy’s Rules Group, a working sub-group of the Council of Standards, is in the process of addressing this issue by removing the parentheses from this phrase and addressing the issue here, in print.

The intent of the INEFFECTIVE BREATHING section, and its link to the ECHO code, is to capture the most acutely ill patients that can benefit from the immediate response of the closest available trained responder who, in many cases, is not part of the standard EMS response team (e.g., HAZMAT units, ladder trucks, police, etc.). Patients with INEFFECTIVE BREATHING, as the term strongly suggests, are not breathing adequately to sustain life. And it is expected that while emergency callers have predictable tendencies in their descriptions of these patients, there is bound to be some variation. Therefore, EMDs should be encouraged to consider not only the caller’s vernacular, but also the scenario and any additional clues it may provide. Certainly, if the caller describes a patient using one of the listed terms, and there are no obvious circumstances to the contrary, INEFFECTIVE BREATHING must be assumed and the appropriate code assigned. But if the exact term or phrase is not used, and the EMD strongly suspects INEFFECTIVE BREATHING, caution must always err in the patient’s favor; 1st party callers offer direct, audible assessment of their breathing status.

Likewise, a same or similar INEFFECTIVE BREATHING term may be used when it is obvious the patient is not in severe distress, most commonly when 1st party callers are involved. This is most likely when the 1st party patient states “I can’t breathe” but is otherwise speaking in complete sentences without obvious distress. Again, the goal here is appropriate triage in the best interest of the patient, not simple word matching by the EMD.

The Academy owes a great deal of gratitude to the EMDs and their agencies who take the time and effort to provide the feedback so important to the evolution of the MPDS. In this case, the feedback is being used to “fast-track” this change into ProQA® and make it available to users as soon as possible, perhaps even by the time of this printing. In the meantime, EMDs and ED-Qs should consider the phrase “Can’t breathe” with discretion when it is offered alone or without further clarification, meaning it is no longer a mandatory, ECHO-level phrase in and of itself.

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

Special thanks to the Central Communications Center for Alberta Health Services in Edmonton, Alberta, Canada; the Toronto Paramedic Services Communications in Canada; the Alameda County EMS Authority in San Leandro, California, USA; the Oakland Fire Department in California, USA; and the various IAED™ National Q clients who submitted their concerns and supportive data to facilitate this important change in the MPDS.
The halls were lined with row after row of intriguing research summations presented on posters and submitted from the finest researchers in prehospital care. This was a celebration of innovation and genius in a health profession considered a significant link in the history of health care.

The event was part of the annual National Association of EMS Physicians (NAEMSP) conference, which was held in New Orleans, Louisiana, USA (Jan. 21–26). Educational sessions and research posters highlighted response safety, challenges unique to demographics and geography, and contemporary issues involving social media and credentialing. There were several papers on emergency dispatch.

The International Academies of Emergency Dispatch® (IAED™) research team presented a summary explanation signifying the first release of data from the Academy’s metronome study. A metronome audio built into the Medical Priority Dispatch System™ (MPDS™) ProQA® software signals the rescuer to do a chest compression at each click of the metered sound when providing CPR to a victim of sudden cardiac arrest.

The IAED research group conducted the study in 2016 at four sites in Salt Lake City, Utah, USA, with each site characterizing a different demographic population (junior high, assisted living residential setting, community college, and university). Participants were randomly allocated to either of two groups: standard instructions given by EMDs over the phone (control group), and instructions complemented by the metronome audio over the phone (experimental group).

The results support related (non-IAED) studies: A metronome for dispatchers to direct bystanders in giving CPR is effective in helping bystanders achieve the correct compression rate.

The popular research poster exhibit serves several purposes, not the least of which is the venue to share innovation, spark discussion, and encourage networking among the many disciplines under the EMS umbrella. The contest has also grown beyond expectation, resulting in daily rounds to assemble, view, and take down posters in preparation for the next scheduled group. Each day, conference goers paraded along the poster route, stopping to hear a synopsis of the information organized according to a standard research paper but condensed to fit in a smaller space (a board).

Standing in front of a research poster to explain the research and answer questions is little different from standing in front of a classroom audience, at least in terms of potential unease. Both can be daunting. You might ask yourself: Is data presented logically? What about visual appeal? Did we catch spelling and grammatical errors and graphic blemishes? Did we prepare an adequate summary? Will our research generate discussion and questions? Will we leave our audience a take home message, perhaps stimulating further research? Time is a huge concern, with NAEMSP allowing researchers five minutes to explain their research, leaving two minutes to field comments or questions from the people assembled at your display.

As it turned out, our concerns went unwarranted. Our research was well-received, and we will carefully consider the recommendations to improve (metronome) protocol. We are confident moving forward to the next step: writing a paper for publication in a peer-reviewed journal. We are also planning future research posters for conferences addressing public safety issues that benefit from the use of sound, time-tested, and internationally recognized protocol systems.

The research poster competition complements the Academy’s goal to evaluate dispatch protocols through an evidence-based process. It’s a stage allowing the Academy to showcase the importance of emergency dispatch to public safety and the power of protocol. We returned to our offices knowing our research lends to the vital link of understanding where we came from and where we go from here.
RIGHT THING TO DO
First ACE was accomplished for the people

Audrey Fraizer

Tom Montoya helped write one for the Academy records nearly 24 years ago in his move from Denver, Colorado, USA, to Albuquerque, New Mexico, USA.

At the same time, he’s reluctant to take any credit for the history-making first-ever Accredited Center of Excellence (ACE) achieved during his three-year (1990–1993) tenure as chief of the Albuquerque Fire Department (AFD).

“I would like to take more credit,” said Montoya, who retired from firefighting in 2008 and now lives in Denver. “I kind of stood aside and let staff do their work.”

The AFD Alarm Room is a fire and medical ACE. In February 2017, the center received its sixth medical re-accreditation and in 2015, it was re-accredited in fire for the third time.

Montoya recalls the names of people involved both in protocol implementation and the ACE award in February 1993 like it occurred in more recent times: Lt. Cosmes Madrid, supervisor; Lt. Randy Pennington, quality assurance; Capt. Jay Staeden, who was in charge of the Alarm Room; Assistant Chief John Brown, who later became a fire chief in Texas; and Sharon Eberly, who provided direct IT support and data analysis.

“Those were the guys cementing the changes in the Alarm Room,” Montoya said. “This was all part of an EMS system change, and there was a lot I needed to get done.”

The Alarm Room, or communication center, is an assignment. AFD operates on a four-year rotation, promoting and assigning firefighters to a multitude of department roles. Dispatch wasn’t always a coveted position, explained Patrick Chavez, who retired in 2012, following a 25-year career with AFD.

“Dispatch was moving in a forward direction,” he said. “This was a promotion and not a place for recovery.”

Gaining momentum

In 1990, two dispatchers working out of a converted storage room handled 28,000 calls, with each medical and fire response meriting the full cavalry: rescue vehicle and pumper truck rushing to the scene, lights-and-siren blaring. The Alarm Room was the communication hub for 19
Montoya assigned Brown to oversee dispatch changes, and a three-month study subsequently conducted in 1991 showed an ALS response necessary in 35 percent of the calls; firefighters trained as EMTs could sufficiently handle the remaining 65 percent.

At the same time, Montoya had others in his department scope out potential protocol systems. The existing call-taking and dispatching system was “ad hoc,” and Montoya wanted a measureable method as part of a long-term goal to improve patient outcomes and response times.

Several systems were vetted with the MPDS coming out on top because of scripting, structure, and a constantly evolving approach to complement EMS best practices and research. Codes established to dispatch appropriate response were a clincher.

“A serious call and you could pop a dispatch right away,” Montoya said. “Less serious calls and the dispatcher could spend more time on the call without affecting patient outcomes.”

The Emergency Medical Authority, which had EMS oversight in Albuquerque and the county, approved reducing staffing on the rescue unit from three firefighters to two firefighter paramedics, with backup by a pumper truck, and implementing the new MPDS.

Montoya left AFD in November 1993 for the Castlewood Fire Protection District (now South Metro Fire District) in Centennial, Colorado, less than a year after AFD achieved the world’s first ACE. Montoya recalls Academy President Jeff Clawson, M.D., and Academy Curriculum Director Scott Hauert presenting the award at a press conference at AFD Station 1, where the two newly certified EMDs were mastering the use of the MPDS v10.1 cardset.

Staeden, Montoya said, deserves a lot of the credit.

“He was the one to run with the protocol,” Montoya said. “He fought hard to get them going and accepted by the other dispatchers.”

Some members of the local firefighters’ union expressed doubt about protocol. The then-newly elected International Association President Capt. Eddie Varela wanted the system changed. The determination of ALS or BLS response should be up to the crew, not dispatch.

Staeden had an advantage. As former union president, he persuaded them to give MPDS a chance. After all, a change some perceived as political should not get in the way of improved procedure, potentially better patient outcomes, and widely accepted standards.

He also had trusted advocates on his side.

“I liked what protocol could do,” said Madrid, who stayed 12 years in the Alarm Room following his promotion from the field (firefighter/EMT-B). “It made sense. The biggest part was giving instructions over the phone before response got there. Bleeding. Choking. Heart attack. We had our part, and we could make a difference.”

Protocol remained in force.

The ACE designation also sent a hands-off message to media looking for a story critical of emergency communication.

“The press came after our dispatch center twice and didn’t find anything,” he said. “ACE and protocols help. We’re not the type of center news salivates over.”

Out of storage

In 1996, the two EMDs left their storage room for the new AFD fire/EMS and police consolidated public safety communications facility and administrative building. The Fire Academy on the first floor eventually moved to a dedicated building next door,
freeing both floors for the separate police and fire/EMS communication centers.

Today, AFD is one of the few dispatch centers in the country staffed by uniform firefighters. In 2016, the 26 certified EMDs and EFDs dispatched 105,000 calls requiring medical or fire response, a number expected to grow at least 10 percent in 2017. Four shift supervisors review 30 calls each month, with any overflow channeled to QA Supervisor Alejandro Marrufo, firefighter, EMT-B, EMD, EFD, EMD-Q®, EFD-Q”. Marrufo asked for the dispatch assignment three years ago. He wanted to test a new environment, off field, and found the change to his liking.

“I get to see the situation from the start,” he said. “I have the ability to calm the caller and situation before response arrives.” The intuition gained from relying on voice and background has also helped. Marrufo won’t ever forget the call from a woman who reported her daughter drowned in the bathtub. The mother sounded almost relaxed, composed, even as he gave instructions to get the two-year-old girl out of the bathtub for CPR.

“Something wasn’t right,” he said. “The girl survived, but there was something off about the situation, the way the mother behaved.” Marrufo relayed his suspicions to police. Further investigation revealed the near drowning resulted from the mother’s attempt to punish the child by forcing her into a bath of ice water.

“Those kind of calls stick with you,” he said. “They are meaningful. They prove the importance of our work and the protocol system.”

Chavez gives credit to the support from Dr. Clawson and the team behind AFD Alarm Room’s continued peak performance.

“Doc has always been supportive of us,” Chavez said. “Reps like Tim Martin and Chris Murdock [PDC™ client service representatives] have taken the relationship to a new level. They are considered friends and members of our fire department brotherhood and sisterhood.”

The AFD Alarm Room answers all emergency and non-emergency medical and fire-related requests for service in Albuquerque, and they work in conjunction with the Bernalillo County Emergency Communications Center to provide service outside of city limits.

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In the world of dispatch centers, there is nothing that quite compares to a place that is truly a “home” to its staff. A place where family comes first, and the health of the organization depends upon the good and purposeful work of the family members. A place where the mission, vision, and values are daily fare ... along with the state's famous cheese. Such is the culture at one of Wisconsin's consolidated emergency dispatch centers, Waukesha County Communications (WCC).

Waukesha County, in southeastern Wisconsin, USA, consists of 576 square miles and, according to the 2014 census, a population of 395,118. WCC engages 35 emergency telecommunicators, eight telecommunicators in training, seven supervisors, training and operations manager, director, communication center specialist, and emergency preparedness assistant. The WCC team provides emergency communication services for 19 law enforcement agencies and 21 fire/EMS agencies in Waukesha County. In 2016, we answered 346,000 calls for service. We continue to grow.

The beginning
WCC was formed in 2004 with the consolidation of the Waukesha County Sheriff Department dispatch center, the Lake Area Communication Services dispatch center, the Brookfield Police Department, and the majority of municipal fire departments in Waukesha County.

“It wasn’t easy those first few years,” said Sherri Stigler, Training and Operations Manager. “I always tell people that it was like blending three families together, each with their own way of doing things. It certainly wasn’t the ‘Brady Bunch’ by any stretch of the imagination. There were hurdles for sure. We learned that with open minds and appreciative attitudes, obstacles and challenges can be overcome.”

Consolidation is a challenge under the best of circumstances. Technology, human resource management, and the ability to serve the respective law, fire, and EMS partners efficiently and effectively does not happen overnight. New and unaccustomed processes require open and respectful communication to create a center determined to provide the best service to agencies and the public.

Keeping connected
Organizing police and fire/EMS protocol groups went a long way in unifying WCC, and they continue to do so. Monthly meetings of fire, police, and EMS field leaders and WCC staff provide...
the conduit to address issues, including personnel and equipment updates, feedback, and problematic calls. The center stays connected and hears what is working and what is not.

**Recruiting and selection**

Recruiting qualified individuals as telecommunicators is a never-ending task. To assist with that initiative, WCC appointed a committee of telecommunicators, led by a supervisor, responsible for advertising job opportunities, recruiting, assembling resources used to help in making selections, and participating during the panel interview. The WCC hiring team is always on the lookout for potential recruits at community and four-year college job fairs.

Applicants must take a typing test and a telecommunicator exam, and those passing both tests are scheduled for a two-hour “sit-in” with a telecommunicator and a one-hour written questionnaire covering introductory knowledge typical of a first interview. Candidates proceed to a panel interview, representing communication center staff, human resources, and fire and law enforcement departments. The final hurdle is a background investigation by the Waukesha County Sheriff’s Department, and conditional offers are provided pending successful completion of hearing and drug screenings.

**Training**

The WCC Training Team consists of 12 communication training officers (CTOs), three training supervisors, and the training and operations manager. Each training team member is APCO CTO certified and, as part of the job, updates training materials and takes adult learning training courses when not actively training a probationary telecommunicator.

Training begins with six weeks in a classroom. Probationary telecommunicators certify as International Academies of Emergency Dispatch (IAED)™ ETCs, EMDs, and EFDs, and are taught basic skills in geography, CAD system/record management systems navigation, customer service, phone system operations, and center specific call types. It’s the dispatch floor where probationary telecommunicators begin calltaking training with a CTO and progress through their training on the Teletype, five police dispatch radio channels, and one fire dispatch channel. Based on prior experience and skillset, the process takes six to nine months.

**“The level of trust and cooperative spirit we see among our agencies and the center is a testament to the commitment of everyone who works or partners at WCC. We can be very proud of that.”**

**Community**

WCC is more than “just” an emergency dispatch center.

During the December holiday season, staff donates non-perishable goods, personal hygiene items, and money to local nonprofit organizations. This past holiday, a group of telecommunicators and supervisors baked and distributed thousands of cookies to law enforcement departments and fire departments in Waukesha County.

The WCC leadership team created a Community Education Team (CET) that promotes positive community relations between dispatch and the public and provides education about the 911 system and emergency dispatch. The CET participates in several events to forge better relationships with the community and law enforcement and fire agencies.

Staff has been working with Wisconsin state legislators to raise awareness for public safety communication minimum standards of education and training as well as #iam911 to reclassify dispatchers to the status of protected safety telecommunicators.

**Celebrating success**

We celebrate what we do, especially calls involving dispatch-assisted CPR “saves” and births. Family, media, and staff are invited to these celebrations—when a dispatcher is able to cradle a newborn she helped to deliver or hug a cardiac arrest survivor.

“It does not get any more real for dispatchers,” Stigler said. “These are the reinforcing moments that soundly deliver the ‘this is why we do what we do’ message.”

**We are family**

Each new hire receives a WCC Challenge Coin and signs the “WCC Oath” describing our mission, vision, and value statement with an emphasis on core values: Family, Integrity, Respect, Responsibility, Service, and Trust.

As a family, we throw parties or potlucks to celebrate major life events such as milestone birthdays, pending births, and weddings. WCC Director Gary Bell also gets into the act; he recently baked a cake in the center’s kitchen to celebrate a probationary employee’s 30th birthday.

Through trial and error, WCC discovered that focusing on hiring people complementing existing staff and principles, offering comprehensive training, providing community involvement opportunities, and establishing core values provide the foundation for best serving the public and the fire and police agencies depending on what we do.

“We are in such a better place now that we are established,” said Stigler, who was hired in 2004 for a supervisory position. “The level of trust and cooperative spirit we see among our agencies and the center is a testament to the commitment of everyone who works or partners at WCC. We can be very proud of that.”
FALL OR PUSH?
Protocol 30 handles both

Brett Patterson

Brett:
We have had several recent cases where people were thrown from a moving car. They were not in an accident or anything—just people thrown out of the car! My calltakers didn’t know how to properly code these incidents. All of the calltakers used different protocols and Determinant Codes, such as Protocol 30: Traumatic Injuries, or various codes on Protocol 29, i.e., Pedestrian struck or MVA with Ejection. Could you provide me with clarification as to how we should properly code this?

Regards,
Nicholas J Camisa MICP, NREMTP
EMS Supervisor, University Hospital-REMCS, Newark, New Jersey, USA

Hi Nicholas:
Protocol 29: Traffic/Transportation Incidents was designed more for mechanism of injury and scene safety issues associated with motor vehicle crashes and traffic than for individual patient injuries. Specifically, ejection mechanism is related to the force of going through a windshield, and auto versus pedestrian is related to the discrepancy in mass of one versus the other.

Therefore, Protocol 30: Traumatic Injuries (Specific) is most appropriate for a person falling or being pushed out of a vehicle, provided there are no significant traffic accident concerns, and the person wasn’t subsequently run over. Notably, there is a new Determinant Descriptor in MPDS® v13.0 that addresses cases such as this when the patient does not appear to be critically injured but the EMD is concerned about the mechanism of injury: 30-D-5 “HIGH VELOCITY impact/MASS injury.”

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

Hello Juan,
Please help us solve a long-standing issue within our call center. Is a parachutist injury a traumatic injury or a fall? The jumper jumps out of the aircraft, doesn’t fall out, has a fully inflated parachute, lands on ground but breaks an ankle, leg, etc. What is it? I say it’s a traumatic injury; my co-workers say it’s an EXTREME fall, but like I said, he comes down at the regular rate of descent as other jumpers but just doesn’t land right.

Thanks,
Juan Rodriguez
Communications Officer
Joint Communications Unit
Fort Bragg, North Carolina, USA

Hi Juan:
I love long-standing disputes! You are correct. This mechanism simply doesn’t equate to the same forces involved with an EXTREME fall, and the specific
injury is the reason for the call. I’ve attached an article from Dr. Clawson that addresses issues such as this. I would also point out that Protocol 30, v13.0, has a new Determinant Descriptor (HIGH VELOCITY Impact/MASS Injury) for cases when the EMD is concerned about a high mechanism, but the body area injured doesn’t code high enough to satisfy the EMD. A similar code is also available on Protocol 29. Hope that helps to settle the debate!

Brett

Juan:
Protocol 30 would be the appropriate choice. There are a zillion things that cause injuries to people (all you need to do is think of an amusement park and the potential of accidents there). We don’t have a special protocol pathway for accidents involving falls from bicycles. The same goes for skiers. The spectrum of “Tour de France riders” through “kids on tricycles” cannot be jammed simply into a mechanism of injury format. Regarding velocity, we don’t assess on Protocol 30 how fast the boom on the forklift was going when it hit the worker in the back or the speed the skier was going in a downhill race, either. The Protocol does, however, provide information about the severity of the injury in terms of the body area affected in much more detail compared to Protocol 29.

As you’ve probably determined, even if you go to Protocol 29, you basically end up in the same Determinant Level based on what is known and what is not known about the patient’s priority symptoms and injuries.
Hope that helps.
Onward through the “what-if” fog ...

Doc

Brett:
My co-workers and I were having a discussion about which protocol to use for an anxiety attack. I wonder if you can provide some clarification.
It’s for a patient with no priority symptoms. Some use MPDS Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt, while others use MPDS Protocol 26: Sick Person.
Which would be most appropriate?
Thank you,
Michelle Rossi
CMED Telecommunicator, North Central Connecticut EMS Council Hartford, Connecticut, USA

Hi Michelle:
When you think about it, a complaint of “anxiety attack” is actually a caller diagnosis rather than a description of what has happened. It’s like saying the patient is drunk or is having a heart attack. All of these conditions or caller diagnoses may present in different ways, and the EMD needs to know “… exactly what happened” in order to select an appropriate protocol.
So, the answer to your question is to find out not what the caller thinks is the underlying problem but rather what sign/symptoms/actions are prompting the call. By far the best way to do this is to repeat Case Entry Question 3. Common to the anxiety attack diagnosis are symptoms such as rapid breathing (Protocol 6), racing heart or palpitations (Protocol 19), chest pain (Protocol 10), or simple anxiety/nervousness (Protocol 26).
I hope this response helps to answer your question.

Brett
New Orleans
By the Numbers
2017

113 sessions

1,320 attendees

12 research posters

1,056 candy bars handed out

15 countries represented

42 exhibitors

16 tracks

169 speakers
Excellence has a way of moving you to the next step and beyond.

Excellence has a way of opening your eyes, letting you see the best path to follow.

Excellence builds a foundation that benefits you and everyone connecting to your world.

And excellence was the theme this year at NAVIGATOR, held April 12–14, in the Big Easy.

“It’s what you do that makes the difference,” said Academy President Jerry Overton during his Opening Session remarks building up to this year’s Dispatcher of the Year Award.

Contrary to the nickname bequeathed upon New Orleans, Louisiana, USA, in the 1970s, however, excellence in emergency communications is neither a slow nor easygoing way of life.

“What you’re doing is everything but that,” Overton said. “You are committed 24/7 to making a difference. Your excellence makes a difference in each and every call.”

The distinction of being “extremely good” doesn’t work independent of objectives. It also depends on where you choose to concentrate professional efforts, and, as Overton pointed out, at NAVIGATOR opportunity abounds, with choices packed into every hour and bordered by some of the best networking in the industry.

“NAVIGATOR is an eye-opener,” said Richard Lindfors, Quality Improvement Manager, Richmond Ambulance Authority, Richmond, Virginia, USA. “I get to see what other agencies from the rest of the world are doing. At the end of the day, we’re in the same business, with the same issues, and we’re here able to discuss them in a focused, nonworking atmosphere.”

Awards

NAVIGATOR attracts the dedicated—emergency dispatchers, supervisors and center directors, and public safety experts—to a single source that celebrates the profession. The awards start on opening day and continue through the Closing Luncheon two days later. When each recipient accepts an award, it’s also a sure bet that the person will acknowledge co-workers.

“I couldn’t have done it without my partners,” said Dispatcher of the Year Erin Berry, EMD, Loveland Police emergency communications, Loveland, Colorado, USA.

Berry was honored for professional excellence exemplified by her lifesaving efforts during a call that led to the revival of a Loveland High School student (read the DOY story on pg 24 to learn more).

And NAVIGATOR awards were just getting started.

Jeff Cicillian, former Lake County Sheriff’s Department police officer and 911 center manager, Lake County, Illinois, USA, received the Instructor of the Year Award. Cicillian specializes in Emergency Police Dispatch and the Active Assailant Protocol.

Sherri Stigler, Training and Operations Manager, Waukesha County Communications, Waukesha, Wisconsin, USA, won first place in the Research Poster Contest.

Janice Warshauer, RN, Northwell Health Center for Emergency Medical Services, Syosset, New York, USA, received the Bill Boehly Award for Clinical Support Desk (CSD) Clinician.

Charles R. Goodwin, Lead Dispatcher, Natick Police Department’s Public Safety Communications Center, Natick,
LET THE GOOD TIMES ROLL

First-time USA NAVIGATOR attendee Stephanie Dandonneau, Operations Chief, Groupe Alerte Santé Inc., Québec, Canada, said she was impressed with all of the sessions she attended, and was especially interested in Kim Rigden’s stress management presentation. Dandonneau said their personnel take turns attending conferences, and NAVIGATOR in New Orleans, Louisiana, USA, was especially exciting for her.

“This place is just beautiful,” she said. “I am meeting lots of people and learning, too.”

Mindy Thomas, Manager, Queensland Ambulance Service, Rockhampton, Australia, traveled all the way from the Land Down Under in order to breathe in the sights and sounds of NAVIGATOR, her first American conference. She said networking was a highlight, particularly when it came to discovering the universality of emergency dispatch issues, such as investing so much in training only to see the new person leave within a few years.

“We all have a difference in structure, yes, but I am finding out that the challenges are the same,” she said.

The exquisiteness and excitement of New Orleans cuisine was fully enjoyed. Though some of us (myself included) did not venture past the safety of our accustomed palates, others were quite adventurous as they feasted upon the likes of charbroiled oysters, spicy jambalaya, and even alligator wings. I think it was just as much fun to watch their reactions during those first few bites!

Sherri Stigler, Training and Operations Manager
Waukesha County Communications, Waukesha, Wisconsin, USA

I was pleased to see several breakout sessions that focused on stress management, health, and wellness. Christine Bannister, Supervisor, Waukesha County Communications, Wisconsin, USA, gave a comprehensive overview of stress and healthy ways to manage it in her presentation, “Wellness For the First, First Responder.” Tami Wiggins, Training and QA Manager, Harford County Department of Emergency Services, Maryland, USA, and Madeline Marks, Clinical Psychology Program, University of Central Florida, USA, partnered for the session, “When Trauma Hits the Dispatch Center.”

New sessions included a how-to in creating a 911 public education program, presented by Ben Bills, PIO, El Paso-Teller County 9-1-1 Authority, Colorado, USA, and Sasha Vargas-Fimiani, Public Educator, Charleston County Consolidated 9-1-1 Center, South Carolina, USA. Both are pioneers in the industry using creative ways to engage their communities in the 911 system.

Ricardo Martinez, Founder, “Within the Trenches Podcast,” and Creator of #IAM911, recorded several new episodes with guests for his podcast, recorded live from the Exhibit Hall. I had the honor of recording Episode #141.

Ryan Dedmon, Founder, Operation 10-8
Anaheim, California, USA

This is my fourth NAVIGATOR, and it’s always so awesome, especially the people you get to meet. You realize you’re not alone. NAVIGATOR is a great time to focus on the issues and share ideas.

Cindy Sparrow, 911 Communications, Red Deer Emergency Services, Alberta, Canada

I was impressed with the ETC Instructor manual someone from a neighboring 911 jurisdiction showed me, so I signed up for the instructor course at NAVIGATOR. We have a lot of new hires and want to give them an overview of the profession beyond policies and procedures. The ETC course will provide a great foundation.

Laurel Strandberg, Lakewood Police Department, Lakewood, Colorado, USA

It’s amazing to be in a room with so many agencies and open your mind to what the rest of the emergency communications world is doing.

Richard Lindfors, Richmond Ambulance Authority, Richmond, Virginia, USA

Dispatch is my career. I started as a volunteer firefighter, got into dispatch, and have watched it evolve for the past 19 years. I liked the protocol from the start. It gives you something great to go by.

Shawn Trainor, Montgomery County Hospital District, Houston, Texas, USA

This is my second NAVIGATOR, and I definitely come for the training. I started out wanting to be a police officer, changed into dispatch, and loved it. There’s so much about it that I enjoy: the adrenaline rush, helping people, and never having the same day twice.

Angela Barnes, Dispatch OIC
Gulfport Police, Gulfport, Mississippi, USA
Massachusetts, USA, was recognized by the National Center for Missing and Exploited Children (NCMEC).

Eric Parry, PSAP Implementations at Next Generation Advanced 911 Inc. (NGA911), Salt Lake City, Utah, USA, received the Dr. Jeff Clawson Leadership Award.

First-time ACEs totaled 23 medical, five fire, and three police agencies. Forty-eight agencies were re-accredited.

True intentions

NAVIGATOR offers the premier educational and networking venue. New Orleans drew 1,320 attendees. The 113 sessions spread over the three days included 16 tracks presented by new and veteran speakers (169 total). A total of 42 exhibitors lined up in rows inside the coliseum-sized exhibit hall.

A global tone reverberated throughout the three days, with attendees from 15 countries (including the USA and Canada) and a dedicated international track.

Sonia Bounouh, Training/QI Manager, Communications, Hamad Medical Corporation, Doha, Qatar, described the impact of protocol updates on her staff. Siegfried Weinert and Dr. Susanne Ottendorfer, Special Projects Manager and Medical Director, respectively, 144 Notruf Niederoesterreich, Lower Austria, provided insight into Austrian EMS innovations that they have helped develop. James Gummett and Zerena Duhaney, both in Quality Assurance for the London Ambulance Service NHS Trust, U.K., explained how their large communication center shares the QA load.

A special guest appearance by a young lady and her family accentuated the positive effect of emergency communications when you might least expect it (which is the nature of the business). Emily Cox proved “The Power of Protocol to Save Lives, Change Lives, and Make Friends” in a final day session given by Kim Rigden, IAED™ Associate Director of Accreditation, and Michael Spath, Manager, Communications, Sunnyvale Department of Public Safety, California, USA. In 2007, Rigden coached Emily’s grandmother Cynthia Cox in CPR after then-7-year-old Emily was shocked in a home accident. The Cox family lived within the 911 region covered by the British Columbia Ambulance Service, where Rigden worked as an EMD.

“I knew I made a difference that day,” said Rigden, who introduced Emily and Cynthia to the standing room only presentation. “We all are a helping hand when people need it most.”

Spath, who later Q’d the call at Rigden’s request, admitted Rigden’s protocol compliance wasn’t perfect, at least not in comparison to her customer service.

“That was phenomenal, off the charts,” he said. “The caller was responding. They had made a connection.”

Entertainment hit a high note with the eagerly anticipated The Big Easy Attendee Party held Wednesday evening at Generations Hall, and the ACE Reception, held Thursday at Mardi Gras World.

Getting to the events was half the fun. The second line parade on Wednesday was a tribute to New Orleans in the name of emergency dispatch. A costumed group and brass band, considered the parade’s “main line,” were followed by a large group of revelers (NAVIGATOR attendees), known as the “second line,” starting at the Hilton New Orleans Riverside, overlooking the Mississippi River, down the famous and fabled streets of the French Quarter. Generations Hall was built in the early 1820s as a sugar refinery and has since been renovated to depict the history of New Orleans jazz.

The drive to Mardi Gras World introduced ACE attendees to the tastes of New Orleans, from hurricanes (and not the type known for winds exceeding 150 mph) to Cajun, Creole, and French cuisine, and everything in between. Mardi Gras World gives a backstage look at the 300,000-square-foot float-making warehouse.

Of course, nobody goes to NAVIGATOR overlooking those they left back at the comm. center, especially when the week happens to coincide with National Public Safety Telecommunicators Week (NTW) (April 10–14, 2017). NTW, celebrated in honor of the very people attending NAVIGATOR, is often the most anticipated week of the year, featuring dress-down days, games and prizes, daily drawings, and food provided by just about every branch of local public service.

“Sure, I’m missing the celebrations with co-workers,” said Melissa Trcka, Training Coordinator and Quality Assurance Officer, Vicksburg Warren 911, Vicksburg, Mississippi, USA. “But that’s OK because this is very important for our agency.”
Awards recognize Emergency Dispatch advocates

Audrey Fraizer

When it comes to awards, NAVIGATOR produces top-notch results. This year, the IAED™ saluted leadership in the emergency dispatch profession and contributions to research.

Dr. Jeff Clawson Leadership Award

There’s something about the Dr. Jeff J. Clawson Leadership Award that leaves the recipient speechless.

At least, the reaction seems to be the norm in the years Dr. Clawson has announced his selection at NAVIGATOR’s Closing Luncheon, and this year was no different.

“I’m stunned,” said Eric Parry, Director, PSAP Implementations at Next Generation Advanced 911 Inc. (NGA911), a company based in Los Angeles, California, USA. “I truly don’t know what to say. It’s such an honor. I never thought in a million years I’d get this award.”

Parry was introduced to protocol through his 24-year career with the Royal Canadian Mounted Police (RCMP) where his focus gradually shifted from police work in the field to overseeing the operations of police dispatch centers. He was a Priority Dispatch Corp.™ (PDC™) Police Consultant for nearly eight years and was instrumental in developing the Police Priority Dispatch System™ (PPDS™).

And that’s where Dr. Clawson said he made his mistake.

“I should have known him a lot earlier than I did,” he said. “His work has helped changed the course of dispatch in the world.”

Parry became one of the first Emergency Police Dispatch (EPD) instructors and comprehensive implementation specialists for the Academy and PDC. He literally wrote the book on 911 management training: Emergency Number Professional—the “must-read” textbook for National Emergency Number Association (NENA) certification course and designation. He is past Chair of the EPD...
Council of Standards. Dr. Clawson has often referred to him as “the Michael Jordan” of police dispatching.

“He has helped the Police Protocol to become what it is today,” Dr. Clawson said.

In many cases, being left speechless is not that unusual for the award recipient, and Parry is no exception. Parry is a familiar face and voice in an emergency services career spanning 47 years in the U.S. and Canada.

Following more than 30 years combined with the RCMP and PDC, he was far from leaving the emergency communication profession.

Parry was Program Manager for the State of Utah 911 Program and then Manager of the 911 Division, Utah Communications Authority. He is a charter employee of the nearly year-old NGA911. He is on the Denise Amber Lee Foundation board and Chair of the NENA Education Advisory Board.

Through it all, Parry said he has one person at the top of his list to thank.

“My wife [Joanne] is my cheerleader and has been for all these years,” he said.

He gave the $500 honorarium that goes with the award to the American Cancer Association in honor of Joanne’s sister who recently struggled with breast cancer.

**Poster contest**

Sherri Stigler’s concern for dispatchers led her to first place in the Academy’s fifth annual Research Poster contest.

Stigler, Training and Operations Manager, Waukesha County Communications, Wisconsin, USA, focused her research on patient outcome and providing emergency dispatchers with the rest of the story.

“We seldom learn what happens to the patient after we hand over the call,” she said.

While keeping to the background is part and parcel to the profession, not knowing the outcome of a medical emergency can be downright irksome.

It’s like Erin Berry, EMD, Loveland Police Department, Loveland, Colorado, USA, said after receiving the Dispatcher of the Year Award at NAVIGATOR.

“If you want to know how it sometimes feels to be a dispatcher, open a book, read partway, and then slam it shut,” she said. “You never know the outcome.”

**NAVIGATOR is about learning to improve on so many levels—Next Generation 911, technology, adult learning, training, and keeping up with changes in protocol. My agency is an ACE, and that holds us to a higher standard.**

Kristy Moore, Training Coordinator
Kern County Fire Department
Bakersfield, California, USA

Stigler’s research is working to keep the book open. She was able to connect with the local hospital EMS coordinator and ER physician (also their medical director), in order to assist in developing changes to a specialized report that would now include time stamps for initial call to 911, dispatch of medical units, and also hands-on-chest times for dispatch-assisted bystander CPR.

These completed reports provide a short patient summary as well as X-ray images of the affected artery both pre- and post-stent placement. The hospital coordinator sends copies of the reports directly to the communication center, where they are then shared with the dispatchers who took the initial call. They are also displayed on the center’s EMD bulletin board, where they are viewed by all staff.

Stigler said Emergency Dispatchers have welcomed knowing more of the narrative, and she would like to expand the outcome program to cover other medical emergencies.

“It is amazing for our folks to have the opportunity to see how they can impact the entire chain of survival in a very tangible way,” Stigler said. “Ultimately, when dispatchers know ‘the rest of the story,’ it creates a deeper understanding of why we do what we do … and that ‘buy-in’ is invaluable.”

IAED Director of Academics Isabel Gardett, left, congratulates Sherri Stigler for her winning Research Poster.
Erin Berry figured something was up when she recognized a family she had met at the police department in Loveland, Colorado, USA, sitting in the front row at the NAVIGATOR Opening Session.

Berry was among 40 dispatchers nominated for the Dispatcher of the Year award, and Loveland Police Chief Robert Ticer had insisted she attend the conference held in New Orleans, Louisiana, USA.

Not that she would have turned down the invitation, and, yes, she did catch on to the possibility of receiving the award when 17-year-old Zander Kunselman and his father, Dirk, and mother, Shaudin, walked into the ballroom. Then, the call from September 2016 was broadcast to the nearly 1,400 communicators in the audience.

But to be named Dispatcher of the Year?

“Are there so many dispatchers from different agencies, and they all do an incredible job.”

Berry was recognized for her professional abilities exemplified by her first in the EMS chain of survival effort that led to the teen’s complete recovery. Zander, who was 16 at the time, collapsed while running laps on the practice track east of the high school. He wasn’t breathing, and he was turning blue. Tyler Royse, a member of the Crimson Regiment percussion section, and Loveland High School Resource Police Officer Bruce Boroski, performed CPR while others rushed to retrieve the AED inside the high school.

After the first shock, Zander’s pulse returned just at paramedics arrived to the field.

Berry closed the call, congratulating the team on the “really great job” they did for their friend. Zander spent two weeks in recovery.

NAVIGATOR wasn’t the first time Berry had the opportunity to meet Zander’s family. Shortly after the event, nearly 20 people who had helped save his life were honored at the Thompson School District Board of Education meeting. Zander was unable to attend; he was still recovering at the hospital.

While at that time the family declined to talk about the incident, Dirk was ready to address the audience at NAVIGATOR.

“Sept. 13 [2016] might have been the worst day of our lives, but because of Erin, it turned out to be the best,” he said from the stage. “The hardest part wasn’t the call telling us what had happened, the drive to the hospital, watching the helicopter take off for the children’s hospital in Denver, or waiting. The hardest part for us was how we could say thank you for saving our son’s life. Thank you for all you do. Thank you for everything you continue to do.”

This was the second time in three years that Loveland Police Department dispatchers have assisted in saving the life of a high school student. In 2014, Tommy Lucero, then a freshman at Thompson Valley High School, collapsed on the baseball field after running at a team practice. Coaches were able to revive him following CPR PAIs over the phone and using the AED at the school.

“Tommy and I are friends for life,” Berry said.

Since then, the Lucero family and McKee Medical Center Foundation officials have worked to increase the number of AED units inside schools and in the community. The Loveland Police Department and emergency dispatch are members of the “Heart Safe City,” designated by the American Red Cross.

Berry has been with Loveland Police dispatch for a total of seven years.

Ticer was sworn in as Loveland Police Chief in June 2016, appealing to the type of leader staff wanted, engaged and present, which is just what he was doing at NAVIGATOR.

“Erin is a perfect example of what we do for our community,” he said. “I’ve got a great department, and I really want them to know that I’m here for them.”

Erin Berry accepts the DOY award among peers and the family she assisted.
If you think people have forgotten Katrina, think again. The hurricane that devastated New Orleans, Louisiana, USA, and its people is as fresh today as it was on Aug. 29, 2005, when Katrina made landfall and the next morning when the levees collapsed.

Scars from the monster storm and compromised levees still weigh heavily on the most damaged parts of the city and in the hearts of residents forced to flee and those who stayed behind. Ultimately, 80 percent of New Orleans and large portions of nearby parishes became flooded, and the floodwaters did not recede for weeks.

Barbara Ireland doesn’t skip a beat when asked about Katrina.

“This affected everything about our routines, our worlds,” said Ireland, who was named Deputy Chief of Communications for New Orleans Emergency Medical Services (NOEMS) shortly after Hurricane Katrina. She has worked in New Orleans EMS for 32 years.

When the storm hit and the levees broke, Ireland was in the worst possible place. She wasn’t home; she was out of state visiting her son. The story of her frantic efforts to return and the subsequent residency on a cruise ship temporarily housing EMS would take up a volume of words. Suffice it to say, disregard images of luxurious accommodations on a ship built for oceanic adventure, Ireland said.

“Each morning, we’d leave the boat and go to work.”

Hurricane Katrina changed everything about communications. Katrina flooded both E911 call centers and all E911 switching equipment. No E911 or regular telephone service was available. On Sept. 15, the New Orleans Police Department established a rudimentary 911 center with the assistance of the FBI using 10 single telephones with calls distributed in round robin (circular hunt group) on the first floor of the Royal Sonesta Hotel on Bourbon Street. EMS and fire set up similar bare-bones answering points.

On Sept. 26, one month after Katrina, the Orleans Parish Communication District (OPCD), established in 1982, co-located the three public safety agencies in one room at the Hyatt Regency Hotel, next to the Superdome.

This was the first time fire, police, and EMS were co-located, Ireland said.

“It had been talked about for years,” she said. “Katrina brought it home. We needed consolidated or, at least, co-located communities.”

Three months later, on Dec. 16, OPCD moved operations to temporary facilities at its current location (near Canal Street and City Park Avenue). Seven double-wide modular buildings formed one large room. Construction of the 25,000-square-foot dedicated emergency operations facility spanned three years (2009–2012). Consolidation of police, fire, and EMS telecommunicators into OPCD personnel was completed in April 2016.

To avoid the shutdown Katrina caused, OPCD was built on a site not flooded in the aftermath of Katrina plus raised another 5 feet for added protection. Steel-reinforced concrete walls can withstand winds greater than 155 mph (Category 5 hurricane). The building is blast proof and ballistic resistant.

OPCD provides the CAD system, telephone customer premises equipment, electronic mapping (GIS) system, audio logging of the telephone and radio systems, and an uninterruptible power supply (UPS) for the entire E9-1-1 building, backed up by dual generators with eight days of full operations without resupply. Emergency well water produces 80 gallons per minute, and an on-site sewage treatment plant, independent of city sewage services, can process 15,000 gallons per day.

More than a decade after Katrina, people, their communities, and commerce are still recovering. The emotional toll lingers, Ireland said.

“The trauma of being part of something causing others so much pain stays with you,” she said.
HAPPENING APPS

Smartphones can extend chance of survival

Audrey Fraizer
While there’s not a boatload of apps available exclusively to emergency communication centers, we found some great apps made for mobile devices to complement the goals of first responders behind the headset.

**GoodSAM**

London Ambulance Service (LAS), NHS Trust, U.K., is not about to skip a beat when it comes to phone apps to increase survival rates for patients of cardiac arrest.

The “shockingly easy” campaign, which made its debut in 2013, aims to increase public access to automated external defibrillators (AEDs), while a partnership between LAS and the U.K.-based GoodSAM (SAM stands for Smart Phone Activated Medics) organization alerts clinically trained ambulance staff and the public to life-threatening emergency calls, including cardiac arrests. Public members must possess basic life-support skills trained to an LAS standard.

As part of the shockingly easy campaign, LAS offers an accreditation program that includes advice, automatic alerts, and debriefings in using the AED in a cardiac emergency.

The automatic alerting system informs the accredited organization when a medical emergency occurs and verifies that someone with life-support skills has been informed; the call also alerts the organization to the arrival of ambulance crews.

In 2015, 88 bystanders gave electric shocks to people experiencing cardiac arrest, and almost three-quarters of those patients were alive when they arrived at the hospital; more than half of that number recovered and were later discharged.

There are about 2,600 defibrillators available across London.

The app provides voluntary help to cardiac arrest patients across London. If the control room receives a 999 call about someone in cardiac arrest, an alert goes to the three nearest volunteer responders registered to the GoodSAM app. The app does not replace ambulance response, and it depends on clinically trained ambulance staff and members of the public trained to an LAS standard of basic life support.

The volunteer accepting the alert receives a map showing the patient’s location and the closest AED. If the volunteer does not accept the alert or the alert goes unanswered, the alert defaults to the next volunteer. Unanswered alerts are diverted within 20 seconds.

Co-founded by prehospital and IT specialists, the GoodSAM app allows users to send a distress signal to the three nearest medically trained Good Samaritans, and in the LAS system, at the same time the call automatically dials 999 (the U.K.’s three-digit emergency number).
BUYER BEWARE
Not all apps work realistically

Emergency preparedness has hitched its wagon to the still-rising app star.

App enthusiasts on the market to enhance their readiness have a stack of apps to chose from, with a majority of these products developed by a third-party rather than the traditional emergency communication system. The app developer might promise faster connectivity to a communication center or better location tracking, or request personal information that can be input into the app’s program for relay to the emergency communication center in tandem with the caller’s connection.

Sales points
Because location accuracy is a big concern, many apps promise to determine your location more accurately than the current emergency services system. There is no guarantee that will happen. Wireless phones are mobile; they are not associated with a fixed location or address the same way as a landline. A cell site might provide a general indication to the caller’s whereabouts but at this point not as accurately as a fixed line.

The Federal Communications Commission (FCC) requires wireless carriers to provide more precise location information to PSAPs at either a county-based or PSAP-based geographic level; however, technology is still in the works. In addition, standards apply to outdoor measurements only, as indoor use poses unique obstacles.

As far as efficiency, it might be faster and wiser to call the three-digit emergency number from your cellphone than to rely on an intermediary to make the connection for you. Most smartphones require only a swipe and a tap to activate, even if the phone is locked.

Other apps connect callers to a call center, not a PSAP, and the call is answered by an operator who asks questions and routes the caller to the PSAP. The liaison is not necessary since this is the way most emergency communication centers work, particularly if using the Medical, Police, or Fire Priority Dispatch System™ (PDS™). The EMD, EPD, or EFD asks questions that determine the appropriate response and provides Pre-Arrival and Post-Dispatch Instructions. In addition, it’s not such a good idea to share personal information without reading a privacy policy and looking into the security platform in place to protect your information.

Registered responders—such as doctors, nurses, and paramedics—within a specified radius can proceed to the emergency prior to the arrival of an ambulance. The bystander can continue to provide information to the Emergency Dispatcher, who can also convey instructions for CPR.

Built-in tools include a “Life Detector” that provides readings of the patient’s pulse and respiratory rate, a metronome for CPR timing, and instant on-scene video streaming. GoodSAM Pro is an advanced version that gives ambulance services the ability to dispatch registered responders or co-responders to calls other than cardiac arrest.

The LAS has stressed the benefit of an additional resource to the emergency ambulance response, which is deployed as normal to a patient in cardiac arrest. GoodSAM does not replace response; it supplements services already available with the intent of getting volunteers with the right life-support training skills on the scene as soon as possible.

The app is available in several countries, and nearly 18,000 people have downloaded the GoodSAM app launched in June 2014, according to GoodSAM Project Director Deepti Bal.

According to the American Heart Association, almost 90 percent of people who suffer out-of-hospital cardiac arrest die. Survival depends on getting help as soon as possible, and it is estimated that CPR, especially if performed in the first few minutes of cardiac arrest, can double or triple a person’s chance of survival.
**PulsePoint**

An ambulance, with full lights-and-siren, pulling into a plaza where Richard Price was eating lunch alerted the former San Ramon Valley Fire Protection District (SRVFPD), California, USA, chief of an impending medical problem.

And, also, to a solution to assist in sudden cardiac arrest (SCA) survivability.

“The victim was next door,” said Price, who despite his position as fire chief did not receive pages for medical calls. “I rushed over knowing each moment lost was decreasing the patient’s ability to survive. Response time is the biggest obstacle we face.”

The patient died despite over-the-phone CPR instructions an EMD provided to a bystander before the ambulance crew arrived.

Price believes a missing element could have changed the outcome.

“If I had heard, or if someone else close by had been notified, that could have made all the difference in saving the man’s life,” he said at the time of the incident. “Time is critical.”

A victim of SCA has about 10 minutes to live, although brain damage begins to occur well before then. The relatively low number of bystanders providing CPR and retrieving an AED, however, keep the number of deaths related to out-of-hospital SCA distressingly high. Fewer than 9 percent survive.

That got Price thinking. There had to be a way to connect CPR-trained bystanders and AEDs to victims of SCA. He looked around. He knew an increasing number of people depended on their smartphones but not typically to make phone calls. Many were glued to their phones, looking at a new work email, a new Facebook notification, a YouTube video, podcasts, or online banking.

There was always a reason to check your smartphone. So, why not include a lifesaving app? Having the potential to save a life could be as easy as viewing a text message.

Price sat down with an IT team from Northern Kentucky University (USA), and together, along with other members of the SRVFPD, developed a CPR notification alert. When an SCA occurred in a public place and 911 was contacted, the app would notify users within a specific radius of the patient’s location and where to find the closest AED.

While there was a boom of apps, that wasn’t necessarily a blessing for Price’s technology. Thousands of apps face identity crisis, getting lost among other apps. People scroll through the top 10, maybe, before moving on. To test the market, the SRVFPD piloted the software-as-a-service pre-arrival app. The software, PulsePoint, attracted attention. In a little over six years, 900,000-plus residents and off-duty EMS personnel in 2,000 communities across 28 states have downloaded the app. Activations exceed 35,000, and of those, at least one-third were SCA emergencies.

Price retired from SRVFPD in 2012 after a 33-year career with the fire service. He is founder/president of the PulsePoint Foundation, a 501(c)(3) nonprofit corporation based in the San Francisco Bay Area. The foundation provides a suite of mobile apps to support public safety agencies to improve SCA survival rates through better bystander performance and AED access.

The money the foundation raises goes back into development.

Innovations include building an extensive cloud-based registry of AEDs. Locations are precisely mapped according to community data verified by public agencies. Through work with the International Academies of Emergency Dispatch® (IAED®), the foundation plans to connect the registry to 911 centers for automatic retrieval of information.

“That saves the calltaker from asking if an AED is available,” Price said. “The calltaker will automatically know the closest AED.”

They “gamified” the app to further engage and motivate people and developed various ways agencies can trigger PulsePoint activations, such as sending alerts based on keywords indicative of SCA.
The foundation has partnered with the IAED and Priority Dispatch Corp.™ (PDC™) to incorporate PulsePoint with ProQA® software. The process queries a third-party agency when, during the call, MPDS® Determinant Descriptors categorize and prioritize the emergency situations based upon caller interrogation and the presence or likelihood of priority symptoms and threat to life. The software will display the locations of AEDs within a specific proximity of the incident (the radius is yet to be determined by the IAED Medical Council of Standards). The third-party agency will also have the ability to notify a qualified responder to assist or perform the defibrillation.

The same prompt would apply to ECHO response initiated at Case Entry, and the new ProQA feature will tie into the existing system that tracks AED device usage.

Price is dedicated to PulsePoint and his motivation is simple.

“It’s vital to decrease the time it takes a family member or other bystander to initiate CPR,” he said. “If someone is down for eight minutes, without help, none of it matters.”

**Bystander CPR**

A nonprofit association affiliated with the New York Fire Department (FDNY) offers an app that gives bystanders step-by-step CPR instructions. Although not connected to emergency communications, the app does link the user to an AED closest to the situation in the city’s five boroughs.

Administered through the FDNY CPR mobile unit, the program includes a workshop introducing the app and provides compressions-only CPR training. The workshop is required prior to downloading the app, and since the app was created in 2013, more than 40,000 people have gone through the program.

The training and app really took off when New York became one of now 42 states to mandate CPR for high school graduation, according to Lt. Jose Borrero, a career FDNY paramedic who directs the CPR mobile unit.

New York’s law mandates instruction in hands-only CPR and the use of an AED for senior high school students prior to graduation. The law went into effect Oct. 7, 2015, and is part of a broader state education law requiring each school to have at least one operable AED and staff volunteers trained and certified in CPR and AED use.

“I know from experience the importance of giving CPR as soon as possible,” Borrero said. “The more people trained, the more people saved. The app gives a quick refresher to how it’s done effectively.”


**FirstNet**

The First Responder Network Authority (FirstNet) was signed into law Feb. 22, 2012, to provide a single interoperable platform for emergency and public safety communications. In March, FirstNet announced a 25-year agreement with AT&T to build a nationwide wireless broadband network that will enable data sharing across disciplines and jurisdictions and give priority to first responders sending voice or text messages, images, video, and location information in real-time during an emergency over a dedicated LTE network. AT&T will build, operate, and maintain the network, which will cover all states, five U.S. territories, and the District of Columbia. The rollout will begin later this year.

FirstNet, an independent arm of the Department of Commerce, took its first major step in achieving interoperability through a test lab that opened Nov. 9, 2016, in Boulder, Colorado, USA. According to the FirstNet website, the lab conducts “validation and verification testing for the network, services, and features, and aids future research and development related to public safety broadband technologies.” Testing is projected to cut the time in field testing and actual deployment of FirstNet services and applications.

FirstNet also allows access to developers for testing apps that would complement interoperability and cybersecurity on FirstNet’s network.

**Source**

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SEE YOU THERE!
On a Sunday, in March 2016, a 16-year-old male called the Alachua County Combined Communications Center (CCC) and told the 911 telecommunicator that he was walking around an apartment complex (Gainesville, Florida, USA) and planning to kill himself using the M16 rifle he was carrying. He did not stay on the line. In spite of multiple call-back attempts by CCC, he did not pick up.

Police arriving on scene ordered him to drop the gun. He did but then picked it up. Fearing the worst, law enforcement opened fire, killing the teen who had been holding a toy replica of the weapon.

Lt. Brandon Kutner, speaking on behalf of the Alachua County Sheriff’s Office, defended their actions. “Deputies gave verbal commands to drop the weapon, which he initially did,” Kutner said, adding “as we tried to establish a rapport with the individual, to try to get him to move away from the weapon, he picked it up, rearmed himself, and started walking toward an occupied apartment complex.”

A report issued by Alachua County Grand Jury found the shooting death lawful, but likely “avoidable.” Recommendations included increased training in interacting with the mentally ill.2

The recommendation emphasized something Jim Lanier had long believed necessary at every stage of an incident potentially involving mental health issues. “We needed to explore what else we could do for the caller, calltakers, and officers,” said Lanier, Technical Services Division Manager, Alachua County Sheriff’s Office. “If you don’t understand what is happening with the caller, you can’t establish the level of assistance necessary to help.”

Crisis Intervention Training

The Durham Police Department (North Carolina, USA) established a Crisis Intervention (CIT) program in 2007 in answer to an increasing number of 911 calls and incidents involving people exhibiting serious mental illness.

As explained by Lt. Mark Morais, Durham Police Department, Assistant District Uniform Police Commander, CIT puts law enforcement in partnership with mental health and consumer advocacy groups, families, and individuals with a common goal to connect people in a mental health crisis to appropriate services rather than the criminal justice system. A primary objective is decreasing the use of force in law enforcement confrontations.

“Jails are not equipped to handle people with serious mental illness,” said Morais, who was instrumental in integrating two federal grants that helped design the current Mental Health Outreach Program (MHOP) that now exists in Durham. “CIT gives police more
options, ways to work with an individual, and de-escalate the incident.”

CIT nationwide is the genesis of training curriculum developed by Memphis (Tennessee, USA) police in 1987 to address public outrage over the fatal shooting of a knife-wielding male with severe mental illness. The “Memphis Model” includes sections covering clinical issues, post-traumatic stress disorder, de-escalation strategies, and lists of community resources.

While extensive training, certification, and overall goals are standard, public agencies are encouraged to develop a model that reflects their community. This includes advocacy groups, such as local chapters of the National Alliance on Mental Illness (NAMI); individuals and family members; and mental health care and treatment professionals.

“Partnerships are vital in making this work,” he said. “You have to get a commitment at the start for CIT to be most effective.”

According to the Memphis Model, an emphasis on emergency communications is essential: Emergency dispatchers are a critical link in the CIT program and may include calltakers, dispatchers, and 911 operators. The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and knowing the appropriate questions to ask to better assist the responding officer. It’s recommended that dispatchers receive training courses (a minimum of 8–16 hours) in CIT and additional advanced in-service training.

Alachua County’s telecommunicators are required to take CIT.

Lanier said CIT training was extremely beneficial for telecommunicators, but he also wanted a program designed specifically for emergency communications personnel that would provide further guidance and tools for effective mental health crisis management. With the proper training, the 911 telecommunicator has a greater chance to de-escalate the incident and the danger to the caller, bystanders, and public safety responders.

“We needed something to get to the next level of empathy and trust with the caller,” said Lanier, a longtime proponent of the police, fire, and medical protocol systems. “We wanted to put more focus on the behavioral perspective [in a non-visual setting].”

In July 2016, the Alachua County CCC, with the support of Sheriff Sadie Darnell, took the lead even before receiving Alachua County Grand Jury’s recommendations by initiating a project where each telecommunicator would attend a three-day certification class (Emergency Mental Health Dispatch (EMHD)) that builds on CIT with an emphasis on the 911 telecommunicator. Facilitated by Jim Marshall, Director, 911 Training Institute, the course targets optimal emergency response based on understanding behavioral factors contributing to a mental health crisis.

Marshall said the certification course fills the gap between the initial call and police intervention and disposition.

“We’re providing real-time crisis intervention from the beginning with the intent of getting help for that person,” Marshall said. “[Through the course] dispatchers develop a greater understanding and compassion for people in a mental health crisis.”

The course provides information on 19 conditions that can affect mental health, such as schizophrenia and severe depression. Dispatchers (EMHD) do not diagnose the behavior or predict outcomes.

“They optimize cooperation using our call-managing objectives,” Marshall said. “We are bringing the same awareness to mental illness, at the same level as science, as the Medical Protocol did for helping people at risk and safeguarding the scene for response.”

Lanier said the course puts dispatchers at ease in calls involving people in mental health crisis situations.

“From my own experience, I know there’s a feeling of helplessness when answering these calls,” said Lanier, who has worked in emergency communications for more than 20 years. “It’s easy to judge the caller, but this training helps the dispatcher look beyond assumptions and at the human being experiencing a crisis. The outcome might not be what we desire, but at least dispatchers have the confidence they did all they could to manage the call.”

The need is there

An estimated 7 percent of police contacts in jurisdictions with 100,000 or more people involve the mentally ill. A three-city study found that 92 percent of patrol officers had at least one encounter...
with a mentally ill person in crisis in the previous month, and officers averaged six such encounters per month.6

According to NAMI, each year 2 million jail bookings involve a person with mental illness. Approximately 15 percent of men and 30 percent of women in local jails have a serious mental illness, and 1 in 4 people killed in officer-involved shootings had a serious mental illness.7

Surveys have found that a majority of Americans believe that people with mental illness are more likely to act violently and more likely to commit violent crimes. Other research has suggested that the opposite is true.

According to the U.S. Department of Health and Human Services, only 3 percent of violent acts can be attributed to individuals living with a serious mental illness, and to 5 percent of violent acts can be attributed to individuals with severe mental illness.8

Police Protocol

Police Priority Dispatch System™ (PPDS®) Protocol 121: Mental Disorder (Behavioral Problems) applies to “any incident involving an individual who appears to lack essential reasoning faculties or exhibits bizarre, possibly mentally related behavior.” Causes for the abnormal behavior include drug abuse and excited delirium.

The EPD would shunt to PPDS Protocol 127: Suicidal Person/Attempted Suicide if and when, during the call, the caller mentions the possibility of suicide. If that does not occur during the call, the EPD would stay with Protocol 121 in cases of abnormal behavior as defined by protocol.

Protocol 121

Protocol 121 is split in two, with Key Questions meant for suspect callers and not suspect callers. The questions are similar in both sequences, although their arrangement differs.

A suspect is first asked, “Is anyone else there with you?” If the answer is “yes” and the suspect hands the phone to the other individual present, the EPD transfers to the not suspect sequence of the Protocol. If no one else is present or the caller refuses to hand over the phone, the EPD continues with the suspect line of interrogation.

A non-suspect caller is first asked, “Is s/he violent?” and the second question, “Were weapons involved or mentioned?” Key Questions continue with the EPD gathering information about the suspect (where the person is now and a description). If the caller does not know whether the person who needs help is violent, according to Rule 2, the EPD should “consider the person to be violent.” Post-Dispatch Instruction c directs the 2nd or 3rd party caller, “If it’s safe to do so, observe her/him continuously. (Beware of being attacked.)”

When the caller is in danger, the EPD provides instructions on Protocol C: Caller In Danger (CID) to guide the caller to a safer place. If the caller cannot take the phone with him or her while getting to safety, the EPD instructs the caller to call back from a safe location and instructs the caller to set the phone down without hanging up. If the caller cannot speak freely, nor communicate otherwise, the EPD will stay on the line as long as necessary. If the caller is able to speak freely, the EPD returns to the main interrogation sequence and continues to obtain critical information for the incident.

The CID Protocol may be accessed at any point in the interrogation when circumstances or caller statements indicate that the caller is in immediate danger; however, it is important to note that the CID Protocol should not be used until after dispatch has been initiated. It is essential to first get responders on the way to provide protection and assistance for the caller.

In PPDS, an ECHO determinant was added as a send point on Case Entry for a CALLER IN IMMEDIATE DANGER discovered at the onset of the call. This early send point allows the EPD to initiate a 100E-1 response, provide PDFA, and go immediately to the Caller In Danger Protocol, bypassing the Chief’s Complaint and addressing the caller’s safety first. CALLER IN IMMEDIATE DANGER is defined as “a situation that places the caller in immediate danger of death or serious injury that does not involve a sinking vehicle, vehicle in floodwater, stuck accelerator, ACTIVE ASSAILANT (SHOOTER), bomb found, suspicious package, bomb threat, mental disorder (suspect caller), or suicidal person/attempted suicide (suspect caller).”

Principles of Emergency Medical Dispatch cautions the EMD to carefully attend “to the hazards that can occur in these cases.” In many cases, police coverage during these situations is standard policy.9

Sources

5. See note 4.
YOU MUST BE POLICE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Fearing The Worst,” which starts on page 32. Take this quiz for 1.0 CDE unit.

1. A primary objective of CIT is:
   a. apprehending a suspect of a violent crime.
   b. decreasing the use of force in law enforcement confrontations.
   c. encouraging neighborhood watch programs.
   d. tracking repeat domestic violence offenses.

2. The success of CIT depends on an Emergency Dispatcher’s:
   a. familiarity with the CIT program.
   b. knowledge of how to recognize a CIT call involving a behavioral crisis event.
   c. knowing the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer.
   d. all of the above

3. What is the estimated percent of police contacts involving the mentally ill in jurisdictions with 100,000 or more people?
   a. 1 percent
   b. 7 percent
   c. 20 percent
   d. 33 percent

4. How many people killed in officer-involved shootings have a serious mental illness?
   a. 1 in 4
   b. 2 in 3
   c. 4 in 7

5. People with severe mental illnesses are more than 10 times more likely to be victims of violent crime than the general population.
   a. true
   b. false

6. On Protocol 121, a suspect is first asked:
   a. “Are you feeling violent?”
   b. “Do you have any weapons?”
   c. “Is anyone else there with you?”
   d. “Are you under medical care?”

7. On Protocol 121, a non-suspect caller is first asked:
   a. “Where’s the person now?”
   b. “Is s/he violent?”
   c. “Are you or anyone else in immediate danger?”
   d. “Does anyone need medical attention?”

8. If the caller does not know whether the person who needs help is violent, Rule 2 tells the EPD to consider the person to be ________.
   a. harmless
   b. violent

9. The CID Protocol should not be used until:
   a. response is on scene.
   b. the suspect actually harms someone.
   c. after dispatch has been initiated.
   d. the caller can make positive identification of the suspect.

10. An ECHO determinant was added in the PPDS as a send point for a CALLER IN IMMINENT DANGER discovered at the onset of the call during which step in the protocol process?
    a. Case Entry
    b. Key Questions
    c. Post-Dispatch Instructions

To be considered for CDE credit, this answer sheet must be received no later than 06/30/18. 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.
Under no circumstances should the phrase “I’m going to kill myself” not be taken seriously. It’s no doubt a genuine topic of concern when someone calls 911 with this threat. Whether from a first- or second-party caller, when a suicide attempt has been announced or attempted, quick, decisive, and effective action is needed. Is it any wonder that hotlines have been established around the world where people struggling with suicidal thoughts can receive support and reassurance? But when the situations escalate, you, the dispatcher, play a critical role in ensuring the safety and well-being of the suicidal person and any bystanders.

Both the Medical Priority Dispatch System™ (MPDS®) and Police Priority Dispatch System™ (PPDS®) address suicide attempts. MPDS Protocol 25 combines Suicide Attempt with Psychiatric and Abnormal Behavior, while PPDS Protocol 127 is titled Suicidal Person/Attempted Suicide. Unfortunately, these behaviors and tendencies are prevalent across the world.

Numbers don’t lie

A quick look at recent statistics from Mental Health America reveals startling information about suicide and mental health. Perhaps most alarming is that suicide is the eighth-leading cause of death in the United States. In fact, suicide accounts for more than 1 percent of all deaths in the country. Each year, 30,000 Americans die by suicide. That number could be much higher considering unsuccessful suicide attempts in the U.S. are around half a million annually.¹ The American Foundation for Suicide Prevention reports that men die from suicide 3.5 times more often than women.²

People who attempt suicide are prone to try it again. As many as 40 percent of people who ultimately commit suicide had been unsuccessful in previous attempts. People are 100 times more likely to attempt suicide again within a year of the previous attempt.³ Suicide rates rise with age as well. Suicide rates are highest in older people, with 40 percent of suicide victims over the age of 60. After age 75, the suicide rate is three times higher than the U.S. average. After age 80, white males in the U.S. are six times more likely to commit suicide than the average person.⁴

As for determining what leads people to commit suicide, alcohol and other substance abuse is a major factor. About 20 percent of all suicides involve people who have alcohol dependency. In addition, those who commit suicide often suffer from a mental disorder. Depression is the most common among...
these, as 70 percent of victims suffered from this illness.5

Understanding the methods by which people take their own lives is important for dispatchers. According to the Centers for Disease Control and Prevention, most men commit suicide with firearms (59 percent). For women, the most common method is poisoning.6 The CDC also reported that in 2013, 494,169 people in the United States were treated in emergency departments for self-inflicted wounds.7

**People who attempt suicide are prone to try it again.** As many as 40 percent of people who ultimately commit suicide had been unsuccessful in previous attempts.

Talking to someone threatening suicide isn’t something one should take lightly. Establishing rapport with a suicidal caller is important, but Marshall said effectively handing the call requires rigorous training through a course supported by research-driven processes for assessing the caller’s risk.

**Warning signs**

Research indicates a number of risk factors for suicide. Some of these common signs to look out for include the following:

- Verbal suicide threats such as, “You’d be better off without me” or “Maybe I won’t be around”
- Expressions of hopelessness and helplessness
- Previous suicide attempts
- Daring or risk-taking behavior
- Personality changes
- Depression
- Giving away prized possessions
- Lack of interest in future plans

**Uncomfortable issues**

Even though data clearly shows suicide is a significant problem and the number of people attempting suicide is increasing, it’s not a topic that gets a lot of attention and focus during dispatcher training courses. According to statistics from Public Safety Training Consultants (PSTC), suicide is discussed for less than 30 minutes in most POST-approved dispatch academies. For every one successful suicide, there are 50 other people calling 911 or suicide prevention hotlines before or during a suicide attempt.

“People don’t want to talk about things that stress them, especially in professions where stressful situations happen all the time,” said Jim Marshall, a mental health clinician and 911 Training Institute Director.

“Managing suicide calls takes knowledge of the science behind mental health issues and a conscious process on the part of the dispatcher to manage (his or her) stress response,” he said.

Recognizing the physiological impact, such as “gut reaction,” can turn the “I can’t get close to this caller” ambivalence into “I can do this.” It’s a matter of the dispatcher balancing empathy with detachment. In other words, the dispatcher can assist the caller while, at the same time, manage his or her own well-being. That ability to push toward a connection, rather than over-distancing for the sake of self-protection, can provide a buffer to keep the person from falling off a cliff.

“Yes, the dispatcher’s primary job is to ensure the safety of the caller and all those on scene, but equally important is building a life bridge of empathy,” Marshall said. “By doing that, you’re showing the caller you can listen carefully. You’re trying to help the person choose life, instead of death, as a solution while waiting for the field responders to arrive. They know they are truly being heard and cared about.”

Marshall also highly recommended a direct approach to the call.

“Now is not the time to indirectly ask about intent,” he said. “While you may be afraid that asking, ‘Are you thinking of killing yourself?’ will increase the risk, the research doesn’t support this. You can ask the question. A caller is apt to feel more understood if asked directly.”

**The Protocol in action**

Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt focuses on the type of medical assistance the caller or victim needs in the event of a suicide attempt. However, as opposed to the PPDS, different methods of an intended suicide attempt may shunt to a different protocol in order to handle the incident appropriately. Protocol 25 shunts to three other MPDS Protocols, when appropriate: Protocol 8 if the person is threatening suicide by carbon monoxide, inhalation, HAZMAT, or other toxic substances; Protocol 23 if the person is attempting a suicide by OVERDOSE; and Protocol 27 if the person has a stab or gunshot wound.

Key Questions 1 and 2 are critical. They ask, “Is s/he violent?” and “Does s/he have a weapon?” The answers to these questions will help the dispatcher code the call with the appropriate suffix, thus allocating appropriate resources and alerting responders to potential danger. Violent people may include those who are refusing help or entry, or those exhibiting frantic, irrational behavior. Police should be notified in these cases, and the appropriate suffix should be assigned. When weapons are involved, include the W Problem Suffix in the Determinant Descriptor. If the person is violent and has weapons, use Problem Suffix B.

This protocol makes special note to teach dispatchers to keep first-party callers on the line if they are violent or suicidal. In fact, Rule 3 is specific in instructing that “1st party callers who are THREATENING SUICIDE should be kept on the line until responders...
arrive.” Not only does staying on the line keep the dispatcher and responders informed, but it may also help to prevent further action by the caller through constant, empathetic interaction.

In addition, it is crucial for the dispatcher to understand the difference between a “suicide attempt” and a “suicide threat.” Protocol 25 defines THREATENING SUICIDE as: “Persons who are threatening to commit suicide but have not yet done anything to harm themselves.” In this case, the call would be given the Determinant Code 25-B-3. Conversely, a suicide attempt is an act toward ending life that has been committed.

Protocol answer options for suicide attempt include jumpers; cut/laceration; near hanging, strangulation, or suffocation; and chemical suicide, OVERDOSE, and stab or gunshot wound, the latter three appropriately shunted to more specific protocols.

In Key Question 4, the dispatcher asks, “Is this a suicide attempt?” If the caller says it isn’t, the dispatcher must ask the follow-up question, “Is s/he thinking about committing suicide?” If a suicide has been attempted by cut/laceration, the dispatcher must ask where the person is cut and if there is any SERIOUS bleeding (spurting or pouring). Key Question 5 asks whether the person is completely alert. If the hemorrhage is dangerous and the caller is alert, the call must be coded as 25-D-2. DANGEROUS Hemorrhage is defined as occurring in the areas of the armpit, groin, or neck. SERIOUS Hemorrhage and MINOR Hemorrhage get separate, BRAVO-level codes. SERIOUS Hemorrhage is uncontrolled bleeding (spurting or pouring) from any area or anytime a caller reports “serious” bleeding. MINOR Hemorrhage is controlled or insignificant external bleeding from any area.

If it has been determined that a hanging, strangulation, or suffocation suicide attempt has occurred and the person is completely alert (as learned from Key Question 5), the dispatcher must ask whether the victim is having difficulty breathing. A Not alert victim always gets a Determinant Descriptor of 25-D-1; a victim that is alert without difficulty breathing in a near hanging, strangulation, or suffocation is assigned 25-B-5.

Chemical Suicide is defined as “suicide by inhaling poisonous vapors that can be created from a mixture of household chemicals.” The definition also explains that: “Often, patients will tape window and door seams shut and post warning notes to prevent harm to others, such as ‘Danger,’ ‘Toxic Gas,’ or ‘Call 911.’ The immediate area also frequently smells of rotten eggs or sulfur, but Emergency Dispatchers should not rely on this indicator alone as a warning signal.”

For obvious safety and response concerns, Case Entry Rule 6 instructs: “If the complaint description involves hazardous materials (toxic substances) that pose a threat to bystanders or responders, go to Protocol 8.” However, if the dispatcher initially selects Protocol 25, the fail-safe shunt to Protocol 8 will ensure appropriate coding and instruction for Chemical Suicide cases.

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**Sources**

3. See note 1.
4. See note 1.
5. See note 1.
7. See note 6.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Proceed With Caution,” which starts on page 36. Take this quiz for 1.0 CDE unit.

1. How many Americans die by suicide each year?
   a. 10,000
   b. 20,000
   c. 30,000
   d. 40,000

2. About _____ percent of all suicide victims in the U.S. had alcohol dependency issues.
   a. 20
   b. 30
   c. 50
   d. 70

3. In 2013, approximately 600,000 people in the U.S. were admitted to emergency departments because of self-inflicted wounds.
   a. true
   b. false

4. Which of the following is a common sign of someone contemplating suicide?
   a. giving away prized possessions
   b. watching sad movies
   c. talking about a loved one who has passed away
   d. overeating

5. There is no established training course for helping assess a caller’s risk for suicide.
   a. true
   b. false

6. Protocol 25 shunts to the following three protocols in the MPDS:
   a. Protocol 8, Protocol 11, Protocol 26
   d. Protocol 8, Protocol 23, Protocol 27

7. Suffix B is used if the person ________.
   a. is violent
   b. has weapons
   c. is violent and has weapons
   d. is belligerent on the phone

8. According to Protocol 25, what is the definition of THREATENING SUICIDE?
   a. Persons who are threatening to kill themselves and have already inflicted harm.
   b. Persons who are threatening to commit suicide but have not yet done anything to harm themselves.
   c. Persons who refuse to speak on the phone to the dispatcher.
   d. Persons who have attempted suicide in the past.

9. What defines DANGEROUS Hemorrhage?
   a. Uncontrolled bleeding from any area
   b. Spurting or pouring bleeding from the head
   c. Bleeding from the legs or stomach
   d. Bleeding from the armpit, groin, or neck

10. What Determinant Code will a Not alert victim always receive?
    a. 25-D-1
    b. 25-D-2
    c. 25-D-3
    d. 25-B-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.) 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:

The International Academies of Emergency Dispatch
110 Regent Street, 8th Floor
Salt Lake City, UT 84111 USA
Attr. CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

Please retain your CDE acknowledgement for future reference.

Name ________________________________
Organization _____________________________
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E-mail ________________________________

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

ANSWER SHEET

May/June 2017 Journal “Proceed With Caution”

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
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

To be considered for CDE credit, this answer sheet must be received no later than 06/30/18. 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.
Errors in EMS dispatching can result in tragic consequences. Dispatching errors may stem from several sources. The dispatchers may underestimate the urgency of a situation or may err in gathering or recording essential information. Should harm result to an ill or injured person because of a dispatching error, the dispatcher as well as his employer risk liability for negligence.

Negligence has been defined as the failure to exercise that degree of care which a person of ordinary reasonable prudence would exercise under the same or similar circumstances. For example, conduct which falls below the standard established for the protection of others against unreasonable risk of harm is considered negligent conduct. The dispatcher’s responses and skill must be as good as those of any prudent, competent dispatcher acting under the same or similar circumstances.

However, the use of reasonable common sense may not always be enough to defend against a charge of negligence. Courts have sometimes found the customary practice of an industry to be unnecessarily risky. Modern courts are reluctant to permit industries to set their own uncontrolled standards. Consequently, meeting the standard of other ordinary and prudent EMS dispatchers may not insulate an EMS dispatcher from potential liability if the EMS system standard is itself inadequate.

EMS systems must develop reasonable procedures to minimize the risks inherent in dispatching. Where serious risks can be reasonably anticipated, the law requires that precaution be taken.

A recent case in federal court, Archie v. City of Racine, 627 F. Supp 766 (E.D. Wis 1986), and on appeal Archie v. City of Racine, 826 F.2d 480 (7th Cir. 1987), illustrates what can happen when emergency personnel fail to follow procedures and protocol designed to reduce the risk of error. This case is particularly interesting in that it is a civil rights case, not the usual negligence suit.

The Archie Case
According to the facts contained in the opinion of the Court, the following persons played a part in this case:

Rena DeLacey, deceased (the suit was brought by the administrator of the estate);

Les Hiles, a person in the community and a friend of the deceased;

George Giese, a dispatcher for the Racine Fire Department on duty during the incident;

Ronald Chiapete, Racine Fire Chief who was responsible for rescue services.

On May 27, 1984, at 7:19 a.m., the following call was made:
Giese: Fire Department, Giese.
Hiles: Hi, Say, this is Les Hiles, and we have a lady that's really, ah, I don't know, I'm not a doctor, hyperventilating. She can't hardly breathe, and I said, well, let's go down to the emergency ward. Say's, "I can't walk," Ahh, so I says, well, I thought I could call rescue squad together, okay. 818 College Avenue.
Giese: What's the address?
Hiles: 818 College Avenue. I'll meet you in front.
Giese: What's the problem with her?
Hiles: She just don't just breathing like, you know, she just can't get her breath or nothing.
Giese: How old is she?
Hiles: Ah, excuse me. Rena, how old are you? Forty-three.
Hiles: Let me talk to her, please.
Hiles: Okay. Come here, come here. Wants to talk to you. She ain't big enough. Four hours don't people—(Makes sound of a person breathing very hard). See, I'm, Les Hiles you know and I could be the best act in the world but-
Giese: Let me talk to her. Put her on the phone.
Hiles: She's coming. She ever gets here. I know what's wrong with her.
Rena: Hello.
Giese: Hi, what's, what's, what's the problem?
Rena: Hyperthermia.
Giese: Hyper what?
Rena: Therma. Having a hard time breathing.
Giese: Have you ever had this trouble before?
Rena: Once, once.
Giese: Why don't you slow down just a little bit and relax?
Rena: And stay in my own apartment?
Giese: Just relax and don't breathe like you're breathing.
Rena: Okay.
Giese: Do me a favor.
Rena: Yes.
Giese: Get, get a little paper bag.
Rena: A little what?
Giese: A paper bag.
Rena: Paper bag.
Giese: And put it over your mouth and breathe into that. That will slow your breathing down.
Rena: Okay, thank you.
Giese: Okay, bye.
Rena: Bye.

The taped conversation clearly shows that the woman was in distress and that Hiles was anxious to get help for her. Almost eight hours later, still on May 27, Hiles again called the Racine Fire Department.
Giese: Fire Department, Giese.
Hiles: Hi, this is Les Hiles, Giese.
Giese: Yeah.
Hiles: Listen, this, this lady, ah, my little black girl friend, I, I, called before and tried the paper bag. She's still hyper-how do you say that word, hyperventilating?
Giese: M'mm.
Hiles: But she sat here for six hours. I mean, did, and I asked, "Did you ever do this before?" She said, (slurred words) only once in a while. But it scares me, you know, me.
Giese: Well, if she's hyperventilating, just, just have her do what I told you to do. She's going to have to breathe into that bag.
Hiles: Yeah, but.
Giese: Over her nose and her mouth and then slow her breathing down.
Hiles: Listen to me now. Is there anything do with the heart?
Giese: No.
Hiles: It isn't going to beat the heart out?
Giese: No.
Hiles: Cause I know...like my chest when...I'm talking. You know who I am. Les Hiles.
Giese: M'mm.
Hiles: The swimmer? Okay, what I thought, my God, man, maybe it'll wear her heart out.
Giese: No.
Hiles: No? Okay. Say, what's your first name?
Giese: George.
Hiles: Okay.
Hiles: Thank you very much.
Giese: Yeah.
Hiles: Bye.

Early on May 28, 1984, Hiles found DeLacey dead in her apartment. He told the investigating police officers of his calls to the rescue squad, but police were unable to find any record of them. Testimony by the investigating officers at trial indicated that the lack of records made them suspicious that the situation had been inappropriately handled. The coroner, following the autopsy, listed the cause of death as respiratory failure due to bilateral vesicular pulmonary emphysema, with superimposed broncho-pneumonia.

At trial, Chief Chiapete testified that he would have sent the rescue squad to DeLacey, but could understand how one could reach a different conclusion. The department's official response was the following press release:

"Addressing the specific incident of May 27, 1984 my conversation with Pvt. Giese indicated to me that he came to the conclusion, based on the conversation with Ms. DeLacey and Mr. Hiles, that an emergency situation did not exist. My review of the tapes of those conversations indicates that his conclusion is not entirely unwarranted. It is my view that, Pvt. Giese made a judgment call based on his present analysis of the conversations with the calling parties. I believe that his decision was honestly made and without any intent on his part to refuse service or harm any person.

In view of my analysis of the situation, it is my present intention not to impose disciplinary action on Pvt. Giese.

Viewing the entire situation from the perspective of hindsight, however, I believe that it may have been better judgment if Pvt. Giese had dispatched the rescue unit. Hindsight is, of course, always perfect, and it is difficult to say what any individual would or would not do at the time an incident arises.

At present my department does not have a written policy with respect to the discretion of dispatchers, and that matter is presently under review by Assistant Chief Jeffrey Peterson who recently assumed the duties of the department training officer.

The department naturally regrets the unfortunate death of Rena DeLacey but cannot assume responsibility for it. At worse, the department can be faulted..."
for an error of judgment which we believe is understandable in view of the circumstances, and must be judged from the perspective of the thousands of calls received by our department each year, and the great number of persons who are helped by our rescue service. We have never refused and never will refuse to send our rescue units in known emergency situations.

Why wasn’t the rescue squad sent to Rena DeLacey? Was it because she was black? Was it because the dispatcher didn’t believe Hiles? Or didn’t he think a real emergency existed?

The trial court found that race had nothing to do with the dispatcher’s failure to respond. There was no doubt that his response to DeLacey’s calls was inappropriate, but it was not found to be racially motivated. The judgment of the dispatcher was not at issue here. Plaintiffs raised a violation of civil rights, so the court had to decide if the failure to provide rescue services to DeLacey violated a constitutional duty owed to her.

To prove a violation of DeLacey’s rights, it must be shown that rescue squad policies allowed this incident to happen. A single incident will not support such a claim, there must be a pattern of incidents. Since this was not the case here, the Fire Chief and the City of Racine were dropped from the case.

Regarding the dispatcher, the plaintiffs also charged that there was a “special relationship” between Racine and its citizens since it decided to provide emergency services. But, the court found that providing such services does not create a special relationship between the city and its citizens. Thus, the dispatcher’s failure to send the rescue squad, while wrong, did not violate DeLacey’s constitutional rights.

The Court of Appeals disagreed. It found that the dispatcher’s conduct could have amounted to a violation of DeLacey’s rights on a theory of abuse of state power. To prevail, on this theory, plaintiffs must show that Giese was acting in his official capacity (not disputed here), and that he was under a duty to disperse those protective services undertaken by the state. If he does this in a way that deprives a person of life or property, that person’s constitutional rights have been violated.

A finding of such a deprivation depends on the totality of the circumstances. It is not enough that the dispatcher was a municipal employee, he must have exercised his state power in an arbitrary and abusive manner. There must be a deliberate misuse of state power resulting in an infringement of a constitutionally protected right.

In the Court’s analysis, the dispatcher had a duty to send an ambulance if one was available. So, if his failure to send one was reckless or arbitrary such that it caused DeLacey’s death, a violation of her constitutional rights occurred. Giese knew the situation was serious, yet he advised DeLacey to breathe into a paper bag and refused to send the rescue squad. With the second telephone call, Giese knew his “unsolicited medical advice” didn’t work. Thus, his continued refusal to send an ambulance could be found to raise an ordinary act of negligence into a violation of DeLacey’s constitutional rights. The fact that he never refused to send an ambulance before this incident, only strengthens this argument.

The District Court’s findings were enough to show that Giese exercised state power in a reckless and arbitrary manner in twice refusing to send the ambulance. But, the record was not sufficient to say that as a matter of law there was an actionable abuse of power, so the Court of Appeals sent the case back to the District Court. The District Court must now determine if Giese’s actions cross the line from tort to constitutional violation. To find this, it must be shown that Giese had reason to foresee the risk to DeLacey if rescue services were withheld, and that he deliberately and consciously imposed this risk on her. In addition, Giese’s failure to act must have been for reasons other than honest error or mistaken judgment. Finally, if there was an abuse of power, it must have caused DeLacey’s suffering and death.

The Court of Appeals also noted that in advising DeLacey to “breathe into a bag,” Giese deliberately assumed control over DeLacey’s physical welfare. This could create the “special relationship” that was alleged during the original trial. It was perfectly foreseeable and reasonable for DeLacey and Hiles to rely on advice given by Giese. Thus, a violation of DeLacey’s rights could be found under a special relationship theory.

At the time of this writing, we are unaware of any further actions by the District Court.

Commentary

The DeLacey case points out the importance of taking all rescue calls seriously. The Court of Appeals specifically noted that because there were two calls, Giese had no excuse not to send the rescue squad.

What kind of safeguards might prevent or reduce error of the kind reported here? At a minimum, EMS dispatchers should confirm all information given to them by the caller.

In addition, the practice of tape recording calls and responses is an excellent method of instantly assuring that the information written down by the dispatcher is the information received.

Finally, dispatchers and complaint writers should be trained and retrained in proper procedures to be followed and communication skills.

Generally, the four basic questions to be asked are: (1) What is the problem?; (2) Where?; (3) Who is involved?; (4) When did it happen?

The dispatchers must be able to ask appropriate questions and provide appropriate answers in a manner that is readily understandable by even the most distraught or uneducated caller.

While a dispatcher may advise the caller to put pressure on a bleeding wound until an ambulance arrives, such advice should never be given as a substitute for sending emergency aid. Providing appropriate answers, however, should not include medical advice of the kind given in the DeLacey case.
EMS IN TANDEM
Cohesive actions save young man’s life

Audrey Fraizer

People suffering a cardiac arrest secondary to a traumatic event have a slim margin of survival. People experiencing a cardiac arrest secondary to a traumatic event and with their body folded in half beneath a mobile trailer might have half of a slim chance of survival, at best.

Considering that's what happened to Jonathan Arteaga, the circle of responders helping him survive the crisis performed nothing short of a miracle in incredibly rapid succession.

The then 19-year-old Arteaga was prepping to move a mobile home, which is a routine operation for Arteaga’s Mobile Home Service, in Conroe, Texas (USA). Sometimes unexpected things happen, as they did on Feb. 24, 2016. A jack holding the house gave way. The 37,000-pound mobile home fell on top of Arteaga, pinning his knees to his chest.

Montgomery County Hospital District (MCHD) communication center EMD Danielle Williams answered the call. She had been there less than one year.

“I knew there would be difficult calls but nothing like this,” Williams said. “A house was on top of a human being. This was really beyond what you’d expect.”

The accident prompted the use of MPDS® Protocol 22: Inaccessible Incident/Other Entrapments (Non-Traffic). PDIs include “Do not attempt to rescue her/him,” and while this may be a given considering the situation, the Arteaga family was eager to do anything to help. Response was on its way.

“I had to tell them not to remove the unit,” she said. “They had to wait.”

Within minutes of the 911 call, Montgomery County Sheriff Deputies Brad Crandell and Kenneth Morris arrived on scene. They contacted Magnolia Towing. Peter Baty maneuvered his wrecker to lift the home to facilitate EMS rescue. Arteaga had a pulse.

Events took yet another turn. Arteaga’s heart stopped. This time, Magnolia Volunteer Fire Department arrived and responders started CPR immediately. Moments later, a third team arrived on scene. MCHD paramedics determined the impact had crushed Arteaga’s lungs. They performed a simple thoracostomy.

In a simple thoracostomy a gloved finger is inserted into an incision to relieve tension in injured lungs. The technique is performed on patients with traumatic cardiac arrest with known or suspected injury to the chest and/or abdomen.

Arteaga’s lungs reinflated, and in seconds he had a pulse. He was in a coma for 10 days and was able to recognize friends and family within six weeks. Physical therapy started while he was in the hospital continues during his at-home recovery.

The people involved in saving his life met the Arteaga family in a ceremony honoring the instinctive and phenomenal EMS chain of survival. Arteaga was there with them. He can’t remember anything from that day, and the same goes for events prior to the accident.

“People there told me what happened,” he said. “My family talks about things before the accident and there’s a month that’s lost.”

Williams shook his hand and they talked briefly about how well Arteaga was recovering.

“This is something I will never forget—the call, Montgomery County Hospital bringing everyone together, and meeting Jonathan,” Williams said. “Without everyone doing their job so well, the results for Jonathan could have been much different.”

By March, Arteaga was walking with the aid of leg braces. He is gratified for the people involved in saving his life.

“There were so many,” he said. “I will always be grateful for what they did to help me.”

Editor’s Note: Julie Martineau, PIO, Montgomery County Hospital District, contributed to this story.

Dispatchers, firefighters, sheriff’s deputies, and even a towing company combined to help save Jonathan Arteaga’s life.
Like all dispatchers, Anthony Bruno has dedicated his career to helping people. Bruno works long and late hours answering frantic phone calls from people who are experiencing the most frightful moments of their lives.

So naturally, the Communication Specialist with Las Vegas Fire & Rescue, Las Vegas, Nevada, USA, came to the rescue even when the headset was off and he was away from the communication center.

In March 2016, Bruno’s instinctive actions helped save a man’s life. In the several months following this heroic intervention, he has been showered with awards and recognition.

The incident happened when Bruno wasn’t even on duty.

Bruno had clocked out from the Fire Alarm Office, as it is locally called, at 2 a.m. After another challenging day on the phones, he was headed home for some much-needed rest. Not long into his commute home, Bruno saw a technical rescue truck enter the freeway; its bright lights signaled that an emergency was nearby. Next, Bruno saw a helicopter getting ready to land on the freeway. As he approached the scene of an accident, Bruno stopped his car a safe distance away and stepped out of his truck to watch the crews do their work.

A Nissan had rear-ended a Ford, sending both cars off the road; the Ford flipped several times and landed far from view. Calls to 911 had reported only one car was involved, so paramedics weren’t aware of the second vehicle. The responders did their work and left the scene.

Bruno prepared to get back into his truck to leave, but he heard a whimpering noise or the sound of an injured animal off in the distance. Initially, he disregarded the noise and was about the drive away, but a “gut feeling” urged him to investigate. Bruno ventured off into the darkness of a deserted field and came upon the Ford, upside down with someone trapped inside, about 100 yards away from the original accident.

“Help me!” the person pleaded.

Bruno spoke to the 20-year-old man—who later was determined to have been trapped for an hour and two minutes—and reassured him that help would be on the way. Bruno ran up the road to where a Nevada Highway Patrolman was helping with the aftermath of the accident.

“I felt terrified and alone,” Bruno recalled.

After summoning help, the officer joined him at the scene, and the officer
called dispatch. Bruno was used to being on the headset, hearing people desperately plea for rescue to come. In an odd twist, he began to have the same feelings that so many callers have when they’re on the phone waiting for help to arrive.

“The first thing that went through my mind was, ‘What’s taking so long?’” he said. “It’s a different feeling to be in [the caller’s] shoes. Imagine being a loved one of a victim. I was a complete stranger, and I was so worried about the guy. It’s a difficult feeling to describe. I’m used to callers getting frustrated as they wait. Now, I feel comfortable saying, ‘I know it seems like a long time.’ I experienced it first-hand on the other side.”

Help did come, and the man survived. Those who arrived on scene said without Bruno’s timely, brave efforts, the victim wouldn’t have survived the accident.

In recognition of his actions, in July 2016, the city of Las Vegas named him employee of the month. In January 2017, at a ceremony held during a city council meeting, he was selected among the city’s other 11 employees of the month in 2016 as employee of the year.

The recognition kept coming for this veteran dispatcher.

The Las Vegas Fire Department named him employee of the month for April 2016. Plus, he received the Everyday Hero Award from the American Red Cross in October 2016 at a ceremony at the Paris Hotel on the Las Vegas Strip. He even got to have lunch with the Las Vegas City Council.

The long list of accolades came as a surprise to the humble Bruno.

“I wasn’t expecting it,” he said regarding the employee of the year award, in particular. “I was shocked. [City representatives] came and surprised me with the award.”

Though grateful for the acknowledgement, Bruno shies away from the limelight and dismisses the notion that he is a hero. In his mind, he was only doing what anyone else would do and was simply performing a duty that spilled over from his everyday work as a dispatcher.

“It felt good to be honored, but I don’t look for recognition,” he said. “I’m not a hero. Heroes are the guys that cut the person out of the car. I don’t look at myself as a celebrity.”

Helping people is second nature for Bruno. Since graduating from high school in 2005, he has spent all his working time as a dispatcher. But it was with Las Vegas Fire & Rescue where he always wanted to be.

“As a kid, I used to come by and visit where I now currently work,” he said. “I tried six times to be a fire department dispatcher.”

Each time a job came up at Las Vegas Fire & Rescue, Bruno didn’t just apply, he was the first applicant each time, submitting his application at 12:01 a.m. the day the job came open.

His persistence paid off, and the sixth time was the charm.

“I was so glad I got accepted,” he said.

Bruno has thrived under the headset, just as he was Johnny-on-the-spot as a bystander in the wee hours in March 2016. One of his secrets of success is a positive attitude and a genuine appreciation for his work.

“I love my job with a passion,” he said. “I love what I do, and I love coming to work. I have the best co-workers; we’re the definition of a team. We talk about the worst every day. We bounce ideas off each other at work. At work I have true friends.”

Bruno said dispatching isn’t for everyone. After all, you’re talking to people on the worst days of their lives—helping them give CPR to a loved one, comforting them when a family member has committed suicide, or assisting with any number of terrible events. Yet, Bruno said the profession is rewarding and that he wouldn’t trade his experiences for anything.

And whether a call for help comes while he’s got a headset on or whether he sees a need away from the console, you can be certain that Bruno will always be ready to jump in and lend a hand.
Unnecessary ambulance collision changes teen’s future instantly

Audrey Fraizer

Sharron Rose Frieburg’s photo in the 1988 Saybrook-Arrowsmith (Illinois, USA) High School yearbook is a trip down memory lane.

Her hair is cut shoulder length, with bangs bobbed above her eyebrows. She wears no makeup. Her smile is genuine, although soft because either she was taken by surprise or shies away from photos that might reveal the braces on her teeth. She is 18 years old.

“She was everything but shy,” said her younger sister Linda Renee Frieburg. “She was a ton of fun to be around. She liked to sing. She was in jazz dance. She was funny—outgoing. She got straight A’s.”

The Frieburgs live in Saybrook, a small, rural town, and part of the Bloomington-Normal metropolitan area in east-central Illinois. The population holds steady at close to 700 residents, and like teens anywhere, Sharron, Linda, and their friends spent a good part of their time away from the scrutiny of parents hanging out at the neighborhood park, driving aimlessly around town, going to movies, dating, and looking forward to high school graduation. Sharron was an honor student and a cheerleader. College was a summer away.

But Sharron never made it to college. Her life took a dramatic turn on March 26, 1988, at the exact moment her boyfriend, Mark, drove his pickup through a green traffic signal at an intersection on their way to a movie. Their vehicle was broadsided by a Bloomington City Fire Department ambulance moving at a high speed through a red traffic signal, without lights-and-siren, and transporting a patient with a sprained ankle to the hospital.

Mark sustained minor injuries. Sharron was in a coma in the hospital for nearly four months, until Aug. 1, 1988. Martha and Charles Frieburg spent every day at their daughter’s bedside. They participated in her therapy sessions, learning how to help Sharron regain at least some of her skills. They brought her home from the hospital after the insurance company would not cover any further care because of a policy clause prohibiting extended treatment when a patient has recovered as much as the company’s doctors think is likely.

Sharron was never expected to fully recover from the physical and cognitive trauma.

And she never did.

“The accident changed everything,” Linda said. “It set a new course for the family.”

Sharron is now 47 years old (as of January 2017). She lives at home with her mother. Charles died in 2005. Linda moved close to her family home, along with her four sons, to assume some of the tasks Sharron’s daily life requires.

She had hoped to give her mother respite, and she does, but Sharron grows increasingly agitated when her mother is out of her sight, even if it’s a walk to the garage outside.

They seldom talk about the accident.

“I don’t at all unless I have to,” Martha said. “It brings back all the sadness and tears that lie deep down in me.”

Sharron can walk a short distance unassisted. Her gait is unsteady and she tends to stumble. The family prefers to bring a wheelchair to grocery shop, attend services at Saybrook Christian Church, where their father was a deacon, and visit friends and family.

Sharron’s eyes don’t focus. Paralysis on her left side makes dressing and personal grooming difficult. Because braces severely lacerated her tongue during the accident, she has trouble enunciating words.

Martha said Sharron can say “yes” and “no.” She more often relies on hand gestures.

“She has lots of her own signs,” Linda said. “Most of the time we understand what she wants.”
Martha lives one day at a time. “At the age of 70, my biggest concern is the concern of every parent caring for severely disabled children,” Martha said. “What happens to Sharron after I am gone?”

In 1989, the city of Bloomington reached a monetary settlement. The funds cover Sharron’s ongoing medical and therapeutic expenses and costs associated with her 24-hour care, housing, and other necessities of daily living.

The Bloomington Fire Department changed its policies on using red lights and siren after the accident involving Sharron.

“In the past, we ran hot all the time,” said Alan Otto, Chief of the Bloomington Fire Department (in a Feb. 4, 1997, article exploring the overuse of red lights and siren published in the Cincinnati Enquirer). “Now, we’re down to 60 or 70 percent.”

Related article

The following article written by Jeff Clawson, M.D., was published in JEMS (“Running Hot and the case of Sharron Rose,” July 1991).

The use of RLS [Red-lights-and-sirens] is not without significant hazard. It has been estimated, for example, that as many as 12,000 emergency-medical-vehicle accidents (EMVAs) occur each year in the United States and Canada as a direct result of RLS use. In addition, because of what we call the “wake effect” of emergency units disrupting, confusing, and startling other drivers, up to five times as many accidents are caused by units responding RLS that don’t physically involve the emergency vehicle itself. Does the number 75,000 get your attention? It should, if you, too, believe that the prime rule of emergency medical dispatch as for medicine itself should be, “First, do no harm.”

In 1989, I subscribed to a national newspaper clipping service, and for one year, I received so many articles of EMVAs that I couldn’t fit them all into a cabinet drawer. And these were just the ones that made the news, such as fatalities, rollovers, lawsuits, and horrible outcomes. Then there was Sharron Rose. Her story caught my eye: In Bloomington, Illinois, nearly $5 million and the quality of life of a talented, beautiful 18-year old girl, Sharron Rose, were lost because of a “sprained ankle” run.

In 1983, Salt Lake City’s Fleet Management department reported that the EMVA rate had dropped 78 percent in that city as a result of the MPDS, and it was estimated that the number of EMS vehicles traveling Salt Lake City streets with RLS was safely reduced by 50 percent through the use of the system. Were any Sharron Roses saved by these changes? I guess we will never know.

Statistics

U.S. Fire Administration firefighter fatality statistics over the years reveal that vehicle-related deaths account for 25 percent of all fire service fatalities. According to the National Law Enforcement Officer’s Fund, for the period of 2002 through 2011, 39 percent of law enforcement officer fatalities were vehicle-related.


According to the National Highway Traffic Safety Administration (NHTSA), between 1992–2011, there were:

• an annual estimated mean of 4,500 motor vehicle traffic crashes involving an ambulance.
• an annual mean of 29 fatal ambulance crashes and 33 fatalities.
• an estimated annual mean of 1,500 injury crashes involving an ambulance and 2,600 injured persons (ambulance occupants and occupants of all other vehicles involved).

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