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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.

Art is a software instructor and IAED-certified EMD-Q® instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey (USA).

Michael is employed as an Emergency Operations Manager with the Sarasota County Sheriff’s Office, Florida (USA). He has worked as a dispatcher, training officer, incident dispatch team leader, and supervisor since 2008. He is certified by the State of Florida Department of Health as a 911 Public Safety Telecommunicator and by the Florida Department of Law Enforcement as an Instructor.

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By meeting certain requirements, certified membership is provided for qualified individual applicants. Accredited Center of Excellence status is also available to dispatch agencies that comply with Academy standards.

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Y ou may be wondering how NAVIGATOR in National Harbor, Maryland (USA), went. Well, look no further than our feature section in this issue of the Journal. Get a big picture view of the goings on and the awards given out in this conference feature written by Audrey Fraizer. Online you’ll find more interviews with attendees and those unique stories only Audrey can unearth.

Staying on that same thread, travel with us to Apache County, Arizona (USA), in Audrey’s Center Piece article. Learn more about this predominantly rural area, which is a prime destination for tourists because of its enchantment. Learn what the dispatch center handles for residents and visitors alike. Audrey also takes us to Haleyville, Alabama (USA), where the first 911 call took place in 1968. Read about Ronnie Wilson and his memories of working as the overnight dispatcher shortly after the 911 system was implemented in Haleyville. If a response required fire equipment, Wilson (also a volunteer firefighter), would end the call, run over to the fire station, and leave for the scene with the person on duty. Hear about things were like before the MPDS’ came on the scene.

Read Sherri Stigler’s final Lean In column. She has been writing for the Journal for several years while working as the training and operations manager at Waukesha County Communications (Wisconsin, USA). We have appreciated her contributions to the Journal and wish her the best on her journey.

Another fan favorite columnist is Art Braunschweiger. In this installment of his column, From the Dispatch Side (formerly From the EMD Side), he discusses becoming more realistic in our expectations of others. In this installment of his column, From the Dispatch Side (formerly From the EMD Side), he discusses becoming more realistic in our expectations of others.

Speaking of contributors, take time to read the Your Space story contributed by Michael Spiegel. It’s a personal account of a tragic event he experienced that also affected his center. Michael talks about experiencing PTSD and his road to recovery. You won’t want to miss this one.

Before we wrap up, check out the outreach feature. Perhaps you haven’t thought much about outreach, or perhaps you have, but you aren’t sure where to start. Becca Barrus outlines ways to kick off your center’s outreach and some of the common things the public needs to know about calling 911 for help.
MY IMPRESSIONS

Your work continually amazes me

Josh McFadden

Legendary baseball player and manager Yogi Berra once famously said, in his typical paradoxical way, “You can observe a lot just by watching.”

Berra was well known for his malapropisms, but if you peel away the layers of humor and sometimes head-scratching sayings, there’s wisdom and truth in his remarks. I found his statement about observations too true ... I simply reword it to read, “You can learn a lot just by watching.”

One of the best examples in my career of learning by watching occurred at the most recent NAVIGATOR event in National Harbor, Maryland (USA). As you can imagine, a lot of behind-the-scenes work goes on to put this conference together. Staff members from the IAED™ and Priority Dispatch® collectively spend countless hours preparing for NAVIGATOR. Once at the event, the tireless efforts continue. Though it can be exhausting, the physical and mental exertion are worth it.

I was impressed by the dedication of the staff, but I saw firsthand the fruits of these labors: More than 1,500 public safety professionals were able to mingle, celebrate, instruct, and learn in a productive, meaningful environment.

As I reflect on this past NAVIGATOR and others before it, I am convinced that some of the bravest, most selfless, and most committed individuals work in this field. Whether you’re nearing the end of a long career, your contributions change lives. It doesn’t matter what position you hold—your work is indispensable.

I only had to sit back and watch NAVIGATOR unfold to come to this conclusion.

Here are some observations I made last April at NAVIGATOR:

• Instructors were prepared with relevant information.
• Instructors engaged their classes with vivid presentations and interesting topics.
• Attendees were eager to learn and develop their skills.
• Attendees participated in sessions by asking questions, sharing experiences, and taking notes.
• The Exhibit Hall was packed with curious conference-goers.
• People at the conference were friendly, courteous, and respectful.
• There was a general feeling of passion and enthusiasm at the conference.
• Everyone collectively shared in the joy and appreciation when individuals were recognized with awards.

The list goes on and on. Sometimes, the work that goes into presenting a big event may go unnoticed. Similarly, the general public sometimes dismisses your heroic profession. What you do matters.

What I witnessed at NAVIGATOR was not an anomaly. Every day, as I scour the news and social media for dispatch-related stories, I read about amazing men and women who continually go about their work with the same zeal and devotion that I saw in National Harbor.

You interact with people on the worst days of their lives, but the overwhelming majority of emergency dispatchers continue to maintain positive attitudes and a desire to do good.

Thank you for teaching me these things and reminding me every day how you play a critical role in the chain of care. ●
THREATENING TO JUMP
How do you decide what response is needed?

Brett Patterson

Hi Michelle:
Great question. Nothing gets by your eyes!
This default has to do with the response code as the “Jumper (threatening)” code recommends both police and fire notifications, and the likelihood of a threatening jumper being not alert is low. If you select the D-1 “Not alert” code [D-3 in the current v13.2], the threatening jumper remains unknown in the code. In essence, the emergent safety needs of the threatening jumper take precedence over the not alert medical condition in this scenario.

Does that make sense?
Was this a real case or a speculative one?

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

Hi Michelle:
Great question. Nothing gets by your eyes!

Brett:
This makes perfect sense. We had a patient that was threatening to jump previously but was now back inside the house and was not alert. So we didn’t have this situation, but as a result of the call it sparked curiosity, and I ran some test calls “switching it up a bit.” Thanks for your time.

Michelle

Good afternoon:
Hope all is well. I was referred to the both of you on a question I had on an EMD code. When utilizing Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt and the patient is presently threatening to jump and is not alert, the EMD code in ProQA® is 25-B-4. Is there a reason why the EMD code shouldn’t code for the not alert patient as a 25-D-1 [D-3 in the current v13.2]? I want to make sure I didn’t find a “glitch” in the protocol as well as if there is a purpose for this that I provide the correct information for the BRAVO response vs. the DELTA. Thank you for your time and have a great day!

Michelle Haynes
EMD Quality Performance Improvement Coordinator
Weld County
Regional Communications
Greeley, Colorado, USA
It's difficult for me to find the words to adequately express the deep sense of joy and purpose I have found in bringing you the Lean In column over the past five years. Like all things in this life, however, there comes a time to step aside gracefully and help plant seeds for a new season.

For me, that time has come. I am pulling back the reins on some of my roles and responsibilities. I have no doubt that very capable writers and storytellers will continue to fill this space with content that is meaningful, impactful, insightful, and that helps all of you remember the "why" behind this incredibly important calling of public safety communications.

As I have described in an earlier column ... part of life is about embracing those "ch- ch- ch- changes."

Within our own dispatch center, we are in the midst of a change that is not coming easy for me. Our Communication Center Specialist, Kaye Kumbier, has announced she is moving on to her next chapter in life at the end of this year. Though I know she hates any kind of attention or personal accolades (sorry, Kaye!), I want you all to “meet” her because I am certain you have similar individuals within your own centers—people who have serious, long-term investment in the health and advancement of the organization.

Kaye has spent 34 years dedicated to our communication center. She has been a devoted leader and an integral facilitator of all of our technical needs, e.g., hardware, software, CAD, and protocol updates. She has positively impacted every project, change, and problem we have faced since the day we opened our doors. She has never shied away from adversity and has always been willing to express her tell-it-like-it-is honesty.

As the days go on and we march toward her retirement date, we try desperately to take in every last sip of her knowledge and wisdom. One of my greatest fears is not adequately capturing one of her greatest legacies—her incredible work ethic.

I remember the early days, the long nights. We still call her at Oh Dark Thirty when an officer gets locked out of a system or when a supervisor needs support. She kept a cot in her office in case there was a snowstorm and she needed to stay overnight so that she was sure to be at work the next morning. She worked endlessly to make sure we were prepared for anything.

Kaye never counts the time she spends answering calls for help throughout the night. When she is on vacation, she's really not. Her laptop computer goes with her EVERYWHERE. Kaye has a strong sense of what the right thing to do is, and she does the right thing even when no one is watching. This, my friends, is called integrity, and it is the heart and soul of what we must harvest from her along with her other many tangible skills.

I will sorely miss the numerous trips to her office next door to mine, for which I have beaten a path to over the years—a haven where I can vent, laugh, cry, complain, and use a few (or lot of) four-letter words if I need to. She has always been my safe place. We all need that, and I will miss that.

However, I am certain that Kaye knows it is her time to move on and move aside after a long, successful, and distinguished career in public safety. Leave your laptop behind, Kaye. Bask in the peace of a full night of uninterrupted sleep. Laugh a little when you hear about the latest malady affecting the center, and be content knowing that YOU no longer have to deal with it. But never forget, Kaye ... never forget that you made a difference here. Thank you!

The Circle of Life continues. Fresh new perspective will find life in our center and also on this page.

A parting quote from Kat Graham: “You make your mark by being true to who you are and letting that be your staple.”

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**CHANGE JUST AHEAD**
SUDDEN DEATH
Losing one of your own puts things in perspective

Art Braunschweiger

As emergency dispatchers we deal with death so often that it becomes commonplace. We develop emotional defense mechanisms to wall off death and other tragic events. If we didn’t, we couldn’t function in an environment where a daily dose of crisis is part of the normal routine.

But what happens when a death occurs inside our four walls? The guy in the photo is Danny Jimenez. Up until a year ago he was an emergency dispatcher at Union County Communications in Westfield, New Jersey (USA). Danny was a former United States Marine who became an emergency dispatcher because he dreamed of being a police officer someday. He was a bodybuilder and loved fast cars and fast bikes. He’s pictured here with his boys, Bubba and Bane. Danny died in a motorcycle crash in the early morning hours of Aug. 11, 2018. He had an argument with his wife, went out for a ride, and never came back. He had been married three days prior.

It took a while, but I’ve changed my outlook in the year since his death. I don’t question or correct anyone anymore unless it’s “mission critical.” I’m hoping my co-workers will notice and forgive me for all the times that I was a bear about policy or protocol or other things that weren’t my job to worry about and that really didn’t matter in the moment. I’ve become much more realistic in my expectations of others, both as a peer and a supervisor.

For all the complaining that dispatchers can do, very few give anything but their best when it’s “all hands working.” And if one person isn’t as good at their job as someone else, that has to be OK. I have to remind myself that not everyone loves their job, not everyone is as wide awake as I am first thing in the morning, and not everyone cares about learning as much about ProQA® as I do. (I really struggled with that for a long time!)

Performance does matter, and some people do need to get better at what they do. But that’s why quality management programs and continuing dispatch education exist. Expecting anyone to improve without them is just fantasy. If you don’t have both in place it’s the system that’s at fault, not the emergency dispatchers.

If you’re over 50, like me, you probably started your career with a senior dispatcher who was a legend on the air. His radio and phone dated from your great-grandfather’s day, and his unit-tracking technology consisted of a sharpened pencil and a stack of run cards. All the things we have today help a lot, to be sure, but in the end it’s the people that make a center work.

If you’re over 50, like me, you know in the first two minutes whether I’d want to work there just from listening to the dispatchers interact.

An effective team isn’t all about dispatch skills. A positive attitude, a sense of humor, or someone who’s just easy to work with (like Danny) can make as much difference as someone who can handle a five-alarm fire without breaking a sweat. I’ve known dispatchers who were the best at what they did, but they didn’t bring anything to the team.

Danny will be missed for a lot of reasons, but none of them have anything to do with how he did his job. Everyone misses him because he was a decent guy that everyone liked to work with.

Someday I hope to have the same thing said of me.
TO SHUNT OR NOT TO SHUNT?
Some symptoms require moving to another protocol

Brett Patterson

Brett:
Clarification is requested regarding Protocol 26: Sick Person (Specific Diagnosis) as follows:

An EMD on Protocol 26 who receives NEW information about the patient’s condition (Stroke symptoms present, or patient starts to seize) that is discovered in KQ 4 (Does s/he have any pain?) is directed by Rule 2 to remain on Protocol 26 for symptoms other than chest pain/discomfort (e.g., abdominal pain, back pain, or headache).

The EMD is not directed to shunt to a more appropriate Chief Complaint code when priority symptoms are indicated, i.e., Protocol 28: Stroke (CVA)/Transient Ischemic Attack (TIA) or Protocol 12: Convulsions/Seizures. Both Chief Complaints launch important diagnostic tools that assess the patient’s breathing or the presence of stroke.

Also, Rule 2 appears to conflict with Case Entry Rule 6, which states:
Protocol 26 identifies only one (1) priority symptom, Chest pain/discomfort, as cause for shunting to another protocol (10).

All other priority symptoms are not addressed leaving the EMD with limited options.

Thank you,
Lisa Elekwachi
Continuous Quality Improvement Manager
Department of Emergency Management
Division of Emergency Communications
San Francisco, California (USA)

Hi Lisa:
Thanks for your question.

It is common for patients without a categorizable complaint (Sick Person) to have secondary complaints such as a head or tummy ache, and even abnormal breathing, that is essentially “discovered” on Protocol 26 but not mentioned on Case Entry as part of the initial Chief Complaint Description. And we know from outcome data that conditions “discovered” on another protocol are typically not as serious as when they are part of the initial complaint. For instance, you may remember when there was a shunt to Protocol 6: Breathing Problems for when abnormal breathing was discovered on Protocol 5: Back Pain (Non-Traumatic or Non-Recent Trauma) and Protocol 26. When we looked at these outcomes, we learned that these “shunted” patients were not as ill as those with a primary complaint of breathing problems so we removed the shunt and added codes for “Difficulty breathing” (Protocol 5) and “Abnormal breathing” (Protocol 26) so that agencies can assign response codes specific to “discovered” versus primary breathing problems.

That brings us to the intent of Protocol 26’s Rule 2. The intent is limited to the discovery of incidental complaints and is NOT intended to prohibit a move to another protocol when it is clear to the EMD that s/he is in the wrong place. You are most correct that if a Sick Person interrogation discovers clear Stroke Symptoms, or the patient has a seizure, we need to move to that protocol. However, this sort of thing is relatively rare as these sorts of symptoms are most concerning to the caller and are normally part of the initial Chief Complaint.

In summary, advise your EMDs that if a move is clearly necessary (“I’m clearly in the wrong place”), and this is usually defined in protocol with Chief Complaint Selection Rules and symptom lists like Stroke Symptoms and Heart Attack Symptoms, they should move to the more specific protocol to address the more specific complaint. However, a Sick Person interrogation has nothing to gain from a move to the Headache or Abdominal Pain Protocol when these symptoms are discovered on Protocol 26 and were not part of the initial Chief Complaint. Rather, such a move only clouds the issue by changing the code to reflect something that was not part of the initial Chief Complaint.

Thank you for reaching out to the Academy.

Brett A. Patterson
Academics & Standards Associate
Chair, Medical Council of Standards
International Academies of Emergency Dispatch
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Accrediting as an ACE seven times puts a center in rare company, but that’s exactly where the Regional Emergency Medical Services Authority (REMSA), in Reno, Nevada (USA), stands.

Founded in 1986, REMSA is one of just 11 agencies in the world to accredit as an ACE seven times. The center officially re-accredited once again in May 2019 as a medical ACE. It has continuously held this distinction for 18 years, meaning by the time this seventh accreditation expires in 2022, it will have been an ACE for 21 years.

Being in this elite company is something everyone at REMSA cherishes. “REMSA has long acknowledged that patient care starts with the call,” said Adam Heinz, Director of REMSA. “Earning accreditation demonstrates our commitment to high-quality, professional emergency dispatching. Through our partnership with the IAED™, we can say with certainty that for every patient within Washoe County that calls 911, there is a standardized, internationally recognized, evidence-based medical dispatch protocol being followed.”

The 10 other seven-time accredited agencies are also medical ACEs, but REMSA has done something none of the others have accomplished: It is also an Emergency Communication Nurse System™ (ECNS™) ACE.

In fact, REMSA is one of just three ECNS ACEs in the world; the others are Northwell Health Clinical Call Center (in Syosset, New York, USA) and 144 Notruf Niederösterreich (in Sankt Pölten, Austria). Those other two centers are also medical ACEs, but they haven’t re-accredited as many times as REMSA. Also, REMSA has been accredited twice for ECNS, making it the only center in the world to re-accredit in that discipline.

“To be honest, we are extremely proud of this accomplishment,” Heinz said. “It’s a real source of identity and pride for our team members; they know this distinction is unique in the industry, and they work hard to live up to that leadership standard.”

Heinz also said the staff takes the achievement seriously and uses it as motivation to work hard and provide the best possible care to callers in need.

“As a team, we also recognize the significant responsibility that comes with being a dual-accredited center,” he said. “There can be rough spots, but we remain committed. Plus, knowing we can lean on the expertise and guidance of the IAED is an important component to our continued success.”

Heinz acknowledged that working toward and maintaining accreditation isn’t easy, but it’s definitely worth every ounce of effort from everyone.

“Preparing for accreditation is no small task, but our supervisors, managers, and staff consistently rise to the occasion..."
because they feel a tremendous sense of ownership and are proud of how they contribute to the health and well-being of our community,” he said.

A team approach

Each year, the REMSA communications team responds to more than 70,000 calls for assistance among the 600,000 residents it serves in Washoe County. The area covers 6,542 square miles. The center is privately owned and is a community-based, nonprofit service. It is funded by user fees and doesn’t rely on local taxes. Any financial profit it makes is reinvested in the staff, equipment, and community.

Not only do REMSA emergency dispatchers work with the paramedics and ambulance services for medical calls, they also coordinate with REMSA’s Care Flight program. This air rescue team responds to emergencies over a 50,000-square-mile range in Nevada and northwestern California as well as in 11 Western states. The Care Flight team has four helicopters and an airplane that can reach most of its coverage area in an hour or less.

Heinz said emergency dispatchers love working at REMSA because it gives them the chance to make a difference on what are the worst days of people’s lives.

“They understand that when someone calls 911, it is likely that they are scared and they don’t know what to expect. Our dispatchers and paramedics work to calm callers and patients while providing them with lifesaving instructions and care.”

REMSA’s philosophy is “ONE TEAM,” meaning that the responsibility of answering calls for assistance or providing care out in the field doesn’t fall on one individual. Heinz said this teamwork approach entails everyone working for and with emergency dispatchers, nurses, paramedics, and pilots.

“In the telecommunications center, we consider ourselves the region’s first, first responders,” Heinz said. “Not only do we provide patient care over the phone, but we are caring for our paramedics as they arrive at the patient’s side and as they transport the patient.”

It also doesn’t hurt that REMSA has what Heinz considers highly capable, exemplary professionals. All emergency dispatchers at the center have medical experience and are trained, at a minimum, as EMTs. Many of them have worked in the field, so they bring a unique perspective to the job.

“The clinical competence and compassion demonstrated by our dispatchers is remarkable,” Heinz said. “They interact with their field counterparts, other PSAP colleagues in the region, and visitors, including community influencers and elected officials. They are true professionals. I also think it’s important to foster a culture of camaraderie and support among the dispatchers. Our team celebrates their colleagues’ successes and uplifts them when there are setbacks.”

Community outreach

REMSA is proud of its longtime ACE designation. The team employs exemplary emergency dispatchers and provides ongoing support and training. The center also believes in giving back to the community beyond the emergency services it so expertly offers each day.

REMSA is actively engaged in public outreach and education. Management and staff do this in an effort to keep people safe and to help residents understand the important role they play in the chain of care. “REMSA’s vision is to be a leader in health care by supporting quality care, improved overall health, and affordable access in our communities,” Heinz said. “These programs are cornerstones for educating all community members about ways to be healthy and safe in foundational ways.”

Some of the following initiatives and activities include:

- **Car seat safety.** In partnership with volunteers from the community and the Safe Kids Washoe County Coalition, REMSA employees offer residents a free inspection of their car seats to make sure caregivers have properly installed these important devices.
- **Hands-only CPR.** REMSA staff educates people on how to use this effective technique to help cardiac arrest patients.
- **Infant safe sleep.** REMSA works alongside the organization Cribs for Kids to provide caregivers with information on the right way to set up cribs for babies and how to ensure they sleep safely. REMSA also educates parents and caregivers on other ways to protect babies from harm such as breastfeeding techniques, keeping babies away from cigarette smoke, and regulating babies’ temperature.
- **Pedestrian safety.** REMSA supports programs that promote pedestrian and traffic safety awareness in Washoe County. The education program received a $15,000 government grant in an effort to help cut down on the number of pedestrian deaths.

In addition, the REMSA communications team strives to educate residents on the proper use of 911 and when they should call for help. The agency is active in promoting and participating in events such as EMS Week, Stroke Awareness Month, American Heart Month, and other celebratory and recognition occasions.
Lovely and Secluded Place

Emergency communications always there to assist

Audrey Fraizer


What’s not to like about Apache County in the northeast corner of Arizona (USA)? Not only is it the sixth largest county by land size in the United States and the longest, but it is also among the easiest landscapes to lose track of your tracks.

Or so you would think.

“Generally speaking, tourists are responsible,” said Apache County Sheriff’s Office 911 Supervisor Levi Coffelt. “But things happen.”

Tourists don’t get lost or stranded—to the point of calling 911—as often as you might guess, but it does happen a few times a year. After all, Apache County is a predominantly rural county measuring 11,218 square miles (29,050 square kilometers) and a prime destination for hundreds of tourists from around the world mesmerized by a land of enchantment.

You’d be hard pressed to find the variety of terrain—and the associated outdoor activities—available year-round. With so much to offer, lots can happen. Elk and deer cross roads unwary of traffic. Rock climbers fall. Photographers step a little too close to an edge of a bluff. Hikers sprain ankles. Travelers get stuck in snow (yes, it does snow in Arizona). A campfire left unattended sparks a fire in dry country. The high fire alert before late summer monsoons prompts red flag conditions—no campfires, no smoking. A campfire in the White Mountains in late May 2011 resulted in mass evacuations, and by the time it was contained in July 2011, it had consumed 840 square miles in Arizona and New Mexico.1

Despite inherent dangers, it is possible to find and provide response to anyone unlucky enough to fall victim to Apache County’s natural and unforeseen hazards.

The Apache County Sheriff’s Office in St. Johns always has at least two of the 10 full-time EMDs receiving emergency and non-emergency calls at the communication center and dispatching response using 10 different radio frequencies. They answer an average of 73,000 calls annually (11,800 of which are 911 calls) for Apache County and the associated three police departments, seven fire departments, and three ambulance companies.

They assist the U.S. Forest Service and Arizona Game and Fish officers and coordinate volunteers of the Reserve Deputy program and the Northern and Southern Apache County posse as well as citizen groups organized for search and rescue.

Tourists are also responsible for their behavior and consequences, good and bad.

Safety in the outdoors takes preparation, and nothing says it better than a cautionary note on the Apache County website: Since
the wild west will not change immediately to accommodate your lifestyle and expectations, you should prepare accordingly.

The hard part for dispatch amplifies rural living. Dispatchers must know which agency covers the relevant area, and the difficulty applies to residents and visitors.

Apache County is home to the 70,000 year-round residents scattered throughout on farms (the highest number of any county in Arizona), ranches, tribal lands, small towns, and isolated single homes and vacation getaways far from the clatter of urbanization.

Forest service roads don’t follow the same numbering pattern as county roads. There are lapses and gaps in ambulance coverage. A fire department responsible for one side of the road might not be the same department responsible for the other side of the road.

There’s not always a clear answer to a dispatcher’s foremost question: “What’s the address of the emergency?” As in many rural areas, people have an address, but not really. Addresses are often based on landmarks, long-established family ties, and tradition. Roads are not always marked. Service levels vary according to property ownership and location.

The Apache County Road Department maintains about 800 miles of off reservation roads. An existing road that is not paved is likely to stay that way. The road department does not maintain rural property that is accessed by public easements (no grading or snow plowing), and property owners are responsible for the repair and reconstruction of roads damaged by natural disasters. If the property is not within an existing fire district, the property owner could be billed a substantial amount for the cost of a response to a fire or medical emergency.

While 68% of Apache County is reservation, tribal land is accessible to non-tribal visitors with limitations. For example, the popular Canyon de Chelly is on tribal lands and managed by both the National Park Service and Navajo Nation. Anyone can drive to sightsee at the overlooks and hike the White House Trail without an entrance fee, a guide, or a use permit. Canyon hiking requires a backcountry permit and must be led by either a park ranger or authorized guide. Access is strictly enforced.

Calls made inside tribal lands—the area in the northern section of the county—are dispatched by agencies on the reservations. Response is a joint endeavor shared by tribal agencies, private ambulance services, and the county’s resources, depending on the situation and response type necessary for the given emergency.

Since tribal lands have their own addressing system—not the same as the county’s and not part of the county’s addressing initiative—Apache County emergency dispatchers rely on mapping software that provides location and assigns an address. The information acts as an aid for response and does not conform to the county’s existing numbering system.

OK, so it sounds like rural living might not be for everybody used to urban amenities. For many, however, urban living doesn’t hold a match to the amenities of rural life.

Coffelt grew up in Apache County and went away for college thinking the way most people his age do—it’s time to leave and see what else the world has to offer. Then he remembered the hunting, fishing, and snowboarding and being in a town where he had friends since kindergarten.

“I like a rural area,” he said. “It’s a great place to raise a family. You can get to know the people. You feel connected. It’s small-town life. You know them. They know you.”

The one drawback in small-town rural living, particularly in EMS, is the high probability of helping someone you know who is in distress. Coffelt considered that when he started his dispatch career in 2014, and the 911 call from a family friend—someone he had known all his life—simply reinforced why he loves the job.

“You do everything you can do,” he said. “It’s tough, but your conscience is clear. You were there for the person and did everything within your power to help.”

No matter where the calls come from, and no matter who in dispatch picks up, there’s one universal standard that applies in the profession. It’s not the adrenaline boost or expectations of a day that’s nothing like the last. Those are factors, Coffelt said, not the end-alls.

“We affect people’s lives,” Coffelt said. “Because of our assistance, people get the chance to see their families again. They can be given another chance. That’s a powerful thing. We’re doing something that at night we know made a difference, and what we’ve done is important.”

Sources
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BY THE NUMBERS

40 exhibitors
1,600 attendees
18 countries represented
183 speakers
13 tracks
175 sessions
18 countries represented
24 pre-conference workshops and courses
42 ace and re-ace
Of all the take homes at NAVIGATOR—and there were many—the biggest, brightest, and boldest message is the changing landscape of emergency communications and the support teams already taking the profession into the future.

“This is an incredibly difficult profession; nobody has to tell you that,” said Jerry Overton, President, International Academies of Emergency Dispatch® (IAED™). “We want to make sure you know we’re taking care of you.”

The theme of taking care of the profession far into the future shined through two days of pre-conference seminars and three days of formal conference, keynote speakers, awards, exhibits, and events to relax the spirit and rejuvenate friendships whether it was attendees’ first or consecutive NAVIGATOR.

Countless sessions drew upon the rapidly moving world of technology, innovation to match increasing demand, and global connectivity through common bonds despite the distances in space and time and culture. Alliances announced, research presented, seminars, and the constant exchange of ideas and information—front and center to NAVIGATOR—transported conference-goers into a landscape that like the evolution of emergency dispatch protocol will always be there to support their journey.

And what better way to show a lifesaving impact than through an alliance forged between the IAED, Priority Dispatch Corp.” (PDC”), and the American Heart Association (AHA)? The AHA has long recognized the vital importance of Dispatcher-Directed CPR (DD-CPR) in reducing disability and death caused by cardiac arrest, while the IAED and PDC have long been instrumental in the science and technology of saving lives through protocol and standard practices.

As announced during NAVIGATOR’s Opening Session, the three organizations have combined forces in their commitment to double survival from out-of-hospital cardiac arrest by the year 2028 through implementing research-based protocol, resuscitation education, and quality improvement programs to deliver high-quality CPR.
“We can do this and you, as emergency dispatchers, are at the frontier of making that happen,” said Brian Eigel, Chief Operating Officer, RQI Partners LLC. RQI is a nonprofit venture partnership between the AHA and Laerdal Medical.

According to recent statistics (2016) there are more than 350,000 out-of-hospital cardiac arrests annually in the U.S., with bystanders providing CPR 46.1% of the time. The survivor rate stands at 12%. Heart disease and stroke still rank as the nation’s No. 1 and No. 5 causes of death, respectively.

In keeping with the NAVIGATOR theme of setting the course, the Dispatcher of the Year Award honored an individual who through personal action exemplifies the values of the IAED and the profession.

Katerine “K.T.” McNulty, EFD, REDCOM, California (USA), was on duty in October 2017 as multiple wildfires propelled by wind and tinder exploded, eventually devastating land and communities throughout Sonoma, Napa, Mendocino, and Lake counties in Northern California. By the end of the 23-day siege, the fast-moving fires and billowing smoke had killed 44 people (including two firefighters), damaged or destroyed 21,000 homes and businesses, and scorched more than 181,000 acres of forests, vineyards, and farmland. Thousands of people had been evacuated and returned to find their homes gone.

In the aftermath, the destructive power of the October 2017 firestorm exposed shortcomings in the chain of emergency preparedness. At 911 communication centers, emergency dispatchers were overwhelmed, juggling dozens of calls at any one time, without the information to tell people the safest way to flee the smoke and flames.

The IAED acknowledged McNulty for her supreme efforts that led to improvements found in the later release of the Fire Priority Dispatch System” (FPDS) Version 7.0 (see more about her heroic actions and those among the crew she worked with in an accompanying article). REDCOM is the fire and medical dispatch center for Sonoma County.

Barry Edward Bagwell accepted the Instructor of the Year Award, presented by Bonni Stockman, IAED Associate Director of Instructor Services. He’s a “people person,” Stockman said. Bagwell was the Deputy Director (he’s now retired) of Mecklenburg EMS Agency (Medic) in Charlotte, North Carolina (USA), and has been an Academy EMD Instructor for the past 19 years.

“It’s an honor and privilege to be associated with the IAED and PDC,”
Bagwell said in accepting the award. “It’s truly special.”

Next on course was the annual presentation of new and re-accredited centers of excellence (ACE) awards, with this year reaching an all-time high.

“This is a remarkable achievement for everyone involved,” said Kim Rigden, IAED Associate Director of Accreditation. “It’s hard work to accredit, and it’s no easier when you re-accredit.”

Standing ovations and applause at opening ushered in three days of formal conference. Prince George’s County Public Safety Communications, Maryland (USA), gave almost nonstop tours of their center, which handles 1.9 million emergency and non-emergency calls a year in a 499-square-mile area. Prince George’s is a tri-accredited agency (medical, police, and fire).

Helping to set the course in leadership, the annual Dr. Jeff J. Clawson Leadership Award honored James Gummett, Quality Assurance Manager (retired), London Ambulance Service, NHS Trust (U.K.), for his dedication, his penchant for going above and beyond the call of duty, and his continued research and ideas to improve patient care and the dispatch profession.

Beyond the awards, the hoopla, and back-to-back sessions, the main attraction continues to focus on the NAVIGATOR community and the enthusiasm they bring to the annual conference. In session after session, speakers reminded their audience of their important work and the relevancy of their profession far into the future despite a world that predicts the dominating forces of technology.

Rest assured, the human experience won’t go away.

“Everything PDC [and the IAED] is looking at involves human augmentation, focused on making the jobs of emergency dispatchers easier and safer,” said Ron McDaniel, PDC President. “Emergency dispatchers will always make a difference in somebody’s life now and into the future.”

Take it from an emergency dispatcher who was there to answer calls on the night of Oct. 1, 2017, when an armed assailant opened fire on a crowd of concertgoers at the Route 91 Harvest music festival on the Las Vegas Strip in Nevada (USA).

“Events of that nature are emotionally crippling, yet we keep going; we don’t stop,” said EMD Matt Grogan, Communication Specialist, Combined Communications Center of Las Vegas Fire and Rescue, Nevada (USA). “I don’t know of a finer group of people. We are unified by the phone call and the compassion to help make a difference in someone’s life.”
Katerine "K.T." McNulty, center, accepts the Dispatcher of the Year Award.
dispatcher of the year  |  FEATURE

Katerine “K.T.” McNulty, center, accepts the Dispatcher of the Year Award.

EDS KNOWLEDGE LEADS TO PROTOCOL IMPROVEMENTS

Emergency Fire Dispatchers are on the forefront of reinforcing and evolving protocol.

Experience and techniques developed over long public service careers reflect their unwavering attention to high standards and consistency of scientifically proven protocol, as recognized in Dispatcher of the Year (DOY) awards in 2008 and 2019, respectively.

Katerine “K.T.” McNulty, REDCOM, California (USA), combined ingenuity and experience during the wildfires devastating Northern California—prior to her center’s use of the Fire Protocol—that led to changes released in Fire Priority Dispatch System™ (FPDS®) Version 7.0. The 2019 DOY award came on the heels of the protocol’s comprehensive revision and included scripted instructions based on McNulty’s advice from many years in emergency dispatch.

Scott W. Dunkelberger, New Castle County Communications (NCC), Delaware (USA), reinforced what was in the Fire Protocol and the personal “know-how” he developed over his career to save four children trapped in a burning building. He was the first EFD to receive the DOY award, preceding the EFD DOY at NAVIGATOR 2019 by over 10 years.

Pam Stewart, IAED™ Director of Operations, said both EFDs represent their commitment to IAED’s standards and signify their dedication to public safety in the most trying times.

“With these awards, we are given the opportunity to express gratitude for events separated by time, not magnitude or commitment to the profession,” she said.

Katerine “K.T.” McNulty

“What she did was so incredible,” said Mike Thompson, PDC™, Medical/Fire Program Administrator, who presented the 2019 Dispatcher of the Year Award to McNulty, REDCOM Operations Manager, Santa Rosa, California (USA). “She never gave up, and she did it without protocol. She relied on base knowledge.”

McNulty was on duty Oct. 8–9, 2017, at the start of the Northern California wildfire milieu that damaged and destroyed hundreds of homes and businesses, killed 44 people either by fire or smoke inhalation or accidents related to the ensuing chaos, and devastated thousands upon thousands of acres devoted to vineyards, farmland, and scenic destinations.

Calls poured into REDCOM, overwhelming the 24 emergency dispatchers who were able to make it to the center from homes already, perhaps, in visible sight of fire and smoke. Most worked 35 hours straight, providing any possible assistance in a multi-jurisdictional battle to combat the massive blaze fueled by high winds and dry landscape.

“No one knew what was going to happen,” said REDCOM Supervisor Holly Ficher. “Fire was moving so fast, and we had
no idea how big it was or the direction it would go."

McNulty’s calls mirrored the other calls coming in. In the audio played at NAVIGATOR, the caller was trapped in her home. "There is fire everywhere," she cried over the phone. Fire blocked the home’s entrance. Fire engulfed the back of her home. Fire was tearing up the driveway close to the front of her home. The family swimming pool in the backyard, which McNulty advised as possible sanctuary from the fire, was inaccessible.

The caller couldn’t escape or, apparently, improve her situation. Yet, McNulty never gave up.

"She never gave the caller any indication that there was little hope," Thompson said.

The call ended, and McNulty went on to the next, but her instructions highlighted in the call presented at NAVIGATOR prompted a meeting between REDCOM Executive Director Aaron Abbott and the International Academies of Emergency Dispatch®. McNulty’s advice to escape—rather than shelter in place—and seek refuge in a swimming pool, among other instructions, were integrated into FPDS Version 7.0 Protocol 82: Vegetation/Wildland/Brush/Grass Fire. The Protocol’s Pre-Arrival Instructions (Wildland Fires - Preparations, Trapped/Evacuate) give EFDs a rescuer role, when necessary, providing lifesaving instructions while firefighters are en route.

What was McNulty’s secret during the days of the fire? There wasn’t one.

"I was grasping at straws to help her," McNulty said. "I was trying my hardest to visualize a way out for her."

REDCOM Communications Training Officer Krista Botts didn’t see it that way. Yes, McNulty was desperately trying to help the woman succeed in escaping the fire, but that kind of advice is something nothing short of a professional can pull out of the air.

"K.T. is an exemplary example of career dispatch," Botts said. "Her base is knowledge spanning over 18 years."

McNulty started in the profession soon after high school graduation. She was interested in firefighting, got a job in dispatch, and hasn’t looked back.

"Something different happens every day," she said. "I’m always learning. There are always problems to solve. I’m always motivated."

Scott W. Dunkelberger

On Nov. 13, 2007, Dunkelberger answered a call from a 16-year-old girl who had rushed two younger sisters and a baby brother to an upstairs bedroom of their home to escape a fire started by an unattended candle. Dunkelberger gave instructions to close the door and use wet towels to prevent smoke inhalation. Firefighters rescued two children through the second-floor window and carried the other two down through the house.

The children survived, with the oldest crediting Dunkelberger for calming her and convincing her that escape through a second-story window was not a plausible option prior to firefighter arrival.

Dunkelberger said it was all in his voice. He keeps his voice low when providing instructions to panicked callers. “You can’t get excited because that leads to excitement at their end," he said. “You have to go in the total opposite direction, almost whispering to them so they have to concentrate on what you’re saying."

Dunkelberger was IAED Dispatcher of the Year in 2008 for the high standards he maintains to “deliver the best help possible,” according to NCC Chief Jeffrey Miller, who nominated him.

Dunkelberger started with Delaware State Police emergency communications in July 1989 and five years later, he moved to New Castle County as a police dispatcher, transferring to fire/medical dispatching within the agency in 2000. During the past 10 years, since the DOY award, he was promoted to shift supervisor in fire and medical and is assigned part time to the QA/QI office. He is President of the Odessa Fire Company in Odessa, Delaware, where he has volunteered since 1986.
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COMMUNITY OUTREACH
How to make it work in your center

Becca Barrus

There are some things that you, as an emergency dispatcher, simply cannot do. You cannot see the scene the caller is phoning from. You cannot respond to emergencies yourself. You cannot prevent emergencies from happening in the first place. With some calls, you might give anything to be able to do all three.

Besides taking every call and treating every caller with empathy (which takes a lot of training and energy), what’s an emergency dispatcher to do?

One possible option is building bridges between emergency response and the community, especially in helping people understand what to expect if and when they call. What’s scarier than the worst possible moment of someone’s life? Going into that moment completely blind, unaware of who to call or what can be done. Educating locals in what questions they will be asked and how emergency response operates can help make the process of calling 911 a much less nerve-wracking process for everyone involved.

As a peak example of this kind of harmony, last April in Sacramento, California (USA), several people were honored with awards for their actions before and during emergencies. An emergency dispatcher named Mary Clark was given a 911 Heroes Award for providing lifesaving instructions to a child during a medical emergency.

Clark, who has worked as a Eureka Police Dispatcher for six years, said the little boy who called her was very calm and patient, even though she had to put him on hold more than once due to the hectic energy of the center that day. He was able to rattle off his address and phone number and knew who to call when his diabetic mother was “acting weird.” Clark gave him her full attention and walked him through the EMD instructions until paramedics arrived to help his mother.

Paul Nicholson was also given an award that day—Public Educator of the Year—for his efforts in educating the children of the Bayside/Eureka area of California in the proper usage of 911. Over the course of a year, he goes to over 20 schools and police, fire, and community events, teaching 3,000 children (most of whom are in kindergarten, first grade, or second grade) the basics of making an emergency call. The boy who saved his mother’s life was among the many students he taught.

Nicholson began teaching young elementary school children how to make emergency calls 18 years ago, after he fell off a cement truck in front of his home. His wife called 911, and he had to be taken to the hospital in an ambulance. His five-year-old son watched the event transpire and, when Nicholson came home, asked why Nicholson hadn’t died. This question led to a discussion about 911 in which Nicholson realized his son didn’t know how to dial 911, which led to the larger realization that other children might not know what to do if they were in the same situation.
At the time, Nicholson was working full time as an insurance agent and had a client who was an elementary school principal. He floated his idea of teaching children how and when to call 911 by her and before he knew it, he was teaching the whole school. The Humboldt County Risk Manager called him up after that and asked if he would be interested in continuing the program in other schools. When he said yes, she put out a press release to all superintendents, and Nicholson now spends 40–50 days out of the year giving the 911 presentation in schools.

Part of Nicholson’s lesson plan allows children to use his 911 simulator to practice giving their address and answer questions on a landline. The simulator’s handset, which functions in both English and Spanish, is becoming more and more unfamiliar to children who are growing up in houses where cellphones are the primary method of communication. Nevertheless, Nicholson says it’s important that they know how to dial on a landline. Among many other stories and useful tips, his presentation also covers teaching students how to bypass the locked screen of a cellphone to make an emergency call, something that not many adults know how to do.

The child honored in April’s ceremony wasn’t the first student Nicholson has taught that ended up saving the life of a loved one due to his lessons, nor will he be the last.

How can you achieve dispatch-educator-caller balance in your own center and community even if you don’t have time to spend entire days at schools like Nicholson? We’re glad you asked!

Common concerns

Outreach doesn’t just involve telling locals what to do in case of an emergency, although that is a large part of it. In order to really address your community’s needs, you need to understand what the needs are in the first place. For instance, rather than only focusing on the frustrating emergency calls that come in, you might look for a disconnect causing certain emergency calls to never be made in the first place. A good place to start with community outreach is listening to the concerns of community members and understanding why they might not feel comfortable calling 911.

The International Academies of Emergency Dispatch’s research team conducted a study in 2018 to find out what the prevailing attitudes toward 911 are in groups that are among the minority in Salt Lake City, Utah (USA). While the data is still being processed, the preliminary findings show that not everyone was aware of the separation between 911/dispatch and the actual responders who show up. It might be the same in your community. Often, the locals interviewed had no problem with emergency dispatchers; it was the responders (particularly police) that they were nervous about. If that’s the case in your community, start a dialogue with your responders to find out how that image can be counteracted.

An issue that came up in the LGBTQ+ group was misgendering. Misgendering is when someone is addressed by the wrong pronouns or title, such as “he,” “she,” or “they” or “sir” or “ma’am.” It’s a good reminder that you can’t always tell someone’s gender just by the sound of their voice or by what their name is—if you’re unsure, be sure to ask how the caller would like to be addressed. Making the effort to use the caller’s correct pronouns may seem like a little thing, but it is an act of respect that can make all the difference to someone who is worried about calling 911 in the first place.

Speaking of language, another problem that cropped up was language barrier issues. Not everyone speaks the dominant language of the area (in most of America, it’s English). Deciding whether or not to call 911 in an emergency is greatly impacted by whether or not the caller knows that translation services are readily available. If your center utilizes translation services, make sure to advertise so the community is aware. What’s the use of having a resource if no one knows it’s there? The same goes for TTY and Text-to-911—if you have resources to help those who don’t speak the dominant language, let people know. Simple public service announcements (PSAs) can be posted on social media, used in non-
English media outlets, or taped up in gathering places like churches or community or recreation centers.

If your center handles Medical Priority Dispatch System™ (MPDS®) calls, another thing to keep in mind is the expense of an ambulance. (This is an issue more pertinent to America since ambulance rides are covered by the National Health Service.
in the U.K. and other countries where medical costs aren’t as steep.) Across the groups surveyed, most people would rather drive themselves to the hospital or deal with the injury or illness on their own than call 911 and potentially have to pay for an ambulance. While you personally can’t change the pricing, you can make community members aware of your area and agency’s policies. In most areas, patients aren’t charged for being assessed by a paramedic who arrives in an ambulance—they only have to pay if they’re transported to the hospital. This anxiety can also be partially allayed if either a community paramedic service or the Emergency Communication Nurse System™ (ECNS™) is available to callers, as calls involving minor injuries or ongoing illnesses will be appropriately triaged.

These are just some examples of concerns locals might have regarding calling for emergency services. The best way to find out what your neighbors are saying is to get out and talk to them. It’s only once you understand the barriers to calling 911 that you can begin to address them.

On the flip side, when deciding what information to present to the public, why not consider what it is you wish callers knew about your job before they call? Clark said she wished callers knew that she strives to give each and every caller her full attention, despite the fact that her center only has two emergency dispatchers on duty at once with one working the radios and one answering the calls. It can get very busy in there, and the same kind of patience the little boy afforded her would go a long way. Give locals a sense of what’s going on behind the metaphorical curtain.

**Do-it-yourself**

There’s no one correct path to get involved in community outreach, especially when you tailor it to your community’s specific needs. There are many resources and assets to help someone who wants to get into 911 outreach in their own community. There’s no reason to start from scratch—there are people all over the country and the world who’ve come up with curriculum, games, and handouts that are ready to be tailored to your community’s specific needs. Great places to get started include 9-1-1: The Number to Know (www.know911.org) and 911 for Kids (www.911forkids.com). Nicholson has his own website (www.a911guy.com) where you can watch his presentation and borrow letters to send home to parents in both English and Spanish. These materials can be taken into schools, libraries, or assisted living facilities and modified to suit your audience.

“Keep updating [your presentation],” Nicholson advised, something he’s been sure to do in the past 18 years. “Also, keep it interesting and keep it short.”

If physically going out into the community isn’t something that’s feasible because you’re short on time or money (or both), perhaps think about creating social media accounts for your center. Coordinate with the agencies you dispatch for and find out the kinds of things they post (if they have accounts) and what kinds of posts get the most engagement. Do highlights of your emergency dispatchers to put a face to the voice. Give reminders of what information callers should have ready. Ask open-ended questions like, “What is the most common cause of house fires?” to increase engagement.

Another way to get the word out about the work your agency is doing without necessarily leaving your chair is by contacting local TV stations and newspapers to promote stories. Did an emergency dispatcher take a difficult call that turned out well? Has your center recently become accredited or re-accredited? Write up a short press release and send it on. Most local stations and papers are looking for stories that inform and draw the community together.

If you’re completely overwhelmed, start small. Hand out coloring pages at the farmer’s market. Talk with the Public Information Officers (PIOs) from your responding agencies to find out how they connect with locals and ask how you can get involved. Post about the basics of calling 911 on your personal Facebook page and encourage your friends and family to share it with their friends and family.

Everyone can do something to make the role of the emergency dispatcher a little more well-known and the process of calling 911 a little more familiar.

**Editor’s Note:** The results of the IAED’s “911 Attitudes” study will be released in a future issue of the Annals of Emergency Dispatch & Response.
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The shocking video is beyond dramatic. The video should force you to look away but, instead, your attention is drawn to the torpedo-like motion and direction of the car heading directly toward its target (youtube.com/watch?v=TTAx4kswkU). The force of the crash at contact—a toll plaza—violently spins the car and launches a passenger airborne. He crashes to the ground and comes to a stop facedown nearly 30 feet from the initial impact.1

While the video is authentic, the following scenario is fictitious and based on what might have been the caller’s answers to the EMD’s Case Entry Questions.

A person collecting tolls inside a booth calls 911/999/112/000 to report what he can’t believe he witnessed.

What’s the address of the emergency: State Route 91.

What’s the phone number you’re calling from: 555-555-5555.

Okay, tell me exactly what happened: A guy just flew out of a car. It happened so fast. I heard a loud noise, and the next thing I know, I’m watching a guy fly outside a car after it hit the toll plaza.

Are you with the patient now: Yes, I’m right next to him. He slid into my tollbooth. He’s face down on the ground.

How many (other) people are hurt/sick: I don’t know. I can’t see anyone else in the car from here. I’m standing with the guy on the ground. He looks hurt. His leg is twisted at an angle.

How old is he: I don’t know. Maybe mid-20s.

Is he awake (conscious): Yes.

Is he breathing: Yes.

In this example, what is your Chief Complaint? Is it Protocol 30: Traumatic Injuries (Specific) or Protocol 29: Traffic/Transportation Incidents?

Protocol 30 is 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. In this case, the force of the crash ejected the passenger from the vehicle and his body came to rest at a tollbooth approximately 30 feet away from impact.

Therefore, the right answer is Protocol 29, which was designed more for mechanism of injury and scene safety issues associated with motor vehicle crashes and traffic rather than for individual patient injuries.

According to Brett Patterson, IAED™ Academics & Standards Associate and Medical Council of Standards Chair, “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.”2

Mechanism of injury

So, how is mechanism of injury defined in terms of the Medical Priority
Dispatch System™ (MPDS®) and how does its definition drive Chief Complaint selection? Case Entry Rule 2 [in selecting the correct Chief Complaint] states, “If the complaint description involves TRAUMA, choose the Chief Complaint Protocol that best addresses the mechanism of injury.”

According to Protocol 21: Hemorrhage/Lacerations, TRAUMA is a physical injury or wound caused by an external force through accident or violence. The external force may be blunt or sharp in nature. In addition to blunt and sharp mechanisms, there is the situation of thermal energy in the form of heat, cold, or chemical agent, which generates the heat or cold. With the event of more frequent war-like situations, blast injuries and other mass casualty events are more common from improvised explosive devices (IED).

Understanding the nature of trauma subjects the EMD’s Chief Complaint selection to several key points:
• The mechanism of injury describes how, with what force, and on which part of the body the patient was injured. Significant mechanisms of injury include: ejection from vehicle, vehicle versus pedestrian or cyclist, high speed incidents, LONG and EXTREME falls, large machinery accidents, and many other forces, including intentional ones.
• Knowing the mechanism of injury helps determine how likely it is that a serious injury has occurred.
• The reported mechanism may indicate the injuries EMS providers can expect to find upon their arrival.
• Sometimes, the mechanism of injury alone dictates what emergency care is provided to a patient who otherwise seems to have only minor injuries.

Your second question
A caller has a seizure on the roof and then falls 10 feet to the ground. Which protocol best handles this situation and why?
Selection relates to the Case Entry Rules (specifically Rule 2 regarding mechanism of injury) and the built-in fail-safes of the MPDS that safeguard the EMD when multiple Chief Complaints are initially present. Protocol 17: Falls is most appropriate because of the mechanism of injury (LONG FALL) and the potential for serious, underlying injuries. Note that the first question on Protocol 17 relates to the height of the fall, which helps to qualify the potential medical shunt to Protocol 31: Unconscious/Fainting (Near). This is qualified by (ground level) when either “Dizziness with fall” or “Fainted or Nearly fainted” is determined to be the cause of the fall.

The rationale is fairly simple, Patterson explained.

“Ground-level falls are not likely to cause life-threatening injuries from a prehospital standpoint, especially when the patient is alert,” he said. “If the cause of the ground-level fall is medical in nature, the protocol automatically shunts the EMD to Protocol 31 to evaluate the medical cause, which is often more serious than the fall itself. In fact, many of these cases turn out to be cardiac arrests, simply because the caller only witnessed the fall, and not the prior loss of consciousness. If the cause of the fall is unknown, the ‘Arrest,’ ‘Unconscious,’ or ‘Not alert’ Determinant Descriptors on Protocol 17 provide the appropriate fail-safe. However, LONG or EXTREME FALLS have the potential to cause very serious, or occult (hidden), injuries that may not be recognized by the caller or even the responder, so knowing the mechanism of injury and coding the call appropriately is paramount.”

[MPDS v13.2 contains a new law on Protocol 17 that relates to this: The fall is the “chicken”; the arrest, its “egg.”]

Your third question
Is the following 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? Traumatic injury? EXTREME FALL? He comes down at the regular rate of descent as other jumpers but just doesn’t land right.

Protocol 30 would be the appropriate choice, said Dr. Jeff Clawson:

“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). 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.

Associated Chief Complaints
Chief Complaints associated with mechanism of injury include:
• Protocol 3: Animal Bites/Attacks
• Protocol 4: Assault/Sexual Assault/Stun Gun
• Protocol 7: Burns (Scalds)/Explosion (Blast)
• Protocol 16: Eye Problems/Injuries
• Protocol 17: Falls
• Protocol 21: Hemorrhage/Lacerations
• Protocol 22: Inaccessible Incident/Other Entrapments (Non-Traffic)
• Protocol 27: Stab/Gunshot/Penetrating Trauma
• Protocol 29: Traffic/Transportation Incidents
• Protocol 30: Traumatic Injuries (Specific)

Trauma calls are among the highest frequency of calls.

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."\(^4\)

**Frequency of trauma calls**

Trauma calls are among the highest frequency of calls received by emergency dispatchers.

In 2012, nearly 20 million EMS activations were reported to the National Emergency Medical Services Information System (NEMSIS) by 8,439 agencies located in 42 states and territories. Of the nearly 11 million 911 EMS activations reportedly treating and transporting a patient, the majority were attended by a paid EMT-paramedic (82%) employed by a fire-based EMS agency (25%) working in an urban area (53%). 911 communication centers most likely dispatched EMS for a “sick person” (14%), while providers most likely reported pain (26%) as the patient’s primary symptom and “traumatic injury” (13%) as the likely cause.\(^5\)

A study analyzing calls and emergency priority level assigned (2011–2013) found “Unclear problem” was the most frequent category (19%). The five most common causes with known origin were categorized as “Wounds, fractures, minor injuries” (13%), “Chest pain/heart disease” (11%), “Accidents” (9%), “Intoxication, poisoning, drug overdose” (8%), and “Breathing difficulties” (7%).\(^6\)

MPDS users record similar results to the NEMSIS-based study. Take the Wilton Volunteer Ambulance Service (Connecticut, USA). In 2017, they handled nearly 300,000 emergency medical services calls from 2009 to 2014. More than 46,000 calls (15% of the total) were for a “sick person,” making it the most common type of call. Ranking next on the list were “breathing difficulty,” “fall/injured,” “vehicle accidents,” and “chest pains.” The least common categories of calls accounted for less than 1% each of the total. They included “carbon monoxide inhalation” (171 calls), “animal bites” (339), “burns” (340), “stabbings” (437), and “shootings” (449).\(^8\)

**Your final question**

A caller reports that his buddy hit a tree while backcountry skiing. The patient is not alert, and his breathing is ineffective. The mechanism of injury (trauma event) indicates that a neck injury is possible. Should the EMD provide PAIs to open the airway (head-tilt method) considering the potential hazards of neck manipulation?

Yes, according to the EMD principle to protect life over limb. Rule 2 on Protocol 30 says “The head-tilt is the only recognized method of airway control in the PAI dispatch environment. When presented with a TRAUMA patient described as not alert with INEFFECTIVE BREATHING, the EMD should protect life over limb and open the airway.”

In a nonvisual dispatch environment, the airway should be opened without hesitation if breathing is INEFFECTIVE, even when the mechanism of injury indicates a neck injury is possible. The risk of exacerbating a neck injury is very low while the risk of death, without appropriate intervention, is very high.

However, when an unconscious patient’s breathing is effective, the trauma protocols mandate the use of the Breathing Verification Diagnostic and, when effective breathing is confirmed, link to X-3 where the patient can be monitored without moving the neck. 

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**Sources**


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**Notes:**

YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Mechanism of Injury,” which starts on page 32. Take this quiz for 1.0 CDE unit.

1. What is the Chief Complaint 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?
   a. Protocol 17
   b. Protocol 29
   c. Protocol 30
   d. Protocol 32

2. If the complaint description involves TRAUMA, choose the Chief Complaint Protocol that best addresses:
   a. foremost symptom.
   b. mechanism of injury.
   c. scene safety.
   d. priority symptom.

3. TRAUMA is a physical injury or wound caused by an external force through accident or violence.
   a. true
   b. false

4. A caller has a seizure on the roof and then falls 10 feet to the ground. Which protocol best handles this situation?
   a. Protocol 17
   b. Protocol 29
   c. Protocol 30
   d. Protocol 32

5. If the cause of the ground-level fall is medical in nature, the protocol automatically shunts the EMD to which Chief Complaint to evaluate the medical cause?
   a. Protocol 26
   b. Protocol 28
   c. Protocol 31
   d. Protocol 32

6. A skydiver jumps out of the aircraft, doesn’t fall out, has a fully inflated parachute, lands on the ground but breaks an ankle, leg, etc., in the process. What is the Chief Complaint?
   a. Protocol 17
   b. Protocol 29
   c. Protocol 30
   d. Protocol 32

7. Protocol 30 provides information about the severity of the injury in terms of the body area affected in much more detail compared to Protocol 29.
   a. true
   b. false

8. A study analyzing calls for causes and emergency priority level assigned found “Unclear problem” was the most frequent category. Some of the five most common causes with known origin were categorized as:
   a. “Accidents.”
   b. “Breathing difficulties.”
   c. “Wounds, fractures, minor injuries.”
   d. All of the above

9. The most common mechanism of injury for trauma calls to Wilton Volunteer Ambulance Service is:
   a. animal bites.
   b. traffic/transportation issues.
   c. stab/gunshot/penetrating wound.
   d. falls.

10. When presented with a TRAUMA patient with a possible neck injury who is described as not alert with INEFFECTIVE BREATHING, the EMD should:
    a. wait for response to arrive and provide no PAIs,
    b. protect life over limb and have bystanders open the airway,
    c. use the Breathing Verification Diagnostic to confirm effectiveness of breathing,
    d. advise the bystander to hold the patient’s neck steady without other intervention.

To be considered for CDE credit, this answer sheet must be received no later than 08/31/20. 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 night and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
NO PEACE AND QUIET
Disturbances, nuisances can cause a wide range of problems
Josh McFadden

Many of you out there have probably faced a scenario like this one: It’s late at night or early in the morning, and your rowdy neighbors are still blasting their music and partying. You’re desperately trying to sleep, but the noise is making it impossible.

Or, how about this example: Two people start yelling at each other in the street in front of your house. It turns ugly, and it appears the situation may escalate to throwing punches. It’s getting pretty rough, and you start to feel uneasy. Intervening might get you hurt, but you know you should do something.

These two examples can fit into Protocol 113: Disturbance/Nuisance from the Police Priority Dispatch System™ (PPDS®). This protocol covers several potential incidents, each with varying levels of severity.

Taking yourself out of the witnesses’ shoes and into your role as an emergency dispatcher, it’s important to differentiate between disturbances and nuisances and to understand what falls and what doesn’t fall into these categories.

Definitions
In the protocol, the definitions for these two issues are quite clear and distinct from one another. A DISTURBANCE is defined as: “Any act causing disquiet, agitation, or interruption of the peace and quiet. This includes mutual combat fights or situations where a physical altercation is imminent.”

On the other hand, a NUISANCE is: “A minor disturbance, such as begging (panhandling), skateboarding complaints, or other activities causing annoyance or bother to others.”

Disturbances are more serious than nuisances and will be coded as such. The most urgent response for a nuisance call, for example, is a BRAVO-level Determinant Code. There is no ECHO-level code for either of these categories. Also, the complaint of a loud party will be coded as a CHARLIE-level response.

Some complaints one might think would fall into Protocol 113 are actually handled in other protocols. For instance, a call about domestic violence or other type of family disturbance should be handled on Protocol 114: Domestic Disturbance/Violence. Chief Complaint Selection Rule 9 breaks this down further by stating, “If a disturbance involves parties that are, or have been, in an intimate or family relationship, use Protocol 114.”

If the caller reports that there has been or is an ongoing assault or sexual assault, you should use Protocol 106: Assault/Sexual Assault. Also, you would
not respond to the complaint of a barking dog by using Protocol 113—you should instead go to Protocol 105: Animal.

Yelling and screaming are common noise complaints you’ll hear about when you address this protocol. Pay close attention to other noises the caller may identify such as a loud television, stereo, fireworks, or construction noise. These include excessive noise complaints. You will code these as 113-B-2 “Other noise complaint.”

Handling disturbances with the Protocol

Once your Case Entry Questions lead you to select Protocol 113, your first question for a DISTURBANCE complaint should be, “Were weapons involved or mentioned?” If the caller answers “yes,” you need to ask what types of weapons were mentioned or involved and where the weapons are right now. You will then use the weapon type to assign the appropriate Determinant Suffix. You will choose one of six if this is the case:

- C = Club
- E = Explosive
- G = Gun
- K = Knife
- M = Multiple weapon types
- O = Other

Obtain a description of the type of each weapon as well. The type of gun could be a pistol, rifle, or shotgun; a club could be a bat or tire iron; an explosive might be a bomb; a knife could be described as long or short; and other weapons may be a glass, a bottle, or even a vehicle.

Next, ask how many people are involved in the disturbance, followed by the question, “Was the disturbance physical or verbal?” You will code a Physical DISTURBANCE as 113-D-1 and a Verbal DISTURBANCE as 113-D-2, both with the appropriate Determinant Suffix. At this point, you can send a response and return to questioning.

Obtaining additional information

Once you return to Key Questions, you’ll ask about the suspect’s whereabouts. If the caller indicates the suspect or person has left the area, you need to find out how he or she left. Make sure you get a description of the vehicle if the person left in a car. This includes asking the mandatory bailed items—Color and Body Style—and any of the additional vehicle information that you can efficiently and quickly gather, such as the year, make and model, license plate number, state or province of the license plate, or information such as paintwork or damage to the vehicle. You may also gather descriptive information about a bicycle if the person or suspect left using that mode of transportation. Description essentials for bicycles include the type or style, color, brand or manufacturer, wheel size, or other noticeable features.

It’s also important to ask, “What direction was s/he going?” as well as, “Do you know where s/he’s going?” if the caller knows the person.

If the caller states that the person or suspect is detained, ask “Is s/he cooperative?”

It’s critical at this point to ask for a description of the person. This isn’t only important if the suspect has left the area, but you should do this even if the person is detained. You’ll want to gather this information in case he or she later flees. Getting a description for the detained suspect also helps the responders know which person is the alleged suspect when they arrive. Description Essentials for this question are the following:

- Race
- Gender
- Age
- Clothing
- Build/Height/Weight
- Hair color/length/style
- Other identifiable characteristics (facial hair, accent, tattoos, piercings, jewelry)
- Complexion
- Eye color
- Demeanor (calm, emotional, intoxicated)
- Name/Relationship
- Address/Phone number

If jurisdictionally approved, you would then ask for a description of the suspect’s vehicle if he or she is still on the scene. When jurisdictionally approved this should be followed by, “Has anyone involved been using alcohol or drugs?” “Intoxicated/Chemically impaired” situations should get a 113-C-2 code. Key Question 8 asks, “Are you or anyone else in danger right now?” If the caller is in danger, go immediately to the Caller In Danger Protocol. If someone else is in danger, ask, “Exactly where are they now?” Conclude your DISTURBANCE questions with, “Does anyone need medical attention?” Follow up with, “How many?” if the caller indicates in the affirmative.

Nuisance

You will follow a similar pattern with NUISANCE complaints as you did with the DISTURBANCE call. However, only ask about whether weapons were involved if it’s appropriate to do so. If there is spontaneous mention of a weapon, then the question would be an obvious one, and you would not have to ask it. You would ask or not ask this question based on the information gathered from Case Entry Key Question 4: “Okay, tell me exactly what happened.” Let’s look at two examples
to further illustrate when you would ask about weapons and when you would disregard this question.

Example No. 1: Someone calls and complains that there are three juveniles skateboarding in front of his home on the sidewalk. They are being noisy and rowdy. Based on this information, you would classify this call as a NUISANCE, but you wouldn’t ask the weapons question for obvious reasons.

Example No. 2: In another call, an upset store owner reports that there is a homeless person sitting on the sidewalk outside his business. As people walk by or enter the store, the person begs for money. Everyone is ignoring him or telling him “no.” When the homeless person doesn’t receive money, he becomes obviously frustrated and agitated. In this case, it would be appropriate to ask the weapons question. Remember, when to ask or not ask the weapons question is based on the information you gather in Case Entry.

If you determine it is indeed appropriate to ask about weapons, and the caller tells you they are in fact involved, once again follow up by asking what type of weapon it is and where the weapons are now.

After you ask the question, “How many people were involved?” you will send and return to questions. Code NUISANCE as 113-B-3 with the applicable Determinant Suffix (if necessary).

Next, find out whether the suspect is still in the area. If he or she has left, is in the process of leaving, or is circulating the area, find out how he or she left (whether on foot, in a vehicle, on a bicycle, etc.). It’s necessary to get a vehicle description at this point and ask what direction the person was going. If the caller knows the person, ask, “Do you know where s/he’s going?” Just like with the DISTURBANCE complaint, if the caller states the suspect/person is detained, ask “Is s/he cooperative?”

End your questions by asking for the person’s description and, when jurisdictionally approved, if he or she is still on the scene and a description of the person’s vehicle.

Other situations

There are fewer questions for a loud party and other noise complaints. For a loud party, start off by asking, “Where is the noise coming from?” followed by, “How many people are involved?” The third question, “Has anyone been using alcohol or drugs?” is a Jurisdictionally Approved Question, which means that your agency will determine whether it should be asked.

For other noise complaints, simply ask, “Where is the noise coming from?”

You may receive what is known as a COLD CALL, which is a “call for service involving a PAST event that does not require a full interrogation because, by the caller’s assessment, the suspect/person/vehicle is not in the area.” Local agency policy determines the timeline for a PAST event. A “PAST DISTURBANCE” is coded as 113-B-1, while a “PAST noise complaint” is coded as 113-A-1.

PDIs

Your Post-Dispatch Instructions could be more important than you may think with this protocol. Your first instruction is, “Lock your doors and windows.”

Axiom 1 of Protocol 113 states that this advice “may be lifesaving.”

Provide the following PDIs if they are applicable to the situation:

- “If the suspect arrives/returns, do not let her/him in.”
- “Do not disturb anything at the scene.”
- (Noise) “Call us if the noise stops.”
- (Court order) “Have all paperwork available for the responding officers.”

To wrap it up

A call with complaints about loud music, hollering or fighting, or similar incidents might seem like a basic matter requiring the most minimal action and response. However, as you dig deeper by asking the right questions, you may find this situation could be more than a simple annoyance for the caller or other people. By selecting the appropriate Determinant Codes and Suffixes, and by sending the right response, you can help keep the peace or even prevent harm to innocent victims.
YOU MUST BE POLICE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “No Peace and Quiet,” which starts on page 36. Take this quiz for 1.0 CDE unit.

1. A NUISANCE “includes mutual combat fights or situations where a physical altercation is imminent.”
   a. true
   b. false

2. There is no __________-level response in this protocol.
   a. BRAVO
   b. CHARLIE
   c. DELTA
   d. ECHO

3. If you receive a complaint of a barking dog, what protocol should you use instead of 113?
   a. Protocol 105
   b. Protocol 122
   c. Protocol 134
   d. None of the above; this is also in Protocol 113

4. In a DISTURBANCE call, what question do you ask after, “How many people are involved?”
   a. “Was the disturbance physical or verbal?”
   b. “Where’s the suspect now?”
   c. “Are you or anyone else in danger right now?”
   d. “Does anyone need medical attention?”

5. You should ask for a description of the suspect’s bike if he or she used that method of transportation instead of a car.
   a. true
   b. false

6. Which of the following is NOT one of the DESCRIPTION ESSENTIALS listed in this protocol?
   a. Gender
   b. Build/Height/Weight
   c. Eye color
   d. Occupation

7. With NUISANCE calls, when should you ask about weapons?
   a. in the first question, in every instance
   b. in the first question, only if it’s appropriate to do so
   c. never ask this question with NUISANCE calls
   d. after getting the suspect’s description in Key Question 4

8. If the caller knows the person/suspect, you will ask _____________ as a follow-up to Key Question 3 in NUISANCE calls.
   a. “Does the suspect have a weapon?”
   b. “Has the suspect threatened you before?”
   c. “Do you know where s/he’s going?”
   d. “Is s/he cooperative?”

9. Which of the following is true of a PAST DISTURBANCE?
   b. You code it 113-B-1.
   c. You code it 113-B-2.
   d. It gets an OMEGA response.

10. Your first Post-Dispatch Instruction for this protocol is ________________.
    a. “If the suspect arrives/returns, do not let her/him in.”
    b. “Do not disturb anything at the scene.”
    c. “Make sure you do everything you can to keep the suspect at the scene.”
    d. “Lock your doors and windows.”

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LESSONS LEARNED

Lawsuit verdicts highlight public expectations

Jeff Clawson, M.D.

When 19-year-old Douglas Gant was experiencing an asthma attack, his mother called 911 three times for help. Two of her three calls went unanswered, each call ringing 26 times at the Chicago (Illinois, USA) Fire Department 911 dispatch center. On the one call that was answered, Gant’s mother did not receive pre-arrival CPR instructions—dispatchers refused to provide them. Paramedics arrived 8 ½ minutes after being dispatched on the first call, coming from a fire station that was located one block away. Gant died, and his family sued the city of Chicago. Gant’s family was awarded $50 million.

In another case, Cooper v. City of Chicago, $3.06 million was awarded after a 59-year-old man died after bleeding from an ulcerated leg. Two CFD 911 dispatchers refused requests to send an ambulance.

Unfortunately, these cases are not the only ones dispatch agencies have faced (see emergencydispatch.org/index.php?q=Litigation-and-Adverse-Incidents-in-Emergency-Dispatching). Lessons public safety agencies should learn from these verdicts include:

• Dispatchers must follow the protocols their agency has adopted
• If in doubt, send an ambulance
• Good listening and common courtesy are important skills for emergency dispatchers
• A public agency will pay a high price if caught trying to destroy evidence of negligence

When this article was published in 2001, a number of state legislatures had already passed laws that required emergency medical dispatchers be trained to specified standards. At the time, the Academy was also working on Model EMD Legislation (emergencydispatch.org/sites/default/files/downloads/EMDStatute.pdf). Illinois was the first state to use this to set their law and administrative rules (Title 77–Section 515.710 Emergency Medical Dispatcher).

After reviewing the legislation that currently exists, more progress still needs to be made. Keep in mind the 15 Legal Danger Zones for Dispatchers: failure to verify basic information; no-send policies; dispatch diagnosis; delayed response; more than one call for help required; no EMD protocols; failure to follow protocols; omission of pre-arrival or post-dispatch instruction; requesting caller permission before providing pre-arrival instructions; asking to talk to the patient; attitude problems; preconceived notions and imposed, personal negative impressions; mistranslation or misinterpretation of caller complaint; problems at shift change; and 1st party-gone-on-arrival situations.
Verdicts Spotlight Dispatch Problems

Legislative remedies sought

Juries hit the city of Chicago with two EMS-dispatch-related verdicts—one for $50 million, the other for $3.06 million—the last week of November. Jennifer Hoyle, spokeswoman for the city’s legal department, said the $50 million verdict represents the largest verdict ever against the city. She also said the city will likely appeal both decisions. Although they may appear extreme, the Chicago lawsuits illuminate important issues for EMS dispatch systems nationwide.

The Chicago Decisions. In Gant vs. City of Chicago, a jury awarded $50 million to the family of a 19-year-old man who died due to an asthma attack. Douglas Gant’s mother called 9-1-1 three times, but dispatchers refused to provide pre-arrival CPR instructions. On one call, the phone rang 26 times at the Chicago Fire Department 9-1-1 dispatch center before the mother hung up. Another call went unanswered for 26 rings, apparently because both a dispatcher and the supervisor were at lunch despite being understaffed. Paramedics arrived 8.5 minutes after someone finally answered the first 9-1-1 call, although they came from a fire station a block away.

The $3.06 million case, Cooper v. City of Chicago, involves a 59-year-old man who bled to death from an ulcerated leg after two CFD 9-1-1 dispatchers refused requests for an ambulance.

But these two cases are not unique. Chicago has settled several dispatch-related cases, and a court will soon decide another, Kazmierowski v. City of Chicago et al.

In August 2000, the Illinois Supreme Court ordered a lower-court trial in the Kazmierowski case to determine whether Chicago and two CFD paramedics had engaged in willful and wanton misconduct. The lawsuit alleges the medics failed to turn the knob on an unlocked door and left the scene while the asthmatic woman had called 9-1-1 lay dying inside the apartment. Prior to leaving the scene, the medics contacted the 9-1-1 center, but the dispatcher had not stayed on the line with the caller. The call back reached only an answering machine.

The Lessons. Jems publisher James O. Page testified as an expert witness for the Cooper family. He said these verdicts illustrate several important lessons for public safety agencies:

- Dispatchers must follow the protocols adopted by their agencies;
- When any doubt exists about whether to send an ambulance, dispatchers must send one;
- Common courtesy and good listening are important skills for emergency dispatchers, and
- A public agency will pay a high price if caught trying to destroy evidence of negligence.

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“Similar cases are arising in other places,” said Salt Lake City emergency physician Jeff Clawson, MD, founder of the Medical Priority Dispatch System. “You only hear about the bad cases, not the much, much larger number of calls involving dispatcher errors that don’t result in serious injury or death.”

While most of the nation’s largest cities use some sort of emergency medical dispatch protocols and give some pre-arrival instructions, many communities allow dispatchers to give ad lib instructions, rather than requiring them to adhere to a scripted protocol.

For example, although Chicago does not use the MPDS protocols, Hoyle said CFD 9-1-1 dispatchers use “some sort of card system,” but the dispatchers did not refer to them in these cases.

Legislative Remedies. Some Chicago plaintiff attorneys have formed an ad hoc group to work with the Illinois legislature to address dispatch problems. “Lives are more important than our businesses,” said Chicago plaintiff attorney Pat Boyle, who represents the Kazmierowski family. “We’re working with [state] Rep. Dan Burke, who is trying to pass legislation that would require dispatchers to prioritize people who are critically ill and on the phone. The message is pretty clear that the system is broken. We hope legislation and the courts will force it to change.”

A number of states legislatures already have passed laws requiring 9-1-1 emergency medical dispatchers to be trained to certain standards. A 1999 National Academy of Emergency Medical Dispatch survey found 18 states have some sort of EMD regulation, although only about half of those require all 9-1-1 centers to adhere to them. Fifteen other states reported plans to regulate EMD.

“The entire state of Delaware uses NAEMD-certified dispatchers using the [MPDS] protocol, as does New Hampshire’s only 9-1-1 center,” Clawson said. “Virtually all of North Carolina, Utah and Maryland are covered by academy-certified EMDs.” Since the NAEMD survey, Connecticut has also passed emergency medical dispatch legislation.

In Connecticut, “Standards will be developed and each [public safety answering point] will be required to provide trained EMDs or contract with another provider to provide EMD for all emergency calls,” said Jessica Chartier, spokeswoman for AMR New England. “We asked Dr. Clawson to come and speak with people so they have a better understanding of EMD and how to get the right resources to the right people at the right time.”

“Indiana is diving into emergency medical dispatching. We’ve pretty much got the standards laid out, but the issue is how to transition from voluntary standards to mandatory ones over the next four or five years,” said Mike Garvey, deputy director of the Indiana Emergency Management Agency. “We want to require all new 9-1-1 centers to have an EMD program in place and others to train their dispatchers as EMDs, but it won’t be easy due to financial considerations and the fact that the sheriffs control most 9-1-1 centers.”

NAEMD recently contracted with EMS consultant Tom Scott to develop model state EMD legislation for use as a nationwide template. NAEMD Executive Director Rob Martin said the model legislation most likely will look much like the Connecticut bill. Among other provisions, “It provides a funding mechanism for EMD training,” said Martin.

Contact NAEMD at (801) 359-6916 or at www.naemd.org. For more on the Chicago cases, visit www.jems.com.

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STANDING IN AWE
Dispatcher excels at what she thought was impossible

Audrey Fraizer

A crisis is just a phone call away in emergency dispatch, and the same goes for the crisis a caller might create because of a seemingly uncontrollable situation.

Take, for example, the father exiting onto the interstate ramp on his way to the hospital and refusing to pull over his car despite the emergency dispatcher’s cautious warning.

“You’re a moving target,” said the emergency dispatcher to the father, who was determined to get his wife to the hospital for a planned breech C-section delivery before the event took its own course prior to arrival. “You need to pull over, and let help come to you.”

The driver followed the advice, confirming just what it takes to stay in a profession that demands pitch-perfect customer service skills at all times, no matter the situation.

“I stood in awe of the people doing this work,” said Ashley Griffith, EMD/EFD/EPD, Valley Emergency Communication Center (VECC), West Valley, Utah (USA). “I had known people in dispatch, and when they talked about what they did, it sounded like something I could never do. It didn’t seem like I would be good at it.”

Maybe because she was a single mom raising two children or maybe because of skills developed at a previous position, but whatever it was, Griffith had what it takes. She could get a caller past the emotions and to the point of following instructions.

A classic example was the father desperate to make it to the hospital. The baby’s breech position had been discovered during a late-term prenatal visit, dictating a C-section on a date that obviously didn’t work for the infant. The mother was in the front seat, prompting the father to pull over, as instructed, to avoid an accident in his haste to make a beeline for the hospital.

“The birth happened superfast,” Griffith said. “They would have never made it in time.”

The ambulance arrived, but not before Griffith heard a cry over the phone. The couple later tracked down where the 911 call was answered to say thank you. That doesn’t happen often, if at all, but seeing that it happened once, “That’s enough for me,” Griffith said.

Or look at the time the caller was berating the 911 system while trying to get help for a family member unconscious from a suspected drug overdose. Griffith got her to calm down. She convinced the caller to begin CPR despite an initial refusal to even listen to the Pre-Arrival Instructions. The caller’s hands were on chest, pumping hard and fast, when response arrived. Griffith later heard the patient had survived.

Griffith never heard back from the caller, but that doesn’t matter, she said. After all, the positive outcome only reinforced what callers might take for granted but emergency dispatchers never do.

Griffith started at VECC in October 2017 and has since been assigned to a training position. She was nominated for the IAED™ Dispatcher of the Year recognition not because of the type of calls submitted with the nomination, but the way in which she connects to her callers. The way she takes the lead. She can project a calm that, in turn, calms callers so they can do what needs to be done before response arrives.

“I didn’t know I would enjoy this so much, dealing one-on-one with people and being there for people when they need it most,” she said. “And when people ask what I did that day at work, I can say I helped save a life. It’s very rewarding.”

Griffith said she’s still in awe of the emergency dispatchers, who, with their years of experience, are what she wants to become someday. That might sound a bit odd, considering how far she has come in a relatively short time, but it’s a learning curve that continues to climb.

“Every day brings something new, and I’m never alone no matter what,” she said. “We’re a tight-knit group. We always have someone at our back.”
WHAT ABOUT US?
Managing the emotional toll of emergency dispatch

Michael Speigle

In 2017, I lost my best friend and fiancé to suicide. This took me to the darkest places I have been in my lifetime. But this tragedy didn’t just affect me. It affected my entire dispatch center. The 911 call I placed was mistakenly routed to my PSAP even though the incident took place outside our coverage area in the next county. At that time, I was unaware of this. To this day, I can remember exactly what was said to the calltaker on the other end of the phone. Needless to say, my trauma was shared on a personal and professional level with each of my colleagues.

I was able to hold myself together fairly well until, unexpectedly, my lieutenant and previous captain arrived, followed by several on duty units and friends from my agency and a neighboring agency. The compassion shown by these amazing people along with countless others at the sheriff’s office was overwhelming. I am so proud to say I work for the Sarasota County Sheriff’s Office (Florida, USA).

We have all heard at one point or another in our career that we need to check our personal lives and emotions at the door. But how do you check something like this? Something that not only affected me but my entire center. As a supervisor, how can I be responsible for my team members along with answering 911 calls and dispatching units if I can’t help myself?

Trauma affects each of us differently. Some of the symptoms of psychological trauma include shock, denial, confusion, anger, mood swings, anxiety, and guilt. For me, a diagnosis of PTSD was reached due to my ability to sleep excessively some days and have insomnia on others, along with nightmares, flashbacks, and the previously mentioned trauma symptoms. For a time, I was unable to drive or leave the house.

Luckily, I had some amazing friends who stepped up to help. Topping it off, over the course of 25 months since this had occurred, I put on a significant amount of weight. It wasn’t until my uniforms and civilian clothes had stretched as far as they would go that I said, “enough was enough.”

I had to start making some healthy changes in my life. I started with good portion control and cardio exercises. Our current captain instituted a step challenge to promote a healthier work environment. This was a fantastic idea and great motivator for me and the entire center. Three months later I’ve dropped forty pounds, and I feel so much better. I am sleeping better, eating better, and working out six days a week. Finally, some progress! Even my shift has started to pick up these good habits. I see them doing laps around the dispatch center between calls to get in their steps.

The work you are doing is important and critical when you are in the office. But when you’re not, you must learn to think about yourself. Take 30 minutes each day to take a walk, go for a run, hit the weights, or just relax and lay in the sun. Eat a well-balanced diet, and get plenty of sleep. Do something that is going to elevate yourself. These small changes have impacted my life for the better. Although nothing can change what happened, we must continue to push forward, keeping the amazing memories of our loved ones.

Each of us lives in a constant state of crisis for 8, 10, and 12 hours a day. In order to truly take care of others we must start with ourselves. Seeking help to deal with the traumas we face daily should not be viewed as a negative. There is only so much one can take on by themselves.

If you are currently experiencing, or have experienced in the past, a traumatic event, please seek some type of help. Talk to a colleague with whom you are comfortable. If available, take advantage of your Critical Incident Stress Management (CISM), Employee Assistance Program (EAP), Victim Advocate Unit, or agency chaplain.

Most importantly, seek professional help. Talking with a professional therapist who passes no judgment and offers to listen and be a guide is extremely helpful. Finally, remember to take that vacation, visit your family, or whatever it takes to recharge your batteries and get back to it. Remember, you are not alone.
Chris Solomons got his 15 minutes of fame plus some with the bonus of benefiting more people around the world than he ever thought possible.

Solomons experienced a potential 13.2 minutes in the spotlight commencing at 7:09 a.m. on July 24, 2010. That initial time increased exponentially to hundreds and hundreds of minutes in the spotlight during the past nine years before thousands of spectators on YouTube.

It all started on his way to work. Solomons, then an EMD, had the feeling of “an elephant standing on my chest.” Sheer determination kept him behind the wheel until he could park his car and stagger into the control room of Yorkshire Air Ambulance, based at Leeds/Bradford Airport (U.K.).

The “elephant” was the massive heart attack that had started as a slight twinge in his chest while he was smoking the day’s first cigarette en route to air ambulance dispatch. The twinge accelerated to a full-blown ache, which, by the time he was sitting in a chair near his console, must have felt like the first elephant had invited a second elephant to join him. On duty Yorkshire Ambulance Service (YAS) Paramedics James Vine and Lee Davison jumped in to assist Solomons, attaching electrodes to his chest and monitoring the EKG. They determined that Solomons was having a massive heart attack.

Things quickly went from bad to worse. The heart attack went into sudden cardiac arrest (SCA).

Vine and Davison started hands-on-chest CPR and activated the defibrillator. They worked on Solomons for about 12 to 15 minutes before there were any signs of life. Solomons was back with them and although he wasn’t out of the woods, he was breathing.

Solomons doesn’t remember 20–30 minutes of the experience because during most of that time, he was clinically dead. Fortunately, he was in a place immediately accessible to paramedic assistance, a defibrillator, and a straight shot to the trauma center. A cardiac team at the trauma hospital installed a stent, and the very next day, Solomons was transferred to a lower-acuity hospital for recovery.

Solomons has revisited the incident dozens of times. Coincidental to his emergency was the presence of a BBC camera crew filming the fifth episode in a “Helicopter Heroes” series. The cameraman turned his focus on the two paramedics when they started to assist the still conscious Solomons, filming their efforts to resuscitate him and prepare him for air helicopter transport. A clip at the end features a brief interview with Solomons from his hospital bed.

“I was scared,” Solomons said. “The pins and needles up and down my legs [on the drive to work] were horrendous. I knew it wasn’t indigestion, something I ate. Nothing I’d like to experience again or something I would want anyone else to experience.”

The video was viewed by family and co-workers, prior to large-scale presentation to professionals in the U.K. and abroad and audiences at resuscitation and SCA survivor conferences.

Initially, Solomons instinctively disengaged from the individual on screen. Now he finds it therapeutic to watch the video and tell his story. He has made lifestyle changes and takes each day as it comes. He promotes bystander CPR and holds a world record for gathering the largest number of SCA survivors together in one place.

Solomons doesn’t consider himself famous despite the video’s viral appeal or the instant recognition he receives. “I’m a human being who had cardiac arrest while working in an ambulance center and filmed,” Solomons said. “I was in the right place at the right time and in the hands of a brilliant crew.”

Solomons said he owes his life to Davison and Vine, pilot Steve Cobb, and cameraman John Anderson.

“If not for them I would not be here,” he said.

Solomons still works for YAS but as an Ambulance Care Assistant. He briefly returned to air ambulance dispatch but found it difficult considering the harrowing event inside the control room and the calls he was again answering.
Everybody knows the story about the first 911 call. While people might not know the names and the exact date, they are usually aware of the event that took place in Haleyville, Alabama (USA), to beat the federal government at introducing its own system.

As the facts go, a local politician—Alabama Speaker of the House Rankin Fite—dialed 911, a three-digit number designated by AT&T, and his call was picked up at the Haleyville police station by another politician—Alabama Congressman Tom Bevill. The day was Feb. 16, 1968, and immediately after making the connection, the two politicians—who would go down in history for making an emergency call despite there being no emergency to report—celebrated over coffee and doughnuts.1 A red phone that figures prominently in the story is on display in the Haleyville town hall (and viewed each week by an average of 10 tourists, mostly dispatchers).

The story not so well-known is about the dawn of over-the-phone emergency instructions. According to the Principles of Emergency Dispatch, the honors for providing the first-recorded pre-arrival instructions goes to Bill Toon, a Phoenix Fire Department (Arizona, USA) paramedic. In 1974, Toon gave a crash course in CPR to a caller who subsequently saved a child’s life. (See related note at end of story) Toon's instructions pre-dated release of the Medical Priority Dispatch System™ (MPDS).

Toon's was the first recorded message and the tape—in today's terms—went viral, making the national circuit to promote paramedic legislation. Maybe someone stored the tape, but without the same attention to prominence as Haleyville's red phone.

But another call might have beat Toon to the PAI punch.

An interview aired on NPR in 2018 puts the spotlight on Haleyville police dispatcher Ronnie Wilson, interviewed by Morning Edition Host Andrew Yeager. Wilson, who was hired shortly after the 911 system was implemented in Haleyville, talked about his career in dispatch and memorable calls. Foremost was a call when a woman's baby was choking and turning blue.

“I told her to place the baby in your lap upside down,” Wilson said. “With two fingers, mash in the small of their back and press them gently up and down. And then I heard that (imitating baby crying). Well, I knew then that we were home free, you know. And then she just grabbed the phone and says, ‘Oh, I love you’ and hung up.”2

Wilson did not date the call, and it wasn’t recorded. So, whether it came before Toon’s recorded call, that’s lost to history.

But that’s not the point.

While being first in something can strike a notation in history, giving potentially life-saving instructions isn’t about big egos. Emergency dispatchers are better known for leaving their egos at the door. They focus on understanding a situation and the people involved.

Wilson stayed in the profession 11 years, up until a massive heart attack affected his health so badly he couldn’t work (but close enough to retirement age that he hadn’t planned on staying much longer, anyway). Doctors put in a stent and then a pacemaker. He’s now 83 and has lived in Haleyville most of life, except for 12 years in active military service.

Wilson remembers a lot about the job. He was on the midnight shift and, aside from a couple of police patrolling the town, he was just about Haleyville’s sole working night owl. He and an ER nurse at the local hospital chatted occasionally on the phone to break a...
long night’s monotony. They never met directly but true to dispatch fashion, hearing a voice was enough.

Despite feeling so tired at times he feared falling off the chair, Wilson preferred working nights. He kept the door to dispatch open to the outside during the hot summers because there was no air conditioning. If medical help was needed, he read instructions over the phone from a guide the ambulance crews used (remember, this was the 1970s and pre-MPDS). Sometimes, a coroner would be called in cases where the patient wasn’t expected to survive the arrival of help. If response required fire equipment, Wilson (a volunteer firefighter) dropped the call, dashed over to the fire station, and he and the person on duty rushed to the scene. He followed the local dispatch written rule.

“If someone died and we didn’t know the name, we wouldn’t pass on the information [to the press],” he said. “You had to have the person’s name, or you didn’t bother people in those days.”

He considered watching the weather as part of dispatch so he could better anticipate the types of calls he might receive. In cold weather—and it gets cold in that part of Alabama—he kept a list of service numbers for people to contact in case they called 911 to report burst pipes, a missing hiker on the Appalachian Trail, trees down, or creeks made impassable by rising storm water.

The lists, though helpful, could also interfere with the nature of a call. One late night, and it was cold enough to freeze pipes, a woman called frantic because her water broke. Wilson said she ought to call a plumber right away. Maybe it was the caller’s pregnant pause that told Wilson it wasn’t frozen pipes she was talking about.

“I realized she was about to have a baby and ordered an ambulance for her,” he said.

Wilson said dispatch involved a lot of decision-making. There were no rules, policies, protocols, formal pre-arrival instructions, training, certification, or GPS.

“We did the best we could and let it roll,” he said. “The job was rewarding, but it was not too regular we’d hear about how we’d done.”

Wilson received an honorary NENA membership at the 25th anniversary of the first 911 call in appreciation of his dedicated service and being among the first group to dispatch using the three-digit number. Haleyville continues to sponsor the annual 9-1-1 Festival, which took place May 31 and June 1 this year.

Haleyville is in Winston County, Alabama. Winston County 9-1-1 Communications District is the Consolidated Emergency Communications Center for Winston County.

Note: In Toon’s call, the child was revived following an all-too frequent cause of deaths among children in Arizona: drowning. Sadly enough, drowning is one of the leading causes of death for children under age four in Arizona. According to an Arizona child fatality review team, drowning claims the lives of 30 children per year in the state, and Arizona children, ages 1 to 4, drown at nearly twice the national average.

Sources
I’M ALIVE.
Your data helped save me.

When I dropped my coffee at the diner, my wife called 911. The dispatcher knew exactly how to diagnose my stroke. Because your agency focused on data and performance using Academy Analytics, I got a second chance at life.

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