

the JOURNAL of emergency dispatch



```
52 // ...
53 // ...
54 // ...
55 // ...
56 // ...
57 // ...
58 // ...
59 // ...
60 // ...
61 // ...
62 // ...
63 // ...
64 /**
65  * Implements hook_permissions().
66  */
67 function taxonomy_permission() {
68   $permissions = array();
69   $administer_taxonomy = array();
70   $title = 'Administer vocabularies and terms';
71
72   foreach (taxonomy_get_vocabularies() as $vocabulary) {
73     $permissions = array();
74     $edit_terms_url = $vocabulary->edit_url;
75     $title = 'Edit terms in ' . $vocabulary->name;
76
77     $permissions = array();
78     $delete_terms_url = $vocabulary->delete_url;
79     $title = 'Delete terms from ' . $vocabulary->name;
80
81     return $permissions;
82
83   }
84 }
85
86
87
```

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GOES REMOTE

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FIRES HAVE
THEIR SEASON



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the JOURNAL

of emergency dispatch

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20 | NO PLACE LIKE HOME

Is working from home really possible in the emergency dispatch profession? Read about centers that are making it work.



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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.



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

ART BRAUNSCHWEIGER
7 | FROM THE DISPATCH SIDE



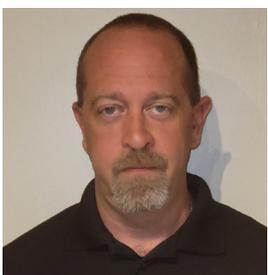
Heidi started in late 1993 in police dispatch and meandered down the career path of calltaking, backup fire dispatch, statistician, SARA TITLE III assistant, supervisor, and finally shift manager for the Harford County Department of Emergency Services in Maryland (USA). What an adventure!

HEIDI DIGENNARO
8 | SURVIVING THE HEADSET



Laurence was born and raised in Bristol, U.K. He graduated with a BA (HONS) in International Business at Plymouth University. After working in financial services, an adventure beckoned, and he spent five years teaching in Southeast Asia. Upon returning to the U.K., he worked in universities and colleges delivering English and customer service courses before joining South Western Ambulance Service and beginning his career as an Emergency Medical Dispatcher.

LAURENCE WARING
9 | GUEST WRITER



James has been with Douglas County E-911 in Douglas County, Georgia (USA), for 2 ½ years and is currently an Operator I with the center. He came to this career after 25 years in a totally unrelated field. He is EMD Advanced certified and attending Jacksonville State University in Jacksonville, Alabama (USA), for a degree in Emergency Management.

JAMES QUEEN
10 | GUEST WRITER

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KEEPING CONNECTION ALIVE

Times may be different but our need for connection isn't

Heather Darata

Summer finished winding down not too long ago. I am not a big fan of the hot days so I was pretty excited when fall arrived. The air became crisp and invigorating. The leaves turned beautiful colors, and the trees are looking pretty bare now. I recently started needing to wear a jacket. The smells of baking are in the air, and the holidays are on the horizon.

I, like everyone else, have been a little unsure of what to expect as we near the end of 2020. While the weather is somewhat predictable, other things haven't been "normal" since at least March. Working from home has become the new normal for some of us. Since mid-March—the day of the 5.7 magnitude earthquake in the Salt Lake Valley—I have been fortunate to work from home.

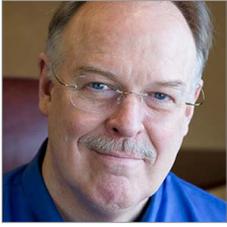
Since that time, I don't go out as much as I used to. There aren't as many places to go these days. I don't talk to as many of my co-workers as I did when we would see each other at Academy headquarters. I miss those impromptu chats. I know Zoom, Microsoft Teams, and GoToMeeting can help bridge the gap of not physically being in the same building, but for me it doesn't quite feel the same.

In a recent editorial meeting, we talked about connection. Do you feel, especially now, that your connection is not as strong with other people? Maybe you aren't seeing your neighbors, family members, friends, or co-workers (especially those who work a different shift) as much right now. Perhaps you miss striking up a conversation with someone new at the grocery store now that your groceries are being delivered. Maybe you miss seeing your favorite server at that restaurant you love.

Even though things are different right now, there is one thing that hasn't changed: People are still calling 911. Whether you are working from home or in the communication center, those calls keep coming in. Emergencies haven't stopped. Perhaps now more than ever, people need to be heard. They crave that human connection. They are reaching out to you for help.

You offer them that help by connecting with them and sending them the right response for their situation in this time of uncertainty. Thank you for being there. Thank you for continuing to do your job in these times of uncertainty. You are the public's lifeline. Keep connecting. We need you. ●

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. ©2020 IAED. All rights reserved.



HUMAN TRUTHS

Article emphasized well-known dispatch concepts, rules, and written laws

Jeff Clawson, M.D.

After publishing “How ‘Black Lives Matter’ and Should Reinforce Our Values in the Realm of Emergency Dispatch” by Jeff Clawson, M.D., and Matthew Miko, J.D., as the Ask Doc column for the July/Aug 2020 issue of the Journal of Emergency Dispatch, the Journal editorial staff received the following message:

Don't ever send me anything else from this day forward. I have been an EMT for almost 20 years and an EMD for almost 10. I can do my job without being supportive of terrorist organizations like Black Lives Matter. How dare you sink to that level. Your organization is pathetic and unpatriotic.

Dr. Jeff Clawson's response:

While we always appreciate anyone's opinion, as is the American way, I am surprised that you can paint an entire organization, that has done so much for your EMS and dispatch profession over the past 35 years, and in so many ways, with such a broad, negative brush. I must assume that your IAED™ training, use of exceptional protocols, and ongoing continuing education is somehow summarily washed away by a single Journal opinion piece, mainly emphasizing a number of well-known dispatch concepts, rules, and written laws meant to provide an unbiased and accepting helpful hand we must extend to all 911 callers when they need it most.

My and Matt's conceptional article wasn't an endorsement of any organization, but only a restatement of some basic underlying concepts and human truths. If, in reading this, your expressed feelings are still the case, just let us know and we will cease your Academy certification, which is linked to, and provides, your ongoing access to the Journal and all that the Academy represents. Decisions, well-made or not, ultimately affect the direction you must now choose.

Your call ... Doc ●



BEST PRACTICES

A small thing can make a big difference

Art Braunschweiger

One thing about writing a column is that you get to be controversial from time to time. That said, I am going to make a bold statement here: Many emergency dispatchers become complacent with their skills over time and don't take an active interest in developing them further.*

When I first shared the topic of this column with a colleague, she thought I was being overly negative. But I do believe we, as emergency dispatchers, often become set in our ways and—without realizing it—become unwilling to change because of the very type of person we have to be: highly confident in our abilities and decisions, with the ability to react immediately and make decisions without hesitation. Small wonder, then, that when we find something that works for us we stick to it and are reluctant to change.

Here's an example. On 911 calls I often hear emergency dispatchers ask, "What's a good **callback number**?" Someone whose primary language isn't English may not know what that means. "What's your **phone number**?" sounds better, but over the course of a thousand calls that's not likely to be as effective as "What's the **phone number** you're **calling from**?"—because a panicked or distracted caller might, without thinking, reply with their

home phone number when they're calling from the house of a relative or neighbor.

The point here is not how to ask for a phone number, but to recognize that there's often a better way of doing something. When codified into a standard operating procedure, performance standard, or protocol, it becomes a best practice. We should all be adopting, training, or promoting best practices whenever we identify them. A best practice isn't something that will make

the region of the Matterhorn, from which the series takes its name. What impresses me more than the scenery, though, is their collective attitude about training. They don't just believe it, they live it. That's understandable given the hostile environment they work and fly in. There's no margin for failure.

The standard is no different for us. Our lives aren't at risk, but other lives are. When we perform CPR through the hands of a caller, and we're not as effective

as we could be, someone might not survive. That someone might be a father who won't be at the dinner table anymore or a grandmother who won't be around to share Christmas again. For that reason we all need to be the best that we can be—every minute, every call.

Rise above complacency. Many things that you'll learn to help you do your job better won't come from continuing dispatch education.

There are things as simple as good habits to adopt and ways of doing things that are more effective than others. Watch your partners at work and adopt their good habits. Be a poster child for excellence—not because of what it will do for you, but for all those who depend on you.

**Many of you do, and if continually striving to learn more and work better is truly part of your belief system, then you have my highest respect!* ●

A best practice isn't something that will make a difference on every call—but it's something that on one out of a thousand calls, it will make all the difference in the world.

a difference on every call—but it's something that on one out of a thousand calls, it will make all the difference in the world. And much like an Olympic athlete's technique, it's often a little difference in the doing that makes a huge difference in the outcome.

There's a series called "The Horn" that I've been watching on Netflix. It showcases Air Zermatt, the air medical rescue service in the Swiss Alps. It features stunning footage of the crews and ships at work in



WHEN 911 NEEDS 911

How do you help yourself?

Heidi DiGennaro

What is your plan when your center finds itself in need of 911? Other than the involuntary “Oh sugar (use expletive of your choice),” do you **have** a plan? Do you know where to find the plan? We deal with other people’s problems and emergencies day in and day out. What happens when you at work need 911 yourself?

Do you call 911 and get your co-worker who has the same number of clues as you? Do you yell for the supervisor? What if **you** are the supervisor?

Um ... who **does** the supervisor call? I better know if I’m in charge, or I better be able to competently wing it until someone more knowledgeable takes control.

Here is an example: You contract to have the building floors stripped and cleaned including the hallway outside your communication center. All chemical cleaners are checked for contents and approved by the center’s safety officer. When the work starts, it is soon

discovered that the chemical cleaners selected aren’t working. The cleaning crew switches to something significantly stronger that requires good ventilation. There isn’t good ventilation. Result: A 911 center full of dispatchers in varying stages of a noxious chemical high: nauseous, headache, lightheaded, and dizzy. Everyone—no exceptions—goes to the hospital to be checked, your backup center is activated, volunteers and “voluntolds” come in, and you must deal with a hazmat situation at your own center. The ER doctor gives

the entire shift 24 hours off. You can see problems multiplying faster than dust bunnies under a console.

This is when having a plan and having people who work the floor trained and more than vaguely familiar with the plan benefits you. While parts of an evacuation plan may be supervisor-sensitive, keep a checklist of things anyone can do to get started.

If you are a combined center, a checklist should apply to each portion of the center with responsibilities specific



to the discipline. Do you know who takes over your radios and takes your calls while you are bugging out? For the one-person centers, is there a procedure to check on you throughout the entire 24 hours? So, at 0330 in the morning if you have not talked on the radio for an hour, does someone swing by and check if you are still breathing? Or call you on the phone? Text you? If they do not, they should.

There should be a process in place to check on personnel, especially in one-person centers, to ensure nothing happens

or happened. Not only for your welfare, because hey, **you’re the most important part of the process**, but to prevent your family from suing them if something did happen to you and no one checked.

Are there routine inspections of the fire extinguishers and AEDs? Is refresher training provided? Are basic first aid kits available? How about training on how to use the fire extinguishers? Minimal first aid training? What about emergency evacuation routes? Anybody walk the building each shift to make sure the

basement has not flooded or the sewage system has not backed up into the building? Or check that the 1970s era AC unit isn’t smoldering because it’s too darn hot outside? How about checking to make sure the AC unit is not a big popsicle because zero degrees is considered balmy today?

The point is to look around, learn, and know your environment. Know your emergency plans, even if you never use them. Spend the five

minutes to ask your supervisor to send you the plans or go over them with you. If you are the one responsible, figure out a plan. Ask questions of your fellow centers. Find out the memorandums of understanding (MOUs) for transitioning. Think long term. If you had to send an entire shift to the hospital and force the entire next shift in early, what are you going to do if someone on the shift after that calls out? Just because we are 911 does not mean we will not need it ourselves. Knowledge and preparation are key. ●



I'LL TELL YOU WHAT HAPPENED NEXT

A good thing for new EMD

Laurence Waring

If you came to me and told me I would be working for the ambulance service as an Emergency Medical Dispatcher (EMD) a year ago I would not have believed you. In fact, if you had asked me 3 ½ months ago, I would not have even known what an EMD was!

COVID-19 has been devastating for many people and communities around the world. If there is a shred of positivity in the crisis, however miniscule, it's that it presented me with the opportunity to join a wonderful organization and start my career as an EMD. Back in March I was just settling into my new home about to start my new job. Then it happened—"Sorry, sir, but due to the unforeseen ... blah blah blah!" I was unemployed, scared, and anxious about what would happen.

I quickly rang around all the local job agencies and luckily, I was offered an opportunity with the South Western Ambulance Service NHS Foundation Trust (SWASFT) based in the control room in Bristol, U.K. SWASFT has two control rooms covering 20% of England—approximately 6 million residents, swelling to over 15 million during holiday seasons. On average the Trust will receive

3,000 calls per day split between the two centers and each EMD takes around 70 calls per shift. These levels were pre-COVID-19, so the need for extra support was pivotal in the fight of the pandemic.

The initial role, termed a "call assistant," was temporary. It was our job to help existing EMDs with the oncoming deluge due to COVID-19. We were dealing with other professional services and not the general public, which meant we were

interviewed and was thankfully selected to attend training. This is where the hard work began. I cannot stress how important the call assistant role had been; it gave me a unique insight into the world of EMDs and a basic skill set before I started training.

However, there were huge differences. We had an intensive course in MPDS* that was mentally draining, but we learned so much. We had four weeks of training,

and each day seemed more intense than the last. During this period there were several assessments that helped determine our progress, a necessary evil but still as daunting as any exam I have taken. Finally, we did simulation calls that were wonderful preparation for coming into the control room.

As I write this, I am three shifts into taking calls from the general public. I have never felt more anxious

and still require a lot of guidance, but fairly well guarded in terms of complexity and triage. After about 1 ½ months, we were notified of full-time positions becoming available for an EMD role. I was delighted.

I had loved my call assistant role and was already thinking about applying for full time when roles became available. I

and still require a lot of guidance, but with tools like MPDS helping me I feel comfortable that I am doing the best I can for the patients. Sadly, what brought me here were a lost job and a global pandemic, but as I begin my journey as an Emergency Medical Dispatcher, I could not be more pleasantly surprised. ●





DEPENDING ON YOU

Don't let complacency take over

James Queen

At some point in your career, you lose track. After answering thousands of calls, listening to countless hours of radio traffic, and providing EMD instructions, you are bound to have a moment of complacency. It may be something as simple as not getting vehicle colors in an accident call. It may be something that does not affect the call's outcome.

Other times, it can be detrimental to the safety of your officers, firefighters, or other first responders. You did not ask about weapons or any number of other things as we run through our checklist of questions. You just happened to miss one on this call. Now you are scrambling, trying to get the caller back on the line to get more information for your officers.

As we go through this career, it is important to remember the very basics. Always go back to day one of your training at the beginning of each day when you put your headset on. What have we always been taught before and above all else? Responder safety. Remember this as you sit down for your 8-, 10-, 12-, or 16-hour shift. Remind yourself of it before you answer the phone or the radio.

It becomes hard to focus as you approach the end of these long shifts. However, that is when it is most important.

We all know that as the day or night drags on, that is when we become most complacent.

If you are a 30-year veteran or have just started this job that we all love for our own reasons, I implore you, every day, every hour, when you answer that phone or that radio, be sure that you have not become complacent. Make sure you ask your caller the pertinent questions. When that officer radios in on a traffic stop, don't rely on where that computer says they are.



Make them tell you the location. Get every bit of detail from your caller that you can. Most importantly, remember responder safety. Because, at the end of the day, we all want to know that each one of our responders is doing well and carrying on. They are going home because we did our job and we did our job well.

We all know the job; we all know the right way to do this job. Some of us have more training than others. Some agencies spend years training before they let you loose on your own. On day one, some hand you a headset and say, "Figure it out." If you are one who spent years learning the job, trust that training, remember that training, and use that training. If you are one who was just thrown to the wolves per se, seek out any information you can that will help

you. Reach out to the IAED™, APCO, NENA, or any of the other organizations. Use Facebook and look for those 911 pages, and make a post saying that you need help or have questions. While most of us get crotchety in our old age, we will always take the time to help someone in need. That's part of why we do this—to help.

The key is no matter how long you have been at this, never let yourself become complacent. Always ask every question. It may seem like a waste of time to

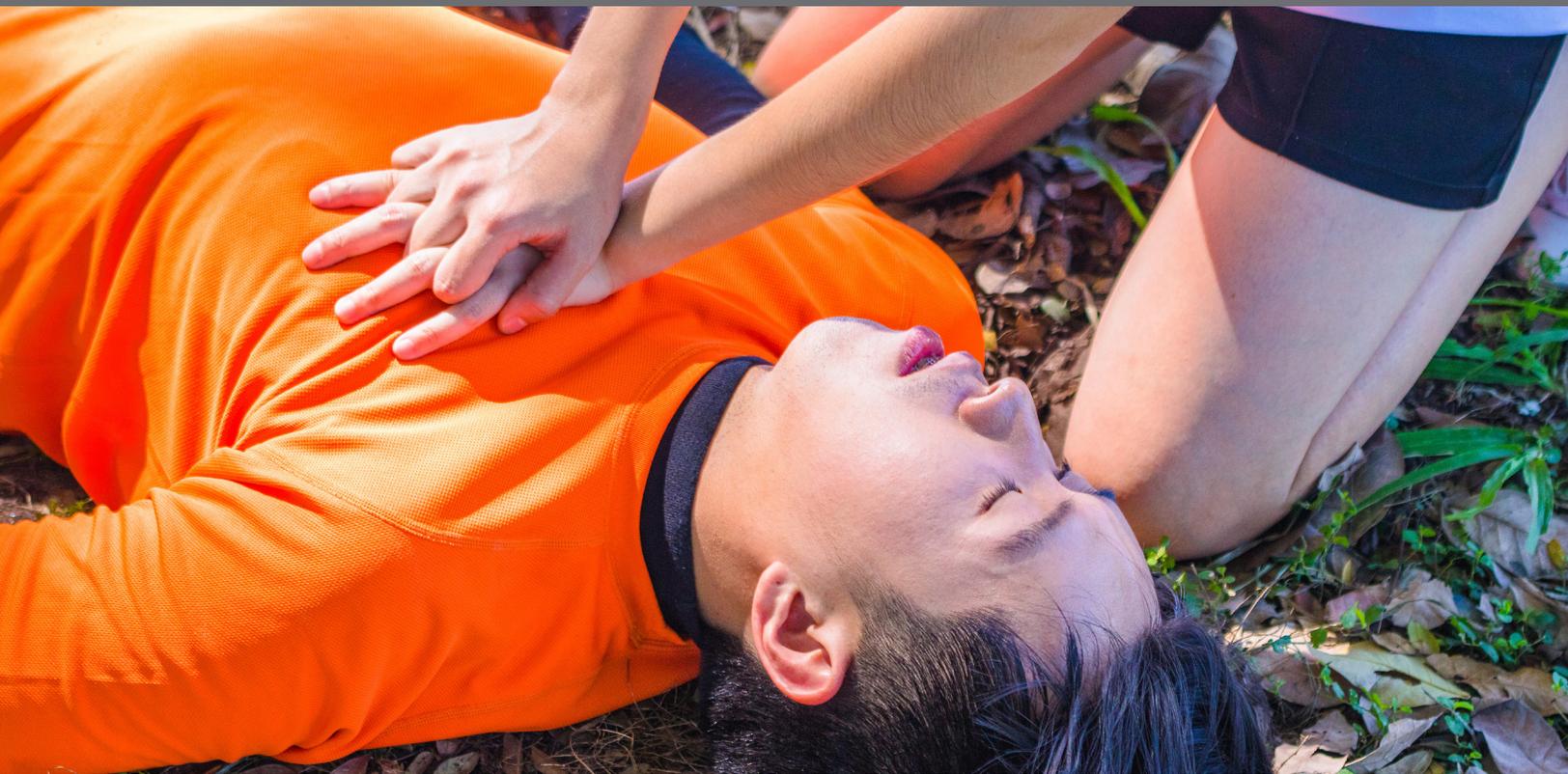
get the officer's location; you can see them on the map. Ask anyway; the map can be wrong. Even though the phone number for the caller is imported to CAD, there may be a problem with something. Always verify the phone number. Just don't become complacent. Your responders' lives may depend on it. ●

I'M ALIVE.

Your data helped
save me.

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

prioritydispatch.net/AcademyAnalytics



SHOULD WE EVER STOP THE EFFORT?

911 is a universally assumed, legally and morally, quest for help

Brett Patterson

Brett:

As you know, our Telecommunicator (TC) Beth Drew was EMD of the Year (NAVIGATOR 2020) for a prolonged CPR time. We are of course proud of her, but we recently had a similar circumstance in which a TC had three callers do CPR on a mountain train for over an hour and we are now hearing concerns about not stopping the effort. The callers never said they wanted to stop. While I think I know the answer already, do you have any advice for us on how to handle this criticism?

*Thank you,
Derick Aumann, NRP
Quality Improvement Supervisor
New Hampshire Department of Safety
Bureau of
Emergency Communications
Concord, New Hampshire, USA*

Derick:

A call to 911 is universally assumed, legally and morally, to be a request

for help. As such, we are obligated to provide that help. This is a simple duty to act, in legal terms. The international standard of care for cardiac arrest is CPR and, with few exceptions, MPDS' CPR instructions are, therefore, provided in cardiac arrest cases.

We assume help is being requested unless the caller provides information to the contrary, and we do not ask permission to provide that help (see *Principles of EMD, 5th ed., 11.21-23*). In the case of cardiac arrest, the patient is unable to make a conscious decision about resuscitation and, in most cases, the caller is not in a legal position to do so either. Therefore, the courts err on the side of the patient and assume care would personally be requested if the patient was able to do so.

There are exceptions to this presumption and protocol pathways are provided for them, i.e., scene safety circumstances and the defined conditions of OBVIOUS and EXPECTED

DEATH. Additionally, a caller's refusal to help, even in the absence of these pre-defined criteria, may lead to the cessation of resuscitative efforts, although EMDs are taught to encourage callers to continue when no other criteria suggests termination of CPR.

I have not heard the case in question but given nothing more than the time frame described, there are no specific resuscitation time limits in the MPDS that would prompt the EMD to stop instructing and encouraging the caller to provide CPR. Generally speaking, rescuer exhaustion or the arrival of responders are the primary limitations in such a circumstance, and a pathway to switch rescuers is available to mitigate the former.

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

Beverley:

I wondered if we could pick your brains about the following.

With regard to instructions relating to the obtaining of and use of defibrillators, some protocols have the defib instructions in the protocol specific PDIs and some don't, even those with arrest codes.

- c. (≥ 1 + Unconscious or Not alert) If there is a defibrillator (AED) available, send someone to get it now in case we need it later.

We are trying to track down the rationale for some protocols having this instruction and some not and, similarly, why some protocols, when using the red sudden arrest icon, do not give any mention of checking for a defib or retrieving one until the panel director in PAIs gives the option of selecting the AED pathway.



When selecting the AED pathway at this point on non-medical arrests, the wording on the next panel is:

Send them to get the defibrillator now, and tell me when you have it.

This will be despite no mention being made previously of the defib in AMPDS™ for the job. Should this instruction, therefore, only be delivered if the AED availability has been established in the CAD (outside of AMPDS, e.g., with a proximity alert for the address) or if the caller has volunteered the availability of one?

Many thanks in advance for any additional understanding you can provide us with.

*Sheridan Halton
EOC Education Developer
East Midlands Ambulance Service
NHS Trust
Nottingham, U.K.*

Sheridan:

In order to answer your question in relation to specific incidents, I would need the ProQA® sequences of the scenarios you are questioning. The protocol logic

is built into the event and the pathways taken by the EMD.

Please create some scenarios and run them through ProQA and then send me the ProQA sequences with a note of the FIRST mention of the defib and at which point it occurred in the sequences. I will then take a look and get back to you with the logic.

*Beverley A. Logan
National Accreditation Officer/
Associate Director
International Academies of
Emergency Dispatch*

Beverley:

I've attached the sequences of four test calls.

- No mention is made of the defib in AMPDS or by the caller or EMD, and it is never known if a defib is available.
- The EMD mentions the defib after a proximity alert is shown in CAD, and the EMD then selects the AED pathway after alerting the caller to the presence of a nearby AED.
- The defib is mentioned as part of the KQ script once the sudden arrest icon is selected.
- The defib is mentioned as part of the script in the protocol specific PDIs. I hope this gives you enough information.
Sheridan

Brett:

I have discussed these cases with EMAS and, I believe, the lack of "defib" instruction in a trauma "sudden arrest situation" versus "medical sudden arrest situation" may likely be down to the complications of "trauma sudden arrest" involving complicated injuries, serious bleed, and likelihood cause of hypovolemic shock (sudden arrest).

Am I on the right track; is there other rationale that I have missed or is this something that the protocol logic appears to have missed (that may need to be looked at)?

Can you please advise?
Beverley

Beverley:

The ECHO-level codes are limited by safety and viability factors and, in that vein, you are on the right track. We don't want to send a non-traditional first responder to a dangerous scene or deplete one on a traumatic arrest where the AED is not likely to make a difference. Traumatic cardiac arrest survival is very low and impacted much more by surgeons than AEDs.

As for the PDIs, these are prompted by the Cardiac Arrest Quotients derived from London Ambulance Service data that shows us the frequency of cardiac arrest within a given code. There are thresholds for each of the two instructions ("... in case we need it later" versus "... tell me when you have it"). In other words, we tell the caller to get an AED based on the chance of arrest in that code.



We tell the caller to get an AED based on the chance of arrest in that code.

So, a code must be determined to trigger the instruction in normal cases, and the code selection happens in various places during Key Questioning based on that particular protocol and where certain criteria have been met, i.e., all higher codes have been ruled out. If you are using the sudden arrest button, the instruction is provided, or not provided, based on whether the protocol being used has an arrest code, what the Chief Complaint is, or if the call has been reconfigured to the 9-D-1 code (Medical Protocol without an arrest code). If the code or protocol has not recommended an AED, but you select an available AED pathway in a PAI sequence, it is assumed an AED is available and you have decided to use it, so no question about availability is necessary.

I hope this helps.
Brett ●



Danielle Dahlke (left) and Jessica Medinger in the Ozaukee County Sheriff's Office.

GETTING TALKY IN OZAUKEE

Putting the spotlight on Ozaukee County Sheriff's Office

Becca Barrus

Ozaukee County Sheriff's Office (Port Washington, Wisconsin, USA) makes an effort to be sure its inhabitants are familiar with one another. In addition to housing the county's emergency dispatch center, the building also contains the patrol division, the coroner's office, the courthouse, the emergency management department, and the county jail. The walk from the dispatch center to the jail is a journey of a mere 200 feet (and several secure doorways).

"We try to make sure that our dispatchers are familiar with our law enforcement officers," said Wayne Lambrecht, Lieutenant of Ozaukee County Sheriff's Office's dispatch center. The dispatch center welcomes new officers hired in the county to visit the dispatch center so they are familiar with the emergency dispatchers they are working with. There are bonding opportunities aplenty on the regular too. Emergency dispatchers do field training

and attend patrol roll call so they can put a face with the voices they hear over the radios.

Dispatch Supervisor Joseph Laurin knows a thing or two about the emergency dispatch profession and the officers he works with. He's been with Ozaukee County for 21 years, 19 of which were spent as a line dispatcher, and he was promoted to dispatch supervisor in March 2020.

The first thing Lambrecht did when he was assigned to oversee the dispatch center for the Ozaukee County Sheriff's Office was to immerse himself in the culture. Although he had 24 years' worth of experience in law enforcement, he didn't have any dispatch experience, so he did what any good leader would do: he learned. Lambrecht got certified in both EMD and EMD-Q® and even reviews calls on occasion.

Laurin and Lambrecht must be doing something right because they achieved ACE status in July 2020, just a

few short months after they submitted their application in mid-February. Due to COVID-19 spreading across North America not long afterward, their application was put on hold for a bit, and Ozaukee County was the first ever to have a virtual site visit, paid by Ron Two Bulls. (Two Bulls also came for an in-person visit to check out one thing that couldn't be covered in a virtual one.) Once all the formalities were completed, Ozaukee County Sheriff's Office became a medical Accredited Center of Excellence.

"That's been the goal since day one," Lambrecht said.

Ever since the center started using the Medical Priority Dispatch System™ (MPDS) in January 2016 (a few years before Lambrecht came on board), they've had accreditation in their sights.

Both Lambrecht and Laurin want to make sure that their predecessors got credit too. Lt. Cory McCormick, Dispatch Supervisor Wendy Maechtle, and Medical Director Dr. Steven Zils

played a huge role in the center's accomplishment. According to Laurin, McCormick, Maechtle, and Dr. Zils were "instrumental in the implementation" of MPDS. McCormick and Maechtle retired before ACE status was given.

"They put in the legwork," Lambrecht added.

Who else put in the legwork to pull off this feat? The emergency dispatchers of course! Laurin said the fact that they're now an ACE is huge for them. "Everyone in the room had to work hard to get to that point," he said. "They had to learn the codes and the procedures, and now we're the two hundred and eighty-second medical ACE in the world. That's big for us."

When fully staffed, Ozaukee County accommodates 18 emergency dispatchers who do everything—they answer phones and run radio at the same time. Typically there is a minimum of four people on the floor at any given time and it can go as high as six depending on how shift overlap goes. Shifts are typically eight hours long, although if there's a vacancy they can be as long as 12 hours.

According to Laurin, the emergency dispatchers enjoy working as a team and not being specifically dedicated as a calltaker or dispatcher. They like working in the room together and can help each other take calls and get them dispatched. Their workstations are fairly close together so they can communicate easily and hear what's going on in the room, allowing them to jump in if needed.

To keep their emergency dispatchers happy and healthy, Ozaukee County has several programs in place to help them handle the stress of the job. There's a peer support team that's available whenever someone has a particularly rough call. Emergency dispatchers are also invited to Critical Incident Stress debriefs conducted by law enforcement in the event of a suicide, serious car crash, or other traumatic event.

It's not just programs that emergency dispatchers need either. The dispatch



Downtown Port Washington in the spring.

center just underwent a remodeling project where the kitchenette and break area were redone and lockers were added.

"We tried to create a better work environment to decrease stress," Lambrecht said. "The job is very stressful and dispatchers are an integral part of the team."

Port Washington is on the west side of Lake Michigan, which can cause its share of problems. There are heavy snowfalls in winter and flooding in the spring, but thankfully the lake tends to help ward off the tornados that other parts of Wisconsin are prone to have.

In addition to weather woes, recently there have been a number of calls where people have gone down a bluff on Lake Michigan and become stuck. It used to be that the center took one of those calls every few years, but they've taken three or four this year alone. Incidents like that

require a lot of resources that need to be pulled from a lot of different agencies. It takes all of the emergency dispatchers in the room together to tackle a task like this: someone to handle phone traffic, someone else to contact the agencies they need to borrow equipment from, and someone else to keep track of the responding squads.

"It comes down to teamwork," Lambrecht said. "It doesn't matter who's in the room with you, everyone works together to get that job done. You know everyone's going to do their part so you can do yours without worrying."

Ozaukee County Sheriff's Office serves an area of 1,116 square miles (1,796 square kilometers) and dispatches for seven fire and EMS agencies and six law enforcement agencies. It fields roughly 46,000 emergency and non-emergency calls annually. ●



Grand Junction Regional Communication Center in Colorado (USA)

MAKING A DIFFERENCE

It's all about the people taking and dispatching the calls

Audrey Fraizer

Wednesday, Jan. 25, 2017, was a real bad day for Rick Cohen. At least, at the start. Cohen collapsed inside of a Grand Junction (Colorado, USA) store next to shelves of shampoo, conditioner, and related beauty supplies. Employees rushing to assist called 911. Grand Junction Regional Communication Center (GJRCC) Communication Specialist Mary Erdis put response into motion, provided bystander CPR instructions while awaiting response arrival, and helped turn what could have been Cohen's last day into a celebration of life.¹

The day ended well. Cohen survived.

Working the graveyard shift in the middle of the night in February 2019, Communication Specialist Bev Lindsay picked up a call from a man who said he was on Colorado Highway 139 and his wife was about to deliver a baby. She asked him what mile marker he was at and the phone went silent for a few seconds until she could hear him running in the background.

"I thought to myself, 'why is he running,'" she recalled.

Out of breath, he told her which milepost he was at and then ran back to his wife. The call got disconnected a couple times, but by the third call they stayed connected and she walked him through delivering the baby in the middle of the night in February on Douglas Pass.²

The way Communication Specialist Chris Waite tells of a call from an elderly male wanting to commit suicide is so powerful, there are no better words than his. As way of introduction, the caller's oldest son was in the military and had recently passed away. "The male felt like he didn't have anything else to live for. Having a family member that committed suicide, these calls are very close to my heart. I spent quite a while on the phone with this male until law enforcement arrived. The male then thanked me for talking him out of going through with it."³

Communication Specialist Mary Guffey answered a call from a female shaken up over an attempted burglary at her home. Guffey was able to stay on the line with her and pass along information to the officers until they arrived on scene. Due to the information she gave, they were able to

apprehend the suspect very quickly. "She was so grateful and kept thanking me for keeping her calm," Guffey said. "It reminded me again why I wanted to do this job."⁴

Communication Specialist Lauren Patrick likes to look back on a call out in Rabbit Valley for a dog that had fallen down a narrow and deep crevice. The dog's owner was rather distraught because he couldn't get to his dog and didn't know what to do. "I was able to reassure him that we would send help. The Lower Valley Fire Department and the Mesa County Search and Rescue Technical Ropes Team responded and were able to rescue the dog."⁵

Communication Specialist Shon Kinston, a former firefighter and EMT, took a call from an ultralight pilot who had crashed at Glade Park. Kinston used the information available from the caller's phone to direct a CareFlight helicopter to the location and rescue the downed pilot. "It's an opportunity to make a difference every day and help people when they need it most."⁶

"If you want to write a story about Grand Junction Regional Communications, do it about the people, the team," said

Director Jennifer Kirkland. “Not the management. It’s all about the team and the great work they do.”

GJRCC teamwork is reflected in the calls of the beholden. Cardiac arrests. Babies born in transit. Ultralight crashes. Dogs stuck in crevices. Lost hikers. Despondent callers. Wildland fires. And the list of things that can go wrong and then turned as right as possible in a predominantly rural—although burgeoning—area in western Colorado is vast. Their Facebook page ([facebook.com/GJIDT](https://www.facebook.com/GJIDT)) is a narrative of the people and place and refreshed daily by the center’s social media group.

And that leads to one more positive note for the people.

Communication Specialist Annika Sheya started at GJRCC three years ago and already pitches in wherever she can—on the social media team, dispatch review committee, and peer support group, and she responds to scenes as a member of the Incident Dispatch Team. Helping people was why she applied, and it is a quality personified in a most memorable call from an “elderly male” who wanted an ambulance for his wife. “I had gotten all of the information that I needed from them but remained on the line in case her condition worsened. He was running around the house getting her slippers and purse and finally sat down. When he did, his wife and I sat there in silence and just listened to him pray over her. It was a really sweet moment.”⁷

Ultra-modern space

Aug. 1, 2020, marked the eighth anniversary of operations in the current building. In 2012, two dispatch crews, multiple technology specialists, and several other support and managerial personnel were on deck to coordinate the official transition from an older police department building.

Four consoles are in each dispatch pod: One person dispatches for the Grand Junction Police Department and one dispatches for the other law enforcement agencies, including the Mesa County Sheriff’s Office, Fruita, and Palisade. A third person dispatches fire and EMS agencies, and a fourth person in the pod handles the data requests.

Training and Quality Assurance Analyst Kelly Wilkinson has been at GJRCC for 21

years, way before Grand Junction was a noted tourist destination and there were three dispatchers on each shift (there are now 10–15 on each shift). The Medical Priority Dispatch System™ (MPDS) arrived in 1999, along with EMD certification and, not too much later, ProQA*. Wilkinson admits Protocol was a “hard sell” for staff and the agencies they serve. Benefits of structure, PAIs, and a consistent process, however, soon won over emergency dispatchers. The increased efficiency in assigning apparatus was a major plus for the Grand Junction Fire Department.

Submitting a completed ACE packet is on Wilkinson’s schedule for November. The accreditation will pave her entry into

EMD instruction and—more importantly, she said—become a metric by which they are measured. Compliance is right on target and part of that she credits to the performance standards philosophy the IAED™ advocates.

“QA is here to support our people,” she said. “We talk about strengths and build from there.”

Kirkland said that when she started at the center in January, she made it a priority to build on the already positive culture. An abundance of awards and opportunities to participate on committees help morale and, also, the programs that enhance networking between personnel. “Undercover TC” assigns Secret Santas for an entire year. Forms filled out at the start provide ideas for the gift-giver.

The annual Phoenix Award sponsored by Mesa County EMS goes to emergency workers who have been involved in calls wherein the patient suffered cardiac arrest, was resuscitated, and not only survived, but was able to return home from the hospital without significant brain damage. In 2020, the award was presented to eight GJRCC emergency dispatchers, some for a second and third time.

Kirkland said creating a positive environment and culture is the ultimate goal.

“Treat the people well, respect them, help them succeed, and they want to stay,” she said. “We have a great team. They’re my job.”

Communication Specialist Christine Gaty said there is no better job than

saving a life or just being there for someone during a tough moment.

“Being a dispatcher comes with a great deal of responsibility and pride,” Gaty said. “It is rewarding to go home at the end of your day knowing you did your part to make this a great place to live.”⁸

GJRCC is the combined public safety answering point for 911 in Mesa County. In 2019, GJRCC managed over 306,000 inbound and outbound telephone calls, more than 140 text messages, and an estimated 155,156 dispatched incidents for 10 law enforcement agencies and 13 fire/EMS agencies. Their service area covers approximately 3,300 square miles within western Colorado and 153,000 residents.⁹ ●

GJRCC 2019 STATS¹⁰

- Tracked nearly **14,000** traffic stops and **297** DUI arrests
- Provided reassurance to more than **1,500** calls involving subjects contemplating suicide
- Provided cardiac arrest assistance to **120** callers, of which 6 of those patients survived
- One quality assurance analyst reviewed in excess of **3,000** medical calls
- Processed over **1,500** audio requests for public safety agencies, attorney offices, and citizens

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FIVE R PHILOSOPHY

Handling whatever comes their way

Audrey Fraizer

Problem-solving for the next generation of emergency dispatchers was the focus of Tiffany Wilson's NAVIGATOR 2020 proposal. Then one of the biggest challenges of her career—an unanticipated one for sure—proved relevant to a lot of what she planned to cover.

The big challenge was the precautions the Valley Regional Emergency Communications Center (Modesto, California, USA) would take during the coronavirus alert and shutdown. They certainly did not see the pandemic coming when the NAVIGATOR proposal was submitted in early fall 2019 but, all the same, the principles outlined are apropos to gearing up the next generation for whatever comes their way.

While Wilson refrains from categorizing generations and assigning stereotypes, she noticed that new,

younger hires do great in the classroom, but when training rolls around, many decided against staying.

"They didn't feel they fit in," Wilson said.

The problem was reaching a compatible ground. The younger new hires and chief training officers (CTOs) clashed. CTOs have a certain way they want the job done. The younger generation, she found, possesses a technical savvy that allows them to "see" shortcuts, ultimately conflicting with a CTO's approach regulated by long experience. Wilson said they could not change the standards or expectations. They had to find a solution within boundaries that was comfortable for everyone. "They question the 'why' and 'how,'" Wilson said. "They want to do a good job, and they're eager. But they want reasons for the way things are done."

Wilson came up with a set of principles encouraging better working

relationships. The five principles each begin with the letter R: Rapport. Relaxed. Rationale. Relate. Research. She said the principles set clear expectations in what it means to be a good working partner. They apply to all ages and are modeled after lessons important to getting along, whether at work or play.

Rapport

Understanding the feelings and ideas of others provides opportunities for developing better personal connections. Wilson said a genuine interest in goals and ideas goes a long way in encouraging new hires to keep with the profession.

Relaxed

This is not about sitting back with your feet on the console. Rather, it's about taking a more flexible and relaxed approach. Wilson describes a more hands-on approach for the trainee. "Let

the trainee do the hands-on and the CTO guide them,” she said. “Coach them but let the new hire drive the training.”

Rationale

A logical course for a basis of action defies the “That’s just the way we do it” approach. Millennials and generations following want to know the “why” behind the action, Wilson said. For example, “Why do we have to ask questions [in protocol] verbatim?” or “Why do I have to go home? I’m not sick. I’m sneezing because I have allergies.”

Relate

The “how” and “why” of a decision has an effect upon the individual. For example, “Why does the CTO correct me when I don’t ask the questions verbatim? How was I supposed to know?” or “Why should it matter if I’m late for my shift?”

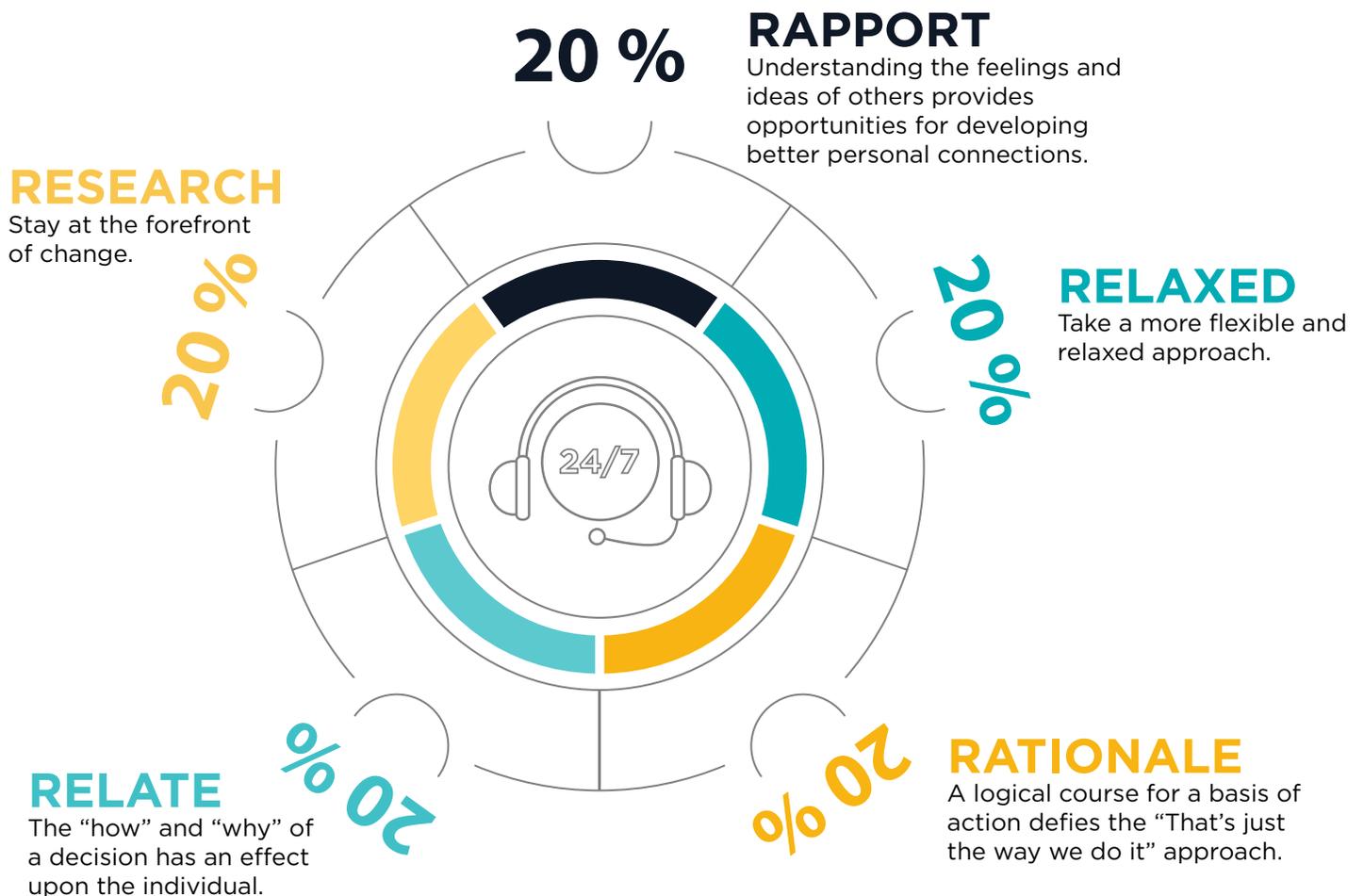
Research

The final “R” addresses staying at the forefront of change, Wilson said. “We can’t get stuck in this is the way we’ve always done things, and it takes research to support the changes we make for the good of the people we serve,” she said.

To intercept a situation involving expectations and standards before they become a problem, a mentor talks to new recruits during orientation. “They address the steps in the training manual, such as why it’s important to arrive on time or why we follow the protocols as scripted.” A CTO is also on the floor during every shift to answer questions and provide direction.

Wilson, who started at the center 10 years ago, said the “Five R” philosophy is a start. “We were struggling with new recruits. It’s still fluid but seems a good approach for all situations we encounter in dispatch.” ●

FIVE R PHILOSOPHY



NO PLACE LIKE HOME

Emergency communications goes remote

Audrey Fraizer

Hurricanes, earthquakes, wildfires, and spreading illness like the coronavirus pandemic mean different working arrangements depending on the profession. For emergency dispatchers, the unpredictability of what can happen next in populations and the environment puts the kibosh on working anyplace other than on-site.

But that's not the case anymore.

Remote work for emergency dispatchers isn't out of the question, considering web-based interfaces with CAD systems, along with mobile capabilities easing the transition and feasibility of calltaking and dispatching from center to home.

And two centers—144 Notruf Niederösterreich (Lower Austria) and the Department of Emergency & Customer Communication, Alexandria, Virginia (USA)—are proving just how well a home office works for calltaking personnel.

144 Notruf Niederösterreich (144 Notruf NÖ)

Christof Constantin Chwojka is a major proponent of working from home. In less time than it takes to find Austria on a world map, the managing director of Lower Austria's 144 Notruf NÖ can list the advantages of a home office and wrap it all up in one succinct bit of reasoning.

"It's a waste of time for the people driving in," he said. "The systems they use are exactly the same. Calltakers sitting in the home office do exactly what they would do sitting in the communication center. There is no difference."

144 Notruf NÖ is the only medical dispatch agency in Lower Austria, and as Chwojka explains, 144 Notruf NÖ is one center in four rooms or branches. The branches are connected in a central system and each is situated in one of Lower Austria's four regions: one in St. Pölten, the state's capital, one in Korneuburg, one in Mödling, and one in Zwettl.

The branches accommodate different kinds of calltakers. The calltakers and dispatchers have complementary functions.

Calltakers are specialized in handling emergency lines (144 for a medical emergency) and non-emergency lines that include the after-hours physician hotline (141), patient transport service numbers, and the telephone health advice service (1450). During the day shift, 24 calltakers and six Emergency Communication Nurses (ECNs) work at each of the four branches. Three calltakers and one ECN work the 12-hour night shift. The number of staff members depends on the call volume, which increases during the daytime.

Dispatchers coordinate resources and send response according to patient needs. The number and variety of resources they allocate staggers the abilities of all but the proficient multitasker: 221 ambulance stations, 889 EMS vehicles, 47 mountain rescue teams, 15 ski patrols, and 835 first responder teams. The list is not definitive. The number of dispatchers coordinating resources varies by shift. During the 12-hour day shift, 12 dispatchers are distributed among the four branches. At night, there is a minimum of three dispatchers. A supervisor is always on shift seven days a week.

From start to ongoing

Tragedy predicated the transition to home office, Chwojka said. Two calltakers killed in separate accidents while driving home after working 12-hour shifts was not only a loss on a personal level, but a wake-up call to charting a course in remote communications.

"I couldn't let this happen again," Chwojka said. "We had to change the culture from reporting to a comm. center to the ability of doing the same work from home."

The pilot project (2017) allowed home offices for EMD-certified calltakers traveling long distances to work, quality assurance reviewers, and back office and IT staff. Numbers steadily increased and surged in response to the coronavirus pandemic. As of May 2020, 105 calltakers and ECNs out of a total of 160 calltakers and ECNs work from a home office. Dispatchers continue to work from the centers, although technology could eventually allow them the same option.

The systems they use [at home] are exactly the same.

A home office saves the drive and, added to transportation safety, protects health and well-being, a point that Chwojka emphasized in relation to the coronavirus pandemic. Only the "absolutely necessary" staff members are present at the locations. "In this way we can ensure that our people do not infect each other or take an illness home with them," he said.

Rules of the home office

Siegfried Weinert is a support team member behind the curtain of the home office concept and implementation. He oversees workplace safety at 144 Notruf NÖ and is constantly keeping an eye out on the program's development and the laws affecting the home office environment.

An overriding acknowledgement dictating the entire outcome relies on attitude. "There must be the acceptance

that you are at work even though you are at home," Weinert said.

For example, it is important to dress the part. While a 144 Notruf NÖ uniform is not required wear, studies show that people perform better when reporting to the home office in their work-style clothing. A structured schedule is inherent in emergency communication. There are no breaks to walk the dog or view a television show on shift. A dedicated workspace is 144 Notruf NÖ policy. Posting a "Do Not Disturb" sign cautions others in the household against interruptions during work hours.

Technical equipment

The technical equipment provided is the same for each calltaker—two monitors, mini PC, keyboard, mouse, USB headset, USB webcam, and pager. The calltaker agrees to several conditions involving the use of the equipment and internet connection. The office must be in the calltaker's primary residence, and the office must be in a protected place. No setups are allowed in vacation homes, for example. No one except the calltaker can view the screen while calls are being taken. No one outside of operations is allowed within a specific perimeter of the computer and laptop during active shift work. Computers are equipped with cameras for video calls to facilitate periodic check-ins between the back office, shift supervisor, and calltaker.

Calltaker competency

Calltakers are assigned to specific emergency and non-emergency lines according to skill level (such as EMD, ECN, or patient transport). Each calltaker is specially trained for the respective position. Call status is monitored (ready, talking, or not ready) and the data automatically collected indicates time spent on the call, calltaker routing (ECNS[™], EMD, or COVID-19 hotline), and disposition (medical doctor, ambulance, or COVID-19 test dispatch). Calltakers can transfer calls immediately to a more appropriate line if the line in which the caller connected to does not best serve the complaint.

Chwojka, an admitted fan of more than one emergency and non-emergency line,

said the multiple numbers available at 144 Notruf NÖ ensure immediate access to the communication center. The responsibility of choosing the correct line, however, does not rest with the caller.

“People do not have to know who to call,” Chwojka said. “It’s the calltaker who has to know where to triage the call.”

At-home efficiency

Rules governing the home office, however, have done nothing to diminish the initiative’s overriding commitment to the 1.8 million Austrian residents and the two million annual tourists.

As Weinert explained, the home office model is constructed to enhance operations.

Working from home gives the ability to cover call peaks, both in short-term events (such as a mass casualty incident) and in planning protracted events (such as the coronavirus pandemic). There is no rush into the center for an all-hands-on-deck alert. It takes two to three minutes to connect from home when an event demands added calltakers.

If any of the four centers are lost due to technical problems or evacuation, the “lost” region is immediately taken over by

another dispatcher, designated by prior standard operating procedure.

“This is nothing unusual,” Weinert said. “We can and do switch regions because of special situations to focus dispatchers on the situation.”

Telephone health advice

The telephone health advice is critical, as documented in a proposal submitted for NAVIGATOR 2020 by Weinert, a volunteer with the Austrian Red Cross for over 30 years, and Susanne Ottendorfer, emergency physician and 144 Notruf NÖ Medical Director.

Calltakers assigned to 1450 (telephone health advice service line) adhere to criteria set by the Ministry of Health, and calls meeting the criteria are immediately transferred to the medical officer. Calltakers also use AMPDS™ Protocol 36: Pandemic/Epidemic/Outbreak (Surveillance or Triage), released in 2010 for managing EMD triage and locally limiting EMS responses in the event of an official pandemic flu outbreak, or for use as a flu surveillance tool to track flu symptoms without changing the EMS response. The Academy extensively revised the protocol to triage EMS response to COVID-19.

By using the line 1450 as a central point of contact for people with health issues regarding the pandemic, calls increased up to 25 times compared to the previous year (2019) to 3,335 calls on the busiest days. The resulting further health consultations also more than doubled.

Associated benefits

Many of the associated benefits of a home office are shared between the employee and company. The transition has proven economical (petrol/gasoline costs are considerably less for the employee), ecologically beneficial (carbon footprint decreases), and risk reducing (travel, illness, etc.). Job satisfaction is two-way or three-way if you count patient satisfaction, although patients can’t always get what they want. They get what they need, Chwojka said, and options offered through the telephone health advice service line reduce the risks particularly to health-compromised patients receiving medical help without transport to a hospital.

Working at home is a good thing, Chwojka said.

“Our calltakers do a great job and enjoy the benefits that go along with it,” he said.



Working from home in Austria. Photo credit: 144 Notruf NÖ

Do the homework

Weinert suggests looking at several factors when deciding to make the home office transition.

Performance

Managers and supervisors need real-time insights into demand, workloads, and performance to ensure effective operation and detect emerging issues.

Operational effectiveness

Mobile apps and web-based interfaces must allow vital information to be easily accessed and shared in real time from any location, ensuring a seamless transition and smooth workflow.

Tools

The technical equipment described, combined with the ability to remotely access their CAD system via web or mobile app, allows dispatchers to work from anywhere. Cloud and web-based systems enable communication centers and home offices to quickly share CAD access with additional personnel if a scale-up is needed during an emergency.

144 Notruf NÖ is a nonprofit limited liability company jointly owned by the Lower Austria government (66%) and rescue organizations. It serves a population of about 1.65 million people and registered 1.5 million calls in 2019 and up to 6,000 dispatches per day (13% time sensitive). 144 Notruf NÖ is a medical ACE and the first center in Europe to implement the Emergency Communication Nurse System™ (ECNS), for which it is also accredited.

Gaining ground

The coronavirus influenced emergency communications in the same way it has affected social and job interactions and that includes protecting workers through on-site precautions, setting up home offices, and placing pending projects on hold.

Charleston County Consolidated 911 Center (South Carolina, USA) began a project a year before COVID-19 to allow

calltakers and dispatchers to work from home, according to center Director James Lake. Although the virus disrupted the process, a portion of the staff (administrative/support/QA/IT) was able to follow through with home office plans and—in that way—provide a beacon to establishing a viable path into the future.

Lake said the home office environment in emergency communications is feasible, considering today's technology. "This won't work for everyone," he said, but it can be extremely beneficial in a childcare situation or other situations in which the individual can be more productive at a home office rather than reporting to the communication center.

DECC plan into action

Purchasing hardware compatible to remote work was all part of long-range plans to establish remote working locations at the Department of Emergency

their fire, law enforcement, and police responders and, of course, the public depending on their non-emergency and emergency services?

They decided it was time to think outside the box.

Modeling the center

DECC management recruited volunteers and, in collaboration with IT and FirstNet, created a near replica of their PSAP communication positions at the individual homes. Each home center was set up with a laptop, headset and smartphone, FirstNet Wi-Fi hotspot, mobile router with CAD, and other hardware. A virtual private network (VPN) is used to secure connection to the FirstNet hotspot, hide the IP address, and make browsing private.

DECC implemented planning and testing in three phases. During the first month (March) the home center calltakers

answered non-emergency calls only. An isolation dispatch team comprised of two fire dispatchers, two police dispatchers, and one telecommunicator was set up at a nearby hotel offering good phone reception (a high number of bars indicating signal strength). The at-home teams shifted to 911 calls once operations met the seamless functionality of

the primary and backup center. They work regular 12-hour shifts.

Calltakers at the primary and backup ECC are socially distanced. Each center is vacant on separate days, one day each week, for a total cleaning and sanitization. Campbell and Director Renee Gordon go into the center for tasks they cannot complete in the home environment. They rotate between the two centers during the 24-hour vacancy periods. They do not go on the floor when a center is staffed and wear masks any time they step out of their offices.

No book of instructions

Describing the transition as a mad dash is an understatement. Project leads put in 18-hour days getting ready for the deployment and filling notepads with contingency plans to solve worst case

There are several factors to look at when deciding to make the home office transition.

and Customer Communications (DECC), Alexandria, Virginia (USA). An upgraded phone system complemented the strategy. But it was not a priority, said DECC Deputy Director Doug Campbell. It was an eventuality.

The coronavirus predicated social distancing at the center in Alexandria. Four shifts were broken into two shifts that reported to the primary emergency communication center and two shifts that were assigned to the backup center.

Numbers climbed. On March 26, the Alexandria Health Department confirmed six additional cases of COVID-19 in Alexandria, bringing the total to 20.¹ Foremost concerns conflicted. How could they protect the health of calltakers and dispatchers and provide seamless, fully functioning operations to safeguard

scenarios and overcoming unexpected obstacles that could negatively impact emergency communications. They had no playbook to follow. While other centers were contemplating the transition, none had gone full bore. They are adapting as they go along.

“We learned to shift gears on the fly,” Campbell said. “We all shared the same concerns. We did lots of testing and discussing it among our people. We found it essential to establish a direct connect between the center and homes, as close to real time as possible.”

The experiment that went live on March 6 is thriving. Calltakers work their regular 12-hour shifts, and they can sign in instantly if necessary, to cover absences or, for example, mass casualty incidents. The list of volunteers is growing and, like training evacuations conducted every four months in the past, responders have not noticed changes in venue affecting their interactions. They are receiving the same stable connection and information regardless of location. The next big push is testing applications to allow radio dispatchers the same option.

Think outside the box

Progress, however, does not always follow a smooth path. There are setbacks

and frustrations. For example, the hotel did not have the optimal phone reception anticipated. Radio dispatch stayed at the hotel but contacted a different internet provider. Since generators are not common backup equipment at homes, each setup now includes a mini generator (with 30- to 60-minute capacity) in case of power outages. Policies and standard operating procedures require constant review and revision. New ones are added.

While Campbell might have preferred a slower dash, he certainly likes the direction they’re going. He calls remote working a “new norm” that provides benefits they’re still discovering. There are cost savings in fuel and wear and tear on vehicles. No long commutes in snarled traffic or rerouted travel due to congestion. There is less overtime and sick leave.

Centers hearing of DECC’s program contact Campbell for more information. He tells them to expect “walking on pins and needles for the first few weeks.” Don’t get discouraged. Things happen. The transition takes a willingness to “think outside the box,” he said.

“If something doesn’t work, go down a different road,” he said. “Write

down the next option and collaborate. You’re bound to learn something new every day.”

DECC is the PSAP for all emergency services within the city of Alexandria.

The FirstNet network is a public private partnership between the First Responder Network Authority (FirstNet Authority, part of the U.S. Department of Commerce) and AT&T. It provides a dedicated connection for public safety for everyday operations or emergency communications. ●

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Communicating on the road in Lower Austria | Photo credit: 144 Notruf NÖ



EYE ON THE PRIZE

Refresh your Protocol 16 knowledge

Becca Barrus

There's a common English saying that goes, "You don't know what you have until it's gone," which can apply to people or places or even simple body functions. Most people don't think twice about how their eyes are doing until there's some kind of problem, like an annoying eyelash stuck between the eyeball and lid, or a contact turned inside out, or a pencil accidentally getting lodged in the white of the eye. Medical Priority Dispatch System™ (MPDS) Protocol 16: Eye Problems/Injuries is kind of like that. You probably aren't using it on a daily, weekly, or even monthly basis, but when you do, your familiarity with it will make all the difference to the caller.

Data collected by the International Academies of Emergency Dispatch® (IAED™) shows that Protocol 16 is used to triage less than 1% of calls annually, and of those calls, only 2% were determined to be DELTA-level. For a call using 16-D-1 "Not alert," the outward severity of the eye injury isn't as important as the level

of consciousness of the patient. The eye doesn't need to be dangling over the patient's cheeks, held to the head by a rope of nerves, in order for it to be emergent. If the patient has an eye injury of any kind and is not alert (which doesn't mean that they're unconscious, just that they're not responding appropriately), it will require a DELTA-level response because in all likelihood, the eye injury is an indication of a bigger problem, such as a head injury—and that can mean the brain or spinal nerves are also injured.

BRAVO-level calls made up 20% of calls using Protocol 16 (10 times the amount of DELTA-level calls), but they are still relatively infrequent. It's not just the IAED data either—a study conducted by the Wills Eye Hospital in 2015 found that only two or three out of 1,000 emergency room visits in the United States involve a foreign object penetrating the eye.¹ However, that doesn't mean that these eye injuries aren't important or dangerous! BRAVO-level eye injuries are described as

SEVERE and can be a result of: a direct blow, the eyeball being cut open, the eyeball leaking fluid (traumatic), a flying object, or a penetrating object. Having something penetrating your eye is hardly anyone's idea of a good time and requires medical attention, so, yes, they are serious—but not life-threatening. Axiom 4 states that, "Major injuries caused by direct blows to the eye include orbital fractures, hyphemia (blood in front of the iris), and retinal detachment. Penetrating wounds of the eyeball are considered very serious and require careful, gentle care."

What are orbital fractures and retinal detachment? An orbital fracture is medical-speak for what happens when the bones of the skull around the eye are broken, which pushes the eye farther back in its socket (the orbit). Retinal detachment sounds scary but is often painless. The retina is made up of a small layer of nerves behind the eye and when the retina is detached, it means that the nerves have come undone from the back

of your eye. Usually when a patient is experiencing the slow process of retinal detachment, they may experience flashing lights or see shadows in their field of vision. They might also see more floaters than they normally do (those weird spots in your vision that are semi-transparent and might look like cobwebs or strings). If retinal detachment has already happened, the patient might describe it as a gray curtain or veil being drawn over their eyes. How exactly does this happen? It can happen gradually over time as a result of aging, diabetes, or being nearsighted. It can also happen more quickly after a traumatic event, such as a blow to the head from a falling object or a collision while playing a sport.² Unlike retinal detachment, an orbital fracture or hyphemia (blood in front of the iris) can only be caused by traumatic events.

Speaking of traumatic events that cause eye problems, when should you triage a call using Protocol 16: Eye Problems/Injuries and when should you use other protocols, such as Protocol 30: Traumatic Injuries (Specific)? Great question! Greg Scott, Associate Director of Protocol Evolution at the IAED, advises EMDs to keep the mechanism of injury in mind, as well as the part of the body that has been impacted.

“Protocol 16 is for an isolated eye injury or problem,” he said. “So this Protocol would only be used when, say, the eyeball is cut from a sharp object directly to the eye, a chemical is spilled directly into the eye, a penetrating object goes directly into the eye, etc.”

If the incident involves other injuries to other parts of the body, it won't be handled on this Protocol. For example, if there's a traffic accident and the caller reports that the patient's eye is bleeding or there's a loss of vision, you will use Protocol 29: Traffic/Transportation Incidents because the mechanism of injury means there is a high likelihood that there are other more emergent issues underlying it. The same principle applies to long falls and stabs, gunshots, or any other kind of high mechanism trauma. So if a person loses vision in

one eye because they got hit by a rogue football? Use Protocol 16. If they lose vision in one eye because they were beaten by an assailant? Use Protocol 4: Assault/Sexual Assault/Stun Gun because of scene safety issues and the possibility of other serious injuries.

One way to determine the mechanism of injury is by asking Key Question 2 “How did this happen?” It's similar to Case Entry Question 3 “Okay, tell me exactly what happened,” and although it may feel like you're repeating yourself, it will help you further assess the kind of care the patient needs based on how the injury happened in the first place.

Most eye trauma will need to be evaluated by a physician as soon as possible; the more serious of these

Most eye trauma will need to be evaluated by a physician as soon as possible.

injuries may require surgery. While isolated eye injuries are typically not life-threatening, they can cause vision loss, particularly if not treated early and properly. The EMD can play an important role in the patient's care by providing complete and precise Post-Dispatch Instructions (PDIs). Protecting the eye from further injury is key to a good patient outcome. Using water to flush harmful chemicals from the eye when present is also important to minimize damage (PDI-c). Eye trauma, even when it may not look serious, can cause leakage of vitreous humor—the fluid inside the eye. Loss of this fluid can cause vision loss, so keeping the eye immobilized after injury is extremely important. Penetrating objects should not be removed (PDI-d).

The mechanism of injury is slightly less important in the ALPHA-level calls, where the injuries are sorted into MODERATE and MINOR categories. MODERATE Eye Injuries (16-A-1) are described as chemical burns and/or chemicals in the eye. MINOR Eye Injuries (16-A-2) include eye abrasions, contact

lens problems, small foreign objects, and flash burns from welding. Any number of things can cause an eye abrasion, from accidentally rubbing sand in your eye to getting scratched by a pet's nails. The patient might describe it as gritty or uncomfortable and in some cases might report having sensitivity to light, headache, blurry or decreased vision, and/or twitching eyes.³ A flash burn most commonly is a result of welding without proper protective gear, but it can be caused by all types of UV light including direct sunlight (especially reflecting off of water or snow) or the lights in tanning beds. It is often described as a sunburn in your eyes and symptoms include pain, bloodshot eyes, light sensitivity, watery eyes, and/or blurred vision.⁴

The third Determinant Code in the ALPHA level covers MEDICAL eye problems and includes allergy symptoms (including puffiness and swelling), infection, and tears (the fluid that comes out of your eyes, not the kind that suggests a muscle or tendon ripping).

These are not caused by an outward force; they're the result of an illness or biological problem and, like the other ALPHA-level Determinant Codes, are not life-threatening.

Remember that whether your patient has shattered glass embedded in their eye or a problem with their contact, it's important enough for them to call emergency services so be compassionate and kind! ●

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FIRES HAVE THEIR SEASON

Structure fires outpace them all

Audrey Fraizer

Major types of fires have their season or, at least, that's an observation from an Academy special report comparing incident data involving outdoor, structure, and vehicle fires.

The data—collected over an eight-year period (2012–2020) from 30 agencies using the Fire Priority Dispatch System™ (FPDS)—shows that structure fires outrank both outside and vehicle fires in terms of sheer numbers, although outdoor fires dominate the scene during the drier summer months of North America. That undoubtedly comes at no great surprise, along with data indicating structural fires are in their zenith during the colder months of the North American year (November through March) and a larger percentage occur in homes.

The Academy's data syncs with a National Fire Protection Association (NFPA) fire report, which states:

- **Occurrence**—"Home structure fires are more common in cooler months when people spend more time inside and in

the hours when people are awake in the home. From 2013–2017, 47% of home structure fires and 56% of home structure fire deaths occurred in the five-month span of November through March."¹

- **Peak Hours**—"Reported home fires peaked from 5 p.m. to 8 p.m., when many people are coming home from work, are preparing dinner, or are engaged in other household activities." A higher percentage of people die from home fires, however, between 11 p.m. and 7 a.m. even though the eight-hour period accounts for just one-fifth of reported home fires.² (Academy data shows precisely the same peak hours). FPDS Protocol 69: Structure Fire is ranked fourth in total call volume, according to the Academy's data set, following alarms, motor vehicle collisions, and service calls. While not the most common Chief Complaint handled by EFDs, the high death toll and other serious consequences that often result make structure fires one of the most important types of calls EFDs handle.

Without the critical information gathered during the 911 call prioritization process, fire units will not be dispatched in the correct response configuration or with complete scene information.³

Using the FPDS, an EFD categorizes each incident by selecting a Chief Complaint Protocol, gathering answers to Key Questions, and assigning a Determinant Code using a systematic alpha-numeric coding matrix that defines the dispatch priority level and a specific Determinant Descriptor. The dispatch priority level defines the relative urgency and type of response needed for a given event.

The Structure Fire Chief Complaint Protocol utilizes two of these priority levels (ECHO and DELTA), never categorizing in the CHARLIE, BRAVO, or ALPHA priority levels. ECHO-level codes are unique in the fact that they are the most urgent type of call and can only be dispatched from Case Entry as send points to allow EFDs to dispatch these codes as soon as possible. The ECHO Situations Additional Information text was modified in

FPDS v7.0 and, among other fire protocols, now includes Protocol 69.

Structure Fire Protocol keeps improving

FPDS versions 6 and 7 made substantive changes to the protocol. Some of these are highlighted in this article.

ECHO-level determinants on Case Entry for REPORTED BUILDING/STRUCTURE FIRE were added to version 6.1. The revision allows an earlier response for all structure fire incidents with a spontaneous report of smoke or flames while also allowing for differentiated responses and resource allocation for ECHO- and DELTA-level incidents.

Protocol 69 contains 10 suffixes. Four suffixes were added, and two of the already existing six suffixes were modified in version 7.0. These added and revised suffixes are: X (Single injured person); Y (Multiple injured persons); A (Appliance, contained); C (Chimney); E (Extinguished fire, 1st/2nd party); and L (Electrical problem). The four existing suffixes remain the same: R (Trapped person(s)); F (Burned food, 1st party); K (LIGHT smoke, 1st party); and O (Odor of smoke).

Case Entry Rule 15, which was added in version 7.0, states, “Key Questions in purple font are Jurisdictionally Approved Questions and are informational. The local Fire Administration/Agency determines whether these questions should be asked.” There are no Jurisdictionally Approved Questions in Protocol 69, however, there are opportunities for fire agencies/administrations to define certain local terms:

- What structure height constitutes a HIGH RISE for their area
- What constitutes a LARGE and SMALL NON-DWELLING Building/Structure for their area

The safety of responders and people on the scene is always the priority, which explains why the protocol often prompts the EFD to provide PDIs and PAIs to callers as soon as possible to help them get to safety or avoid danger.

PDIs

The wording for PDI-a in Protocol 69—“I’m sending the fire department to help

you now. Stay on the line, and I’ll tell you exactly what to do next”—was modified in version 7.0 to “The fire department is being sent. Stay on the line, and I’ll tell you exactly what to do next.” Changing the wording protects the dispatcher from making a promise to the caller. By saying “I’m sending the fire department to help you now” there is an implied promise to the caller that they will arrive soon. The adjusted wording protects the dispatcher from this implied promise while still letting the caller know that the fire department is in the process of being sent and will be on the way.

Any time the caller may still be inside the structure, provide PDI-b, “If it’s safe to do so, leave the building, close the doors

behind you, and remain outside,” to help guide him or her to safety. The caller is the only person who can truly determine the safety of his or her situation, which is why this instruction includes the phrase, “If it’s safe to do so.” This PDI includes the Pre-Instruction Qualifier, “(Inside building or Appropriate).”

There are several reasons for the PDI-c instruction, “Do not try to put the fire out.” First, the EFD cannot know exactly how large or small the fire is and therefore cannot know how dangerous it might be for the caller to try to put it out. Second, although the fire may be small enough for the caller to put it out, the EFD should always avoid providing instructions that may lead the caller into danger. Always provide PDI-c if any fire or smoke has been reported.

Many people will attempt to mitigate the fire damage by carrying flaming items out of the building. This is far more likely to spread the fire than to contain it, and it may well injure the person in the process. Providing PDI-d, “Do not carry out anything that is on fire,” can help contain the fire and reduce the potential for injury.

PDI-e, “If it’s safe to do so, activate the alarm as you leave to warn others. Do not use the elevator,” includes a Pre-Instruction

Qualifier indicating that it should only be provided when the caller is reporting a fire in a COMMERCIAL or INDUSTRIAL building or in a multi-dwelling structure such as an apartment building.

New PDI-f (Chimney fire), “If it’s safe to do so, shut off all sources of outside air, including flues, dampers, and fireplace/stove doors,” serves as a reminder that since air can make the fire worsen, shutting off all air sources will help prevent this from happening.

New PDI-g is, “Please meet with the first arriving emergency vehicle and inform them if any people or animals are inside the structure.” Providing this instruction to callers helps firefighters know if any people or animals are still in the burning structure so that they know how best to attack the fire.

Health/Life Safety

FPDS v7.0 revised former Protocol B: Fire and Hazards Rescue, changing the name to Protocol B: Building Evacuation and Health/Life Safety, and adding several new instructions. For example, Panels 1 and 1a give instructions on how to evacuate a building or structure that is on fire. Panels 2–2i provide instructions to 1st party callers trapped in a building fire on how to escape through a window or, if necessary, how to smash a hole in a wall to escape.

In general, an EFD should stay on the line with structure fire callers to provide instructions if it becomes necessary to do so and continue to gather information if the scene or situation changes. ●

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FPDS v6 and 7 made substantive changes to the protocol.

UP IN FLAMES



BEDROOM FIRES

are started by someone playing with a heat source, such as a lighter, a candle, or matches.

AUTOMATIC SHUTOFFS



on heating equipment, cooking equipment, and irons can mitigate human error and improve safety.

COOKING

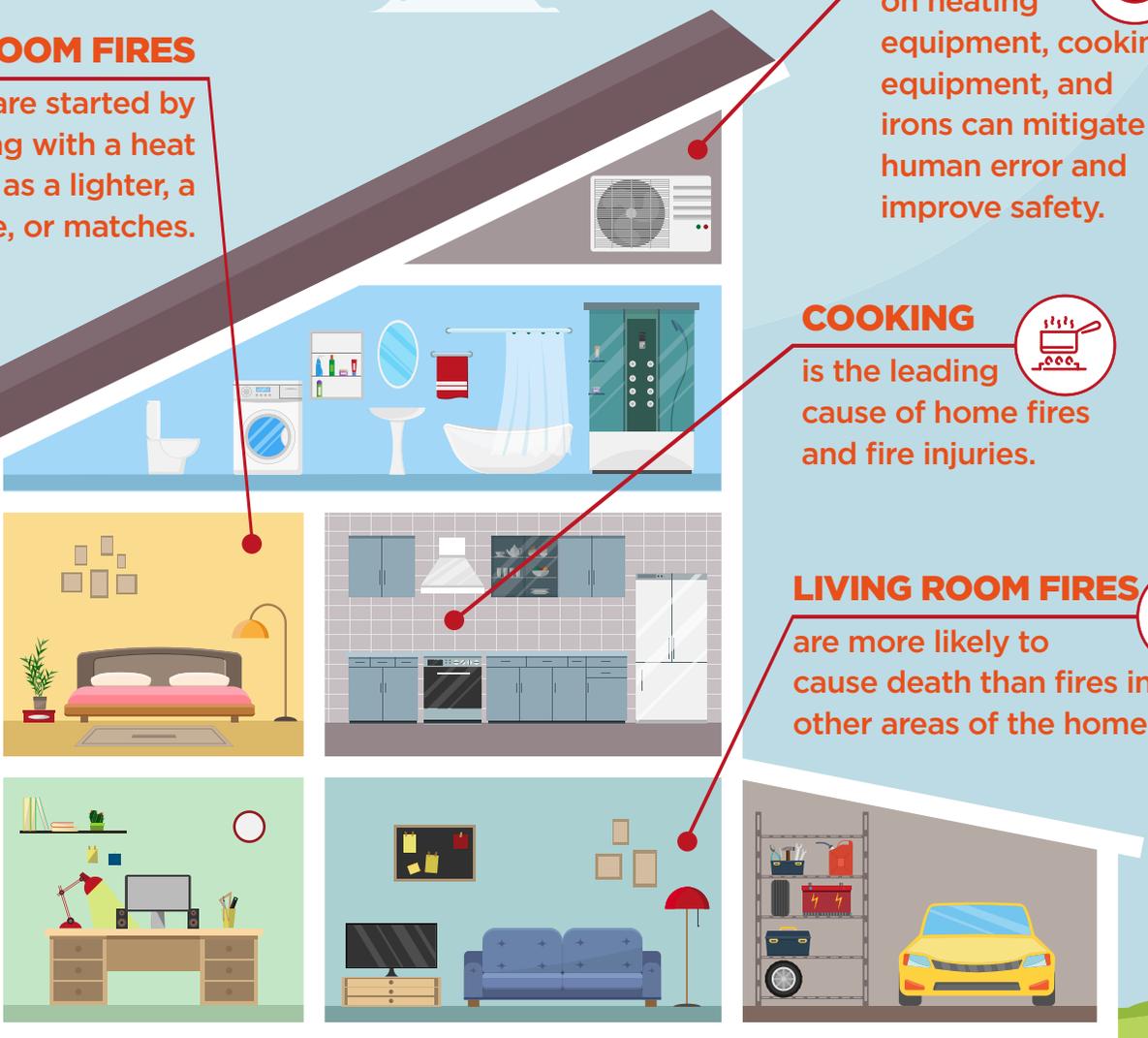


is the leading cause of home fires and fire injuries.

LIVING ROOM FIRES



are more likely to cause death than fires in other areas of the home.





Time machine "1960 Turner Home Entertainment. DeLorean "By Terabass via Wikimedia Commons

PINGPONG BALL

Lights-and-siren debate goes back and forth

Jeff Clawson, M.D., Audrey Fraizer

Spokane (Washington, USA) motorists got a rap on the knuckles in February 1953 at the first meeting of a citizens' committee investigating the operation of emergency vehicles in the city. The group was formed at the request of a coroner's jury following the crash of a fire department vehicle into a farm truck that killed three people.¹

The Spokane County Medical Society had been studying the problem of emergency vehicles running lights-and-siren (L&S) for two years prior to the accident. Their recommendation, which also brought in the results of a county-wide survey of emergency doctors, favored abolishing ambulance use of lights-and-siren.²

Three years later, in 1956, the debate was still playing in the news. Some public safety folks favored abolishing or, at least, minimizing their use, while others viewed lights-and-siren as a public safety duty.

Spokane Police Department Chief Deputy Sheriff William J. Reilly said the use of "code one"—lights-and-siren—was not necessary in most instances. "In the majority of cases it is safer to figure on

getting there all in one piece rather than risking an accident at high speeds."³

On the other side, Yakima Fire Chief W.A. Durham said city fire department rules require use of red lights-and-siren on all vehicles responding to fire and other emergencies. "It is our definite obligation to get to the scene as rapidly as possible." After all, he added, "Red lights-and-siren are used to warn other motorists to clear the way. So-called 'code one' runs do not necessarily signify excessive speed. Frequently our vehicles come to full stops to allow traffic to clear."⁴

Remarkably—or not—the debate in Spokane predated the accompanying article ("The Maximal Response Disease," JEMS 1987) by more than 30 years. Now 30+ years after the article was published, and well into the universal acknowledgment of an emergency dispatcher's role in determining the right response, the matter remains unsettled. An article published in 2017 cites "the risk to EMS providers and the public, minimal time savings and actual clinical benefit."⁵ The National Association of Emergency Medical Services Physicians (NAEMSP) underscores the risk: "Despite the long-term reliance on L&S, it is not a risk-free practice. There are many reports of

emergency medical vehicle (EMV) collisions during L&S responses and transports. These collisions often result in tragic consequences for the EMV occupants and those in other vehicles and may cause significant delays to medical care for the patient the EMV was responding to or transporting."⁶ The message is resounding.

While L&S use can improve patient outcome in the time saved, "There is a risk when L&S lead to EMS vehicle crashes, provider or patient injury, EMS provider hearing loss, or worsened patient condition due to anxiety and stress."⁷

Yet, there are EMS systems that continue to both respond and transport patients using L&S in most, if not all, circumstances.

Where will the debate lead 30 years from now? Back and forth like a pingpong ball? Will maximal response ever be fully delegated to only the highest level of actual or potential response? Think of it this way: The three passengers in the farm vehicle—and many deaths that followed theirs due to overuse of L&S—might be alive today if medical dispatching had determined the nature of the emergency before another was created.

Editor's Note: To view sources, [click here](#) and scroll to the bottom of the article. ●



The Maximal Response Disease

by Jeff J. Clawson, MD

“Red Lights and Siren” Syndrome in Priority Dispatching

Editor’s note: This is the fourth of four articles on medical dispatching. Each article will be accompanied by two Utah Treatment Sequence Cards in cutout form.

The following treatment sequence cards are currently approved by the state of Utah for use by certified EMTs. Any use of these cards outside Utah should be carefully reviewed and approved by local medical control, and the dispatchers using them trained in CPR and the Heimlich Maneuver.

In the beginning the world was without light – not to mention lights-and-sirens. From the EMS standpoint, such a time seems hard to imagine because today it couldn’t be less true. Literally millions of “emergency” responses occur every year in this country alone. Almost every one of them, in the years B.C. (before call-screening), were run red-lights-and-siren – not only to the scene but often to the hospital. Ninety percent of the time, however, there is no medical justification for this practice.

Closer examination of this philosophy

Jeff J. Clawson, MD, is a fire surgeon for the Salt Lake City Fire Department and co-author of “Principals of Emergency Medical Dispatch,” soon to be released by Brady. Dr. Clawson developed the priority dispatch concept and has taught dispatch courses in every area of the U.S. He will present a workshop for emergency medical dispatch instructors in association with the EMS Today Conference in Anaheim (Calif.) February 22-23, 1987 (see page 81).

suggests a Mt. Everest syndrome logic: “Why do we always use them? Because they’re there!” From a medical standpoint, we could consider this aberrant thinking process the “Maximal Response Disease.” It’s a combination of always responding red-lights-and-siren and/or always sending multiple vehicles. And short of the common cold, it infects more EMS response system people everywhere than any other malady.

Dispatch Misconceptions

The “disease” takes root from three traditional notions. First, it’s an emergency, we’ve got to hurry! Years ago when hurrying was maybe all that was done for the victim, from beginning of call to end, the “hurrying” had some value – it got the victim to the treatment. Second, many systems have coupled EMS response logic to that of fire response. Unfortunately it is an apple/orange-type comparison. A fire gets worse by seconds and minutes, therefore, why not a prehospital medical problem? But a single cardiac arrest in a football stadium does not spread in the manner of a fire so that after a minute there are two arrests, then four, eight, 16, until, shortly, the entire stadium is in cardiac arrest. Medical problems do change, but the vast majority involve a single patient in less than a life-threatening crisis.

Then last and unfortunately least palatable of all – running red-lights-and-siren

in and of itself is fun and seems important – at least to some people, including a once 22-year-old EMT who will remain nameless. After the fire department in Salt Lake City first discussed the idea of sending first response EMTs/engines non-red-lights-and-siren, a paramedic captain remarked, “What are you guys going to do, take away the last thing on this job that’s fun?”

Fortunately the maximal response disease is the dinosaur of today’s progressive EMS systems. And medical priority dispatching is the method of its extinction.

The “Marine Corps” response has been touted as the method of ensuring that those in dire straits get all the help they need – and fast. But without medically appropriate guidelines for the dispatcher to follow, so will everyone else. In the past, EMS leaders pointed out that, in order to avoid any errors in judgment, the maximum response was always sent. However, today with significantly greater numbers of EMS-knowledgeable lawyers as the loyal opposition, we may be unable to defend against the myriads of potential cases resulting from significant delays in arriving at a critical emergency because an ALS team was tied up responding on a fractured extremity or a similar BLS call. Systems with the capability of tiered or layered response that don’t use their first-response personnel or their BLS ambulance crews (often private) and still send a “one-of-each” response, are not functioning at today’s required level of medical responsibility.

SUPPORT MATERIAL

Most telecommunications people will readily agree that of the three areas of public safety dispatching (police, fire, and EMS), fire and EMS are more alike than either is to the police version. Their reasoning correctly includes the fact that the majority of fire and medical calls are considered "escalating" emergencies. However, this is only true for less than 10 percent of police requests. But there remains a basic, even less understood difference between the fire and EMS dispatching process that contributes to maximum response thinking.

and makes requests for additional responses or "alarms." The dispatcher gets busier with information relay as multiple command sectors are established and additional units stage. Moveups and mutual aid are often necessary and other agencies such as police and EMS are notified as needed.

The small point at the beginning of the fire dispatch wedge is based on the absolute necessity to get suppression units on the road quickly. A fire is assumed to be spreading. The extent of it can rarely be seen initially. It gets worse each second.

tant point here. At times the caller will offer the EMD information such as "He's dying!" or "Send the paramedics quick!" While these are complaints, they aren't chief complaints containing categorizable medical information such as signs, symptoms, or incident types. As you can see, "He's dying!" doesn't help you select a dispatch priority card. But then by asking "Why do you think he's dying?" you may elicit a response of "Because he's got a really bad pain in his chest and he's just pouring sweat." Age (approximate if not exact) is also determined, as well as the two most important medical questions we ask: Is he *conscious*? Is he *breathing*? You are looking for only yes or no answers at this point. Of course the answer may also be "I don't know" or "I'm not sure."

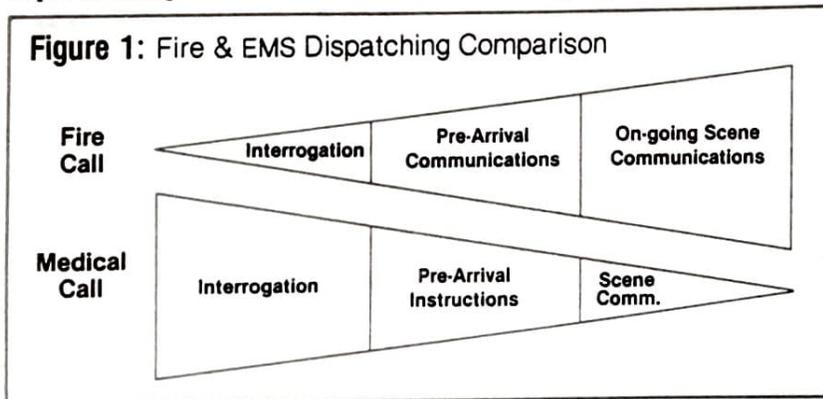
Herein lies one of the most significant concepts to understand about priority dispatching. In situations where, through this initial brief generic questions sequence, the victim is determined to be not breathing, or is unconscious but breathing cannot be verified, cardiac arrest is assumed and a maximum response is sent immediately *before ever reaching a dispatch priority card!* The priority dispatch concept does not waste valuable time asking more specific questions *prior* to response when the answers to these two important "Four Commandment" questions suggest an ultimate time/life threat from the start.

This set of generic questions (location, callback number, and the Four Commandments) constitute what we refer to as the "Invisible Card" (see Figure 2). Obtaining this entry material is an absolute baseline requirement in initiating any medical call for help.

Dispatch Protocol

Much has been said over the years about who is *in charge*. It ranges from who controls response through who controls the scene to who controls the patient. We know now that this role changes as we obtain more precise information from in-

Figure 1: Fire & EMS Dispatching Comparison



Changing Dispatch Role

Since the combination of fire and medical dispatching is very common, a clear understanding of this difference is essen-

Seconds *do* count here. But this set of facts for fires cannot be simply extrapolated to medical dispatching.

Caller Interrogation

By far the greatest responsibility of the EMD is up front, at the *beginning* of each call. The wedge is therefore *reversed* in EMS calls. Like the fire dispatcher, the EMD initially starts at the same place in the interrogation process. The location and callback number is, of course, identically essential. At this point the medical equivalent to the "What is burning?" question is asked - "What is the problem?" This query should elicit a chief complaint if one is not readily apparent at the moment the phone is answered.

The EMD must understand an impor-

Most telecommunications people will readily agree that of the three areas of public safety dispatching fire and EMS are more alike than either is to the police version.

tial knowledge to students of dispatching in general. The changing dispatch role during the unfolding of an incident can be thought of graphically as the variable width of a wedge (see Figure 1). A report of fire begins at the point of the wedge. That is to say, the initial role of the dispatcher is simple and straightforward - get the location and what is burning, then send the right assignment based on these two factors. Varied interrogation sequences are not necessary. However, once the first arriving unit visualizes an active scene, the process often escalates - the wedge expands as scene command relays specifics of the fire (exact location and its extent)

Figure 2: Medical Dispatch Case Entry Protocol.

LOCATION: _____
 CALL BACK #: _____
 CHIEF COMPLAINT (What's the problem?): _____
 AGE: _____
 SEX: M F
 CONSCIOUS: Yes No Unknown
 BREATHING: Yes No Unknown

NOTE: If victim is NOT breathing, a maximum response is sent immediately. If victim is UNCONSCIOUS and breathing cannot be verified by second party caller, a maximum response is sent immediately. The specific priority card suggested by the above information is then referred to for response information and double-check purposes.

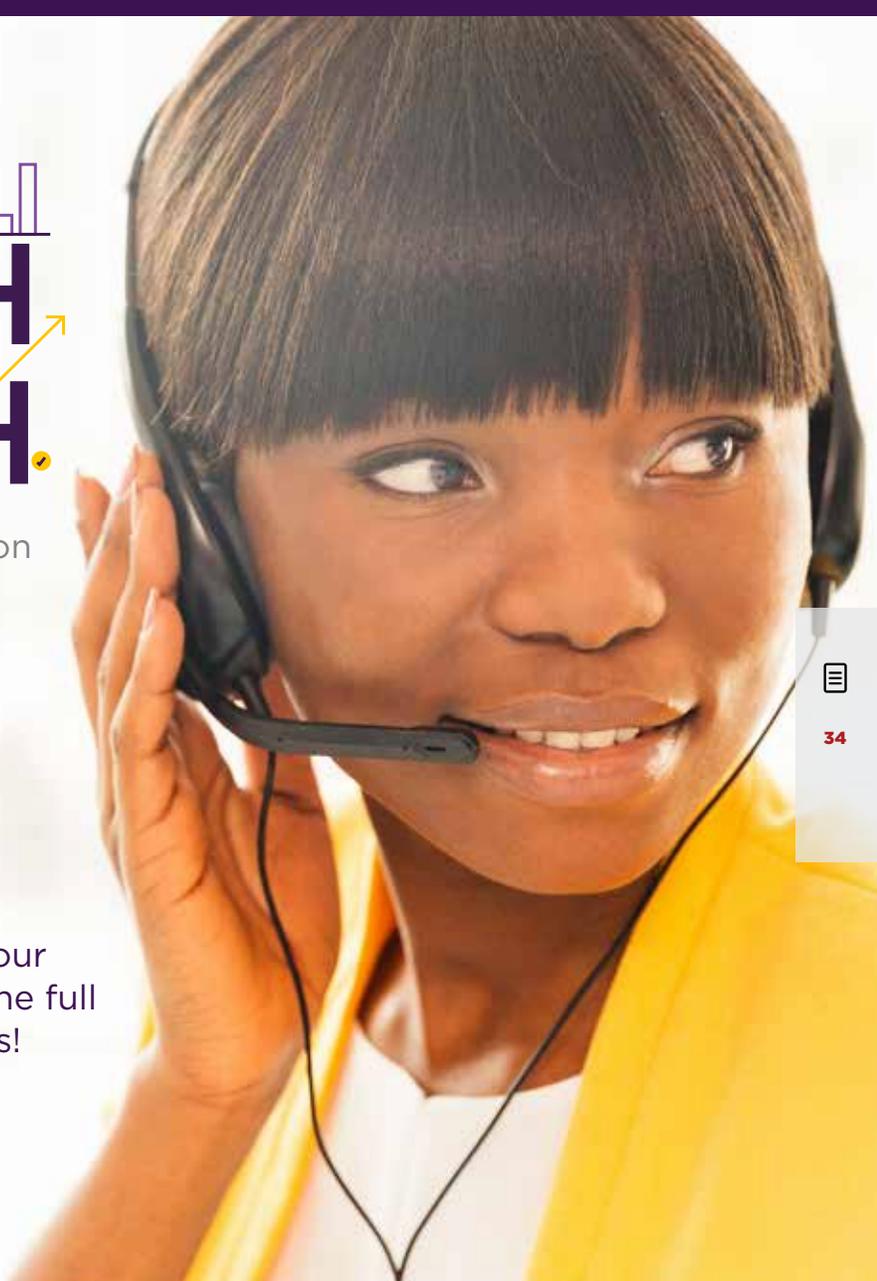
person visual assessment of the situation. However, from the time the call is received to vicinity arrival, the dispatcher "calls the shots." No, the EMD does not outrank the battalion chief or a seasoned paramedic. Hardly (check his salary). The dispatcher is only doing what we (medical control or fire/EMS administration) have determined *prior to the incident* to be the correct level of response for any particular type of emergency. The dispatcher is only carrying out that protocol. But until someone arrives at the scene, no one can know more about the nature of that incident than the dispatcher.

Analogously, response selection could be compared to golf. The dispatcher

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selects the club and the responder then drives, putts, or chips to get to the green. A maximal "Marine Corps" response to every emergency is the equivalent of driving a #2 wood to the hole from 20 yards out. It's just not appropriate for that situation. In the hospital, this would be the equivalent of the emergency doctor dropping everything she's doing and sprinting to the front desk to check the next patient just because she can't trust the triage nurse – also hardly appropriate. Medical priority dispatching has proved to be an effective, safe way to determine the nature of the emergency at the time the call is received, thus eliminating the need for maximal responding in many cases.

As you may better understand now, this outdated maximal response philosophy did not eliminate dispatch errors. It just made the *real* errors less apparent (ALS units tied up on BLS calls, first response where not needed, and emergency vehicle accidents). To you as a trained professional, this wasteful and even dangerous practice of maximal response should be reserved for the highest level of actual or potential crisis. Often, with sending the "Marine Corps" as a knee-jerk reaction, the only crisis present was the one we created. □



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EMD Justin Russo helped deliver a baby over the phone in New York (USA).

Photo courtesy of Justin Russo

PERFECT TIMING

Baby delivery lifts spirits

Audrey Fraizer

The delivery of a beautiful baby boy was perfect timing for Suffolk County Department of Fire Rescue and Emergency Services EMD Justin Russo.

Not only was the baby his first delivery over the phone, but the baby was born on Russo's first wedding anniversary. Call the birth on May 31 a sign or a coincidence, but it certainly heralded a resounding bright moment in a part of the country slowly coming out of a coronavirus shutdown.

The baby's father, however, was not so enamored by the moment. At least initially.

"He was in complete panic," said Russo, who was working his regular overnight shift when the call came in at about 2:40 a.m. Russo started PAIs, and eight minutes later, the mom was holding the baby and reminding the dad to make sure EMS knew they lived in a basement apartment.

The mom's pragmatism provided Russo with welcomed respite following

tense moments of silence on the other end of the line. Worst case scenarios gripped Russo. Thoughts were running through his head. What could have happened?

Then came the sound eagerly anticipated. He heard the baby's piercing cry over his headset.

"Unbelievable," he said. "Music to my ears."

Police pulled up and before Russo could disconnect, the father thanked him repeatedly. Their gratitude spilled over to a larger audience through Facebook.

A picture of a beautiful baby boy swaddled in a white blanket that was sent from the new mom is posted on Jessica Russo's Facebook page. The mom's message reads, in part: *I was screaming. My husband was nervous and your husband calmed my husband down and got us through this crazy experience.*

Jessica replied with a congratulatory note, and the mom once again thanked Justin with the message: *We will forever be grateful.*

Justin Russo makes it a point to stay completely calm. It's his way of keeping the situation under control so that the people on the other side of the call stay focused and do exactly what he says. In the baby call, he instructed the dad to lay his wife on her back on the floor. The baby delivered and Russo was about to give instructions to "tie the cord with a string" when help arrived on scene.

The entire event—from the second he picked up the call to the Facebook message—could not have come at a better time, Russo said.

"It was incredible to get such a positive call with all the dark gloomy times going on in the country and world," he said.

The ironic part, he said, was initially asking for the day off to celebrate his and Jessica's first anniversary. Due to call volume, however, his request was turned down. But no matter. The baby's birth changed the day's dynamics, and he went home after the night shift feeling refreshed.

"That's what I really like about dispatch," he said. "You're helping people tremendously in the moment by keeping them calm and giving them the best instructions."

Like in many parts of the state, coronavirus hit Suffolk County hard. Welcome relief came in mid-June when Suffolk County Executive Steve Bellone reported 47 new COVID-19 cases and zero new COVID-19 deaths—a milestone for a county that so far had lost 1,945 people to the virus.¹

"We're just coming down now from the virus," Russo said. "It's been tough. So many calls and a lot of people who might not make it. It's great we're getting past all that."

Russo has been a certified EMD for over four years and is a lieutenant with the Farmingville Volunteer Fire Department, Farmingville, New York (USA). This was his first baby delivery. Suffolk County Department of Fire Rescue and Emergency Services serves the 1.6 million residents of Suffolk County, Long Island, New York. ●

Source

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EMD Bethany Drew

Photo credit: Wanda Scott

SIXTY-EIGHT MINUTES ON A MOUNTAIN

They never gave up hope

Audrey Fraizer

Hikers generally don't follow the nine-mile trail to the wooded summit of Owl's Head Mountain in the New Hampshire (USA) White Mountains for the view. The flat-topped mountain tucked below and to the east of the Franconia Ridge is often saved for last in the quest to climb each of the state's 48 4,000-footers and receive the official AMC Four Thousand Footer Club decal.

It was the same for two seasoned hikers nearly reaching the peak on a hot day in August 2019. They were within throwing distance of the summit and coveted decal. As was the case in all their hiking trips, the married couple came prepared, carrying water, food, and, most likely, rain gear in anticipation of frequent afternoon thunderstorms in the mountains.

Near the top, ascending along a rocky steep path to the summit cairn, hiker Christopher Purinton collapsed. The other hiker—his wife, Rachel Purinton—pulled essential emergency gear from her pack, including a whistle and water. Because of

spotty cellphone coverage in the White Mountains, a cellphone is not among the 10 items recommended as essential gear, although encouraged and turned on only for an emergency. Remarkably, her 911 call connected to the New Hampshire Division of Emergency Services and Communications.

EMD Bethany Drew, who is familiar with the White Mountain trails and is a volunteer firefighter, instantly realized what they were up against. As the popularity of the White Mountains keeps growing, so do situations that require the expertise of every link in the chain of emergency services, beginning with a call to 911. An average of 200 search and rescue (SAR) missions are conducted annually, often coordinated through the state's emergency communications network.

The New Hampshire Fish and Game Conservation Office, which is responsible for woodland SAR, was the first to be notified of the medical emergency. Members of the Pemigewasset Valley SAR team, along

with conservation officers, responded and prepared for a potential carry-out. Because of the remote location of the victim, an Army National Guard helicopter was requested.¹

Although the couple's location was known, reaching them by foot would take hours. They did not have the luxury of time. The hiker was neither conscious nor breathing. Drew started CPR instructions. For the next 68 minutes, Drew encouraged and instructed Rachel, giving her occasional water breaks near the summit of the mountain. The blowing of a whistle packed in case of an emergency attracted the attention of a lone hiker, who initially relayed CPR instructions before turning back on the trail to get help.

The helicopter crew, unable to land their craft on the mountain, lowered a medic to assist in securing Chris in the stretcher and hoisting the couple on board for transport to Dartmouth-Hitchcock Medical Center. He was pronounced dead at the hospital.

Drew said the Dispatcher of the Year Award was a surprise. Supervisor Dana Jennings had told her of the nomination but accepting the award in a Zoom hosted presentation coordinated by the IAED[™] was sort of a surreal experience. More like a "total shock," she said.

Jennings said Drew went above and beyond in helping Rachel.

"Beth's call needed to be heard by a larger audience because these are the things that we do," Jennings said. "And Beth epitomizes the professionalism that we want to show to the public."

The award, Drew said, is a tough line to celebrate. The call lays heavy on her heart. She takes solace in knowing that she and Rachel did all they could to save Chris.

"I feel like I know Rachel," Drew said. "We were together on the mountain that day. We bonded."

The noise of the hovering helicopter prevented Drew from saying goodbye and a few words before disconnecting. "I wanted to tell her how amazing she was. She never gave up hope." ●

Source

1. "Nashua man identified as hiker dead in Franconia." New Hampshire Union Leader. 2019; Sept. 4. [unionleader.com/news/safety/nashua-man-identified-as-hiker-dead-in-franconia/article_3dca9955-ae40-5e8d-b5e0-bdc7cc260760.html](https://www.unionleader.com/news/safety/nashua-man-identified-as-hiker-dead-in-franconia/article_3dca9955-ae40-5e8d-b5e0-bdc7cc260760.html) (accessed July 31, 2020).



REMEMBERING SEPT. 11, 2001

Emergency dispatchers swung into action

Audrey Fraizer

Most everyone in the USA over the age of 25 remembers what they were doing and where they were on Sept. 11, 2001, at 8:45 a.m. (New York City time).

Most of us also remember the first thoughts going through our heads.

I was stopped at a traffic light and caught the breaking news over the radio midsentence. Something about a plane crashing into a building. A freak accident? I glanced north toward downtown Salt Lake City (Utah). Nothing there to cause concern. I turned off the radio and continued my route. I parked the car and walked across the university campus to my destination. I remember an eerie quiet. The air felt heavy. Once inside the building—the student union—I noticed a small group gaping at an overhead TV set.

Televised scenes of billowing smoke and fire, the shadow of a photographer running with camera in hand, and replays

of jetliners smashing into the World Trade Center in New York City (New York) told me—all of us—America was under attack.

I drove home and stayed close to our TV set, watching in disbelief, horror, and shock. Two 1,350-foot-tall buildings, the Twin Towers, collapsed. A third jetliner smashed into the west side of the Pentagon military headquarters in Arlington, Virginia. A fourth plane plunged into a vacant field in western Pennsylvania.

While I listened to the news in the safety of my home, the experiences of 911 emergency dispatchers could not be any more different. They swung into action.

Frederick County Emergency Communications Center Manager Micky Fyock remembers exactly what he was doing that morning when he first heard the news. “Our center has several TVs—one is always on the Weather Channel and the other is usually on CNN,” he said. “We noticed on CNN a fire in New York in

one of their towers (World Trade Center), and of course this incident, for the fire-oriented personnel in the center, caught their attention. It didn’t take long before the real reason this building was burning revealed its ugly self. Then the second tower was hit, then the Pentagon, and rumors and reports of other places being hit started pouring in.”¹

Fyock’s day did not end when the next 12-hour crew arrived. His next stop, as chief of the Woodsboro Volunteer Fire Company (Maryland), was traveling the 50 or so miles to the Pentagon to lend a truck and his expertise and that of four crew members to extinguish the fire still burning there.

The sight waiting for their help was unforgettable.

“We arrived at the Pentagon and saw firsthand what most people only saw on TV,” Fyock said. “I can tell you this, to see firsthand, to touch, and even smell the devastation and sights inside cannot be put into words.”²

More than 3,000 calls flooded the New York City Metro 911 system in the first 18 minutes (between the time the first and second towers were hit), and more than 57,000 calls came in during the 24 hours after the first plane hit the north tower. The calls from inside the towers totaled about 130, though many of those came from people in groups, sometimes of 100 or more. The New York Times covered the release of call tapes and transcripts from New York City Metro 911 on March 31, 2006.³

Repeat calls came from the 105th floor of the north tower, where 60 people had gathered, as well as other floors like the 97th and 83rd floors of the south tower.

Some dispatchers and supervisors now feel stricken by any suggestion that lives were lost because they relied on the traditional policy of “defend in place” firefighting, where only those at or above a fire in a high-rise building should move.

“When you listen to the tapes, it sounds like we are telling them the wrong thing and in reality we are telling them the right thing,” said Judith Salgado, 36, a borough supervisor who worked in the Fire Department’s Manhattan command center on Sept. 11. “No one thought those buildings were going to come down.”

Audio recordings of emergency dispatchers trying to calm panicked

civilians while juggling engine and ladder companies gave a glimpse into the despair on both sides of the phone. They listened to the voices of people, most of them heard for the last time. The New York Daily News wrote:⁴

Fire Department dispatcher John Lightsey still lives with the voices.

"Sometimes at night you hear stuff," he said. "You hear voices ... you know, calling for help."

Lightsey had the 7 a.m. shift at the FDNY's now-closed Manhattan Communications Center in Central Park. "It started like any other day," Lightsey recalled. "I handled a couple of EMS runs and some other pretty minor stuff."

"The phones never stopped," said Tyron Connell, a beginner from radio training, who estimated he spoke to "hundreds" of people.

One man called repeatedly from the north tower.

"The first time I spoke to him, he was relatively calm," Connell recalled. "By

the fourth time, he was very distraught, talking about his kids and his wife. I think there was a point where he knew he wasn't going to get out. That is something I will never forget."

The attack reverberated across the country.

San Jose Fire Department ED-Q™ (retired) Deanna Mateo-Mih immediately drove to the communication center (San Jose, California). Crisis response plans were already in the works. The Emergency Operations Center (EOC) had been activated, and the fire stations were fortified against forced entry. Extra dispatchers were called in and waiting—just in case—with SJFD instructions for terrorist attacks.

"We didn't know if the whole country was under attack," Mateo-Mih said. "Nobody knew. Everyone was preparing for what might develop into war."⁵

Fyock said Sept. 11, 2001, left a profound impact on his life. "We as dispatchers and we as citizens must

always realize that at any moment our world can be turned upside down. But I am so proud that I chose this career. I am so proud of my brother and sister dispatchers all over the world. I truly believe we make this world safer."⁶ ●

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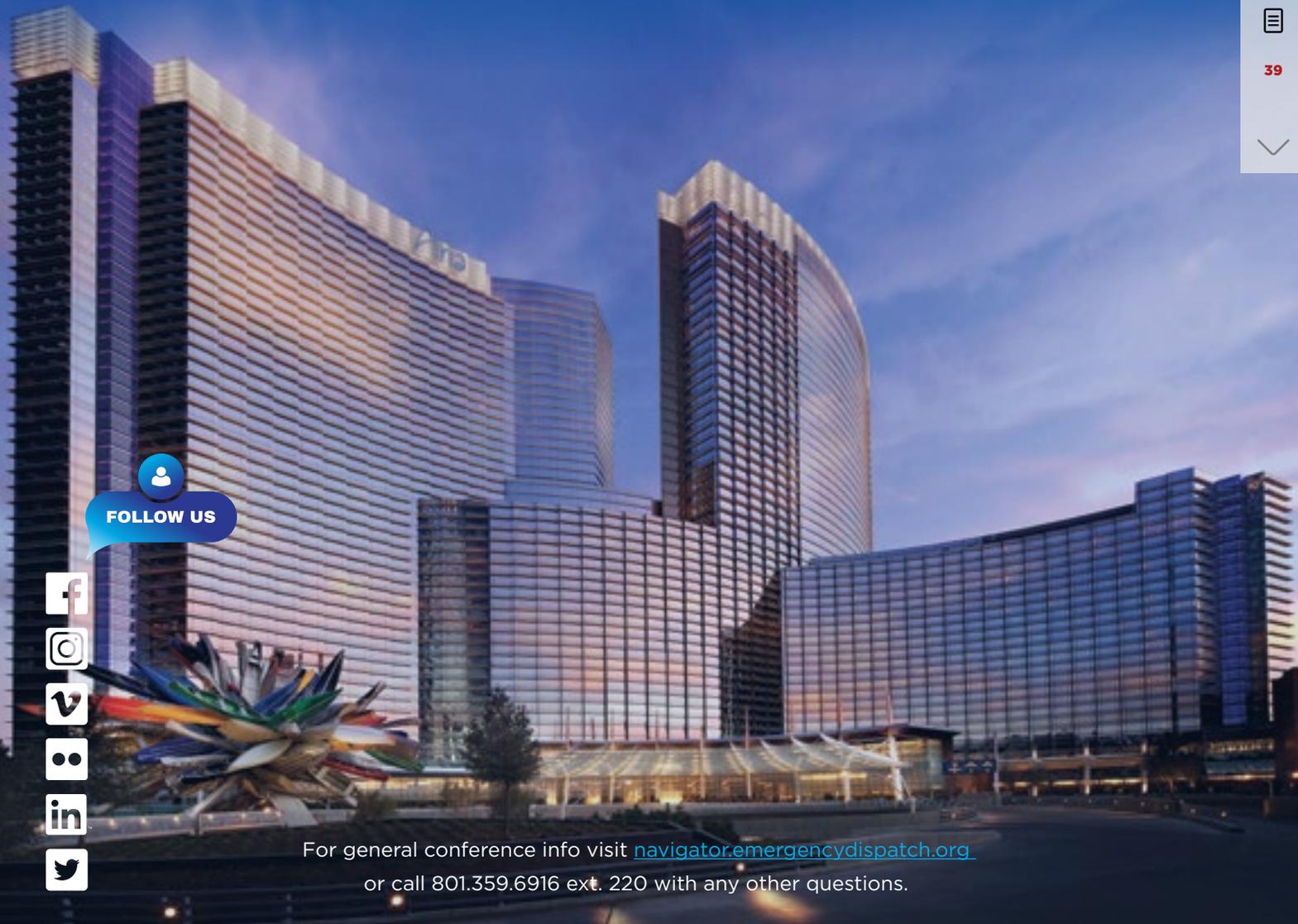


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