

the **JOURNAL** of emergency dispatch



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**911 ACCESS NOT THE
SAME FOR EVERYONE**

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the JOURNAL

of emergency dispatch

MARCH • APRIL 2020 | VOL. 24 NO. 2

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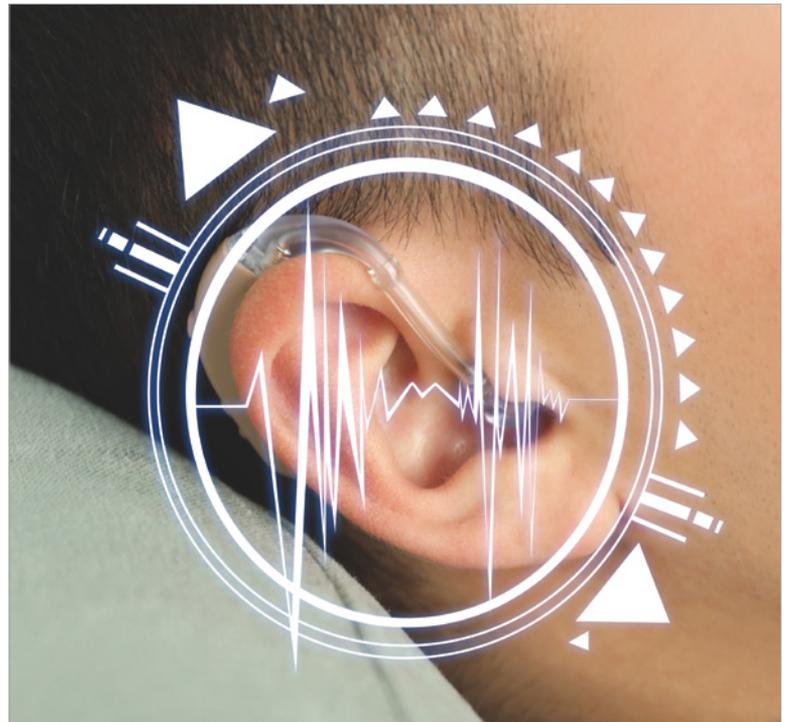
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Access to 911 is sorely lacking for Deaf and hard of hearing.

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The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103,523; 8,294,570; 8,335,298; 8,488,748; 8,494,868; 8,712,020; 8,971,501; 9,319,859; 9,516,166. The PPDS is protected by U.S. patent 7,436,937; 8,396,191; 8,670,526; 8,873,719. The FPDS is protected by U.S. patent 8,417,533. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the IAED's discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.



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ART BRAUNSCHWEIGER
8 | FROM THE DISPATCH SIDE



Heidi started in late 1993 in police dispatch and meandered down the career path of calltaking, backup fire dispatch, statistician, SARA TITLE III assistant, supervisor, and finally shift manager for the Harford County Department of Emergency Services in Maryland (USA). What an adventure!

HEIDI DIGENNARO
11 | SURVIVING THE HEADSET



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10 | GUEST WRITER



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BRITTANY GOODING
24 | 911 ACCESS

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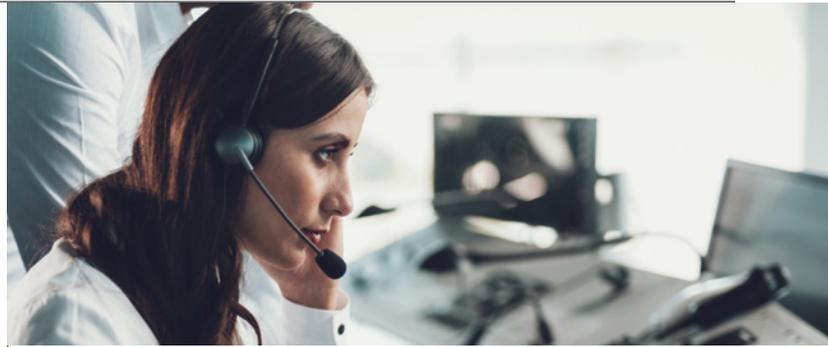
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RECOGNITION YOU DESERVE

More and more places are classifying emergency dispatchers as first responders

Josh McFadden

Those close to and involved in the emergency dispatch profession often refer to telecommunicators as the *first*, first responders. How true it is.

Before fire crews, police officers, or EMS personnel arrive on scene, emergency dispatchers are giving lifesaving instructions.

You hear things that most people will never hear and would dread experiencing. You are there for people during their worst moments of life. And it happens day after day after day.

On March 7, 2019, California Rep. Norma J. Torres (a former emergency dispatcher) introduced the 911 Saves Act to the U.S. House of Representatives. The bill would require that the occupation of a public safety telecommunicator in the United States be classified as a first responder. Congress found that “Public Safety Telecommunicators play a critical role in emergency services” and these individuals perform work that “goes far beyond merely relaying information between the public and first responders.”

The U.S. Congress issued 12 other statements to justify the acceptance of this bill. As of the end of February 2020, the House Committee on Education and Labor was still reviewing the bill. If accepted, the House would pass it onto the U.S. Senate, which would then review it.

In places such as Pitkin County, Colorado; Kanawha County, West Virginia; Brooke County, West Virginia; Mercer County, West Virginia; Owensboro-Daviess County, Kentucky; and the entire states of Texas and California, emergency dispatchers either now have the designation of first responders or are on that path.

This title change increases the visibility of these dedicated professionals. It also gives them better access to health benefits and grants. It's well-deserved and long overdue.

It's no secret that you dedicated men and women can suffer the same physical, emotional, and mental effects as other first responders. Heavy calls can stay with you forever. You may never get closure on such calls; you often don't ever hear what happens next after you hang up the phone. Yet you keep going.

We hope the 911 Saves Act becomes a law in the United States so that all emergency dispatchers get the proper distinction as first responders. ●

The Journal of Emergency Dispatch is the official bimonthly publication of the International Academies of Emergency Dispatch® (IAED®), a nonprofit, standard-setting organization promoting safe and effective emergency dispatch services worldwide. Comprised of three allied academies for medical, fire, and police dispatching, the IAED supports first-responder-related research, unified protocol application, legislation for emergency call-center regulation, and strengthening the emergency dispatch community through education, certification, and accreditation.
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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COVID-19 AND PRE-ARRIVAL INSTRUCTIONS

MPDS modifications address international guidelines

Dr. Jeff Clawson and Brett Patterson

Recently, three related documents were released that contain some basic recommendations regarding resuscitation guidelines during the COVID-19 pandemic. The first is entitled “Resuscitation Council UK Statement on COVID-19 in relation to CPR and resuscitation in first aid and community settings” (released on March 4 and updated on March 24). The second is the American Heart Association’s (AHA) release of “Interim Guidance for Healthcare Providers during COVID-19 Outbreak,” which was based on the March 11 recommendations from the Centers for Disease Control (CDC). The third was released more recently on April 9 and is more comprehensive. Published in *Circulation*, it is entitled “Interim Guidance for Basic and Advanced Cardiac Life Support in Adults, Children, and Neonates With Suspected or Confirmed COVID-19.”

- [gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov](https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov)
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Critical to this discussion is the fact that this guidance is specific to patients suspected of, symptomatic of, or diagnosed with COVID-19, and not the general population at large. This is clearly stated in all of these documents.

Specifically, the more recent AHA document states: “This statement applies to all adult, pediatric, and neonatal resuscitations with suspected or confirmed COVID-19 ...” And the previous AHA guidance asserts: **“Please note that the following guidance is intended specifically for when patients have known or suspected COVID-19.”** In all other cases, follow your standard protocol.

A Refused M-T-M Pathway is available in the event the caller doesn’t want to provide M-T-M respirations.

The Rules Group of the Academy’s Council of Standards recently **approved a temporary change to PAI Panel C/YC-3 that removes the instruction to “Put your ear next to her/his mouth”** and modifies the operant question accordingly. While this change is not exclusive to patients suspected or symptomatic of COVID-19, it is aimed at reducing unnecessary face-to-face contact with all unconscious patients. There will be no immediate changes regarding the head-tilt airway maneuver or Mouth-to-Mouth (M-T-M) instructions for the limited subset of patients where M-T-M ventilations are recommended, i.e., children and arrests with suspected respiratory etiology. The risk-benefit ratio is heavily weighted in favor of these lifesaving instructions for this cohort of patients that are not suspected of COVID-19 infection and have a clear and primary respiratory component that needs to be addressed. Additionally, COVID-19 deaths follow a well-documented pattern

that does not appear to commonly include sudden cardiac arrest but rather a disease progression that results in hospitalization prior to death.

In the vast majority of cardiac arrest cases, respirations are not advised in the MPDS*. They are provided for cases with a known respiratory cause—think suffocation, asthma attack, or overdose—but not pneumonia. They are also provided after 600 compressions in the Compressions 1st pathway, which responder arrival usually precedes. So, simply choosing the Compressions Only Pathway for suspected cardiac arrest avoids M-T-M with all but the relatively rare, primary respiratory etiology patients and children.

Note that a Refused M-T-M Pathway is available in the event the caller doesn’t want to provide M-T-M respirations. Should your agency’s medical control dictate the cessation of M-T-M instructions, a written procedure authorizing the alternative use of this pathway will facilitate such an order. **However, note that this is not advised or supported, in any way, by the IAED™. Airway control and maintenance, and rescue breaths when indicated by protocol, are potentially lifesaving interventions that should not be withheld without clear and obvious scene safety concerns—think infant drowning or teenage hanging.** It is the Academy’s current position that patients not suspected of COVID-19 that qualify for M-T-M (children and suspected asphyxial arrest) do not present a substantial threat to lay rescuers, while withholding such instruction does present a substantial threat to patients in need of such therapy. ●



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VERBAL TOOLS FOR DISPATCH

The spoken word is everything

Art Braunschweiger

When someone is told “You’re acting like a child,” it’s not usually intended as a compliment. But if we only had to deal with children all day long, our lives would be much easier. Think about it: Kids are pretty transparent. They’re very up front about how they’re feeling, they’ll generally tell you exactly what you want to know, and they are often far less emotional than adults during times of crisis. That’s because children, especially younger ones, don’t have enough life experience to know when to panic.

Adults, on the other hand, connect to a lifetime’s worth of knowledge and history before they connect to you. They know their Uncle Gerhardt died of a heart attack when he had symptoms like a family member is now experiencing, and that drives their emotion as they place the call for help. To them, it can’t get there fast enough. “We need help now!” is commonly heard as the emergency dispatcher attempts to get information from an emotional caller.

Back in the day when you had to pick up a telephone handset to answer a call, the caller heard everything you were doing. You would set the phone down on the console near the radio, and the caller would hear you dispatch help. Today’s technology and two-stage dispatch systems (calltakers separate from emergency dispatchers) may expedite the response but don’t help callers to understand what’s happening to get responders to their door. That process is virtually unknown to the general public, and it affects nearly every emergency medical call. Many agencies make it a standard practice to reassure callers up

front that help is being sent. If we don’t, the typical caller will interrupt us before Case Entry is complete to ask, “Are you sending someone?” I doubt you’ve ever had a caller who told you what happened and then said, “I’m ready to answer any questions you have.”

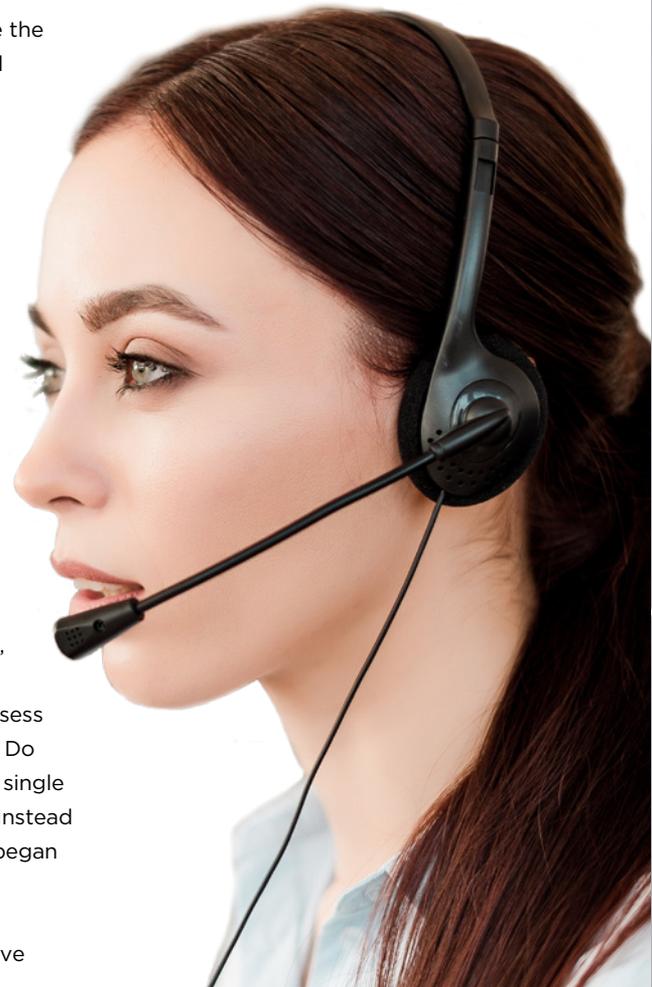
Having covered the subject before, this column isn’t about reassuring callers (not directly, anyway). It’s about what an amazing difference the right words can make. That principle is fundamental to the scripting of the Priority Dispatch System™ Protocols, of course. But the protocols don’t include phrases of reassurance in Case Entry because the when and how of call handling and dispatch varies widely from place to place. So unless an agency mandates a specific statement of reassurance, it’s up to the individual emergency dispatcher.

It doesn’t require time on the job to find something that works well. A new hire who was in training at my agency was getting pushback from her callers from not telling them early in Case Entry that help was being sent. On her own, she came up with the best statement I’ve ever heard to elicit cooperation: “The paramedics are being dispatched as we’re speaking. In the meantime, I need to get some information for them in order for them to better assess the situation before they get there. Do you understand?” In the space of a single call, she turned her callers around. Instead of her callers reacting *to* her, they began cooperating *with* her.

Anyone who’s a professional at anything is always looking to improve

their game. Emergency dispatchers should be no different. Look around you, and listen to what your partners are saying. Even if you think you’re the best at what you do, you can always pick up new ways of doing things. It’s called a growth mindset. No one improves by staying the same. We can always add another tool or technique to bring to the next call.

We work with words. Our words have to calm, control, and connect with our callers, and how we use them is every bit as important as how we use our radio or CAD. ●



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BECOMING A GLADIATOR

Cultivating cooperation through leadership

Andre Jones

Managing change can be an aspiring leader's blessing and a curse. While there are many opportunities to see areas of improvement, there are challenges to implementation. It takes a special someone to cultivate change and inspire cultural evolution. Most importantly, the leader must be able to influence his or her followers to see the vision and commit to it.

As a leader in public service, you are a servant and steward of talent, time, resources, relationships, and information. As a leader, you are charged with exceeding the public's expectations by listening to their voice and providing the services they require, desire, and deserve. The issue is often finding balance between pleasing external customers while avoiding undermining internal customers.

Stakeholder analysis and engagement is therefore critical to the success of any initiative or program, and it requires

someone who can bring the right people to the table, collaborate, and create a mutual understanding and vision to execute the mission. Tyrell Morris, the Executive Director of the Orleans Parish Communications District (OPCD, New Orleans 911/311, Louisiana, USA), is such a charismatic and transformational leader who has showed up to get his followers to be confident in his abilities enough to follow his lead. I flew 8,000 miles and drove six hours to spend the day with Tyrell, meeting his gladiators—the men and women trained to fight against death and to fight for the public in a world of chaos and destruction.

One of the most intriguing aspects of the trip to OPCD was getting firsthand experience of the #SHOWUP campaign developed by Tyrell when he took over as the agency's Executive Director in 2018.

"The #SHOWUP campaign acts as the guide to developing and achieving that standard of excellence within the organization by dictating that everyone—no matter who they are, where they are from, or what kind of mood they are in—must #SHOWUP during every interaction they encounter," Tyrell said. "Why? Because lives depend on it."

Getting to this level of enthusiasm was not an easy journey. It required Tyrell to do an analysis, recognize a need to make improvements, create a vision for change, and communicate that vision. He felt that people were the priority, and their individual talent was necessary for the success of the organization.

In fact, by

developing the quality of the people, he felt he could simultaneously change the organization.

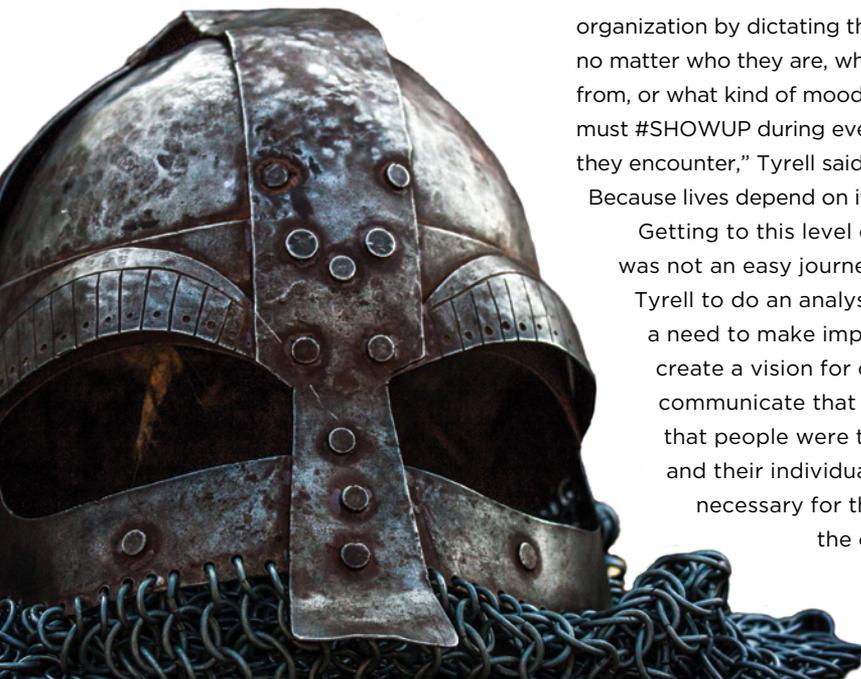
My leadership style is similar to Tyrell's in that we both feel that success could only start with people development and motivation to keep their eye on the vision. This rests in the ability of our leaders to monitor performance and reiterate expectations. These gladiators, when they are engaged, can be more operationally effective, so long as the strategy and structure remain organic. So, how do you create gladiators?

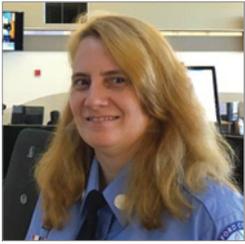
First, gain your followers' trust by empowering them to serve others first rather than the organization itself. Then, use your humility, compassion, empathy, listening, and conceptualization to cultivate your followers and thereby improve their job satisfaction and sustain their performance. Finally, with these developed followers, create a service culture where everyone is individually doing what is right and appropriate with shared trust, shared respect, and shared motivations.

The day will be won or lost by these gladiators, and what they most need is their fearless leader's support. They understand that the arena (field) they are in is not a game and want the leaders to trust that they know what they are doing and to support them while they do it. When asked what kind of tools or resources they need, they will say, "nothing" and humbly claim, "I am the weapon," because support in and of itself is profound.¹ ●

Source

1. Kosinski J. *Oblivion*. Relativity Media. 2013.





NO RAINBOWS OR UNICORNS

Tough calls take knowing the Rules and Axioms

Heidi DiGennaro

When you are a black cloud, your 911 calls often veer into left field, out of the stadium, and if you're lucky, somehow remain in the parking lot. If you're unlucky like me, it's a cluster and a half. Chief Complaint selection becomes critical when you are faced with multiple problems involving, "Tell me exactly what happened."

My Q specialist says I'm most likely to get the call about chest pain on a sinking boat after the caller is bitten by a snake. She's not wrong. I've taken a hot air balloon reported to have crashed into live wires, a building collapse during heavy rains, a heat exhaustion that turned into a mass casualty incident, and a rollover school bus moving vehicle accident on Interstate 95, and more cluster calls than I care to remember. I'm not the kind to attract the unicorn and rainbow calls; I get the down and dirty, drenched in the fan's spray type of calls.

The point is: Choosing the right Chief Complaint will save you significant headaches. The right choice best addresses the situation, no matter how convoluted. Unless you are a paleontologist with an exact blueprint for how scattered dinosaur bones reassemble, you will make guesses.

My personal rule of thumb is: "What has the highest likelihood of harming the caller the most?" Going back to the chest pain/sinking boat/snakebite, the sinking boat will put the caller in the water, and we have a higher likelihood of him or her drowning because of the chest pain and snakebite. Address the sinking vessel (get him or her in a life vest so he or she floats), and when you're done with the PDIs, start

giving instructions for the chest pain and snakebite.

Another way to help yourself is to pull out the cardsets and read the various examples on protocols that offer them. How many of you know that a "UFO" sighting is handled on Police Priority Dispatch System™ (PPDS) Protocol 122: Miscellaneous?

Read your Rules and Axioms. Is a train accident a HAZMAT or an ENTRAPMENT situation?

It's both, according to FPDS' Protocol 70: Train and Rail Collision/Derailment, Rules 1 and 3: "All aircraft, train, or other mass transit vehicle accidents are considered ENTRAPMENT situations until proven otherwise," and "All incidents involving trains, subways, or commuter rails are considered HAZMAT incidents until proven otherwise." Does your center have an SOP or process for HAZMAT rescue in case of a train collision or a commuter bus that overturns on the interstate? Sometimes reading these Rules and Axioms will find holes to patch in your procedures.

Reading the Rules, Axioms, and examples have helped my QA scores and given me more confidence in using the protocols. Picking Chief Complaints

becomes easier when you become familiar with the Rules and Axioms. Did you know that car surfing or car sledding is considered a RECKLESS ACTIVITY handled on PPDS Protocol 125: Public Service? That's not where I would look for it, but that's where to process that type of call.

You are your strongest advocate and your weakest link. Not teaching yourself only hurts you in the long run. Learning makes you better and can make you a subject matter expert or even a leader in the center. If reading protocols doesn't sound fun, make a trivia game out of it to play with your co-workers. Food prizes, competitions, and bragging rights make great motivators. Turn it into a group activity. Create a PowerPoint Jeopardy! game, word search, or crossword puzzle to make it interesting.

The more you know, the easier it is to choose a Chief Complaint. Fumbling for what to choose does not go well with callers; they lose trust in you because they hear your uncertainty. Even if you pick the wrong one, sound confident while you navigate. Reconfigure if you have to but pick something and get started. ●





NIGHTMARE ON EMD STREET

Electrician isn't breathing

Brett Patterson

Brett:

I hope you are doing well! During the month of October, we sent daily Halloween-themed EMD questions to everyone as part of our “Nightmare on EMD Street” game. The winner from each agency got a Halloween bucket full of yummy candy and spooky prizes! We had one question in particular that stumped a lot of people, and they were wanting to understand the why behind it.

The question was, “A male has been electrocuted while doing electrical work in an abandoned home. He isn't breathing. Which CPR pathway do you take—Ventilations 1st or Compressions 1st?” Many EMDs got this incorrect, thinking that they should take Ventilations 1st as they are more familiar with the lightning strike being Ventilations 1st and therefore associating it with electrocution as well.

So, the question is ... why do we go Compressions 1st for electrocution and Ventilations 1st for lightning strike?

We would appreciate any help or resources that you can provide!

*Thanks,
Valarie Turner, ENP
Operations Manager
Larimer Emergency
Telephone Authority
Loveland, Colorado (USA)*

Hi Val:

The answer has to do with the “Lightning Strike Arrest Theory” explained in the Additional Information section of P15. While an electrocution arrest is usually sudden and lasting, lightning strike tends to stop the heart initially, but the undamaged cardiac muscle restarts, only to arrest again because of the long-lasting

respiratory arrest. In essence, it's thought that cause of the cardiac arrest is actually respiratory in nature, therefore we use the V-1st pathway.

It's really a best guess scenario as the issue is difficult to study/replicate and, even if we could, such trials would be unethical in humans. I'm certainly not volunteering!

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

Brett:

I had an employee on a call with a 2nd party caller reporting a 37-year-old female with chest pains. Nowhere on the chest pains card does it ask if she is pregnant; yet, she is of child-bearing age. Critical

EMD Information says not to give the person an aspirin if they are pregnant; yet, how would you know unless you ask a freelance question? If someone can answer or give me some direction, I would appreciate it—thank you!

Michelle Aman

*911 Communication Center Manager
Billings 911 Communications Center
Billings, Montana (USA)*

Hi Michelle:

The simple answer is the clinicians on the Standards Council didn't think we needed to ask the question, so we didn't include it in the protocol.

As you may remember, pregnancy was not a contraindication to the dispatch administration of aspirin until recently. It's not that we didn't know aspirin could be problematic during pregnancy—we did. But we also knew that gestational window for potential aspirin-related complications is very small, and the odds of a single dose being problematic is extremely low. In fact, the only reason this came up for debate again was because callers were offering that the patient was pregnant and that their doctor had told them not to take aspirin (although not specifically referring to a single dose in the presence of heart attack symptoms).

So why do we now include pregnancy as a contraindication? Although the risk of complications is extremely low with a single dose, the risk of actual heart attack in this age range is also quite low, and the emergency physicians we consulted with typically said that because the infarction risk was low, they would likely withhold aspirin until more definitive diagnostics were available, or until advised by a cardiologist.

So, rather than ask a question about pregnancy for every female in cardiac age range with heart attack symptoms, we decided not to ask the question and only stop the aspirin instructions if the caller offered that the patient was pregnant. In essence, the low probability that the caller will offer that the patient

is pregnant, coupled with the extremely low odds of complications from a single dose, justified not including a question that would most often be answered no or be already obvious when yes.

*Thanks,
Brett*

Brett:

So ... this question came up in EMD class about the Heimlich (Protocol D: Choking (Conscious) - Adult/Child/Infant/ Neonate), and I didn't have an answer for it (nor did I see anything in the Principles book). Our instructions say (Panel 5 in the cardset), "In one quick motion, jerk hard, up and into the stomach," but the training I (as well as the Canadians I'm teaching this week) have been through taught it should be "inward and upward"—to get under the diaphragm before pushing upward. Can you share why the instructions are in the opposite order?

*Allen Siorek
Protocol Instructor
Priority Dispatch Corp.™*

Allen:

The instruction states to do this in one quick motion; it's not a two-step process.

I suppose the order could be changed, but I have not heard of any difficulties understanding the instruction, and I wouldn't want to create any.

"... hard, into and up into the stomach" doesn't sound right and seems a bit more complex.

"... hard, inward and upward into the stomach" seems problematic as well.

I say don't fix it if it ain't broke, but if there is a demonstrable problem, we could have the research team do some testing with lay folks and see how it is being interpreted.

Brett

Brett:

I've been going back and forth since you sent this. At first, I agreed: Don't fix what's not broken ...

But do we really know it's not broken?
Allen

Allen:

Interesting thought.

Much of what is in the MPDS[®] is expert consensus-based because when it was originally designed, there was no such thing as evidenced-based dispatch research. All we had in the beginning were problems that needed solving, limited experience, and a motivated and passionate medical director in Salt Lake City (Utah, USA) that was soon to become an inventor. As the protocol evolved, more and more people used it, and user feedback became an important part of that evolution. Both remain important inputs today.

More recently we have developed specific ways to study the protocol, and we have an entire research team devoted to just that. In addition, other organizations are conducting, publishing, and evaluating dispatch-specific research, giving us more tools for protocol evolution based on science.

The instruction we are referring to has been used ever since I can remember, and I started using the MPDS over 30 years ago. So while I don't know of any science behind the format of the instruction, its application in likely tens of thousands of cases over so many years without any related problems reported does give us some degree of confidence.

The answer to your question is no, we really don't know, with scientific certainty, that it's not broken. However, the confidence level is high because of its impressive track record. With that said, science is all about asking questions and testing theories. The overall question then becomes what do we devote our scientific resources to?

Brett

Brett:

I appreciate the insight—one of the reasons I love working with the Academy is how we continue to evolve over time.

Allen ●



PEARL OF THE ORIENT

Hong Kong communications aces standard setting

Audrey Fraizer

Everything about the Hong Kong Fire Services Communication Centre (FSCC) in Kowloon, China, speaks of the city nicknamed “the Pearl of the Orient” for setting a standard against which other public services are measured.

Hong Kong is officially the Hong Kong Special Administrative Region of the People’s Republic of China, a special administrative region in southern China. Hong Kong is a center for global trade, gateway to the rest of China, and a pillar of modernization compacted in the world’s third most densely populated city (6,659 people per square kilometer/square mile).

Above all, the city possesses a spirit that welcomes challenge on an international stage.

The Hong Kong Fire Service Department (FSD), which oversees the FSCC, celebrated its 150th anniversary in 2018 and has scored the highest

satisfaction rate (82.9) of all city forces over the past seven years.¹ The department is divided into seven branches: three Operational Commands (Hong Kong, Kowloon, and the New Territories), the Headquarters Command, the Ambulance Command, the Fire Safety Command, and the Licensing and Certification Command.

The FSCC falls under the Operational Command and provides emergency medical and fire dispatch to roughly 7.5 million people. It coordinates the unified Ambulance Command and the Fire Command, which employs 10,000 uniformed and civilian workers and is comparable to the average population of a small city in the U.S. (*more info on iaedjournal.org*).

Protocol journey

The FSCC’s drive to protocol started slowly, beginning with giving instructions over the phone, when necessary, for six

common types of injuries and sicknesses: bleeding, burns, fracture/dislocation of limbs, convulsion, heat exposure, and hypothermia.

The public’s response to the six sets of instructions was favorable, said Pang Sze-yuen (Eric), Senior Ambulance Officer (Mobilizing and Communications Group), Quality Improvement Unit, FSD.

Following international trends, they took larger steps to upgrade the FSCC computer system to complement the immediate, comprehensive, and appropriate Pre-Arrival Instructions available through the Medical Priority Dispatch System™ (MPDS). Three languages were built into ProQA® (English, Cantonese, and Mandarin), and major efforts were expended during the preparatory stage to obtain consent on the final translation since there may be more than one way that an English phrase can be presented in Cantonese and Mandarin.

Protocol in any language

At the end of 2018—three months after going live with MPDS—the FSCC provided Post-Dispatch Instructions for 133,632 emergency medical calls, including cardiac and respiratory arrest, choking, and childbirth. Prior to MPDS implementation, emergency dispatchers did not give over-the-phone instructions. They gathered the information and dispatched resources. CPR was provided upon paramedic arrival (29%) or by health care professionals after hospital transport (50%).

The rate of CPR provided has risen dramatically for all cardiac calls since then, according to IAED™ President Jerry Overton, who has visited the FSCC, and the entire increase (44%) corresponds directly to EMDs guiding layperson CPR. During that same period, EMDs used childbirth PAIs in the successful delivery of five babies.

A feat to remember

Medical ProQA went live at the FSCC in October 2018, and 13 months later, in November 2019, the FSCC became an Accredited Center of Excellence (ACE). FSCC is the 275th IAED-recognized ACE and the first ACE in Hong Kong.

Achieving ACE was a feat garnering high praise from IAED Associate Director of Accreditation Kim Rigden, who has approved 74 brand-new ACEs (medical, fire, police, and ECNS™) and 151 re-accredited ACEs (across all disciplines) over the past three years.

“This is one of the quickest implementations to ACE we have on record, and the application was simply excellent,” said Rigden, who acknowledged a “village” of support here [the IAED] and in Hong Kong to review cases, satisfy the Twenty Points of Accreditation, translate documentation, and conduct a site visit.

The ACE certainly means a lot, Eric said. “It proved that FSCC is recognized as one of the centers providing superior and up-to-date public care service in emergency situations. That helps to provide confidence to the general public

for the post-dispatch advice (PDA) service we provide.”

Credit to success

Eric credits public acceptance to de-emphasizing the technical details and simply launching a public awareness campaign on their “new value-added PDA service.” The more frequent callers, such as security at shopping centers, needed clarification but as far as general public acceptance? It was close enough to what had been done [before launching ProQA] other than listening to a few more questions systematically asked and receiving Pre-Arrival Instructions while an ambulance was on the way.

The success of ACE he credits to the EMDs and an unspoken but keenly felt peer pressure.

More than 25% of their EMDs were new to the industry (less than three years), and close to 10% of them were hired when MPDS was scheduled to go live. The new people picked up on the system easily. For the more experienced emergency dispatchers, however, Eric said the transition required closer attention from quality improvement. Successful outcomes seal the importance of EMDs and PDAs, Eric said.

“The PDAs proved to be helping the public, and our EMDs began to feel job satisfaction,” Eric said. “They realize their critical role in helping people needing immediate assistance.”

Operations

The FSCC is equipped with a computerized mobilizing system linked to all fire stations, ambulance depots, and fireboat stations for dispatch of resources. The department has six Mobile Command Units (MCUs), which serve as

on-scene command and control centers in major incidents. In 2018, 93.8% of urban area fire calls were handled within the pledged six-minute response time.

All console operators are cross-trained and deployed on control room and mobilizing duties. Initially, they are required to undergo an 18-week training, followed by the EMD certification course. Two operators, the “calltaker” and the “emergency dispatcher,” handle over-the-phone PDAs and ambulance dispatch, respectively. Once a calltaker confirms the location of an incident and the nature of a call, ambulance resources are immediately dispatched to the scene. The calltaker continues dialogue with the caller and follows the protocols to determine the patient’s current condition and gives the appropriate PDA. At the same time, the emergency dispatcher monitors and provides instant follow-up. ●

Source

1. Davis H. “Why are Hong Kong’s firefighters so celebrated? From hellish infernos to rescue missions, city’s bravest go where they are needed.” South China Morning Post. 2019; March 23. [scmp.com/news/hong-kong/law-and-crime/article/3002525/why-are-hong-kongs-firefighters-so-celebrated-hellish](https://www.scmp.com/news/hong-kong/law-and-crime/article/3002525/why-are-hong-kongs-firefighters-so-celebrated-hellish) (accessed Dec. 4, 2019).



Hong Kong Fire Services Communication Centre



NO MAN IS AN ISLAND

Guernsey is one of a kind

Becca Barrus

The island of Guernsey—which is situated in the English channel between England and France—is the home of the famed Guernsey cattle and their rich, delicious dairy products, the Guernsey Lily, and the world’s first underwater arrest. In addition to the cattle and lilies, one can also see and/or harvest a certain variety of ormer (shellfish) on the shores of Guernsey, provided one follows the proper procedures.

In 1968, Mr. Kempthorne-Leigh did not observe the rules regarding ormer harvesting as he dove 12 meters (40 feet) below the surface of the ocean for his spoils. A passerby noticed this criminal activity and accordingly called the police. Guernsey Police sent Constable David Archer to take care of it; Archer suited up in scuba gear and tapped Kempthorne-Leigh on the shoulder underwater. Once

they both got to the surface, Archer arrested the scoundrel, making the world a little safer for ormers.¹

As of 2020, the Guernsey Police have been active for 100 years. The mandate of the duties and functions of the Island Police Force include, but are not limited to, “watching over all criminal affairs of the Island; maintenance of peace and good order in this Island; and carry[ing] out the laws and Ordinances of the Royal Court.”²

The island has seen many changes in the last 100 years. At the time of the founding of the police, there were 750 motor vehicles on Guernsey; as of today, there are approximately 43,000. The police force continued to carry out their business during World War II while the island was subject to German occupation.

In addition to changes in uniforms, headquarter location, police vehicles, and

the methodology that today’s policing brings, there have been changes in the force’s demographics. The first female officer commenced duty in June 1975, and roughly one-third of the force is now female, as are five of the seven latest recruits.

One of the most recent changes the Guernsey Police and the island in general have seen was the consolidation of police, medical, fire, and coast guard dispatch services under one roof. The Joint Emergency Services Control Centre (JESCC) opened its doors in St Peter Port in March 2015. The JESCC serves the entire bailiwick of Guernsey, which includes Guernsey and the neighboring islands of Herm, Sark, and Alderney, comprising, in total, 63,000 people in an area of approximately 71 kilometers (44 square miles). Although it falls under the protection of the British Crown, Guernsey

is its own sovereign with its own parliament, laws, and currency. English is predominantly spoken on Guernsey (and the other islands), although French is spoken for administration, and there are small communities that speak Portuguese, Latvian, and Polish.

St John Ambulance, which handles all medical emergency calls for the bailiwick, has been around on Guernsey nearly as long as the police force—the first recorded activity of St John on the island was in the early 1930s when one Dr. Robertson began teaching first aid courses, followed by the establishment of the Guernsey Ambulance Division.³

Because JESCC's jurisdiction covers a few islands, St John Ambulance has a unique piece of machinery in its repository. In addition to conventional ambulances, St John also dispatches a marine ambulance. You read that right—the Flying Christine III is an ambulance boat. The Flying Christine III has been in service for 25 years as of 2019 and “is operated by volunteer boat crew from the local maritime community and medical clinicians from the emergency ambulance service. [It] is not funded by the States of Guernsey and relies entirely on charitable donations and bequests.” Using the Flying Christine III, the EMTs are capable of sending ALS services to patients on outlying islands as well as transporting them to Guernsey for more advanced care.⁴

The Flying Christine III and the other ambulances had a busy year in 2019—in fact, it was St John's busiest year on record with a reported 5,658 calls, all of which passed through JESCC.

Though 5,000 medical calls is impressive, JESCC saw roughly double that number in police calls from April 2018

to May 2019. During that period, calltakers and dispatchers handled 13,196 calls for the Guernsey Police from callers needing both emergency and non-emergency services. These calls included vehicle collisions, crime reported (mostly thefts), assaults, vandalism, drunk driving, and disorderly conduct. The number of fire calls from the same period was 1,493.

“The 999 calls coming in to JESCC are answered by the control center dispatchers rather than a separate call center,” explained T/Inspector Tony Jones, JESCC control room manager. “This is as opposed to the majority of call centers that are single service who, when



Ben Barling and Rebecca Le Cheminant with St John Ambulance.

they receive a call, know which of their services the caller requires.”

Jones has served as a police officer for over 25 years. Initially stationed in West Midlands in England, he transferred to Guernsey in 2004 and has been there ever since. He took over management of JESCC in January 2018.

JESCC employs 24 emergency dispatchers/calltakers, four team leaders, two quality assurance officers, and one manager. Shifts are 12 hours long with six emergency dispatchers and one team leader on the floor at any given time.

According to Jones, dispatchers are kept engaged on the job by never quite

knowing what's coming down the pipe.

“We have dealt with a huge range of incidents since becoming active—from coordinating a multi-agency response to a major fire, which happened near the island's main fuel depot, to aiding in the organization of the search operation for the plane carrying footballer Emiliano Sala and pilot David Ibbotson, and anything and everything in between. To our knowledge, three dispatchers have delivered babies over the phone!”

Medical, police, fire, and coast guard calls are all handled differently, making each call unique in its own right. And because the center and emergency

dispatchers are involved with all services, they have contact with the first responders as well as the caller through the duration of the call, allowing them to follow the event from start to finish. It's a rare thing indeed for emergency dispatchers to be able to get that level of closure on any call, much less on most calls. This, Jones says, contributes to a sense of satisfaction in the emergency dispatchers who work at JESCC.

“The information flow between the services is immediate and accurate, which enables a great sense of being fully involved in the incidents,” he said. “This is a 24/7 operation, and the dispatchers do an incredible job.” ●

Sources

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2. “History of the Guernsey Police.” Guernsey Police. 2020. guernsey.police.uk/history (accessed Jan. 6, 2020).
3. “History.” St John. stjohn.gg/about/history (accessed Jan. 6, 2020).
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INEQUITY IN A

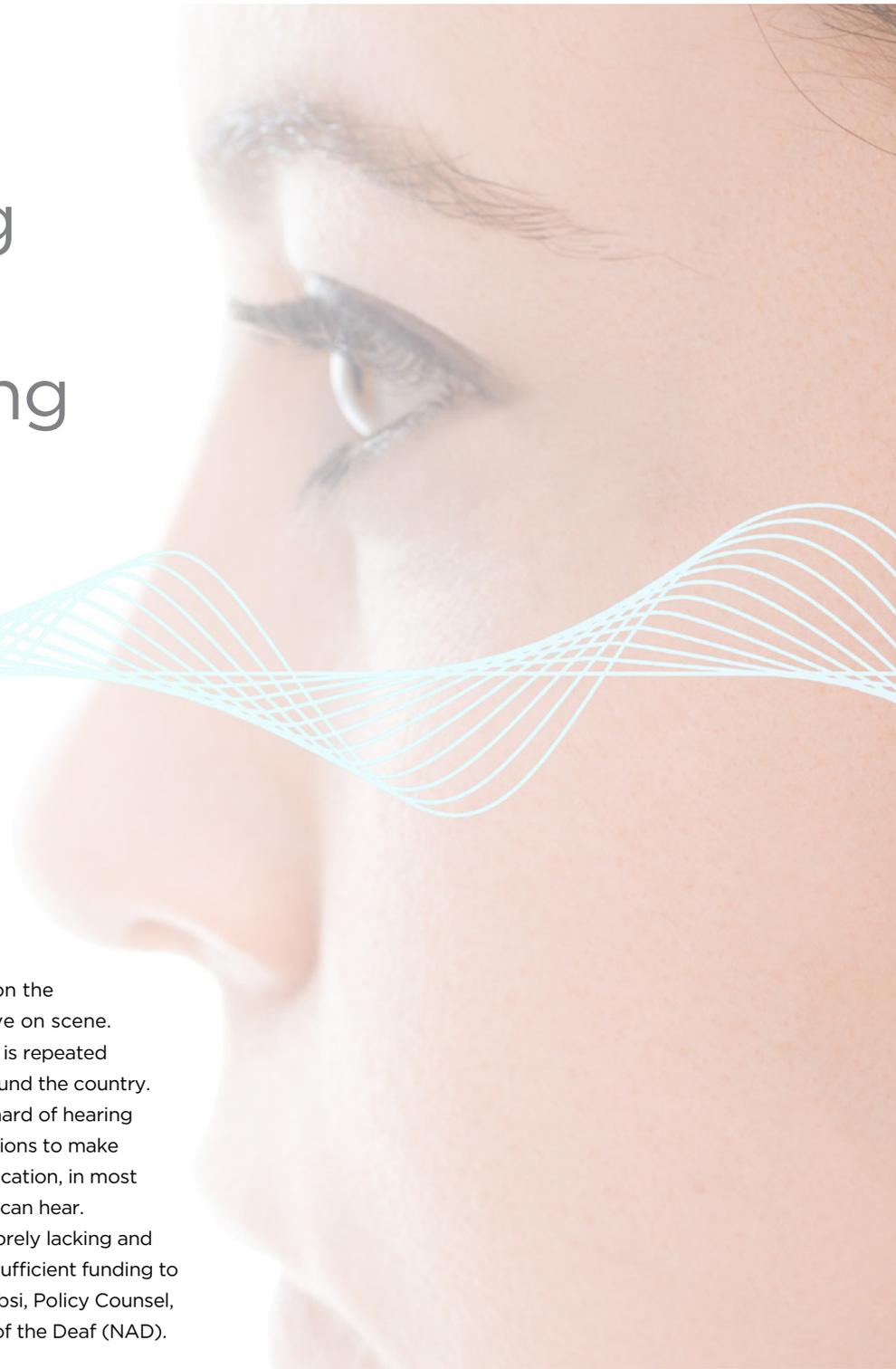
Access to 911 sorely lacking for Deaf and hard of hearing

Audrey Fraizer

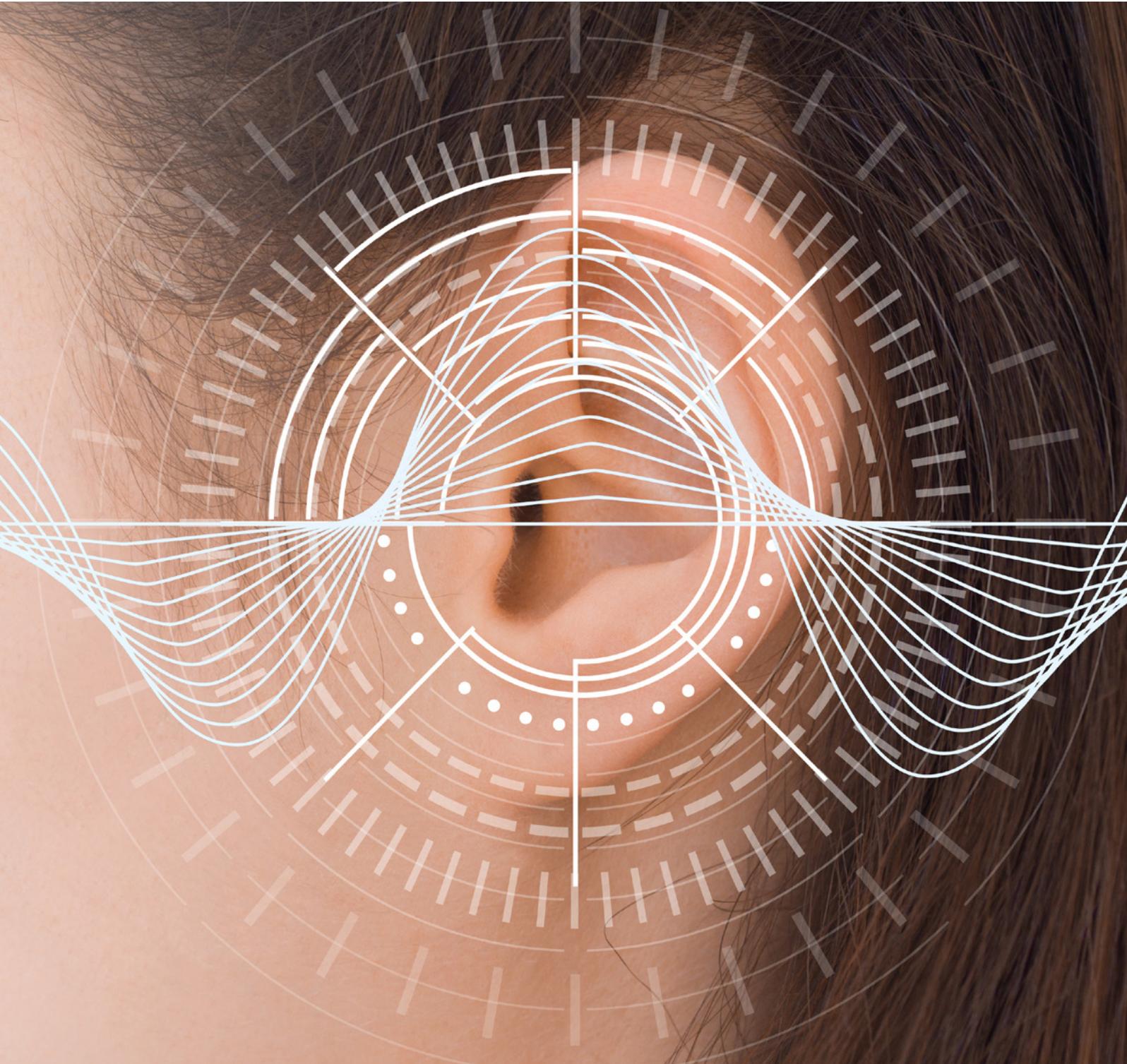
Calling 911 and speaking to an emergency dispatcher is something most take for granted. The emergency dispatcher asks questions, gathers information, and notifies response. The caller follows over-the-phone Pre-Arrival Instructions, when necessary, and the emergency dispatcher optimally stays on the line until fire, police, or medical responders arrive on scene.

Although a simplified description, the process is repeated thousands upon thousands of times each day around the country. It's also a process that people who are Deaf and hard of hearing cannot take for granted. Despite laws and regulations to make things equal and accessible, emergency communication, in most cases, is not functionally equivalent to those who can hear.

Within the Deaf Community, access to 911 is sorely lacking and generally assumed to be inadequate in light of insufficient funding to update to modern technologies, said Zainab Alkebsi, Policy Counsel, Law and Advocacy Center, National Association of the Deaf (NAD).



N EMERGENCY



“Most 911 call centers have not updated to text-to-911 because local administrative agencies in question have failed to take proper steps to set aside appropriate funds necessary to upgrade the call centers’ equipment to handle such technology,” Alkebsi said. “Without these appropriations, Deaf or hard of hearing people lack appropriate access to 911 in many areas. They are unable to communicate in the way of the 21st century.”

The NAD is a national civil rights organization of, by, and for Deaf or hard of hearing individuals that advocates for improving lives through early intervention, education, employment, health care, technology, telecommunications, emergency communications, and youth leadership.

Some headway

Text-to-911

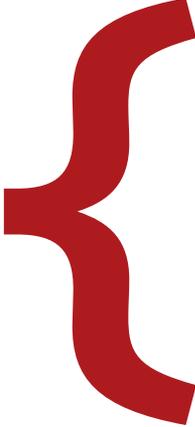
In December 2012, the Federal Communications Commission (FCC) released a proposal requiring all wireless carriers and providers of “interconnected” text messaging applications to support the ability of consumers to send text messages to 911 where PSAPs are also prepared to receive the texts. The proposal included a carrier provision to send automated “bounce back” error messages when a text is sent to a 911 center where the service is not available. In 2014, this proposal was codified into a rule mandating this access.

The number of PSAPs ready to receive text-to-911 has grown significantly since 2012, according to the FCC Master PSAP Registry. As of Nov. 15, 2019, there were 2,113 PSAPs listed, up from 189 PSAPs appearing when the FCC started the registry in September 2015.¹ In 2015, less than 3% of the nation’s 6,000 public safety answering points had implemented text-to-911; since then, the number of PSAPs

using the platform has increased to 30%.² Six states have 100% population served by NG911 capable services, although at different stages of services offered to the public.³

The lack of text-to-911 is a disservice to the majority of Deaf or hard of hearing people who no longer have TTYs.

“The Department of Justice (DOJ) is not doing anything to mandate these centers to deploy text-to-911,” Alkebsi said. “Imagine being faced with an emergency and being unable to contact 911. Deaf or hard of hearing people are faced with a stressful, scary event and on top of that, are unable to easily obtain help when needed simply because the authorities have not prioritized accessibility within 911 services.”



The lack of text-to-911 is a disservice to the majority of Deaf or hard of hearing people who no longer have TTYs.

Text-to-911 advantages

Indiana is in the unique position of having 100% of its counties using text-to-911.

Primary PSAPs in all 92 Indiana counties have had the ability to receive and send text messages since 2016 and, though not every PSAP jumped immediately on board, the state now tops the nation with the number of text sessions processed by telecommunicators. Thirty secondary PSAPs can send outbound messages after being transferred text sessions from a primary center. In the last 12 months (through November 2019), they exceeded even their expectations with 273,080 text sessions for inbound and outbound text messages combined.

PSAPs received 11,181 text sessions in the centers, while telecommunicators initiated 261,599 outbound text sessions because of 911 disconnects.

Text-to-911 was introduced in 2014 to the Indiana Statewide 911 Board, said Ed Reuter, Executive Director. The Statewide 911 Board Office implemented a plan by approaching six counties initially known for their progressive direction in providing emergency communications services.

At first, PSAPs were concerned the text-to-911 system would create extra work and require additional personnel to work within the centers, causing an increase in local budgets. However, as a result of success stories from the

inaugural group, agencies from across the state wanted to be a part of this program. Text-to-911 is also second nature to the new generation of telecommunicators who have grown up using cellphones and texting. They’re versed in digital technology.

As Reuter explained, text-to-911 was expanding beyond the board’s original intention to

improve services for the Deaf and hard of hearing, which it does, but also broadened its appeal to offer vital assistance when voice communication endangered the caller.

The Indiana Statewide 911 Board still recommends “Voice is Best,” with callers texting when unable to speak or in a position when they cannot talk that could jeopardize their safety. Texting might be the only or last option for a person in danger. Reuter has a catalog of examples of how text-to-911 has provided the best defense for a range of crises: hiding from a kidnapper, hiding from burglars in your home, needing access to a legally protected parking space when someone has illegally parked there, and witnessing a drug deal.

Indiana Statewide 911 Office Deputy Director Laurel Simmermeyer was with the Decatur County (Indiana, USA) Sheriff's Department for nearly 20 years. As a telecommunicator, she attended her department's annual TTY training, but never did she receive a call requiring a TTY device for a person who was Deaf or hard of hearing.

That did not diminish TTY's importance, Simmermeyer said. "It was there if we needed it."

Indiana's 2,200 dispatchers answer approximately 3.6 million 911 calls per year. They also answer about 12 million additional administrative calls by people who don't call the emergency 911 line. The Statewide 911 Board provides approximately 40% of the funding for local PSAPs' operational expenses. User surcharges provide 911 funding from monthly end-user surcharges—\$1 for landline, wireless, and other types of phones—which are collected by phone service providers. Indiana continues to explore how to improve the text-to-911 services through real-time text.

At Charleston County Consolidated 911 in Charleston, South Carolina (USA), text-to-911 was introduced in 2015 and while it isn't used as commonly as voice calls, it is an important tool for 911, said Brittany Gooding, an emergency dispatcher who because of her hearing loss can educate the Deaf Community on what information an emergency dispatcher is looking for in a text message.

"I'm looking for the 'W's': Where the incident is, who is involved, what

happened, when it happened, and are there any weapons involved," Gooding said. "I need to gather these details from a caller to give my responders."

(See Gooding's column accompanying this story.)

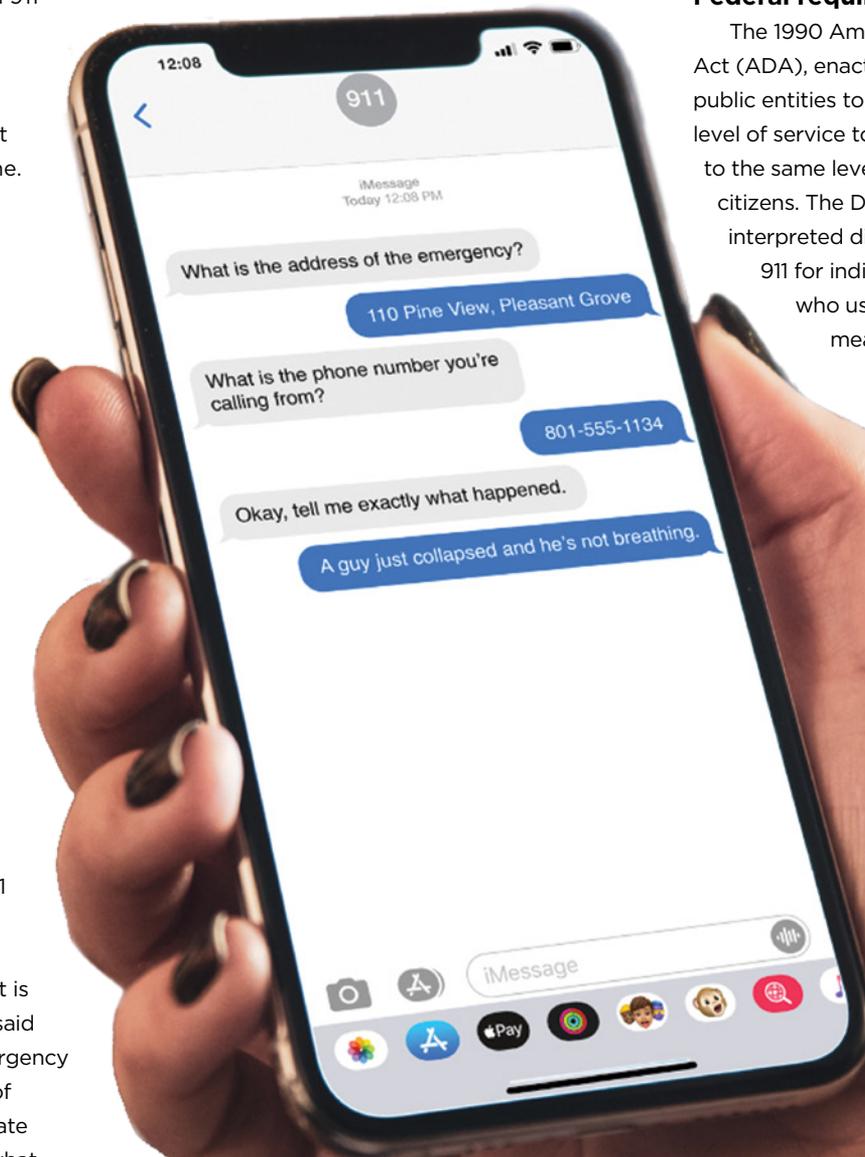
ProQA*

In 2012, ProQA Paramount introduced a feature in which the user can right-click on any question or instruction and an option will appear to "Send SMS" that is passed to the Command and

Control system or existing messaging infrastructure. If technology allows it, the caller's response can be passed to ProQA and appears in a response window. There is also an option to "Send clarifier," which allows for freeform text exchange to confirm the appropriate response to the answer or next action for the instruction. The Salt Lake City (Utah, USA) 911 Bureau software incorporates the scripted medical, fire, and police protocol for use in every call and text.

Federal requirements

The 1990 Americans with Disabilities Act (ADA), enacted July 26, 1990, requires public entities to provide an equitable level of service to persons with disabilities, to the same level provided to all other citizens. The DOJ has historically interpreted direct and equal access to 911 for individuals with disabilities who use TTY/TDD. Direct access means that PSAPs MUST be able to directly receive TTY calls without relying on outside relay services or third-party services (TPS).



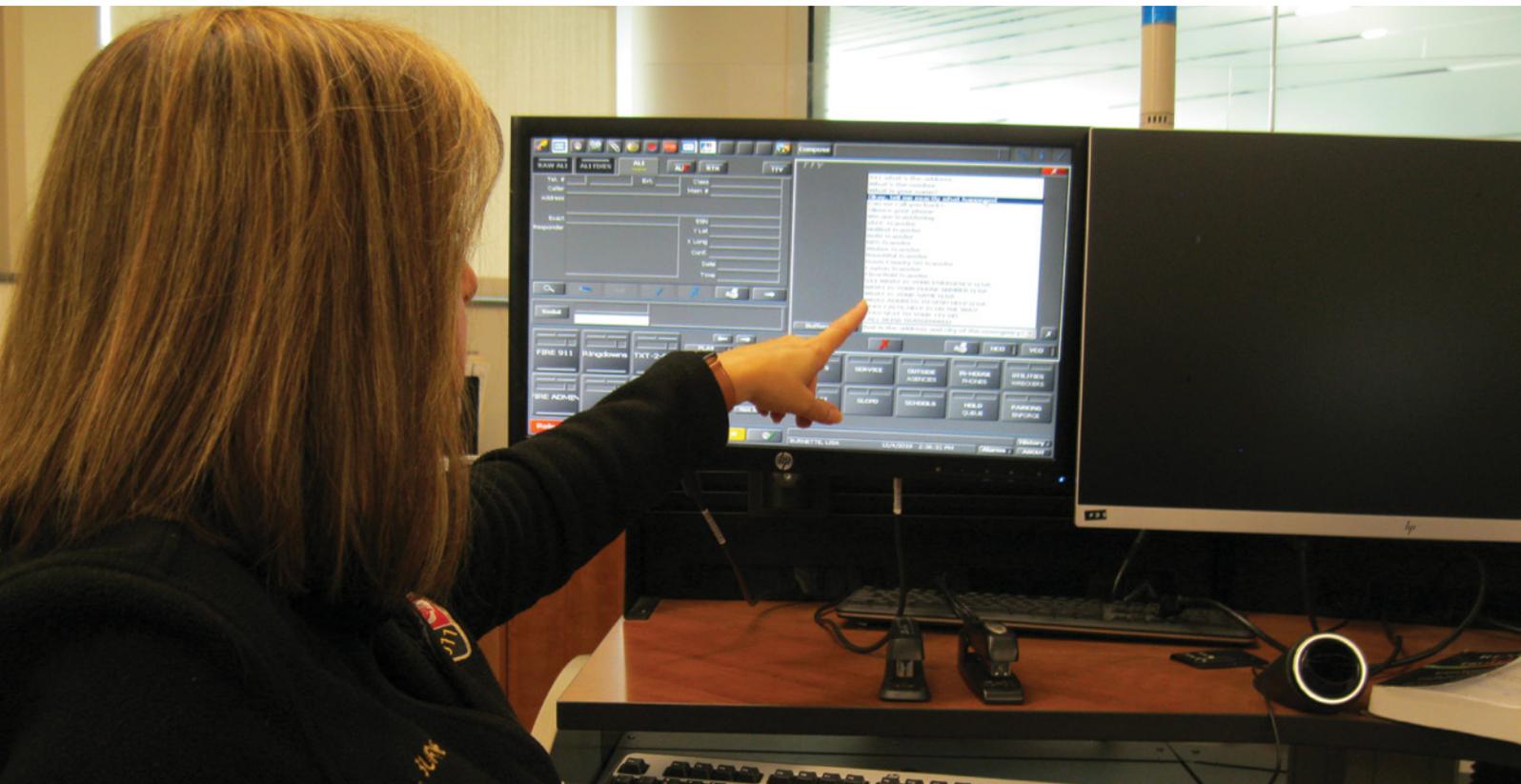
TTY (invented in 1960 and mandated in PSAPs since 1991/1992) pairs an electromechanical typewriter with a communication channel that allows people to communicate through typed messages. Early models were cumbersome and as electronic technology advanced, so did TTY. Digital technology enables computers to talk directly to TTYs through either

drops to the general console and goes to the first available line according to the automatic call distribution system.

The Salt Lake City 911 Bureau activated text-to-911 in February 2015, soon after the installation of a new software and phone system. The center received 30 texts the first year, a number that increased tenfold by 2018. Text-to-911 revolutionized emergency

Safety & Homeland Security Bureau at the FCC, during an FCC-sponsored PSAP Education Day: Real-Time Text.⁴

The FCC regulates telecommunications and advanced communications service providers and manufacturers—not PSAPs. The DOJ, which is responsible for enforcing laws, has not changed its requirement for TTY since the ADA was enacted and



Lisa Burnette, Salt Lake City 911 Bureau

a landline or cellphone. TTY (TeleTYpe) and TDD (Telecommunications Device for the Deaf) acronyms are used interchangeably to refer to any type of text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

“Back in the day, a handset was plugged into the TTY machine,” said Lisa Burnette, Director, Salt Lake City 911 Bureau. “Now it’s all in the phone system. When a person using TTY dials 911, the phone system recognizes the beeps as incoming beeps from a TTY.” The call

communications, Burnette said, but even before text-to-911, the bureau’s TTY system was seldom used.

“We trained every month to stay current, but a lot of times when we picked up, it was a fax coming over the same phone line,” said Burnette, who has answered “maybe one” call requiring TTY during her 27 years and nine months at the bureau.

The Salt Lake City 911 Bureau isn’t alone. As technology develops, TTY is losing its relevance. “Typically, PSAPs receive few if any TTY calls because TTY usage has declined so precipitously, but they still must maintain it,” said David Furth, Deputy Bureau Chief, Public

mandated. All PSAPs must have TTYs, although the department did issue a letter—not a rule—in 2013 stating that PSAPs can allow alternatives as long as they maintain TTY capability.

These alternatives go beyond legacy-based devices into NG911 capabilities that include digital and IP-based devices. Among the devices replacing TTY are wired and mobile videophones, SMS, and text messaging over wireless devices including smartphones, as well as electronic faxing over a computer with internet access, along with use of a webcam and voice over internet (VOIP) technology.⁵

TPS uses a relay operator called a communication assistant (CA) who relays the call between the caller using text or video and the PSAP. In most IP-based video or text-relay services, the CA receives the call from the person originating the call, places the call to the PSAP, and then relays the conversation between the caller and the PSAP.

Real-time text

Real-time text (RTT) is the up-and-coming technology for the Deaf, hard of hearing, DeafBlind, and speech impaired. It allows text to be sent immediately as it is created through wireless handsets that use IP-based technology on networks that support RTT.⁶ With RTT, characters are transmitted immediately once typed and displayed immediately to the receiving party. The immediacy offers the same conversational directions and interactivity as voice.

The FCC adopted rules to facilitate a transition from TTY technology to RTT “as a reliable and interoperable universal text solution over wireless Internet Protocol (IP)-enabled networks for people who are Deaf, hard of hearing, DeafBlind, or have a speech disability.”⁷ The rule went into effect Feb. 22, 2017.

RTT can be used as a stand-alone feature or it can be used in conjunction with other real-time features such as TTY and video conferencing. RTT and TTY are to be treated as a voice call; RTT must also be compatible with TTY to support PSAPs that are not capable of RTT-to-RTT communications and continue to rely on TTY.

“PSAPs need to be prepared for that,” Furth said. “It should also make them think about technology upgrades and moving to NG911 because everyone recognizes the choices it offers to consumers. TTYs are rather dormant.”⁸

NG911 allows direct access to 911 emergency services using various communication modalities. On Feb. 23, 2016, the National Emergency Number Association (NENA) announced its support to accelerate the deployment of NG911 services using

voice, video, text, and data across the United States by the end of 2020.⁹

Can't go away

A TTY still has its place, despite up and coming technology, according to the NAD.

“While the NAD advocates for implementation of modern text-to-911 technologies, we also believe the needs of these populations should not be left behind,” Alkebsi said. “There are certain populations within the Deaf Community that still rely on TTYs, such as those who are DeafBlind, senior citizens, or who live in rural areas without internet.”

When there is a power outage and the internet is down, for example, having a TTY with battery backup power and a landline may be the only way to connect to emergency services.

Companies that choose to provide RTT services instead of supporting TTYs over their wireless IP networks must follow the following timelines¹⁰:

Wireless providers

Dec. 31, 2017: Companies that provide wireless services nationwide—AT&T, Verizon, T-Mobile, and Sprint—must either make a downloadable RTT application or plug-in available or implement changes to their networks to support RTT and offer at least one RTT-capable handset.

Dec. 31, 2019: Nationwide carriers must support RTT on all of their new wireless devices.

June 30, 2020: Companies that provide wireless services locally or regionally, but not nationwide, must either make a downloadable RTT application or plug-in available, or implement changes to their networks to support RTT and offer at least one RTT-capable handset.

June 30, 2021: Local and regional providers (including resellers) must support RTT on all their new wireless devices.

Wireless equipment manufacturers

Dec. 31, 2018: Manufacturers of handsets for use with wireless IP-based voice services must implement RTT in all handsets manufactured after Dec. 31, 2018.

Prior to working at the center, Gooding was aware of relay services. She has video relay on her cellphone but is hesitant to use it in an emergency because, as a relative newcomer to ASL, her signing is slow although she understands it well. She did not know of anyone who had used TTY.

“Then I learned about text-to-911,” she said. “Not only do Deaf or hard of hearing callers find texting information easier, but callers who are in a dangerous situation where speaking freely is not an option can use text-to-911.”

While TTY is not commonly used, Gooding supports the continued presence of TTY in the communication center.

“You never know if someone has TTY,” she said. “If we didn’t have it, the call would be lost, and we never want that to happen.” ●

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Brittany Gooding

HANDS FLYING WITH CONVERSATION

Deaf EMD doesn't miss a word

Brittany Gooding

My favorite time is sitting with a group of friends at a coffee shop, hands flying with conversation. There's a low murmur of background sound, but no one in the background can tell what we are saying. Everyone at the table is Deaf or hard of hearing and most of the conversation is taking place by American Sign Language (ASL).

I have an advantage over my friends because as someone who lost her hearing in June 2017, I have 30 years of speech while most of my friends have been Deaf since they were two years old or younger. I lost my hearing due to unknown causes. It could have been progressive hearing loss from childhood that was missed due to years of speech therapy, or it could have been due to several medical conditions. No matter what caused the hearing loss, my world is quiet. Without my hearing aids in I feel as if I am underwater, only able to

hear loud noises and a murmur of sound but nothing distinguishable, especially not words.

Due to extensive speech therapy, I speak very clearly. I don't have a deaf accent, and it wasn't until two years ago that I even became connected with the Deaf Community. Once connected, I jumped in with both feet, and they welcomed me with open arms. They continuously help me learn ASL, let me practice my lip reading, and teach me how to advocate for interpreters. I regularly use captions on videos and trainings that I participate in, and I use interpreters for medical appointments.

When starting my emergency dispatcher job at Charleston County Consolidated Dispatch Center in Charleston, South Carolina (USA), I was getting used to being newly diagnosed as hard of hearing and finding my identity in the Deaf Community. I had often wondered how my friends, and now

I, would handle emergency situations that would arise. Now, because I have the experience of being a 911 dispatcher and am a part of the Deaf Community, I can use that to also educate the Deaf Community.

The Deaf Community can be nervous and scared of the police because of the language barrier and difficulty with communication. I know for my first traffic stop I was terrified. I could speak to the officer, but I didn't know if I would be able to understand him. Luckily, I had learned tools from the Deaf Community and my job to handle the situation.

As an emergency dispatcher, I face difficulties that hearing dispatchers don't have, while also appreciating advantages that hearing emergency dispatchers don't have. If a caller mumbles or is screaming, I rely on my maps and knowledge of the geographical area more than what I am hearing since I can't rely on lip reading. Background noises in the center can make it harder to hear the caller on the line, and I have a special headset that goes over my hearing aid to cover the microphone so I can hear.

Wearing bilateral hearing aids and a one-sided headset often means when the room gets loud from an influx of calls and in-progress events, it can become hard to hear what is going on with the caller. I can take my left hearing aid out and wear only my right hearing aid under my headset. There is silence to my open ear and only the caller's voice coming in under my headset. It's in the moment when I can turn off the rest of the world that I realize what a benefit being deaf is compared to hearing emergency dispatchers.

Losing my hearing wasn't a devastating thing for me. In fact, I asked my audiologist if my hearing aids would have a mute button on them for moments when the hearing world became too much. At times, having one foot in the hearing world and one foot in the Deaf world is incredibly hard, but I wouldn't trade the experience for anything. I love what becoming deaf has taught me and the experiences it has provided. ●

HEARING LOSS

The number of people with hearing loss is more than those living with Parkinson's, epilepsy, Alzheimer's, and diabetes combined.



17,700
CASES

out of 59,100 recorded cases of occupational illness in manufacturing are occupational hearing loss.

30
MILLION

people in the United States aged 12 years or older have hearing loss in both ears, based on standard hearing examinations.

50
MILLION
+/-

Americans have hearing loss.

18%
+/-

of adults aged 20-69 have speech-frequency hearing loss in both ears from among those who report 5 or more years of exposure to very loud noise at work.

37.5
MILLION
+/-

of American adults aged 18+ report some trouble hearing.



LET'S TALK ABOUT DEATH

Handling calls reporting a deceased person

Becca Barrus

Everyone dies. Some die when they're young, some die when they're old, and some die somewhere in the middle. People die at home, in hospitals, and in the middle of nowhere. Some people even die more than once. Eventually, though, everyone dies permanently, and those left behind must navigate the legal and emotional (and sometimes spiritual) logistics of having someone else's mortal remains as one's responsibility.

According to a study conducted by the Centers for Disease Control and Prevention (CDC), some 47 million people died in the United States between 1999 and 2014. Roughly half of

those people died in hospitals, a quarter died either in a nursing home or hospice facility, and a quarter died at home.¹ In a hospital, nursing home, or hospice facility, death is declared by a physician or coroner, but what's a person to do when someone dies somewhere else, either expectedly or unexpectedly?

This is where you, the Emergency Police Dispatcher (EPD), come in. In the event that a civilian calls to report a deceased person, whether in the home or elsewhere, you'll use the aptly named Protocol 112: Deceased Person in the Police Priority Dispatch System™ (PPDS) to ensure that the caller gets the right help at the right time—even if that help doesn't necessarily involve saving a life.

Grave circumstances

Key Question 1 on Protocol 112 is "What caused the death?" If the caller mentions that he or she witnessed another person causing the death in any way, it should be considered an assault and you should shunt to Protocol 106: Assault/Sexual Assault. If this is not the case, response can be divided into one of three categories: SUSPICIOUS DEATH, SUDDEN DEATH, and EXPECTED DEATH.

According to IAED™ data, some 60% of all calls using Protocol 112 were triaged using 112-B-1 "EXPECTED DEATH (unquestionable)" from 2013 to 2019. Generally an EXPECTED DEATH comes with old age, at the end of a battle with

a terminal illness, and/or coupled with a DNR (Do Not Resuscitate) order. In some locations there might be a POLST (Physician's Orders for Life-Sustaining Treatment) document outlining whether the patient should or should not have CPR administered. Be certain to check what qualifies as an EXPECTED DEATH in your center as your area's local authorities are in charge of defining and authorizing those situations. (Often they will line up with the special definitions outlined by local authorities on MPDS' Protocol 9: Cardiac or Respiratory Arrest/Death.)

A SUDDEN DEATH is "A death that is witnessed and occurs unexpectedly (e.g., cardiac arrest, respiratory arrest, and choking)." A key difference between SUDDEN DEATH and SUSPICIOUS DEATH is that a SUDDEN DEATH is witnessed—Rule 2 states that "All unwitnessed deaths are considered SUSPICIOUS until investigated and proven otherwise." Thus, if someone chokes on a piece of bread and dies when no one else is in the room, the police will still conduct an investigation to determine that there was no foul play involved. If the person chokes on a piece of bread and someone else—ideally the caller, but it doesn't have to be—is with them, it will be classified as a SUDDEN DEATH. Both SUSPICIOUS DEATH and SUDDEN DEATH cases warrant a DELTA response, so the final call on whether or not the death is suspicious is mostly helpful in letting the police know what kind of scene they're being called to rather than one Determinant Code getting a faster response than another.

Whether or not it's an EXPECTED DEATH, SUDDEN DEATH, or SUSPICIOUS DEATH, you will ask the caller if the deceased person is beyond

help. If the caller's response is no, he or she doesn't think the deceased person is beyond help, you will transfer the call to a medical PSAP or notify an EMS service. If the response is yes, you will go on to ask why it looks like the deceased person is dead. As with EXPECTED DEATH, your area's local authorities will have predetermined what descriptions qualify as OBVIOUS DEATH—some examples may include cold and stiff in a warm environment; decapitation; decomposition; incineration; non-recent death (> 6hrs); severe injuries obviously incompatible with life; and submersion (> 6hrs).

In most cases, as Brian Dale, Associate Director of Medical Control and Quality Processes for the IAED, pointed out, callers won't use phrases like "decomposition" or "non-recent

death;" they'll use less clinical phrases like "It stinks in here!" if the body is far along in the decomposition process or "Their skin is all purple" if livor mortis has set in. It's up to you as the EPD to take those statements and translate them into information that the officers will be able to use to respond appropriately.

Speaking of livor mortis, here's a quick crash course on the science of death in case you're curious. Decomposition begins just a few minutes after death when the body literally begins to digest itself. When cells become deprived of oxygen

because the lungs stop taking in air and the heart stops beating, their levels of acidity go up and enzymes (proteins) begin to digest the cell membranes (walls) and the contents begin to leak out. The process usually begins in the liver and brain. Body temperature also begins to drop (called algor mortis), cooling to match the surroundings, and rigor mortis sets in, beginning with the eyelids, jaw, and neck muscles. The body can get stuck in the position in which it expired, which is where the slang "stiff" originates. Around 48 hours after the death, however, rigor mortis dissipates and other signs of death take its place, such as rigor mortis' lesser-known companion, livor mortis. Livor mortis is the phrase used when all of the blood in the person's body follows the pull of gravity and pools in the part of

the body that's closest to the ground (like the back and backs of legs). Remember how the cell membranes dissolved? Those were the only things keeping the blood (and other viscera) from doing that in life.

Keep in mind that the aforementioned facts don't necessarily apply to bodies that have been submerged in water. The condition of the body

often depends on the temperature and/or depth of the water. Decomposition works quickly in warm, shallow water, whereas cold, deep water slows the decay, making the process of telling the time and date of death different from doing so on a body on land.

If the death is not OBVIOUS, you will request medical assistance. In the case of an EXPECTED DEATH, you are instructed to "Notify proper authorities," which generally means getting ahold of the deceased person's physician and asking him or her to sign a death certificate. In extreme cases, a disaster cleanup or biohazard company might

As with EXPECTED DEATH, your area's local authorities will have predetermined what qualifies as OBVIOUS DEATH.

be called to clean up the effects of advanced decomposition or other unpleasant byproducts of a death. They might also be called to resecure a residence if the doors or windows had to be broken to reach the deceased.

If you determine that the death is a suspicious one, you will ask Key Questions 5 through 7 in order to give the responders a better sense of the scene they'll be going to. You may or may not need to ask the sub-questions on Key Questions 5 or 6, depending on whether or not the caller is aware of the involvement of other persons who may have been at the scene. Key Questions 3 and 4 provide evidentiary information that will be logged as part of the police case whether or not the death is deemed suspicious.

Dave Warner, Police Protocol, Academies and Standards Associate for the IAED, advises keeping the caller on the line until police arrive if the deceased person is found somewhere unconventional—like a park or other public space rather than inside his or her own residence.



Suicide

Unfortunately, incidents of suicide are on the rise in the United States and other countries. From 1999 to 2017, the suicide rate increased 33%, and since 2008 it has ranked as the 10th leading cause of death for all ages in the United States.² There is a very real possibility that you will take a call sometime in your career involving suicide, assuming you haven't already.

While attempted and threatened suicides should be handled on Protocol 127: Suicidal Person/Attempted Suicide,

completed suicides ought to be handled on Protocol 112, whether the method of suicide was hanging, shooting, overdose, or something else. Completed suicides fall under the category of SUSPICIOUS DEATH, even if it appears that the caller reports knowing precisely what killed the deceased person. This is in keeping with Rule 4, which states that you should "Always consider that reported suicides may be homicides." Key Question 5 will help you determine

what the method of death was and where the weapons (if any) are now. If the person's method of death was chemical suicide (which is rare), be sure to pass that information along to the officers so they can take proper precautions in their response.

Conclusion

As far as police calls go, Protocol 112: Deceased Person isn't used on an everyday basis. Out of a sampling of 1.76 million police cases logged in ProQA*

from 14 agencies between May 2013 and November 2019, only 1,310 were triaged using this protocol. However, despite the apparent infrequency of the event, it is imperative that you're prepared for the day you have to use it.

Calls involving deceased persons are a peak example of not being able to save every person, but being able to help every caller. In a majority of Protocol 112 cases, the deceased person won't be revived and resuscitation might not even

be attempted. However, the sensitive and competent way you handle the call will ensure that the caller's experience is as painless as possible. ●

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FIRES, CRASHES, SPEED, AND RAGE

Protocol's got your caller covered

Audrey Fraizer

A lot can go wrong involving cars and traffic, but whatever comes your way, the fire and police protocols have you covered and together complement the goals of fire/rescue and law enforcement. The Medical Protocols address scene safety conditions during Case Entry and focus on the potential severity of injuries.

The Fire Priority Dispatch System™ (FPDS) and the Police Priority Dispatch System™ (PPDS) each contain four Chief Complaints directly involved with various types of vehicular incidents. All eight of these protocols were revised in the latest releases (FPDS v7.0 and PPDS v6.1).

The Medical Priority Dispatch System™ (MPDS) directs EMS response to vehicular accidents with one major Chief Complaint—Protocol 29: Traffic/Transportation Incidents. Axiom 5 within the Protocol reminds EMDs “to obtain complete information. Even if law enforcement personnel initially

request ‘paramedics,’ response should be driven by specific priority problems (*see SEND Protocol*).”

FPDS

The Fire Protocol directly addresses vehicle fires (Protocol 71), vehicular collisions (Protocol 77), and vehicles that are sinking or trapped in floodwater (Protocol 81). New Protocol D combines existing and new potentially hazardous situations including getting locked inside a vehicle trunk.

Protocol 81: Sinking Vehicle/Vehicle in Floodwater was sheared from Protocol 72: Water/Ice/Mud Rescue and specifically addresses calls for sinking vehicles and vehicles in floodwater. Protocol D: USAR/Vehicle and Other Hazards was designed to provide callers with basic instructions on what they should or should not do to enhance survival chances until specialized teams trained to handle these incidents arrive.

PPDS

The Police Protocol addresses reports of a driver suspected to be under the influence of intoxicating liquor or drugs (Protocol 115), carjackings (Protocol 126), and road rage (Protocol 132). An EPD can help secure the scene and provide safety instructions in a traffic crash with or without injuries and in hit-and-run incidents (Protocol 131) as well.

PPDS v6.1 did not include the release of any new protocols, although EPDs will note major changes in one of the most common Chief Complaints—Protocol 131: Traffic/Transportation Incident (Crash). This same protocol interrogation was significantly modified in PPDS v4.2 to reduce the number of questions and to get to relevant details more quickly. In PPDS v6.1, questions regarding airbags and potential hazards on scene were added.

Just in case

The fire and police protocols also address incidents such as a stuck

accelerator, a fuel spill at a gas pump that could cause incendiary problems, flammable substances leaking in or near a vehicle, and precautions to take when electrical wires are in contact with a vehicle on fire.

New and revised FPDS Protocols

The division of former Protocol 72 into two separate protocols allows for more appropriate Key Questions, PDIs, and Determinant Codes. Rule 1 on Case Entry reminds the emergency dispatcher to consider sinking vehicles occupied until proven otherwise to prevent injury or death of passengers possibly overlooked inside the vehicle. Rule 1 on Protocol 81 has been added: "For a 1st party caller in a sinking vehicle, go directly to PAIs without obtaining an address, phone number, or name during Case Entry." These situations are recognized as extremely high risk/low frequency, and no time exists to obtain this information because the vehicle will typically sink prior to any instructions being given with a higher likelihood the vehicle occupants will drown.

As already cited, Protocol D highlights optimal instructions for survival in situations requiring assistance from specialty safety teams. The protocol is not limited to vehicular-associated perils and includes survival instructions in instances of trench and structural collapse, which were moved from Protocol B: Building Evacuation and Health/Life Safety.

Panels new to the FPDS in Protocol D focus on vehicular incidents.

Panels D-4 through D-4d provide the caller with instructions describing how to escape a trunk by recognizing and utilizing the vehicle's features. Do the back seats fold down, or is there space to maneuver around the spare tire compartment and retrieve the tire iron for prying the latch open? Can you find the automatic release lever?

Accidental or intentional entrapment in a trunk is a serious life-threatening hazard. A person of any age can die from the high temperatures and poor ventilation. Between 1970 and 1999,

nearly 1,000 incidents of accidental and intentional trunk entrapment endangered 1,175 people. Between 20–25% of trunk entrapment victims did not survive, and that percentage increased to 35–40% for victims ages 14 and under.¹ In 2001, federal law required all manufacturers to equip cars (2002 and beyond) with glow-in-the-dark trunk release levers.

Panels D-5 and D-6 instruct the caller on what to do if the vehicle is on fire and what to do if the vehicle on fire is in contact with electrical wires, respectively. Callers are advised not to attempt extinguishing the fire and, if electrical wires are in contact with the

Emergency care is at the core of post-crash response.

vehicle, to jump clear of the downed wires when escaping the burning vehicle.

Vehicle fires are not uncommon, according to data collected in the U.S. Fire Administration's National Fire Incident Reporting System: Each year, from 2014 to 2016, an estimated 171,500 highway vehicle fires occurred in the United States, resulting in an annual average of 345 deaths, 1,300 injuries, and \$1.1 billion in property loss. These highway vehicle fires accounted for 13% of fires responded to by fire departments across the nation. The term "highway vehicle fires" includes fires in passenger road vehicles (e.g., cars, motorcycles, and off-road recreational vehicles), freight road transport vehicles (e.g., dump trucks, fire apparatus, and tank trucks), and agricultural and construction vehicles.²

Revisions in FPDS Protocol 71: Vehicle Fire and Protocol 77: Motor Vehicle Collision provide clarification, such as specificity in the type of vehicle involved, and both feature a new ECHO code to immediately alert responders of occupants trapped inside a vehicle on fire.

Revised PPDS Protocols

Similar to the FPDS and MPDS, PPDS Protocol 131 includes an "H" suffix for "HAZMAT." The FPDS includes seven suffixes on Protocol 77, of which four address HAZMAT and varying conditions of the fire and the number of vehicles involved.

The deployment of an airbag is specific to the PPDS to indicate that there may be unseen or unrecognized injuries to people in the car even when the caller reports that no one is injured.

Working in tandem

Not a day goes by without emergencies related to road traffic crashes, and global fatality statistics worldwide bear the consequences of what the World Health Organization (WHO) calls a preventable cause of death that requires strong policies and enforcement, smart road design, and public awareness campaigns to drive down a problem that appears to be getting worse. According to the statistics³:

- Every year, approximately 1.35 million people die as a result of a road traffic crash (or nearly 3,700 people die on the world's roads every day).
- Road traffic crashes are the eighth leading cause of death among people of all ages and the leading cause of death for people between the ages of 5 and 29 years old.
- Key risk factors include drinking and driving, motorcycle helmet use, seatbelts and child restraint systems, speed, distracted driving (mobile device use), and road infrastructure.
- An estimated 35% of all road deaths are reported as alcohol-related.

Emergency care is at the core of post-crash response, and the series of actions essential to care for the injured begins with the activation of the emergency care system and continues with care at the scene, transport, and facility-based emergency care.

In addition, the WHO recommends robust data collection to reach future targets in reducing road traffic crashes and to identify gaps in existing systems.

The medical, fire, and police protocol systems work similarly in response to traffic incidents. In Case Entry, the first two questions in each protocol are location and callback number. The caller is asked to state exactly what happened in response to the third question in MPDS and the fourth question in FPDS and PPDS. The report of a traffic accident alerts emergency dispatchers to the respective Chief Complaint (MPDS Protocol 29, FPDS Protocol 77, or PPDS Protocol 131).

The traffic incident Chief Complaints may address caller interrogation in varying order, but each focuses on mechanism of injury and scene safety. These protocols identify potentially major incidents to correlate resources to the size of the event, whether injuries are involved, the types of vehicles, problem suffixes to further clarify the incident, and each provide caller/ bystander instructions to steer clear of an active roadway to prevent being struck by another vehicle.

MPDS Protocol 29 is designed for mechanism of injury and scene safety issues associated with motor vehicle crashes and traffic rather than for individual injuries, although Key Questions highlight potential severity of injuries (completely awake, normal or abnormal breathing, serious bleeding). Protocol 30: Traumatic Injuries (Specific) is more appropriate to address an individual patient's injuries resulting from a vehicle crash.

FPDS Protocol 77 Key Questions concentrate on the situation (number and type of vehicles involved, hazards that could jeopardize people on scene and responders, and mechanism of injury suggesting level of injury). PPDS Protocol 131 Key Questions provide law enforcement with on-scene safety precautions (blocked or slowed traffic due to the collision) and potential criminal conduct (leaving the scene and alcohol or drug use).

Reflecting the times

Protocol 77 was modified in FPDS v7.0 to delineate in the Determinant Descriptors

between accidents involving a motorcycle/ vehicle vs. motorcycle (77-D-7) and a vehicle vs. pedestrian/bicycle (77-D-6). The new descriptor (77-D-7) includes dockless electric scooters (e-scooters).

E-scooters entered the public mode of transportation choices in September 2017, and in 2018, the number of rides Americans took via dockless scooters, bikes, and traditional bikeshare systems more than doubled to 84 million trips.⁴ The numbers are expected to continue their climb.

According to a ProQA[®] review of Protocol 77 (April 2014–November 2019), there were 86 calls in which a scooter was specifically mentioned in the initial information gathering during Case Entry before any Chief Complaint was selected.



An additional 51 calls (for a total of 137) during this same time period volunteered information about what type of vehicle based on the Chief Complaint. The determinant 77-D-7 includes, for example, van vs. scooter, fall off scooter (no other vehicles involved), and some mention of injury (bleeding and head trauma).

Roughly, in September 2017 and November 2019, the number of accidents reported was 134 and 85, respectively. In the three years prior, the numbers remained basically flat, never exceeding two for each succeeding year until 2017.

E-scooters are adding a new category to emergency room visits for fractures, dislocations, and head trauma.

A three-month study (September to November 2018) found the e-scooter injury rate was 14.3 per 100,000 trips.

The most common wound after head injuries involved upper extremity fractures at 27%, followed by lower extremity fractures at 12%. Since this is the first-ever study of its kind, a comparison to earlier trends is not available and the CDC, in collaboration with state and local partners, is developing and evaluating methods to find and count the number of injuries related to dockless e-scooters on a national level.⁵

SEND Protocol

The SEND (Secondary Emergency Notification of Dispatch) Protocol facilitates better initial information and fewer relay of questions between police officers, sheriffs, security officers, federal agents, highway patrol, or military police and EMS as a response is coordinated. The protocol walks emergency dispatchers through the process of evaluating and recording a reporting officer's on-scene assessment and guides them in sending the most appropriate resources.

In addition, the SEND Protocol relies on the professional judgment of on-scene officers to recognize situations such as uncontrollable hemorrhage, when to send a lights-and-siren EMS response, and how to evaluate serious vs. non-serious injuries. ●

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CENTURY'S FIRST PANDEMIC

Protocol 36 used for Swine Flu, Ebola, and now for COVID-19

Greg Scott

While still in the grip of a crippling pandemic, we struggle every day to keep up—working to maintain adequate staffing in our dispatch centers, in the field responder workforce, adjusting to a new makeshift policy or procedure almost daily—always hoping our local hospitals can handle the load. Too often we watch our colleagues, friends, and family members fall ill and wonder if we're next. In times like these, a little reflection can be instructive—and perhaps therapeutic—adding context and even giving us a glimpse of the calm after the storm. In this issue's "Blast From the Past" we look at an article from this century's first pandemic: the 2009 H1N1 flu outbreak, sometimes known as the Swine Flu.

According to the Centers for Disease Control (CDC), the H1N1 pandemic (a strain of influenza A) inflicted tremendous

damage on the U.S. population between April 2009 and April 2010: 12,469 known deaths, 274,304 hospitalizations, and nearly 61 million total cases. This sounds ominously familiar to us now.

Dr. Jeff Clawson's article from the July/August 2009 issue brings up a now-familiar topic—the use of Protocol 36 (Pandemic/Epidemic/Outbreak). As Chair of the IAED's Chemical, Biological, Radiological, and Nuclear (CBRN) Fast Track Committee, I can confirm that some of these same issues are still being discussed and evaluated—but this time for the latest pandemic, COVID-19. Indeed, the same discussion about which symptoms are most relevant for this disease—and therefore should be considered in the use of Protocol 36—is one that occurs regularly among members of our committee, and with certified EMDs and EMD-Qs at large.

If you've had a chance to review the latest version of Protocol 36, you'll notice

Rule 1 has been adjusted for COVID-19 to include only three Chief Complaints: Breathing Problems (P6), Sick Person (P26), and Chest Pain (P10). This was done because COVID-19, unlike H1N1, is a true respiratory illness. Headache is a common flu symptom. Another change includes the dropping of several common gastrointestinal (GI) symptoms in the Key Question sequences. While we know that GI symptoms do occur in COVID-19 patients, they are not the true indicators of the most potent, severe form of the disease. As of this writing, doctors and hospital staff are focused on the respiratory component of COVID-19 because of the risk of mortality in patients that present with respiratory symptoms (plus fever). Of course, as we learn more about COVID-19, we must continue to evaluate and critically review the content of Protocol 36. So, let the discussion continue! We welcome your feedback. ●

■ ASKDOC

Not Yet Over. Spread of swine flu continues to alarm public



Jeff Clawson, M.D.

The Academy* continues to field questions regarding the H1N1 swine flu and, of course, the spread of the infection in relation to emergency center call volume and the use of MPDS* Protocol 36. I will summarize answers to both, beginning with the most recent information about the spread of the virus available at the time of publication.

As of mid-June, nearly 36,000 people in 76 countries had been infected with the H1N1 virus, according to figures from the World Health Organization (WHO). Of these, 160 had died, including 45 confirmed deaths in the United States where almost 18,000 cases of swine flu had been reported. According to the BBC, the number of cases in the United Kingdom reached nearly 1,600, during the same month (June), which didn't include the latest diagnosed cases in Scotland where the virus has reportedly spread particularly fast.

June reports also indicated mild infections, for the most part, with people recovering fairly quickly. Obviously, the infection can be fatal but that generally depends on the severity of symptoms at the time of diagnosis, vaccination, and the presence of underlying health conditions that could aggravate the illness.

Within the level of severity lies a common misconception. The level 6 the WHO declared in issuing the pandemic alert is not a statement of clinical disease indicating the severity of infection. Rather, the number designates the extent of geographic spread. When the level 6 was declared, H1N1 was raging through North America, Australia, South America, Europe, and regions beyond; it had hit all 50 states.

While few have ventured a guess at future spread here or abroad, a lull over the summer months doesn't indicate the worst was over. Flu season in the United States generally runs late fall into early spring. In



While few have ventured a guess at future spread here or abroad, a lull over the summer months doesn't indicate the worst was over.

the meantime, vaccines for swine flu are currently being tested in preparation of a potential outbreak later this year.

The possibility of H1N1 mutating into a different form, as suspected in the case of a patient in Brazil, has raised a question regarding the clinical basis/consensus for the selection of symptoms triggering the shunt to Protocol 36. As those familiar

with the shunt know, these symptoms are difficult breathing, chest pain, headache, and sick person. At this time, the Academy has no plans to revise the selection of symptoms but it is helpful to explain at how the Academy arrived at the decision.

Academy arrived at the decision.

In working with the Chemical, Biological, Radiological, and Nuclear (CBRN) Fast Track Committee under the Council of Standards, these Chief Complaints were considered direct symptom mimics of presenting flu patients and the most likely to capture the majority of cases. It does not attempt to capture every flu patient, as Protocol 36 is designed for use only when initiating a declining response matrix. This group of patients represents about 30 percent to 35 percent of all patients, statistically.

If the service is trying to identify who might have symptoms, they should use the SRI Symptom checklist for evaluation of patients based on center policy. This is actually the first device to be used and will generate information for responders on any suspect patient. Protocol 36 is only used once there is a patient overload/decreased hospital capacity and triage must begin (declining response by stages based on the local severity rating of 1(suffix A), 2(suffix B), or 3(suffix C).

Finally, the WHO, Centers for Disease Control and Prevention (CDC), or other national or international health agencies have not reported abdominal pain and syncope as H1N1 symptoms, although it wouldn't surprise me if some flu patients had these symptoms. We will pass this concern along to the CBRN Committee for its expert consideration.

Hope this helps clarify... Doc ■



Jamie Knapman had three farewell parties when he retired.

FULFILLING CAREER

Emergency dispatcher retires after 29 years on the job

Audrey Fraizer

Emergency dispatch was a profession Jamie Knapman had never considered, although in the long run it turned out to be one he could never give up.

“Never had crossed my mind before,” Knapman said, and after the first day he didn’t look back for the next 29 years. “Then I definitely enjoyed it to the end.”

Knapman calculated 6,555 shifts and close to 78,600 hours that came to a halt on Nov. 24, 2019. While he holds no regrets over his career choice, he does admit a bit of trepidation during the last six months despite plans he and his wife, Coleen, a retired Regina (Saskatchewan, Canada) police officer, eagerly anticipated.

“It will definitely take some time to adjust,” he said.

The job, however, appealed to Knapman almost from the start.

“The hands-on of helping people” was Knapman’s intention in attending an EMT course. In 1983, he got his start with Olson’s Ambulance, a contracted private service in Regina. Four years later, in 1987, he was among the first

employees of Regina Area Municipal Road Ambulance District (now known as Regina EMS), splitting his time between ambulance response and 911 emergency communications.

“I definitely enjoyed dispatch,” Knapman said. “Helping people was a real positive. Quite a rush being able to do that.”

The job, he admits, did not come without the associated stress, and there’s a scenario he likes to describe when asked about the life and death possibilities that could come over the phone at any time.

“On one phone line I could be helping someone perform CPR on a loved one, and on another line I could be helping someone deliver a baby,” he said.

Although the scenario terrified him, he approached the situation exactly as predicted when it did happen (going back and forth between the callers).

“I was helping someone bring a baby into the world while at the same time trying to help someone save another [person] from leaving this world,” he said. “Yes, I always thought this scenario could happen but really, what were the odds of it?”

Rarely finding out the outcome of a call was something he also described as a drawback, although the ability to give DLS instructions when the MPDS* was implemented in the early 1990s gave a better indication of the patient’s chances and what responders were getting into. The years prior to protocol, he refers to as the “cowboy days.”

“No interrogation of callers,” he said. “We’d get an address and phone number. We never knew what we were sending our responders to. It might be a murder scene or cardiac arrest. Protocol added a lot of value.”

Knapman’s last day wasn’t a matter of going out on a whimper. His retirement attracted such a slew of co-workers that it took three farewell parties (one at the office and two at home) to fit in all the goodbyes and well wishes.

The events underline the respect co-workers had for Knapman, said Dusten Gessner, Communication Specialist/Superintendent, Medical Communications Coordination Centre (South).

Knapman was at the top of experience and, yet, always looking to improve when he observed or heard something that impressed him, Gessner said.

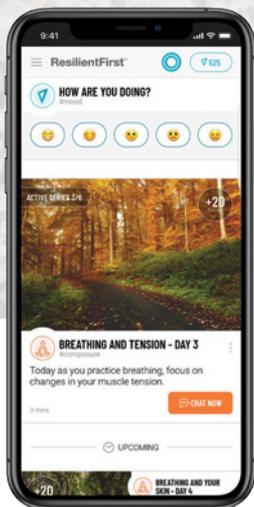
“He’d ask the newest employee, ‘Hey, how did you do that?’” Gessner said. “He wouldn’t sit back and act as if it was no big deal or something he would have done, given the chance.”

Saying goodbye, though difficult, is not the end to long-lasting friendships and, of course, the memories of answering literally thousands upon thousands of 911 calls endure. The final two calls Knapman answered—cardiac arrest and uncontrolled hemorrhage—were typical for emergency dispatch, but certainly nothing short of a crisis for the people involved, he said.

Despite the outcomes, which he doesn’t know, he went home at the end of his career the same way he did at the end of any day in his long career.

“I know I made a difference in someone’s life,” Knapman said. “We do our job the best we can with the equipment we have and hope for the best.” ●

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JOURNAL TURNS 30

To move forward we reflect on where we've been

Heather Darata

While the Journal of Emergency Dispatch hasn't always existed for members of the International Academies of Emergency Dispatch[®], it has been around for three decades. But it didn't start with the same name or look that it has now.

Two years after the Academy was founded in 1988, the Journal was published for the first time—as a quarterly newsletter called Emergency Medical Dispatch! The inaugural issue (Vol. 1 No. 1) featured big names: Dr. Henry Heimlich and William Shatner. Both attended the 1989 International Conference (now known as NAVIGATOR), which received front-page coverage. Other noteworthy announcements included a welcome letter from Dr. Jeff Clawson, in which he said: “We will bring you up-to-date information on issues, opinions and news relevant to the often overlooked world of the EMD.”

Let's look at some of the ways the Journal has changed over the years to do just that.

In 1990, regular contributors included Dr. Clawson (NAEMD President), Scott Hauert (NAEMD Director of Training), and Robert Martin (Production Director for Medical Priority Consultants). Familiar names also included Steven Carlo, Bill Kinch, and Alexander Kuehl in the 1990s.

Until 1999, Emergency Medical Dispatch! kept the same name with variations on layout design. Color started being utilized in 1993. Issue length ranged from 4-16 pages, often 4-8 pages.

In 2007, big changes came about. The name switched to the Journal of Emergency Dispatch, and a new magazine format was introduced. Along with using cover shots that “pop,” the layout became more colorful and vibrant. The new magazine was organized in sections that are, for the most part,

familiar to you now—Columns, ViewFinder (Academy opinions and perspectives), OnTrack, RightOn (Industry Insider), Best Practices, Your Space, and feature.

When you flip through the Spring 2007 issue, you'll notice articles that are standard in our issues today including Dear Reader, Ask Doc, Medical CDE, Police CDE, and ACE Achievers. Audrey Fraizer, our Managing Editor, joined the Academy in 2007, the year the quarterly newsletter changed into a more robust, bimonthly magazine. She and the rest of the Journal staff have been instrumental in making today's Journal what it is.

The Journal has only grown since its early beginnings. In the 13 years I've been with the Academy—I came on board in July 2006—I have seen numerous changes to the Journal both in contributors, content, and the introduction of our Journal website (iaedjournal.org), which launched seven years ago. How many pages each issue of the Journal is, how the Journal is delivered, and the type of content we have on the Journal website include some of our recent changes and foreseeable changes.

And that's the point, isn't it? Things don't stay the same. Emergency dispatch continues to change. Technology continues to change. The Journal continues to change as we look to bring you what we believe will help you do your job to the best of your ability while ensuring you belong to the Academy community—and all during these times of increasing change. Dr. Clawson said it best in the From the President's Desk message in the inaugural issue of Emergency Medical Dispatch!

“It is my sincere desire that this initial newsletter will grow to meet the growing needs of our new and dynamic profession. The sharing of information that we hope can be provided through this forum is a prime goal of the Academy. Please share with us your cases, experiences, thoughts, ideas, and expectations so we may share them with others herein.” ●



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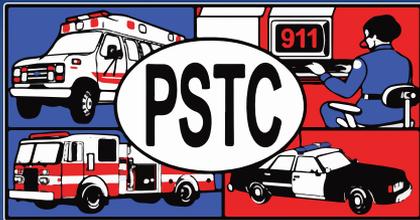
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Born out of the heavy equipment and automotive industries, United Group, Inc. manufactures its own brand of ergonomic office chairs and custom heavy-duty seats under the IRON HORSE Seating brand.

Through extensive market knowledge and known customer requirements, IRON HORSE Seating is designed for 24/7 intensive use for a variety of user statures across multiple environments. As a part of United Group, Inc. the team at IRON HORSE Seating prides itself on offering custom seating solutions.

ironhorseseating.com



PRIORITY DISPATCH CORP. SOFTWARE SUPPORT

Don't miss out on meeting with the experts. Experience live demos and learn the do's and don'ts for Priority Dispatch software. If you have a question, we have the answer. Come on over and meet us!

prioritydispatch.net



SCHEDULE EXPRESS BY INFORMER SYSTEMS



Schedule Express, a cloud-based scheduling solution, uniquely automates shift-based schedules, absences, trades, overtime, training, special assignment, and shift/vacation bidding processes—from request through approval—effectively eliminating paperwork and lowering costs while substantially reducing errors, omissions, and abuse.

informersystems.com

SORENSEN COMMUNICATIONS



Sorenson Communications, LLC (www.svrs.com) connects people by delivering the world's most trusted service and innovative products for people who are Deaf. These include the option to conduct real-time calls, including 911 emergency calls, through a qualified American Sign Language (ASL) interpreter. Sorenson is the leading provider of Video Relay Service.

sorensonvrs.com

SOUTHERN SOFTWARE INC



An employee-owned company in business since 1988 providing cutting-edge dispatch, mapping, RMS/JMS, and mobile computing software solutions. Our commitment is to provide excellent customer support and long-term consistency of ownership. Our solutions for PSAPs, sheriffs, police, detention, campus, and security are user-friendly and relevant to today's standards.

southernsoftware.com

THE HEALTHY DISPATCHER



The Healthy Dispatcher provides training classes and culture change consulting services to communications centers across the country.

thehealthydispatcher.com

TYLER TECHNOLOGIES



New World public safety software from Tyler Technologies is a fully integrated, multi-jurisdictional product for police, fire, and EMS. It features computer-aided dispatch, records, mobile, field reporting, decision support, corrections, and fire solutions. With Text-to-911 functionality in CAD and Esri-powered mapping, this software is designed to meet the needs of today and the future for those who serve and protect.

tylertech.com/publicsafety

WATSON CONSOLES



With your team in mind, Watson Consoles prioritizes user comfort and focus, easy IT integration and long-standing 24/7 durability to create the best console environments in the world. Watson has been designing and building console furniture for more than 35 years. We have fine-tuned materials selection and functional design to support height-adjustable ergonomic solutions that last for 15+ years of active duty. Take a seat at Mercury today a solution for every application and budget.

watsonconsoles.com

WITHIN THE TRENCHES



The podcast series called Within The Trenches invites dispatchers on to tell their stories and other guests in the industry who advocate for the profession and try to elevate it. Stop by the booth to be a part of the show.

Visit us online at thejabberlog.com/within-the-trenches

ZETRON, INC.



Zetron has been designing and manufacturing integrated mission-critical communications systems since 1980. Its expandable offerings include NG911 calltaking, CAD, mapping, IP-based radio dispatch, voice logging, fire station alerting, and location service systems. They are interoperable and able to support geo-diverse operations.

For more information, visit: zetron.com.

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prioritydispatch.net/AcademyAnalytics