HELP!
Don’t let stress take you under.
PROTECT THEM
ASK THE RIGHT QUESTIONS

Quickly sending the RIGHT on-scene information to responding officers and updating it in real-time can help save lives. That’s what the Police Priority Dispatch Protocol System® does better than any other. When your team takes a 9-1-1 call using ProQA® dispatch software, you can be confident that both your new and veteran dispatchers are doing it RIGHT and that responding officers are receiving the information they need to protect themselves and the citizens around them.

We agree with what master mathematician Claude Shannon said in 1963:
“Information is the reduction of uncertainty”
ProQA® Dispatch Software—reducing uncertainty for over 29 years

ask the right question. get the right answers. send the right information.
Stress. That’s the story of, and for some the glory of, working as a dispatcher in a 9-1-1 communications center.
Storm Tracks.
Questions prepare for right response

Audrey Fraizer, Managing Editor

A Science Daily column about the weather that I occasionally enjoy reading on the Internet predicts the current La Niña event will persist through the middle of the year. If that’s the case, La Niña, which is characterized by a period of strong trade winds and unusually low sea-surface temperatures, could mean a more active hurricane season in the Atlantic. In addition, the weather systems that form in the deep tropics are more likely to develop into major hurricanes, particularly in the Gulf Coast region. La Niña was behind the punch of Hurricane Katrina.

La Niña, however, doesn’t confine its effects to the Gulf region. According to the National Oceanic and Atmospheric Administration, La Niña often translates into drier than normal conditions in the South-west in late summer through the following winter. The Central Plains and Southeast experience drier than normal conditions during fall and winter. The Pacific Northwest is more likely to be wetter than normal in late fall and early winter.

I don’t spend a great deal of time tracking weather but I do like to note on occasion the type of weather patterns predicted, particularly in consideration of the preparations required to safeguard people and property. After all, since weather systems oscillate between El Niño and La Niña on average every three to four years, the United States could be in store for continued La Niña conditions that trigger wildfires in the West and severe storms along the southern coast. Nothing like knowing, or at least anticipating the type of weather that lies ahead.

This all goes along with the job of emergency dispatch. Face it, when disaster strikes, the public relies on emergency response. Since the caller generally wants immediate help, it is sometimes difficult for calltakers using the Fire®, Police®, or Medical Priority Dispatch Systems® to ask the questions necessary for determining the nature and seriousness of the problem. A newer questions do not delay response, as some may think. Help is on the way. The calltakers are asking the questions to obtain more information about the patients for the responders. The questions and answers help to improve chances of survival even before the emergency vehicles arrive (think of the instructions given to people trapped in a burning building).

The questions are written based on the knowledge of the intervention necessary for the specific emergency, and the 30 years thus far devoted to their development got a long way in appropriately responding to the emergencies people encounter every day. It’s like tracking the weather. The questions help first responders anticipate the type of intervention that lies ahead. They know better about what to do when arriving to the scene. Through the questions, the calltakers are able to make the best preparations possible to better safeguard people and property no matter what events like La Niña may bring.
A series of stories in this issue of The Journal explores a topic that people in our profession know a lot about but few actually want to discuss.

The avoided topic is stress and from my own experience, it is something our culture rarely will admit to feeling despite professions that put us in daily contact with trauma, crisis, and the anxiety emergency services can produce from not knowing what may be coming down the pike or, in our case, over the radio or 9-1-1 lines.

Perhaps that’s true of life in general. No one can see into the future. But as emergency responders we face the uncertainty 24/7 and as professionals we are trained to respond to the emergencies of others with minimal emotional display. We are there to alleviate the pain from the disaster for those who are directly involved in the incident. Some have called it the Superman or Superwoman syndrome: bad things that happen to others don’t have a negative effect on us because we’re in control of the situation and, better yet, of ourselves.

Of course, not all situations end in tragedy, and the stress of what can and does happen is the reason why many of us chose emergency services for our work. Aside from the desire to help people in crisis, we are motivated by situations that take quick action and thinking. We are risk takers. We are not happy taking a backseat view of life; we want to play an active role in helping people get through their emergencies and in protecting the good of society.

We are victims to what writer and Sunstar Communications Center (Fla.) Manager Jim Lanier defines in his article as compassion stress, the natural consequent behavior and emotions resulting from helping or wanting to help a traumatized person. If left untreated (and in many cases, ignored) the stress can build to a point where the individual becomes less effective, which, of course, only adds to the problem.

There’s also the effect on our health. According to several medical studies (just check the Internet), the stress we don’t manage can be a more dangerous risk factor for cancer and heart disease than either cigarette smoking or high cholesterol foods. I’ve read that stress related disorders account for 80 percent to 90 percent of all visits to health care professionals, although the complaint going in may be physical in nature such as stomach disorders or chronic headaches (physical signs of stress).

So, what can we do about the stress that comes with our territory? First, we have to acknowledge the feelings and understand we’re not alone. Help may be as close as the people we work alongside. We can talk about situations that leave us unnerved. We can also take advantage of the programs communications centers now offer in recognition of our occupational hazard.

It comes down to taking care of ourselves before stress becomes immobilizing and consequently jeopardizes the very ones we are charged to help. Easier said than done but as Karen Hileman, of the Stafford County Sheriff’s Office (Va.) said, “If the dispatchers can’t function, it makes things very hard for those who depend on them.”
Are You Completely Alert? Asking the question depends upon who makes the call

Jeff Clawson, M.D.

Dear Dr. Clawson:

What is your opinion about asking the question “Are you completely alert” to a first party caller when the person obviously sounds alert? I appreciate your thoughts and possible solutions.

Thanks,
Paul M. Stiegler, M.D.
Medical Director, Dane County EMS
Medical Advisory Chairperson, Dane County EMS

Dear Dr. Stiegler:

It should be part of the EMD’s training that asking first party callers the question “Are you completely alert” is not necessary and basically illogical. A first party caller would not know if they were not alert by definition—at least not reliably so.

The act of speaking with the patient is enough to make the determination. If, at this point, the EMD is unsure, then the caller should be considered not alert. Being “with the program” as the Fonz would say on the old “Happy Days” television show, is a good way to think about how the caller is interacting with you.

Another first party don’t ask question is “Are you changing color?” At the point where the patient is actually changing to a clinically critical color, again, the answer would be unreliable and, most of the time, the person just can’t really tell if he or she is actually doing so. Changing to a color of clinical significance generally occurs at a dire point in the patient’s decline and is usually associated with other priority symptoms.

Interrogating first party callers requires the EMD to have a good grasp on the dispatch concept of the “obvious” or “already answered” rule. The best (and most ridiculous) example of “obvious” would be on Protocol 9—where we of course would never ask, “Please tell me why it looks like you are dead?” However, 25 years ago I did hear a tape from Oregon, where the caller stated, “I think my heart has stopped.” Correctly, the EMD went to Protocol 25 and not 9 (although given the situation, it could have been Protocol 19). Again, listening to the context of what the patient is saying makes all the difference.

Another way to assess generally whether a first party caller could reasonably answer a given question is to apply the definitional difference between signs and symptoms. A symptom is something that the patient can tell you he or she is experiencing, while a sign is something we can see or hear regarding our observation of the patient. Alertness is a sign, as is changing color. Difficulty breathing can be both a sign and a symptom since the patient feels it and an observer might be able to see or hear it. Chest pain is a symptom, even though seeing the patient clutch his chest might suggest it.

Technically, ProQA® currently contains no architectural feature that can automatically change wording based on the party of the caller, like it does with gender. We have duplicated questions on the most commonly encountered protocols to reflect first party language; however, doing this throughout the protocol would create significant testing issues in the logic system, which contains about 70 million question and answer combinations. The next major version of ProQA will have this as a built-in feature. Currently, first party wording appears on 14 protocols: 1, 5, 6, 10, 13, 17, 18, 19, 24, 25, 26, 28, and 30. Also, “Is the caller completely alert?” and “Is the caller violent?” questions are listed as an operator-only (blue) question globally in all applicable protocols.

Thanks for finally sending an easy, but complex, question this way,

Jeff Clawson, M.D.
The e-mail from Communications Supervisor Michele Thomas, EMD-Q, provided an intriguing introduction.

“It has been a big year at MD Communications and I wanted to share some of our accomplishments with you,” the brief and to-the-point e-mail read. “This year during National Telecommunicators’ Week, one of our dispatchers received Telecommunicator of the Year from Saskatchewan 911, our provincial body. Our center was also awarded the Excellence in Teamwork award at the same awards night. This coupled with our re-accreditation has made for very exciting times for us.”

The packet Thomas included was equally stunning: an 11-page document outlining the reasons the center in Saskatoon, Saskatchewan, Canada, should win—and did win—the Saskatchewan 911 award for their teamwork.

“It’s the positive attitude,” Thomas said, repeating the words in the award nomination written by the center’s Director of Communications LeeAnn Osler. “This is the way we work with everybody, including each other.”

MD Communications is housed in a state-of-the-art center and employs 22 certified Emergency Medical Dispatchers (EMDs), who are also certified as Emergency Fire Dispatchers (EFDs). The center has been an Accredited Center of Excellence (ACE) since 2000; the only ACE in Saskatchewan, and one of only six in Canada. They are the largest communications center of the Saskatchewan 911 provincial government emergency service initiative coordinated through Canada’s Department of Corrections and Public Safety.

“We’re a busy center,” said Osler, in an obvious understatement of their work. “We are also exceptionally diverse. With each member of the team EMD and EFD certified, we are prepared to help the mother breathe life back into her own child while juggling the coordination of a medi-evac and dispatching a fire call.”

Demanding job

The city itself, which is situated on the banks of the South Saskatchewan River, is the largest city in the province with an estimated population of 208,300 (as
of December 31, 2007). The dispatchers answer, on average, 500 phone calls per day of which 100 calls are for medical or fire emergencies. Doing simple math, that’s more than 180,000 calls a year divided among the 22 dispatchers who work on rotating 12-hour shifts.

The calls come in from an area that covers an estimated 150,000 square miles of predominantly rural landscape with some urban setting thrown in as part of the mix. As dispatcher Janice Marcotte describes it, “We are very rural. We have fields and fields of grain and a few farms. It’s a huge area to search when someone gets lost.”

Can you answer these?
1. You will be working 12-hour shifts with paid breaks and lunch periods. Are you willing to work through breaks, when necessary?
2. Are you able to listen to several conversations and make quick, accurate decisions based on what is said?
3. Are you willing to speak with traumatized or hysterical people in a professional manner or deal calmly with angry people?
4. Are you willing to deal with a crisis call where a child might have died, a rescuer is injured, or a woman has been assaulted, and then set it aside and continue calmly with your next call?

With each member of the team EMD and EFD certified, we are prepared to help the mother breathe life back into her own child while juggling the coordination of a medi-evac and dispatching a fire call.”  – LeeAnn Osler

The breakdown of their coverage area includes the city of Saskatoon and West Central and Northern Saskatchewan, as well as emergency fire dispatch calls for the rural Saskatoon area. Their team interacts with 30 EMS services, 125 first responder groups, 30 fire services, Corman Park Police Service, Saskatchewan Air Ambulance, and Northern Medi-Evacs out of the Keewatin Yathë Health Region.

And if you think this is a job anyone can do, or they want anyone to do, check the self-assessment questions MD Communications posts on its Web site and Osler modeled after similar questions she had previewed from other communications centers. Without a doubt, they are meant to influence whether the would-be MD emergency communications specialist downloads the two-page application.

According to the nomination packet for the team excellence award, the self-assessment is not far off base. In 2007, four callers required help delivering their babies and that included a call made from a payphone at a service station in a rural area where the soon-to-be father had stopped his mini-van for the sudden delivery. The dispatcher directed the mother to lie down in the back of the van and coached the father through the Medical Priority Dispatch System® (MPDS) Pre-Arrival Instructions.

In January 2008, the center received attention throughout Canada for a call...
that occupied the dispatchers for three hours. A man found himself lost because of the twists and turns he had taken down intersecting gravel roads while driving his van through rural Saskatchewan in the early hours past midnight. He was not wearing shoes, socks, or a shirt and followed dispatcher Marcotte’s advice to wear a seat cover for a hat to keep in some of his body heat while awaiting help in temperatures hugging –39 degrees on the Celsius scale.

During the ordeal, which lasted from 1:30 to 4:30 a.m., Marcotte shifted between his call and other emergencies coming in, while she and coworkers Lisa Perverseff and Joanne Austin helped plot out his whereabouts using all the resources available to them.

“We kept in contact the whole time,” said Marcotte. “We would go over and over where he might be, the place where he had left, and the turns he had taken. If it hadn’t been for the way the team worked together that night, he may not be here today.”

ACE is a motivator

Osler credits the work that it takes to achieve and maintain ACE status for their consistent high level of performance. They started the process in 1999, achieved ACE status in 2000, and were recently approved for their second recertification.

But the hard part, said Osler, was not the initial application.

“We bit into it and worked really hard to achieve that but over the years we’ve found the bigger achievement in sustaining accreditation,” she said. “We’re at the top of our game and we plan to stay that way.”

To stay on top, M D Communications has a Quality Improvement Unit (QIU) that measures and evaluates the dispatchers’ compliance. The compliance numbers are put on a bulletin board at the center and those with 95 percent or better have their names posted alongside the scores.

In addition, their response standards incorporate time-to-alert, time-to-determinant, and time-to-notify first responders into the computer-aided dispatch (CAD) system. They survey clients—those they send on response based on the emergency calls—and the feedback they receive is reviewed for possible implementation into their policies and procedures.

The feedback has been positive, said Osler. For example, Corman Park Police gave them high scores for empathy and respect: “This is much appreciated and I can never say thank you strongly enough.”

M D Communications is also the only center in the world using a modified Protocol 33 (Transfer/Interfacility/Palliative Care) that allows an attending physician or a registered nurse to make a judgment call about whether to respond hot or cold to a call based on their medical assessment to the patient.

“The doctor or nurse takes the responsibility for the light and siren response,” said Osler. “This was an important change for us that took a long time to formalize.”

Team building

Efforts to build a cohesive team are found in projects both inside and outside the communications center. The internal Rewards and Recognition Program recognizes the quarterly outstanding call, any saves or childbirths, and the dispatcher with the highest compliance. The annual awards night acknowledges team accomplishments and it is the prototype of a similar program the Saskatchewan 911 holds each year (and M D Communications won for their teamwork in 2008).

There’s also the year-round fundraiser that sends two dispatchers to the Navigator Conference, sponsored by the National Academies of Emergency Dispatch® (N A E D). Over the past eight years, the fundraiser has netted more than $24,000 through chili lunches, car washes, gift baskets, and other activities.

Outside the center, the dispatchers get involved in community events, such as last year’s Adopt-a-Family program that provided Christmas gifts and food for a single mother and her children.

They have also donated money to the Pediatric Ward at Royal University and the Breast Cancer Center of Care at Saskatoon City Hospital.

Snow flurries that quickly developed into a full-fledged blizzard in January 2007 had dispatchers coordinating first responders who were on snowmobiles helping people trapped outside in the storm.

“We are more than a team,” Osler said. “We are more like a family.”

Professional growth

Osler has been with M D Communications for 23 years, just a decade short of when the company started its service to Saskatoon. She got involved in emergency services at age 14 through her dad’s ambulance service and couldn’t imagine doing anything else but public service.

When Osler came onboard with M D Communications in 1985, it was relatively small, at least compared to today’s operations. At that time, there were four dispatchers who answered calls and sent ambulances, said Osler.

“That changed in 1990 when we became certified EMDs and over the years, the shift in the way we see ourselves has filtered through the EMS community,” she said. “We take our work seriously and that’s what people see.”

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A Shot in the Cold. Dispatcher stays on line three hours to aid caller stranded in sub-zero temperatures

True to the profession, dispatcher Janice Marcotte doesn’t quite know what to expect when she answered a call to 9-1-1 and in January 2008, there was little warning that the emergency call she took would last three hours and put MD Communications on television sets all over Canada.

To put things into perspective, the temperatures were hovering near -39 degrees on the Celsius scale when Marcotte left on January 16 for the night shift at the center in Saskatoon, Saskatchewan, Canada. Snow covered the ground and it was so cold, she remembers, that it felt like her skin would freeze if she spent more than a few minutes it would take walking from her car into the communications center.

“It was not a good night to be outside,” she said.

But several hours into her shift, at 1:30 a.m., she received a call from a man lost outdoors. To make things worse, the caller told Marcotte that he had gone out without adequate winter clothing. He was dressed only from the waist down. The sole protection from the snow, cold, and wind was the inside of a van that would not start after it rolled into a snow bank along a road in the remote backcountry.

“He didn’t know where he was,” said Marcotte. “He had taken to so many twists and turns while driving, he couldn’t remember the way he had come or how long he had been gone.”

In an urban area, a person stranded in an uncooperative van would be relatively easy to find even during the early morning hours. But this was during the darkest hours of morning in rural Saskatchewan. Marcotte, who has lived in the area all her life, describes the back roads as very isolated places that only the knowing take as shortcuts.

“We have fields and fields of grain and a few farms,” she said. “It’s a huge area to search when someone gets lost.”

The driver thought he had turned off at a city called Biggar, a small city of about 2,300 people in the heart of the Canadian prairies in the West Central corner of the province of Saskatchewan. But with little else to go on, Marcotte radioed for help in the order they send response at MD Communications – ambulance, first responders, Royal Canadian Mounted Police (RCMP), and the fire rescue team.

“We really didn’t know where to direct them,” she said. “He was on his cell phone and we couldn’t get an exact location.”

While Marcotte hung onto the phone call, her coworkers Lisa Perverseff and Joanne Austin helped plot out his whereabouts. They dragged out all of their maps and called the cell phone company to get the nearest tower based on the signal from the caller’s cell phone. When other calls came in, Marcotte put him on hold until his phone battery neared empty. At that point, he disconnected his phone and she called him back at regular intervals.

The minutes ticked away. A voice that spoke in fairly hopeful tones at the beginning of the call for assistance took on a frightened edge as the minutes added up to hours. “He was cold,” she said. “He couldn’t feel his feet any longer and he started talking about dying.”

Marcotte reassured him that they were doing everything possible to find him, and that responders were out there looking for him. Since the man had jumped into his van without first putting on his shoes, socks, or a shirt and coat, Marcotte suggested he find something that could provide even minimal warmth. He put a car seat cover on the top of his head and wrapped a sheet from a roll of shipping paper around his torso.

Three hours into the ordeal, the ambulance crew found the lost traveler near Harriss, about 60 kilometers southwest of Saskatoon. He was delirious and hypothermic but alive, according to local news reports. He was transported to a local hospital and went home a few days later. Marcotte heard, without lasting injury. RCMP charged him for the search.

He told local news reporters that it was the craziest thing he had ever done.

The timing to find him was none too soon. “He was getting disoriented,” she said. “The help was needed before he worked.”

Marcotte, Perverseff, and Austin gave a high-five upon hearing “16 to the hospital” and went back to their CAD’s.

The call made headlines and Marcotte was featured on a Canadian national news program. She received the Telecommunications of the Year award from Saskatchewan 911, their provincial body, during an annual recognition ceremony that honors emergency workers. At each notice, she’s certain to mention her coworkers Perverseff and Austin, the responding units, and the team effort it took to rescue the caller.

“If it wasn’t for all of us, I don’t know what would have happened to him,” she said. “We worked as a team and were lucky enough to nail his location on the head.”

Marcotte is, of course, surprised by the attention the call has received. After all, she said, this is something dispatchers do every day. The exception, perhaps, was the amount of time she stayed in phone contact with the lost driver.

“You never know when the phone rings, what it’s going to be,” she said. “I’m just thankful we live in a place where people don’t give up looking.”
Name That Structure. Does asking what type confuse your caller?

By Charlotte Hughlett

Do you find this to be a confusing question: What type of structure is involved? I know our callers do from time to time. There seems to be confusion on both our part and the callers we serve. So, let’s try to clear the smoke (there’s no pun intended) on this confusing question.

This question appears in the Fire Priority Dispatch System™ (FPDS) in Protocol 52—Alarms; Protocol 60—Gas Leak/Gas Odor (Natural & LP Gases); Protocol 63—Lightning Strike (Investigation); and Protocol 69—Structure Fire. The featured cards show the determinants from each of the protocols; as you can see, each list is a little different depending on the call type.

We need to understand the intent of the question, and it is our job to help the caller understand.

In each protocol the intent of the question is to determine which Determinant Descriptor you are to select for dispatching. It is not to find out the construction of the building (like we get from some callers). We need to understand the intent of the question, and it is our job to help the caller understand if he or she becomes confused.

When you ask this question, remember that it must be asked as written. If there is confusion or an off-the-wall answer from the calling party, you then clarify and help him or her to provide the most useful information. If the caller says “I don’t know” don’t select “Unknown.” Help out the caller.

Also, equally important, if you already know the answer to the question, don’t ask it. Auto-answer and move on. Generally, this information has already been obtained in Case Entry when you are verifying the address, either through voluntary information from the caller, your geo-file in CAD, or your familiarity with the address.

Do you remember from your training what it means when a Determinant Descriptor is in all caps? It means there is a definition in the Additional Information section of the protocol. This is to aid you in making your decision. Use the tools you have to assist you in making the correct selection. This is just like the lists in Medical Priority Dispatch System® (MPDS) protocols like Traumatic Injury when you need to identify what are DANGEROUS, POSSIBLY DANGEROUS, and NOT DANGEROUS Body Areas. The wrong answer choice will give you the wrong Determinant Code.

Hopefully this tip will help you choose an appropriate Chief Complaint and facilitate smooth navigation through FPDS.
FREQUENTLY ASKED QUESTIONS

Two-Tire Vehicle Crash: What are the instructions for removing a helmet when breathing is compromised?

To the NAED:

Can you confirm that the standard in Pre-Arrival Instructions (PAIs) for a motorcycle scene crash is to (a) avoid helmet removal and (b) give CPR in the event of respiratory compromise or unresponsiveness? Are there any instructions for helmet removal prior to arrival of emergency personnel? I was unable to find any and the information is necessary for a grant that I am submitting.

Thank you for your time,
Suzanne M. Martens, MD, FACEP, MPH, EMT
Interim EMS Medical Director
Bureau of Local Health Support & Emergency Medical Services
Wisconsin Department of Health & Family Services

Dr. Martens:

The Academy’s Council of Standards has long considered the issue of airway maintenance in the suspected trauma patient.

The head-tilt method of airway control is still used in the Dispatch Life Support (DLS) environment for two primary reasons:

1. In the nonvisual realm of EMD, without the aid of visual instruction or confirmation, instructions must be nonvisually clear and effective, as current DLS instructions for the head-tilt are. Instructions for other maneuvers, such as the chin-lift or jaw thrust, are simply not practical or well understood when provided non-visually.

2. Studies have shown that when a neurological deficit is the result of a neck injury, the deficit is most likely to occur at the time of the insult. The deficit does not often occur as a result of movement after the injury and, when the deficit is a result of movement, it is generally flexion or rotation, rather than extension of the neck. In the DLS environment, where more detailed airway instructions are not practical, and may actually interfere with life-saving airway maintenance, the current standard of care is to open the airway, using the head-tilt method when airway compromise is apparent; specifically, when breathing meets the DLS definition of ineffective.

The Academy evolves DLS standards through a process based on research and expert consensus. Part of that process considers Proposals for Change (PFCs) to the MPDS, submitted by MPDS users. To date, while we have reviewed many concerns about neck movement in the trauma patient, no evidence of spinal injury exacerbation due to DLS airway maintenance has been reported and the MPDS is being used in more than 3000 communications centers worldwide. With that said, the Academy welcomes any data and/or suggestions regarding better care for the trauma patient that considers the risk of delaying airway instructions and the nonvisual realities of the DLS environment.

To answer your question directly, EMDs advise callers not to move the neck of a trauma patient who is breathing effectively, but to provide prompt DLS airway instruction to all callers of patients who are not breathing effectively, provided scene safety issues are not apparent. Helmet interference is not mentioned specifically; it is implied, as is the case with other common scene complications, that if breathing remains ineffective, the patient must be manipulated in a manner that allows airway maintenance and, if necessary, mouth-to-mouth rescue breathing.
Thirty years ago J. Chris McNamara accepted his first “real” job as a police dispatcher for the newly opened Howard County 9-1-1 Center in Ellicott City, Md.

He was one of six dispatchers (three still remain) at the center that sent officers to emergencies using an index card system and a wall map with flashing red and green lights to coordinate the police responses when it started operations in March 1978.

“Response depended on the individual,” said McNamara. “We took the calls and then went to the map to find an available officer. You had to be quick.”

Boy, have things changed since then or, at least, to the extent of administration and technology. They’re still quick.

McNamara, now the training and quality assurance supervisor, works out of a state-of-the-art communications center that combines police, fire, and EMS call-taking and dispatching for a population that has at least tripled during the past three decades. The Howard County 9-1-1 Center in the basement of the county office building is also a division within the county police department.

Computer-aided dispatch (CAD) has long replaced the manual system for emergency response and they track locations using GPS technology. The 63 people who answer the 9-1-1 lines are trained in dispatch and call-taking, and they use the Medical Priority Dispatch System® (MPDS) to help residents at their times of crisis.

“We’ve birthed many babies over the years,” said McNamara.

Most of their calls are in response to property crime—such as burglary and theft—much the same as they did in the earlier years. A predominantly bedroom community between Washington, D.C., and Baltimore, Md., they don’t have the amount of violent crime more prevalent in the larger cities.

But that doesn’t mean their dispatchers and call-takers are any less on the ball.

The call volume has increased substantially over the years and the job demands at least six months training in the classroom and on the floor before anyone goes solo. The division gives out quarterly awards to its call-takers/dispatchers and each year an awards ceremony is held to recognize one individual as the Dispatcher of the Year based on performance and participation.

McNamara plans to stick around a job he says still offers him plenty of challenges. “There’s always something going on here,” he said. “It’s been a good 30 years that has given me lots of opportunity.”

Tourist bus crashes down embankment

A bus crash in Utah’s San Juan County that killed nine people was an incident like no other Kirk Hazleton had handled in his two years as a dispatcher for the sheriff’s office.

According to news releases, one of the 17 buses chartered for a ski trip in Telluride, Colo., rolled 41 feet down an embankment in a remote location in southern Utah during the return trip to Phoenix, Ariz. Fifty-two of the 53 people aboard were thrown from the vehicle as well as ski equipment and luggage when the roof of the bus was seared off in the sudden plunge from the icy road.

The first call that came in ended before Hazleton could get any information. “We knew that a bus had flipped but that was it,” he said. “The caller said lots of people were injured and then the call went blank.” Cell phone reception is “horrible” in that part of the state, said Hazleton. Not only that, but because wireless phones are mobile, the call that did come in could not be associated with one fixed location. All Hazleton and his co-dispatcher Corey Patterson could do was to wait for the next call.

Twenty-four minutes later a second call came in from a passer-by who was able to make a connection when dialing 9-1-1 from the closest town, Mexican Hat, which is 10 miles away from the accident. Lighting from cell phones in the ditch alerted first responders to their location, and, upon discovering the magnitude of the situation, more help was dispatched through the San Juan County Sheriff’s Office.

The sparsely populated county (an estimated two residents per square mile) rarely sees an accident of such magnitude.
911 Lifeline opens press release center

Freehold, NJ — 911Lifeline, a national membership organization that provides support and services to 9-1-1 professionals, opened a press release center to provide vendors, public service organizations, and related sources with a cost-free channel to distribute their product and service announcement, notices, and other information.

911Lifeline founder Michael Wallach set up the center to aid in the timely release of information that, because of rapid technology advances and legislation, changes on a moment’s notice.

“The 911Lifeline Press Release Center provides another pathway to ensure individuals most affected by 9-1-1 legislation and initiatives stay informed,” he said.

911Lifeline was founded in April 2006 to provide support and resources for the 9-1-1 system professional. Its membership consists of telecommunicators from national and international agencies. The press release center and instructions for submitting press releases can be accessed under the “News” option on the main menu of 911Lifeline at www.911lifeline.org.

Cell phones outpace landlines as safety blankets for emergencies

Cell phones play a much bigger role in helping Americans find work, make money, and respond in emergency situations than three-to-one margin.

“Cell phones provide instant communication in all types of emergencies,” he said. “People want that kind of security and studies show that’s the type of phone they want in case of an emergency.”

The problem has been devising a system of locating individuals using a cell phone in an emergency, and that’s a problem the 9-1-1 emergency-calling system called Enhanced 911 or E911 is supposed to accomplish. E911 was established a decade ago to automatically associate a physical address with the calling party’s telephone number; the second phase of the service calls for a system to geographically locate a wireless or mobile telephone user through some form of radio location from the cellular network or by using a Global Positioning System (GPS) built into the phone.

Newer cell phones that

YOUR FEEDBACK IS WELCOMED

NFPA 1221 open for public comment

By Jay Dornseif

You have until August 29 to provide comments in reference to the National Fire Protection Association Standard 1221 (NFPA 1221). NFPA 1221 is the Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems.

Many 9-1-1 users have expressed an interest in making comments about the time measurable benchmarks set by the standard, specifically Section/Paragraph 7.4.2, Proposal No. (from ROP) 1221-12.

The entire Report on Proposals document is 18 pages in length and part 1221-12 is on page 14 of the ROP document. Directions for downloading the ROP document that includes the proper form for comment are as follows:

1. Go to the NFPA Web site at www.nfpa.org
2. In the middle of the homepage under “Highlights” click on the first link titled “Reports on Proposals for ‘09 annual documents posted. Comments due 8/29”
Sullivan said most people don’t choose a phone solely based on GPS mapping capabilities, despite the expressed urgency to have a cell phone handy in case of an emergency.

“The GPS feature is not going to be the only reason for the decision,” he said. “Americans like the bells and whistles.” Sullivan’s study is based on two surveys: a scientific poll by Opinion Research Corporation (ORC) of 1,005 Americans and a statistically large online sampling of 110,000 prepaid cell phone users.

### The Journal breaks into the big league

Western Publications Association (WPA) bestowed top honors on *The Journal of Emergency Dispatch* with its recent nomination as the Most Improved trade publication (circulation over 50,000) for the 2008 Maggie Awards. The Maggie Awards, the WPA’s annual publishing event, honors editorial, design and promotion excellence in magazine, tabloid, newsletter, and online publishing. Although *The Journal* did not win for the category nominated, the recognition puts the magazine published by the National Academies of Emergency Dispatch® (NAED) among the top tier in the publishing industry. This year a total of 88 awards were presented at the event held in Los Angeles, attended by more than 500 industry giants.

“Being nominated as one of the four finalists in the most improved category for a prestigious award like the Maggie was a payday to all of us on *The Journal* staff,” said Kris Berg, NAED communications director. “Giving our members the best magazine, visually

There are also general requirements for a communications center, including its design, operations, receiving equipment, the dispatching equipment, and system testing and record keeping.
Prank call isn’t one after all

The call coming over the radio was taken originally as a prank. The stranger at the other end seemed to be talking nonsense for the personal amusement of throwing off the dispatcher. Or, maybe, it was a bad connection.

“The person was making no sense whatsoever,” said dispatcher Jamie Xayavong, of the Polk County Sheriff’s Office in Des Moines, Iowa. “No one listening could understand a word he was saying.”

Rather than turn off the radio or simply ignore the caller, Xayavong did what she was taught to do. She put all her concentration into what the caller could possibly be trying to say. “From listening closely I knew someone was calling for help,” said Xayavong.

It wasn’t until after paramedics responded that she realized the caller was having a stroke. Because of the medical trauma, the caller, Altoona Fire Chief Jerry W helmet, was having difficulty relaying his plea for help over the police radio. Although he was trying hard to give directions, all he could tell her was his unit number. Xayavong used that to find the address and her partner paged it out.

Chief W helmet has little recollection of the event. “I don’t remember what was said or how she found me, but they did,” Chief W helmet later told reporters.

Xayavong’s persistence at the radio that day earned her a Hero of the Heartland award from the American Red Cross. She was one of 11 people from Iowa, along with two animals (Chloe and Kirby), to be honored for acts of courage that make an impact in the community.

The award came as a surprise, Xayavong said. “I was shocked,” Xayavong said. “I knew I had been nominated for the award but I certainly wasn’t expecting to win. This is a very big honor. This covers the entire state.”

Xayavong has been with the Polk County Sheriff’s Office for nearly four years. She is also a paramedic and volunteer firefighter in neighboring Pleasant Hill. She enjoys the work because it gives her the opportunity to make a difference in people’s lives.

Not all the calls, however, are as memorable as the one she received from Fire Chief W helmet.

“This incident will always be with me,” she said. “The award presentation and a chili dinner held in honor of the call really brought it all back.”

For those wondering about the two animals winning Hero of Heartland awards, keep reading. Their stories are summarized below.

Chloe

One July evening, Devan Winne was riding his bike in rural Carlisle, with his constant pal Chloe running alongside. A truck came speeding toward Devan who did not see it coming. Chloe jumped in front of Devan, knocked him down into the ditch, and saved him from being hit by the truck. Chloe was hit and seriously injured, but has recovered and is being honored as a Red Cross animal hero.

Kirby

Kirby got his name because he loved to put everything in his mouth—and eat it (just like the brand name vacuum cleaner)! On a walk, Kirby spotted a folded-up piece of notebook paper, picked it up with his mouth, and sat down immediately. He would not move until Brad Peterson took the paper out of his mouth. Written on it was a suicide note written by a high school student, with details about his funeral. Brad took the note to the high school and thanks to Kirby, the student got the help he needed to graduate with his class.

The Journal of Emergency Dispatch is distributed to an audience of more than 60,000 readers, and they are predominantly members of the 9-1-1 emergency services dispatch profession. This range of readers extends from management and supervisory positions to call-takers and dispatchers who use the medical, fire, and police protocols on a daily basis. The publication also goes to medical directors, physician groups, and others involved in providing emergency medical care.

Dedicated training funds could make the difference between life and death

Wanda McCarley, president of the Association of Public-Safety Communications Officials (APCO), wants federal funds to keep communications centers well staffed and well trained. “Having well-qualified and trained staff can make the difference between life and death,” said M McCarley when speaking before the U.S. Senate Committee on Commerce, Science, and Transportation. “Keeping this staff after they have been trained has become a daunting challenge for public safety.”

And therein lies the problem: the lack of dedicated training funds. “Most often federal grant programs go to funding equipment, but the grants neglect the most important element in any emergency—the human element,” M McCarley said.

“Training in the front end of the call will most likely save money but more importantly save lives. Public safety communications grant programs should be used for training, as well as equipment; however, the use of these grants should be tied to the acceptance of a nationally accredited standard by the local emergency communications center.”
Study suggests why some cope better with another’s pain

A new study suggests why some people are better able to cope with somebody else’s pain and, in turn, have the potential to control their emotions in medical treatment and emergency situations.

According to the study, summarized in the AMNEWS published by the American Medical Association (AMA), the physicians who participated were able to shut off the part of their brain that lets them empathize with a patient’s pain during medical treatment. Instead, their brains activated an area that controls emotion, enabling them to treat patients without being distressed or distracted by the pain they witness.

While the study did not indicate implications beyond medical treatment, it could explain why some people are more capable of handling emergency situations in general.

The research, conducted by Jean Decety, Ph.D., a professor in psychology and psychiatry at the University of Chicago and Taiwan researchers, involved 14 doctors and 14 nondoctors in Taiwan. The subjects watched videos of people stuck with acupuncture needles in their mouth, hands, and feet or people touched with cotton swabs.

Brain scans of nondoctors showed that the pain circuit comprised of the anterior insula, periaqueductal gray and anterior cingulate cortex was activated when they watched people pricked with needles.

Physicians, however, showed no increased activity in the pain portion of the brain while watching the needle or cotton swab videos. But they registered increased activity in the frontal brain areas related to emotion regulation and cognitive control.

Researchers also asked study participants to rate the level of pain they thought people in the videos experienced. Non-doctors rated pain at seven on a scale of 1 to 10. Doctors gave a rating of three.

The research was published in the Oct. 9, 2007, edition of Current Biology.

SOURCE: AMNEWS, NOV. 12, 2007

Company brings quality checks to compliance

Admit it. Although quality assurance is a primary responsibility in the communications center, not every agency has the time or resources to do it right.

That’s why Michael and Tammy Spath created EDQ 911, a company that measures call compliance according to National Academies of Emergency Dispatch (NAED) standards.

“This is something we feel strongly about as do most people in this industry,” said Tammy Spath, ENP, a public safety dispatcher II for the Santa Cruz (Calif.) Consolidated Emergency Communications Center. “People want to provide the best quality, but for agencies it’s a position [the QA or QI] that gets overlooked. The agencies don’t have the staffing or funds to do the type of quality assurance demanded.”

The Spaths put out their business shingle in February 2008. They can provide a full-blown call compliance/quality assurance program for an agency or develop a plan that complements the system an agency may have already designed.

Along with a promise to measure compliance according to NAED standards, the couple has compiled a list of objectives they say also guides their work. Chief among these is a pledge to return feedback from their review to the contracted agency within seven days of receiving the call recordings. The number they review is agency specific and, similar to the NAED, based on call volume.

Spath said system improvement is their ultimate goal. They’re not interested in weeding out people for punishment and they prefer that an agency use the results to improve their overall compliance, rather than penalizing those not getting 100 percent for their efforts.

“It’s about helping people reach full potential,” said Michael Spath.

Tammy Spath started her dispatch career in 1993 for Henderson, Nev., which is the same year she became EMD certified. In addition, she has worked as an EMD-Q and in communications training. Michael Spath started as an entry-level 9-1-1 calltaker for San Jose, Calif., in 1991. In addition, he has worked as a Q, supervisor, training coordinator, and as an instructor for the NAED. For more information, contact the Spaths at EDQ 911@comcast.net.
An incident that captivated the entire country earned dispatchers’ honors for Outstanding Response in a Specific Incident at the annual awards ceremony sponsored by the Utah Bureau of Emergency Medical Services. It was Aug. 6 and the dispatcher at the Emery County Sheriff's Office received a call from the University of Utah seismograph station.

"The director [Walter Arabasz] wanted to know if we had received any reports of a seismic event from that area," said Emery County Sheriff's Office Supervisor Bliss Mead. "He told us that it looked like it was something that happened in the mine."

According to the recording from the call made to the sheriff's office, and not the emergency 9-1-1 line, Arabasz told the dispatcher that readings near the Crandall Canyon Mine in Emery County showed an earthquake of about 4.0 magnitude on the Richter scale (a magnitude that was later revised to 3.9). He attributed the activity to a coal-mining related event due to the character of the seismic recording.

Three minutes later, at 3:47 a.m., a worker at the mine called 9-1-1 to report a collapse and said they would probably need an ambulance to go up the canyon toward the mine.

At that time, no one knew exactly what had happened and if miners were trapped in the collapse.

The collapse filled the mine where miners were working with rock and coal. Six miners were indeed trapped—and never recovered—and during a rescue attempt 10 days later three more were killed and six others injured in a second cave-in. A congressional committee has since requested a criminal investigation of the tragedy.

Bliss said the collapse and subsequent rescue efforts triggered thousands of calls into the small office. Although in dispatch for 27 years, he'd never seen anything like it, even when compared to rescue efforts following the Wilberg Mine Fire in Emery County, which claimed the lives of twenty-seven miners on Dec. 19, 1984.

"In the words of one of our dispatchers, it was controlled chaos," he said. "Twenty years ago we didn't have the cell phones. This time, we were receiving calls from all over the place, and people who couldn't get through on the business lines would call 9-1-1. We got a call from Japan from someone who wanted a radio interview."

Bliss said although his department appreciated the award—this one and the one they received from the Association of Public-Safety Communications Officials (APCO)—an award is not something they look forward to. "It's a tragedy when something like this happens," he said. "We're a close community and it has been really tough on everyone."

An editorial in the Deseret News (Utah) also recognized the heroics of the dispatchers working under the pressure of world attention. According to the opinion piece, published April 26, 2008: The dispatchers fielded hundreds of calls from around the world, helped frightened families, and directed the media while blithely carrying on their daily duties of dispatching emergency vehicles to other accidents and keeping the law enforcement team on the same page.

They must be part air-traffic controller—shouldering the responsibility of getting tons of metal here and there without a disaster.

They have to have a dose of hostage negotiator to them as they try to calm and defuse tense situations.

They must have some counseling skills, too, as they try to talk troubled children through emergency moments and try to soothe and assure people on the other ends so they can relay accurate and important information.

And they need the nerves of a golf pro—an ability to get up in the morn-
ordinator. “They want to become the successful leaders of the future.”

CCM is an accelerated program that takes place over 10 weeks. Two one-week sessions are spent in the classroom bridged by eight weeks working online with a project group as well as completing individual learning exercises. The course begins online for three weeks before the attendees meet in Kansas City, Mo. By beginning online, class members are able to interact and learn about each other prior to meeting face to face.

“It takes away some of the inhibitions,” Williams said.

Although the CCM course is in its sixth year that doesn’t mean the same goes for the curriculum. The material keeps evolving, as does the approach since it’s tailored to meet the demands of students.

Something new this year is the use of Webinars. In case you’ve never sat in on a Webinar session, it brings real time to distance learning. Students can watch and listen to the instructor without time delay.

“We can bring in faculty that we couldn’t traditionally bring into Kansas City,” Williams said. “It opens up the potential number of presenters and topics that we can use.”

By the end of the first onsite week, the project groups are established and each group has posed a research question.

“It’s often sparked by what sessions they see,” he said. “Our goal is to be able to have people do something that’s usable.”

After the first live session is over, group members continue to work on their project during the next eight weeks before coming back together for the last six-day session, which is set up much like the previous onsite learning week. The groups present their research and share their papers with the class during the final week.

To submit your last-minute registration, contact Sharon Conroy, Fitch & Associates, at 816-431-2600 or sconroy@emprize.net.

Falls injure more than hips

Breaking a hip may not be the only fear in a fall when an elderly person takes a tumble. In fact, according to a study by the Centers for Disease Control and Prevention (CDC), a greater fear may be the possibility of a head injury as a result of the hard landing since brain injuries account for half of all deaths from falls among older people (age 65 and over).

The CDC study, based on information from 2005, looked at 16,000 deaths among the elderly that listed unintentional falls as an underlying cause of death. Although there were a variety of other medical conditions including heart failure or strokes that caused the fall and subsequent death, nearly 8,000 deaths were directly attributed to the brain injuries sustained in the fall.

Among the facts cited in the report:

- Each year, one in three Americans age 65 and older falls, and about 30 percent of such falls require medical attention.
- Deaths and hospitalization rates for fall-related brain injuries increased with age, and brain injuries accounted for about eight percent of hospital stays for non-fatal falls.
- Of those who survive the fall, about one-quarter of these patients have injuries that result in disabilities that last a longer term.
- So, what can an EMD do? Protocol 17 (falls) provides the assistance.

According to Principles of Emergency Medical Dispatch, many variables determine the severity of a fall, such as how far a person fell, how they hit the ground, what caused the fall, and the age of the person. While some people have miraculously survived falls from a great height and others have died falling only a few feet, the EMD’s rule for assessment is based on the distance they fell as defined in the Additional Information section. For example, a long fall is defined as falling from a distance of six feet/2m.

In addition to the three Axioms and five Rules in the Additional Information section, there is a table that the EMD uses to differentiate NOT DANGEROUS, POSSIBLY DANGEROUS, and DANGEROUS injuries according to the area of the body involved.

In the event of a dangerous situation, the EMD can instruct the caller (not the person who has fallen) using Post-Dispatch Instructions.

For additional information, CCM course agenda, and objectives

Visit www.emergencydispatch.org
Stress is up to anyone's interpretation. On the one hand, there is the good stress that keeps us alert and in some cases, especially for emergency services workers, it's the type that can actually help people to perform their jobs better. Stress gets bad when we feel overwhelmed and without any control of what's happening in our lives; the persistent stress can break down the body and mind. The stress can immobilize us.

Stress and the dispatcher

The very nature of emergency services puts dispatchers in the path of stress every time they report to their jobs. Stress can be the result of many factors common to the emergency communications center career, including sleep disruption due to shift work, the lack of personal space, the anticipation of an emergency, and, of course, the occurrence of actual emergencies. For some dispatchers, stress may be the result of a single incident or, for others, the product of events that accumulate over weeks or months at the job.

Take, for example, the personal stories featured in this issue of The Journal. There is the award dispatchers in Utah received for a horrific event—a mine collapse that claimed the lives of six miners trapped in the cave and three others who went into the mine to rescue them; another story details an attempted robbery and the wounding of two police officers.

The good stress activated quick and efficient responses. The bad stress may come later, once the calls have ended and the depth of the tragedies sinks in.

Camille Critchlow, a dispatcher for the Tooele County Sheriff's Office in northern Utah, said dealing with the stress, good and bad, accompanying emergency calls is all...
part of the job. “There are some calls that get to you more than others and when that happens, Heather [her coworker] and I talk about it. But generally you let it go. You have to. You can’t take the job home.”

Not so easy to let go

Sometimes, it’s not so easy to let things go and an incident that may have happened months ago may come back to haunt an individual when triggered by another, similar occurrence. Or there may be events particularly painful, like the accidental death of a child or, in the case of Stafford County Sheriff’s Office (Va.), the October 2007 death of Deputy Jason Monev, 24, who lost control of his sheriff’s cruiser while responding to a motor vehicle accident and died in the ensuing accident. His fiancé, a firefighter and medic for the Stafford Fire Department, witnessed the accident from Engine 9 while responding to the same traffic accident.

Dispatcher Karen Roy received a meritorious award for her outstanding performance during the incident but as Supervisor Wesley Melson said, an award like this is tough to take, same as the other awards won by several other Stafford County Sheriff’s Office dispatchers at a presentation in May 2008 that paid tribute to 53 public emergency service workers.

It’s kind of like a Catch-22 situation in which a person is caught in a set of circumstances impossible to escape.

“We certainly don’t do this for the recognition,” Melson said.

Stress is as unique as the individual

Dispatchers are not often publicly honored for the work they do behind-the-scenes. They are the voices on the calls sending response and, with the advent of Pre-Arrival Instructions (PAIs) and Post-Dispatch Instructions (PDIs), they’re the first in line to help the victims until help arrives on the scene. Once the call to 9-1-1 ends, so often does the dispatchers’ involvement. They simply move on to the next call. Resolution is rarely part of the communications process.

The lack of follow-up can be a cause of stress, the same as the rapid fire moves from one call to the next.

It’s all part of the work environment, said Karen Hileman, operations manager for the Stafford County Sheriff’s Office communications center.

“Stress is certainly not unique to our line of work,” Hileman said. “But the situations that trigger stress and the way stress is handled is unique among the individuals who work here.”
Limits of stress can change
Change over time also adds to the mix and the consequent reaction that can be attributed to a growing urban center.

In her 28 years of dispatch, Debby Peterson, training and floor supervisor for the Salt Lake City Fire Department communications center, can't help but notice a change in the level of stress caused by critical incidents in Salt Lake City and the surrounding area.

"What was huge 25 years ago is no longer thought about in the same way," she said. "As an area grows, bad things are bound to happen more often and because of the population size, you're less likely to know the people involved. It's different in a small city where you have a greater chance of knowing those affected."

Despite the personal factor, however, she said stress is still a big part of the profession and her department is always looking at ways to alleviate the pressure.

"If you don't deal with stress, it builds," she said. "What matters is making sure people get help. They have to understand that a strong reaction to an abnormal situation is perfectly normal."

There's help out there
Similar to many agencies Stafford County offers programs to help dispatchers relieve the stress. Their approach avoids a one-size-fits-all method. Nick Stepaniak, who was recently promoted to training officer, was asked to coordinate his agency's stress management training and was told to take a novel look at a program Hileman wanted for her crew.

"I wanted something unconventional," she said. "Stress is unavoidable as part of their jobs but it's a different sort of stress than most people encounter in their lines of work."

Stepaniak teaches skills that can distract the dispatcher from dwelling on a bad call immediately after it occurs so that the dispatcher can return to the task of answering calls with a fresh frame of mind. If a call hits a personal note, the dispatcher is allowed to approach the subsequent stress on the same personal level. For example, a tragedy involving a child answered by a dispatcher who has a child of the same age may result in the dispatcher calling home for a welfare check. For greater separation without leaving the communications center, there is a quiet room off of the Stafford ECC floor that provides space for decompression.

"We don't train anybody on how they react to stress," said Hileman. "That's not possible, and we're taking the same approach to alleviating stress. We give them choices. We create an environment that lets them say, this is going to turn into an OK day."

Accumulative bad stress and the stress of a major incident render different approaches. After all, a bad call handled by one dispatcher is not the same as a group effort to resolve a crisis. Stafford County dispatchers Kim Cottle, Andrea Mullen, Karen Stephenson, as well as Tammy Tolson and Melson each earned letters of commendation at the recent awards presentation for their combined efforts to maintain order and control with 739 incoming radio and telephone traffic calls during a January 2007 snowstorm that took the community by surprise.

There was no time for quick games on the Internet or a visit to the quiet room. The six dispatchers on duty spent five hours answering calls and dispatching response crews to the 340 snow-related incidents reported. No one had the luxury of leaving the phones or radio, let alone the time to take a trip upstairs to catch a glimpse of the storm raging outside of the county courthouse where their center had been located.

This type of uninterrupted focus can be demanding, said Melson, who has been at the job going on 10 years.

"It creates a certain amount of stress, so at times like that everybody works together to keep the environment friendly," he said. "We work really hard at staying upbeat and that keeps us motivated."

Training Officer Stepaniak conducts stress management training for the in-house ECC Training Academy in an environment that is conducive to relaxation and group participation. Proposals from the communications officers for the sessions include cooking classes in the ECC kitchen. No longer cramped in the basement of the courthouse, they now have more room and windows in their new facility that also serves as the headquarters for county fire and rescue.

"We can see out without leaving the floor," said Melson. "To us, that's a big relief from a small room seven of us used to share at each shift."

Peterson said a group's ability to communicate during any phase of an emergency—including the time after an event—is one of the best stress breakers.

"Dispatch has an advantage that way. There is a gathering place for them to talk," she said. "You have people in the same room who can talk about what's going on, and they usually know each other well enough to recognize when someone is not doing well."

Peterson is part of a statewide group of volunteers that form the Critical Incident Stress Management team (CISM). The team was created 21 years ago through the Utah Bureau of Emergency Medical Services. Like the program in Stafford County, the help provided depends on the individual and the type of stress encountered.

The CISM team can be called to any agency in the state at any time. During what used to be called "debriefings," they may suggest stress busters such as exercise or a healthy diet. These group sessions are considered highly confidential. In other words, what goes on in the meeting never leaves the room.

Hileman said the importance of any approach to stress management goes beyond simply reducing the stress of an event.

"Their jobs are very important to the well-being of others," she said. "If the dispatchers can't function, it makes things very hard for those who depend on them."

"The situations that trigger stress and the way stress is handled is unique among the individuals who work here."

- Karen Hileman
Have you ever wondered why you stick around and do this job shift after shift even though those you’re trying to help do not seem to appreciate you? Have you ever picked up all the extra shifts you could to help out the team when you are mentally and physically exhausted? Ever have images in your mind from something traumatic you heard or saw at work that you cannot get out of your head? Have you ever felt like your work is what makes you who you are and that family is secondary? It’s not uncommon for those involved in the emergency services profession to answer “yes” to any of these questions. Through presentations provided at venues such as Navigator, CDE sessions, and other health care and public safety educational forums, I’ve learned that a common thread among us exists when it comes to the personal impact of helping others. We are inherently not great at taking care of ourselves, while we take great pride in our ability to help others.

Your behavior relates to the evolving study of traumatology.

BY JIM LANIER
Traumatology and stress management have some core terms associated with them relevant to this article:

1. **Stress**: a demand for action.
2. **Burnout**: a debilitating psychological condition brought about by unrelieved work stress, resulting in: depleted energy and emotional exhaustion, increased depersonalization in interpersonal relationships, increased dissatisfaction and pessimism, increased absenteeism, and work inefficiency.
3. **Post-Traumatic Stress Disorder (PTSD)**: a debilitating condition that often follows a terrifying physical or emotional event causing the person who survived the event to have persistent, frightening thoughts and memories, or flashbacks, of the ordeal. Persons with PTSD often feel chronically, emotionally numb. Once referred to as “shell shock” or “battle fatigue.”
4. **Compassion Stress**: natural consequent behavior and emotions resulting from helping or wanting to help a traumatized person.
5. **Compassion Fatigue**: a state of exhaustion and dysfunction, biologically, psychologically, and emotionally.
6. **Compassion Satisfaction**: satisfaction derived from helping others.
7. **Primary Trauma Exposure**: work that puts one directly in the path of danger (soldier, public safety, humanitarian aid workers, etc.)
8. **Secondary Trauma Exposure**: exposure to traumatic events experienced by others as a result of your work (counselor, emergency room employee, public safety telecommunicator, etc.)
9. **Vicarious Traumatization**: persons who work with primary and/or secondary trauma victims experiencing profound psychological effects that can be disruptive and painful for the helper and persist for months or years after work with traumatized persons.
10. **Critical Incident Stress Management (CISM)**: a way of providing crisis counseling that includes debriefing people who have been exposed to a traumatic event. CISM is stated to be “a comprehensive, integrative, multi-component crisis intervention system. CISM is considered comprehensive because it consists of multiple-crisis intervention components, which functionally span the entire temporal spectrum of a crisis.

What is traumatology?

The textbook definition of traumatology is: The treatment and prevention of the unwanted consequences of highly stressful/trauma-producing events affecting those in harm’s way and those who care for them. The unwanted consequences can be psychological, systemic, biological, political, and aesthetic. The roots of traumatology as a discipline began to take hold after the Vietnam War. While many of the veterans received some form of mental health counseling and were debriefed to a degree, symptoms of post-traumatic stress disorder (PTSD) often showed up well after the counseling sessions, sometimes months or years later. Due to a lack of fully understanding what was occurring to them (the veterans), a somewhat limited focus on the treatment and true understanding of PTSD by mental health community establishment at the time, combined with a lack of access to qualified counselors led to a serious situation. Some veterans were “going off the deep end” for no apparent reason. However, in retrospect there were reasons: deep-seated, painful and/or scary reasons that had stayed dormant because they were not uncovered properly. Another factor was the effects that the counselors who debriefed the soldiers experienced themselves. Some of the counselors began to feel many of the same emotions that the soldiers were describing and had nightmares based upon soldiers’ experiences.

The International Society of Traumatic Stress Studies was formed in 1985 to better understand the consequences of traumatic exposure. A sentinel event for the study of traumatology was the Oklahoma City Bombing in 1995. Mental health workers were overwhelmed by the aftermath of the events. This led to the formation of the "Green Cross" organization by Professor Charles R. Figley. In 1997, Dr. Figley established the Academy of Traumatology to bring world leaders in the study of traumatology together to establish and maintain professionalism and high standards.

I first became interested in traumatology from a conversation with my wife Sharon, who is a registered nurse. We were discussing the generic term burnout and how it sometimes seemed like a convenient label to place on someone who was having issues at work. Sharon told me about compassion fatigue, which was coined in 1992 to describe a severe form of "burnout" in nurses.

I related back to at least two periods of so-called burnout from my career. The first was working as a field paramedic in a very busy urban central Florida area. I only knew that I was beginning to not like my job. It did not happen overnight; it took time to evolve. Initially, maybe I was cranky for an hour or two on a shift. Next it was for half the shift. Then it was me acting like I had a bumblebee up my wazoo for 12 hours every day.

Unfortunately, at the time, I really had no idea what was happening to me, only that I felt frustrated at not liking my job and not being satisfied with helping others. I began to judge my...
patients (“What am I, a glorified taxi driver?”). At that time I didn’t really have anyone with whom I could share my feelings. I thought I might be viewed as weak and not a true professional. My eating and sleeping habits changed. Off duty, I began to self-anesthetize some of the pain 12 ounces at a time.

Fortunately for me, I had an epiphany. It was as if Jim Page, the paramedic’s paramedic, had reached out and slapped me around a little bit. I realized while mired in a funk, just me and my bumblebee, that what I do does make a difference. Every call I respond to is for a person who needs assistance, one way or another. Yes, it might just be for a ride to the hospital to get out of the rain, to get a hot meal, or to get a toe evaluated. Yes, it might be someone who called for help and is now trying to bite, kick, or punch me (usually it was my partner who was trying to do that, not the patient) as a reward for my assistance. And yes, it might be the frail, sweet elderly man who grins at me through his tooth as he unloads a giant protein shake gas bomb and a Code Brown pie on my stretcher.

Not only did I have to find both the humor and the irony in all this, but I had to realize that whether or not I had a good or bad attitude, if I acted with a servant heart and myself, others will or cannot. Was it burnout and compassion fatigue causes different degrees of stress (a.k.a. compassion stress) on us, dependant upon the situation. The effects of dealing with secondary trauma in public safety telecommunications can be acute (sudden) or chronic (long term).

In my opinion, the chronic can lead to the acute. For example, I had the experience of dealing with a stellar employee (John, not Jim’s real name) who pride himself on being an excellent calltaker. Suddenly, he had an inappropriate emotional outburst at a caller who would not follow the ED instructions, which left him sobbing at the console afterwards. There was the normal intervention that we felt was appropriate at the time. We promoted him. Not really. We got John out of the dispatch environment and into an area of peace and quiet. After giving John sometime to collect himself, he requested to go home. There was also the offer of professional mental health counseling and to call us if he needed anything. The next day John told us that he didn’t know what had happened to him or why. He was embarrassed and somewhat scared by his actions of the previous day. He wanted to put this behind him and come back to work. Not knowing any better, he was immediately welcomed back; after all, there was a communications center to run. John went home two hours into his next shift, complaining of a headache and stomach ache, and then called out for the next three shifts. Something did not add up here, and we did a little more investigating. We learned that John had been working multiple overtime shifts for about four months secondary to financial and relationship pressures at home. He had not been promoted to a position he felt matched his qualifications. The pizza delivery guy was going to his home more often than he was. John’s son had been diagnosed with a serious illness. On top of that, the employee had experienced two “bad calls” in the three days prior to the outburst. Peers had noticed a change in their coworker’s attitude, but they had not told anyone since they thought it was just a case of being “stressed out.”

We realized that all these factors could be the source of John’s behavior, and the employee’s immediate actions. We called it “burnout.” The cumulative effects of stressors had led to an acute reaction. Simply coming back to the same environment was not the answer, so we arranged for John to receive mandatory mental health counseling through an Employee Assistance Program (EAP) before being allowed back to work. Over a period of time he was once again a highly productive and motivated employee. John’s diagnosis: burnout and compassion fatigue.

The outburst John had was a sentinel sign that he displayed after his coping system gave out. Folks with compassion fatigue work more and try harder to do better, while...
Red Flags of Burnout, Compassion Fatigue, and Vicarious Traumatization*

- Abusing drugs, alcohol, or food
- Anger and blaming
- Change in libido
- Chronic lateness
- Depression
- Diminished sense of accomplishment
- Frequent headaches
- Gastrointestinal problems
- High self-expectations
- Hopelessness
- Hypertension
- Inability to maintain empathy
- Inability to maintain objectivity
- Increased irritability
- Increased absences from work
- Less ability to feel joy
- Loss of sense of humor
- Low self-esteem
- Psychosomatic complaints
- Paranoia
- Sleep disturbances
- Workaholism

*Multiple signs and symptoms may be present, not an inclusive list. This is not a diagnostic tool.

Identify the Symptoms

The caregiver: traits and characteristics

So what makes us as caregivers so vulnerable to the effects of burnout to the point where we reach compassion fatigue? One answer to this question lies in the word caregiver. By giving assistance and care to others in a time when they are in pain (i.e. experiencing trauma) we are giving of ourselves. Victor Frankl (1905-1997), a psychologist interned in the Nazi concentration camps of World War II, said he survived by finding a meaning in the suffering: “That which gives light must endure burning.”

We can deny it all we want, but we are affected at one level or another with what we as human beings face while assisting other human beings through their times of need and suffering. We have programmed ourselves to try to “be tough” and not acknowledge that what we deal with is difficult. A prevalent characteristic of public safety personnel is being very rule bound. Our so-called “role” (telecommunicator, EMS, firefighter, law enforcement officer) is something that we take very seriously and we take pride in our ability to do well. We identify so strongly and personally with our job titles that we can stop being an effective spouse or parent when we begin to get burned out or start going into compassion fatigue. For example, a law enforcement officer might begin to get overprotective of his family and become completely authoritarian; essentially the person becomes the “protector” for the family instead of the parent or spouse. Our focus becomes our job role and the other hats we wear become secondary.

Many of us place our self-esteem, our self-worth on how well we are able to perform our public safety role. “I have to do my job well or I am not as successful as a person!” And just for fun, many of us entering this profession are also perfectionists, idealistic, and altruistic. We have our ideas of how things need to be done and how the world around us should be. We perceive that people will appreciate our efforts to assist them. When we encounter the opposite, it can bring about frustration. This makes us vulnerable to burnout and compassion fatigue since we try to save the world one call at a time: the world seems to be fighting back, sometimes spitting in the face of those who are trying to help.

Being workaholics is another characteristic of public safety personnel. Sometimes we work as much as possible so we can always feel like we are assisting others. Because we are sensitive to our work environment and issues such as short staffing and increasing workload, we won’t take a vacation. We take all those extra shifts to try to “help out the team.” If we are very role bound, we will work as much as possible to make sure that we are the designated provider for the family (staying in control).

A sense of “gallows humor” allows us to try and find the “lighter side” of tragedy to help us cope. This gallows humor can be a protection and in an ironic way it provides a methodology to convert something horrific into something that we can better mentally digest. This gallows humor has to be tempered with the seriousness of the situation it is based on and be used with discretion (not discussed with the in-laws at a holiday dinner). There can be a direct relationship between burnout and compassion fatigue evolving from the loss of your sense of humor.

As a group, we are an interesting mix of traits and tendencies. Hopefully, you can see how this ties in with making us vulnerable to the damaging cycle of burnout and compas-
We are inherently not great at taking care of ourselves, while we take great pride in our ability to help others.

painful memories from the past “escape” and compound the issue. It's like kicking a hive of yellow jackets knowing you are going to get “stung.” It can literally change someone's personality and outlook on life since this involves both internal and external stressors.

There can be counter transference between a call taker and caller that can lead to vicarious traumatization. Carl Jung (1875-1961) warned other psychologists in 1907 that participation in the patient's painful world of traumatic images has significant deleterious effects for the therapist. When our coping mechanisms are weakened, we are at a greater vulnerability to let these images and experiences break through our mental firewalls and run rampant. People affected by vicarious traumatization have described this as an “awful movie clip” that just seems to “pop-in,” playing over and over again. Vicarious traumatization is very prevalent among post-Vietnam war veteran counselors.

If a person has vicarious traumatization, entry into a critical incident stress management (CISM) program should be strongly considered. Vicarious traumatization goes beyond “normal” reactions to trauma that can supersede burnout or even compassion fatigue.

What to do about compassion fatigue?

Short-term fixes may compound the situation and need to be avoided if at all possible. For example, a person suffering from compassion fatigue leaves his or her agency to perform the same job at another and finds him or herself in the same boat. Substance abuse and food abuse (overeating as opposed to whipping eggs and mashing potatoes) can ease some of the pain but obviously have negative side effects. Another short-term fix is blaming others for the situation the individual is in and complaining incessantly in order to try to get attention and acknowledgement. This is just avoiding the issue(s) within the individual and misery loves company. And, as stated earlier, working as a workaholic, you might have to force yourself to get some rest and downtime outside of work. This can be easier said than done because it can go against our natural tendencies (in this case to work more to try and get past the reactions). We can't be afraid to ask for help when unable to deal with the reactions effectively despite a carefully devised personal wellness plan. Exercise or taking time each day to read from a good book are examples of beneficial behavior modification. Cognitive change might be easier than one realizes and is an extremely powerful tool to adjust to what confronts us. The steps to maintain a healthy ability to cope take time, desire, and action. No one can expect overnight results but the personal investment can lead to a longer and more fulfilling career. One might call it the “mental Viagra effect.”

Tools are available to assist in assessing our vulnerability on a continuous basis. These self-tests have been developed to provide a check and balance evaluation between our level of compassion satisfaction and our risk for compassion stress, burnout, or compassion fatigue. The Freudenberger Burnout Scale and the Professional Quality of Life Scale (ProQOL) test are examples that can be found using an Internet search engine and downloaded at no cost.

The upside of helping others

On the positive side, powerful satisfaction can be gained from helping others. Traumatologist Charles Figley has coined the term “compassion satisfaction” to describe this process, which involves the development over time of a much stronger sense of strength, self-knowledge, confidence, meaning, spiritual connection, and a respect for human resiliency.

Compassion satisfaction can help blunt many of the effects of compassion stress.
As I took this call, I got tunnel vision and was less aware of everything else going on in the communications centre.

A couple of years ago (July 11, 2006), I answered a 9-1-1 line from a caller in Surrey, a province of British Columbia, that forever changed the way I look at the importance of our work. I’d always held the view that we can help people and play a part in saving lives, but that call really showed me what we can do given the right tools and the tenacity to calm and reassure callers during an emergency.

The phone call came from a very upset grandmother, Cynthia Cox. Her 7-year-old granddaughter, Emily, had an electrical shock and was unconscious. From what she told me, the little girl had put a metal filing into an electrical outlet. Immediately, I knew that this was a “monster call,” a career-defining, life-changing call. I remember looking out the window of the dispatch centre and thinking, “But it is such a beautiful sunny day. Children don’t get electrocuted on days like this.” Children should never get electrocuted; yet here I was, on this gorgeous day, asking a grandmother if her granddaughter was conscious and if she was breathing. It was a day that forever changed this family.

As I proceeded through the Medical Priority Dispatch System® (MPDS) protocol it soon became apparent that this little girl was in cardiac arrest. This was challenging on both a professional and personal level. I had to navigate quickly through Protocol 15 (Electrocution/Lightning) to provide the crucial Pre-Arrival Instructions (PAIs) while dealing with the grandmother’s acute anxiety and my own stress. I was relying on a protocol that’s not used very often (at least not at our centre) combined with PAI set B (Airway/Arest/C choking (Unconscious)—Child 1-7 yrs) which every EMD hopes that she or he never has to apply.

As I said, this call was personally challenging not only because I had to meet the emotional needs of the grandmother while giving her instructions on how to intervene in the physical needs of Emily, but I was also dealing with my own emotional reaction to the events. Emily’s grandmother and I were both having a reaction known as critical incident stress. Generally, the condition is triggered by a sudden, unexpected, incomprehensible, shocking, and personally upsetting event. Emily’s grandmother was confronted with a situation that was overwhelming her ability to cope. I was shaken by the situation since, among other reasons, I could relate the event to my own life. I had a 9-year-old child at home with a babysitter.

Critical Incident Stress

Critical incident stress involves an understanding about the dynamics of people reacting to a crisis. As dispatchers,
we have to remember that we are talking to normal people having normal reactions to abnormal events. Stress is a normal reaction in a crisis. The signs and symptoms of this kind of stress, however, are varied.

In the article "Traumatic Stress: Sources, Reactions, and Solutions," Dr. Toby Snelgrove describes the signs and symptoms people can experience during events like this. The physical signs may include nausea, upset stomach, sweating, muscle tremors, loss of coordination, heart rate and blood pressure increases, hyperventilation, chest pains, difficulty breathing, headaches, muscle soreness, loss of appetite, dizziness, and vomiting. The cognitive symptoms may include impaired thinking and decision-making, disorientation, poor concentration and confusion, difficulty performing calculations, memory and concentration problems, poor attention span, time distortion, and other perception alterations.

In the dispatch environment, the most obvious signs of stress exhibited by the callers are often the emotional ones. These include anxiety, guilt, fear, grief, emotional shutdown or inappropriate emotional responses, and feeling lost, abandoned and helpless, angry, numb, shocked, overwhelmed, uncertain, and agitated. Callers can experience behavioral symptoms that can be safety concerns such as being paralyzed or stunned (unable to act) or rescue responses like taking unreasonable risks or becoming detached.

Pushing aside emotional reactions

An emergency dispatcher experiencing the symptoms of critical incident stress while processing a call creates a difficult situation. This work requires us to push aside whatever we are feeling to help the caller. Slow, clear, verbatim instructions so she could perform CPR on her granddaughter. I needed to slow down my breathing and quiet the thumping of my heart. As I took this call, I got tunnel vision and was less aware of everything else going on in the communications centre. I felt this call in the pit of my stomach. I wanted desperately to help Emily and her grandmother and my concern took its toll during the call as well as for a number of weeks after it was over.

We're going to help you

In the non-visual environment of the communications centre, it is sometimes impossible to recognize what a caller is feeling, yet it is safe to assume that all people calling 9-1-1 have an elevated level of stress. An emergency dispatcher must minimize the distress. Sending a response isn't enough— as emergency dispatchers, we have to provide calming statements and reassurance early and often to treat the psychological patient, the caller. After all, if a caller is too panicked to follow CPR instructions it will affect the outcome for the patient. A caller who is watching a house burn may attempt to enter it unless the EFD warns him to keep out. A caller may forget important details about the description of a kidnapping suspect unless the EPD asks for the description during the protocol.

It may seem obvious, but we must tell the caller that we are going to help him or her, and reassure the caller that he or she is doing everything that can be done to help the victim until emergency help arrives. Once a caller knows that there is someone helping during the crisis, the anxiety decreases and the caller is much more likely to concentrate on the questions and instructions. The tone of our voice tells the caller that we will carry that person through the call. This is a tall order, but it is what emergency dispatchers are called upon to do every day; meet the needs of those who dial 9-1-1. No judgment, no criticism, just help. Callers should never feel guilty or like they failed after placing a 9-1-1 call. Even in situations where the outcome is poor, if the caller is encouraged and told that he or she has done everything possible (and remember that everyone copes differently) then we are laying the foundation for healing.

Encouraging efforts

I couldn't change the events that happened two years ago. I couldn't change the fact that I was spending what amounted to seven minutes on the phone giving a grandmother instructions on how to administer CPR to her seven-year-old grandchild. During this time, I encouraged her efforts and kept reminding her that help was coming; I felt like I was helping even more when telling her, “You are doing everything you can to help her. This will keep her going until the paramedics arrive.” It gave both the grandma and me hope!

This call has a very happy ending. After 28 minutes in cardiac arrest, and heroic interventions by her grandmother, the first responders, the paramedics and the ER staff, Emily’s heart started to beat again. She spent 10 days in the hospital, but she has made a full recovery. Her grandma saved her life that day.

One year later, Emily’s grandmother was given a Vital Link Award for performing bystander CPR and saving Emily’s life. Meeting this healthy little girl and her grandmother has been the highlight of my 16-year career in emergency communications. It was a beautiful sunny day, exactly the type of day you could want for such a wonderful celebration of life.

The Journal would like to run stories in a later issue relating to your stressful calls and what you do to relieve the stress. Understandably, every call presents some degree of discomfort but we’d like to highlight the particularly tough calls along with your advice about how you made it through the call and on to the next.

To submit your story, send it to Audrey Fraizer, The Journal’s managing editor, at audrey.fraizer@emergencydispatch.org. Remember to include contact information (your name, e-mail, phone number, and agency).
On Track

Saving Hearts and Saving Lives. Using the MPDS Aspirin Diagnostic and Instruction Tool takes strict attention to the details

By Greg Spencer

There is strong evidence that early aspirin administration may reduce heart damage and improve survival rates in acute heart attack patients. Aspirin works by interfering with the ability of blood platelets to stick together and form clots. During a heart attack, prompt aspirin therapy can inhibit the growth of an artery-clogging clot and, thereby, reduce damage to the heart.

The 2005 International Consensus on CPR and ECC Science issued by the International Liaison Committee on Resuscitation (ILCOR) states: “It is reasonable for dispatchers to advise the patient with suspected acute coronary syndromes and without a true aspirin allergy to chew a single dose of 160 to 325 milligrams of aspirin. It is also reasonable for EMS providers to administer aspirin because there is good evidence that it is safe and that the earlier aspirin is given, the greater the reduction in risk of mortality.” With help from numerous physicians and dispatch experts, the National Academies of Emergency Medical Dispatch® (NAED) responded by developing the Aspirin Diagnostic and Instruction Tool. Be aware that local medical control must authorize the EM D’s evaluation and administration of aspirin in patients presenting with chest pain or heart attack symptoms. The NAED does not sanction the use of the Aspirin Diagnostic and Instruction Tool without local authorization.

Aspirin is not for everyone

Despite its potentially life-saving effects, aspirin is not for everyone. EM Ds should never advise aspirin for patients under the age of 16 to suffer a heart attack, which means that aspirin is not likely to provide a cardiac benefit for these patients. In other words, risks associated with aspirin administration outweigh potential benefits in children under the age of 16.

EM Ds should also not advise aspirin for patients with signs of active or recent gastrointestinal bleeding. The anti-clotting effects of aspirin have the potential to make such bleeding worse. For obvious reasons, EM Ds should not recommend aspirin for patients who are allergic to aspirin or have a history of bad reactions to it. Finally, EM Ds should never advise aspirin for patients who are unconscious or not alert. Doing so could result in an airway obstruction that could make the patient’s condition significantly worse.

Many household medications contain aspirin, others do not

A number of household medications contain aspirin. For early treatment of acute myocardial infarction, or heart attack, the medications listed below can be considered the same as aspirin.

<table>
<thead>
<tr>
<th>Same as Aspirin</th>
<th>Same as Aspirin</th>
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<tbody>
<tr>
<td>A-Ika-Seltzer (dissolve in water first)</td>
<td>A spergum</td>
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<tr>
<td>A spirin</td>
<td>Goody’s Powder</td>
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<td>A nacin</td>
<td>Bayer</td>
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<td>A scriptin</td>
<td>Doan’s pills</td>
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<tr>
<td>A scriptin</td>
<td>Vanquish</td>
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</table>

Many household medications contain aspirin, others do not.
Notice that Alka-Seltzer should be dissolved in water before use. Also notice that only aspirin based varieties of Excedrin should be administered. Some Excedrin varieties contain only acetaminophen and no aspirin. Acetaminophen does not provide the cardiac benefits that aspirin does, and should not be advised.

Since aspirin is often used as a pain reliever, some callers may mistakenly assume that other pain relievers will have the same effects. For early treatment of heart attack, the medications listed below are NOT the same as aspirin and should NOT be administered.

### NOT the same as Aspirin

- Advil (ibuprofen)
- M Motrin (ibuprofen)
- Aleve (naproxen)
- Nalfon (fenoprofen)
- Celebrex (celecoxib)
- Naproyn (naproxen)
- Feldene (piroxicam)
- Orudis (ketoprofen)
- Indocin (indomethacin)
- Tylenol (acetaminophen)
- M idol (acetaminophen)
- V loxx (rofecoxib)

If callers have a medicine not listed in the Aspirin-C containing medications, they should be advised not to take it unless they are sure it contains aspirin.

### Using the tool

As approved by local medical control, the Aspirin Diagnostic and Instruction Tool should be used for all alert patients over the age of 16 presenting with non-traumatic chest pain, including those identified using Protocol 19. The tool is designed for use after asking all Key Questions and initiating dispatch. Typically, it is used prior to the provision of Post-Dispatch Instructions (PDIs). However, if certain PDIs appear to take precedence in an unstable patient, those PDIs should be provided first. Cardset users will find the Aspirin Diagnostic and Instruction Tool on a double-sided pullout card that slides out from behind Protocol 10. ProQA® users can activate the tool by clicking on the Aspirin Diagnostic button on the tool bar or beneath the DLS Links on Protocol 10 or Protocol 19. Cardset users will notice that the Aspirin Diagnostic and Instruction Tool is formatted much like the Chief Complaint Protocols. When using this tool, you start by asking the Diagnostic Questions located in the upper left-hand corner of the card. If the answers to these questions confirm that aspirin administration is appropriate for the patient, you will next provide the appropriate Administration Instructions from the bottom of the card. After providing these instructions, you move to the upper right-hand corner of the card and provide all appropriate PDIs. The PDIs on this card are identical to PDIs contained on both Protocol 10 and Protocol 19, making it unnecessary to return to the original Chief Complaint Protocol card. After providing PDIs, you should quickly consider the Critical Information and then follow the appropriate DLS Link just like you would do from Protocol 10 or 19. If aspirin administration is ruled out by any of the Diagnostic Questions, you are directed to bypass the Aspirin Administration Instructions and go directly to PDIs and then DLS Links.

ProQA® users must specify if they are speaking to a 1st or 2nd party caller by clicking on the appropriate button at the top of the tool. After doing this, the Diagnostic Questions automatically activate one at a time. For each question, you indicate the caller’s answer by clicking on the appropriate answer choice. If aspirin administration is ruled out by any question, you are instructed not to proceed with aspirin instructions and to return to the normal PDI sequence. When this occurs, simply close the Aspirin Diagnostic and Instruction Tool and continue on as you would with any other call. If the answers to the Diagnostic Questions confirm that aspirin administration is appropriate, you will proceed with the instructions located at the bottom of the tool. After providing these instructions, you should close the tool, provide all appropriate PDIs and follow the appropriate DLS Link. Notice that when you close the tool, ProQA® asks if the patient took aspirin. This information can be very useful for responders.

### Diagnostic Questions

Diagnostic Question 1 is: “Is he allergic to aspirin, or ever had a bad reaction to it before?” True aspirin allergies are rare. Symptoms can be mild or severe. Aspirin sensitivity is more common especially in patients with asthma or sinus problems. Symptoms of aspirin sensitivity and aspirin allergy are similar and may include: hives; itchy skin; itchy, watery eyes; swelling of the lips, tongue, or face; and difficulty breathing. In severe cases, anaphylaxis can occur. Anaphylaxis is a rare, but potentially life-threatening systemic reaction. Because of the risk for breathing difficulty and anaphylaxis, EMDs should not advise the use of aspirin when the caller reports that the patient is allergic to aspirin or has had a previous bad reaction to it.
Diagnostic Question 2 is: “Has she passed black or bloody stools in the last 24 hours?” Partially digested blood is often described as coffee grounds. Callers who are not medically trained may not recognize this dark material as blood. However, vomiting of either bright red blood or dark, coffee-ground material is a sign of active or recent gastrointestinal bleeding. EMDs should not advise aspirin for such patients. The anti-clotting effects of the medication could make the bleeding worse.

Diagnostic Question 3 is: “Has he been initiated.” When the caller reports that she has the aspirin, it may be necessary to ask: “Which type do you have?” Whether already obvious or not, the answer to this question will help you determine the proper Administration Instructions to provide. Be aware that in some situations it may become necessary to hang up with the caller before the aspirin is located. If the EMD must hang up before the caller has located the aspirin, the EMD should tell the caller how to administer the aspirin and then use the Urgent Disconnect on Case Exit. Also be aware that callers may sometimes report that the patient has just taken aspirin or routinely takes aspirin. If the patient is reported to have just taken aspirin, or routinely takes aspirin, it is okay to advise him or her to take the dispatch-recommended dose now. Since aspirin resistance is quite common, an additional dose should not commonly be a problem.

The Aspirin Administration Instructions are quite simple to follow. For adult aspirin, “Tell him to chew one adult aspirin right now.” For baby aspirin, “Tell her/him to chew four baby (low-dose) aspirins right now.” Research shows that chewing aspirin tablets before swallowing speeds absorption so the medicine can start working faster. Be aware that aspirin tablets not specifically designed to be chewed are quite bitter. Patients may ask to have a drink to wash it down. If the caller asks if the patient can drink something to wash down the chewed aspirin, tell them that they may use just a mouthful of water to wash it down. Cardset users will find these wash down instructions just below the Aspirin Administration Instructions. ProQA users can access these instructions by clicking on the “Request to wash down aspirin” button. In either case, these instructions should only be provided when the caller asks if the patient can have something to drink. In the absence of such a request, the patient should be advised not to have anything to eat or drink as it might make him sick or cause problems for the doctor.

In conclusion

The Aspirin Diagnostic and Instruction Tool embodies a significant advance in the practice of Dispatch Life Support. The recommendations contained within the tool represent the current best practice approach as defined and approved by the Academy’s Council of Standards regarding the potential life- and heart-saving early administration of aspirin in acute heart attack conditions. The Academy’s experts understand that aspirin administration might have an undesirable effect on a few patients. However, acute myocardial infarction (AMI) is a high-risk situation and early aspirin administration clearly benefits significantly more patients than it might compromise. Since the tool must be approved by the local medical director, and then activated by supervisory personnel, each center/EMS system must determine for itself the risk/benefit value of using this protocol for their patients.

The tool is designed to be used after all Key Questions have been asked and dispatch has been initiated. Typically it is used prior to the provision of Post-Dispatch Instructions.

Administration Instructions

When the caller reports that she has the aspirin, it may be necessary to ask: “Which type do you have?” Whether already obvious or not, the answer to this question will help you determine the proper Administration Instructions to provide. Be aware that in some situations it may become necessary to hang up with the caller before the aspirin is located. If the EMD must hang up before the caller has located the aspirin, the EMD should tell the caller how to administer the aspirin and then use the Urgent Disconnect on Case Exit. Also be aware that callers may sometimes report that the patient has just taken aspirin or routinely takes aspirin. If the patient is placed on a daily aspirin regimen by their physician often take low-dose aspirin. For purposes of the MPDS Aspirin Diagnostic and Instruction Tool, 81-milligram, low-dose aspirin should be considered the same as baby aspirin. Also be aware that even though 500-milligram, extra-strength aspirin falls slightly above the ILCOR-recommended ideal dosage of 160 to 325 milligrams, experts consulted by the Academy indicate that this higher dosage would not typically be problematic and is much more likely to be beneficial.
1. Aspirin may reduce heart damage and improve survival rates in acute heart attack patients by:
   a. dissolving blood clots in coronary arteries.
   b. dissolving plaque buildup in coronary arteries.
   c. interfering with the ability of blood platelets to stick together and form clots.
   d. stimulating the heart to pump blood more forcefully.

2. What is the ILCOR-recommended aspirin dosage for qualified patients with suspected acute coronary syndromes?
   a. 81 to 160 milligrams
   b. 160 to 325 milligrams
   c. 325 to 500 milligrams

3. Local medical control must authorize the EMD’s evaluation and administration of aspirin in patients presenting with chest pain or heart attack symptoms.
   a. true
   b. false

4. Aspirin use in non-allergic children has been linked with a rare, but potentially life-threatening condition called:
   a. Acute Myocardial Infarction
   b. Gastrointestinal Infarction
   c. Anaphylaxis
   d. Reye’s Syndrome

5. EMDs should never advise aspirin for patients who are unconscious or not alert.
   a. true
   b. false

6. During a heart attack, pain relievers such as Advil and Tylenol have the same cardiac benefits as aspirin.
   a. true
   b. false

7. When aspirin cannot be immediately located, 1st party callers should be asked to check for aspirin with neighbors or others close by.
   a. true
   b. false

8. When aspirin is available and aspirin administration is appropriate for the patient, the caller should be instructed to “get _______ and tell me when you have them.”
   a. one adult aspirin or two baby aspirins
   b. one adult aspirin or four baby (low-dose) aspirins
   c. two adult aspirins or six baby aspirins
   d. two adult aspirins or eight baby aspirins

9. Research shows that chewing aspirin tablets before swallowing:
   a. speeds absorption so the medicine can start working faster.
   b. provides an important placebo effect by making the patient more aware of the medicine.
   c. guarantees that the full dose is absorbed by the body.

10. If the caller asks if the patient can drink something to wash down the chewed aspirin, the EMD should provide which of the following instructions?
    a. “Don’t let him have anything to eat or drink. It might make him sick or cause problems for the doctor.”
    b. “Tell him that he can use just a mouthful of water to wash it down.”
    c. “Remind him to do what his doctor has instructed for these situations.”

To be considered for CDE credit, this answer sheet must be received no later than 8/31/09. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE certificate to be submitted to the Academy with your application when you recertify.
Complementing the Search. Police Priority Dispatch System and the recent joint operational guidelines encompass all ages of people gone missing

By Audrey Fraizer

About two years ago, several agencies, including the National Academies of Emergency Dispatch® (NAED), came together to develop guidelines that outline dispatch procedures to bring a missing or neglected child home quickly and safely.

Plans for the guidelines developed through the efforts of the Joint Steering Committee on Call Center Best Practices in Cases of Missing and Exploited Children were announced at the Navigator Conference in 2007. Later that year, the committee rolled out a comprehensive standards document along with, more recently, the chance to receive various levels of training at minimal cost to participants.

The guidelines are designed to help recover missing children (younger than 18 years of age and whose whereabouts are unknown) and protect children from exploitation, according to the document available from the National Center for Missing and Exploited Children (NCMEC) is the coordinator for training. The effort to reach their target audience—chiefs of police, sheriffs, and communications centers—is a task considered as part of the programs mandated by the new bipartisan law Protecting Our Children Comes First Act of 2007 (H.R. 2517, S.1829) that President George W. Bush signed on June 3 (see related story).

Police Priority Dispatch System™

The standards released by the Joint Steering Committee are not the first to address the problem of missing and exploited children on a broad scale. Communications centers using the Police Priority Dispatch System™ (PPDS) already have these guidelines in place to use and, because of the public served by the PPDS, they go beyond reports of missing and exploited children and into protocols that encompass all ages.

This does not diminish the importance of the Joint Steering Committee document since the recommended guidelines in the national standards focus on the recovery of missing children and on the consistency in the manner 9-1-1 centers handle these cases. But there is a major difference, aside from age. PPDS is a structured protocol while the Joint Steering Committee document provides recommended guidelines.

PPDS Protocols 101 and 123

Protocol 101 addresses abductions and kidnappings while Protocol 123 identifies missing, runaway, and found persons.

The type of emergency, and subsequent applicable protocol, is determined at Case Entry. The caller’s response to the initial questions sends the dispatcher to either Protocol 101 (Abduction/Kidnapping) or Protocol 123 (Missing/Runaway/Found Person), although the actual protocol that applies can change from one to the other as the call progresses and the dispatcher collects more information about the incident.

Protocol 101 Abduction (Kidnapping)

An abduction is the taking and carrying away of one person by another by force, fraud, or persuasion. A third-party caller who sees either an actual abduction or suspicious activity, a parent whose child has not returned home when expected, or a parent in a custody dispute are examples of incidents that prompt calls falling under this protocol.

On this type of call, the time lapse between the incident and the call is very important. Police will want to set up a perimeter around the area in an effort to keep any vehicles or victims contained, increasing the chances of finding them.

That is why the dispatcher needs to find out how much time has passed since the abduction actually happened. A car traveling at 45 mph can cover 2 ¼ miles in just three minutes, and another three-quarters mile every minute after that. In six minutes, the car may be 4 ½ miles away, making it difficult to set up an effective perimeter.
If police field units are going to set up a perimeter, an accurate description of the car is necessary. When obtaining this description, dispatchers should follow the protocol and use the format described by the acronym C Y M B A L S (C olor, Y ear, M ake/ M odel, B ody style, A dditional descriptors, L icense plate, and S tate/ province). This provides a logical, standardized format for receiving and broadcasting information relating to an automobile’s description.

In some cases, a suspected abduction may be reported as a past incident. Many of these calls actually turn out to be missing person calls wherein the reporting party has surmised that the victim must have been abducted rather than a matter of not returning home on time.

When processing these calls, determining the time lapse between the event and the call will dictate the priority of most of the other actions that are taken.

Protocol 123 Missing/Runaway/Found Person

Protocol 123 identifies cases of those who are missing, without reference to age. The protocol also addresses runaways (the act of intentionally leaving without permission) and found persons (any person who has been located).

The PPDS defines a missing person as someone whose location is not known but there is no evidence that a criminal act has taken place. Evidence of a criminal act indicates a potential kidnapping/abduction. The “at risk” missing person is defined as very young people, the elderly, and persons with physical or mental conditions that impair their ability to care for themselves or to make sound decisions based on circumstances presented to them. These important identifiers are listed in the Key Questions, which also address the possibility that the missing person could be a runaway.

Found persons are any persons reported to be missing who have been located. Found persons may also be at-risk persons who are noticed by others, even though they have not been reported as missing.

When someone is reported as missing, the chain of events that follows depends on the situation and the age of the missing person. A three-year-old who has been missing from home for 15 minutes will bring an army of searchers to an area, while a 17-year-old who disappeared after dinner with a suitcase and a $100 bill may be seen as a runaway case. A 70-year-old Alzheimer’s patient who has been missing for an hour from a nursing home will bring an immediate search, while a husband who hasn’t come home from work by 9 p.m. may not generate such an urgent response. Agency policy, procedure, and protocol will dictate the response to each situation.

A found person call may involve a very young person, an elderly person, or a mentally ill person. These can be difficult calls because the person who has been found may not be able to tell the police where they belong. Other agencies may need to be contacted, such as social service agencies. Recent missing person reports should also be consulted for cross-reference.

For missing persons, callers should be instructed to find a recent photograph of the person and also to make a list of friends, including their addresses and phone numbers. Callers should be instructed to write down the person’s favorite places and try to locate the person by looking under the beds, in closets, and other hiding places. Callers should be instructed to call back if the person is located. For found persons, callers should be instructed to try to keep the person there until officers arrive.

PPDS is a structured protocol while the Joint Steering Committee document provides recommended guidelines.

Missing and exploited children

The standards document, available from the Web sites of NCMEC, the National Emergency Number Association (NENA), and the Association for Public-Safety Communications Officials (APCO), is intended for voluntary use among communications centers. As explained on the APCO Web site, the document is a reference specifically for emergency calltakers to present the missing and/or sexually exploited child response process in a logical progression from the initial call through the first response.

According to the standards document, the guidelines do not replace the AMBER (America’s Missing: Broadcast Emergency Response) Alert program; rather they are meant to help in gathering the information necessary for an appropriate response consistent with agency policy. AMBER Alerts are emergency messages that are broadcast when law enforcement determines that a child has been abducted and is in imminent danger. The broadcasts include information about the child and, if possible, the abductor, such as physical descriptions, as well as information about the abductor’s vehicle, which could lead to the child’s recovery and the apprehension of the suspect.

Similar to the goals the N A E D emphasizes in its training and certification courses, the standards document stresses the methodical collection of pertinent information (incident location, callback, and contact information) through systematic inquiry. The document recommends entering all information into an electronic format that can be sent to law enforcement in conjunction with on-air broadcasts.

In a breakdown of the procedures expected of
Protecting Our Children Comes First Act of 2007

Protecting Our Children Comes First Act of 2007 authorizes the appropriation of $40 million for fiscal year 2008 and such sums as necessary for each of the fiscal years 2009 through 2013 for the Department of Justice (DOJ) to continue funding NCMEC. The act will also authorize the appropriation of such sums as necessary for each of fiscal years 2009 through 2013 for other DOJ programs to prevent the abduction of children and assist the families of missing children. Congress mandated that NCMEC perform 19 specific functions on behalf of the federal government:

1. Operate the official national resource center and information clearinghouse for missing and exploited children
2. Operate a national 24-hour toll-free missing children’s hotline
3. Coordinate public and private programs that locate, recover, or reunite missing children with their families
4. Provide technical assistance and training to law enforcement
5. Provide assistance to families and law enforcement in locating and recovering missing and exploited children, nationally and internationally
6. Provide analytical support to law enforcement through searching public records databases in locating and recovering missing and exploited children and helping to locate and identify abductors
7. Provide direct on-site technical assistance to law enforcement agencies in child abduction and exploitation cases
8. Provide forensic assistance to law enforcement in the identification of unidentified deceased children through facial reconstruction of skeletal remains
9. Track the incidence of attempted child abductions to identify links and patterns, and provide such information to law enforcement
10. Provide training and assistance to law enforcement agencies in identifying and locating non-compliant sex offenders
11. Facilitate the deployment of the National Emergency Child Locator Center to assist in reuniting missing children with their families during periods of national disasters
12. Operate a CyberTipline for reporting Internet-related child sexual exploitation
13. Work with law enforcement, Internet service providers, electronic payment service providers, and others to reduce the distribution on the Internet of images and videos of sexually exploited children
14. Operate a child victim identification program to assist law enforcement in identifying victims of child pornography and other sexual crimes
15. Develop and disseminate programs to the general public, schools, public officials, youth-service organizations, and nonprofit organizations on Internet safety and the prevention of child abduction and sexual exploitation
16. Provide an annual report to the Justice Department regarding the number of missing children reported to NCMEC in four categories: total missing; nonfamily abductions; parental kidnappings; and recoveries
17. Work with governments and nonprofit agencies to use school records and birth certificates to locate missing children
18. Assist governments, nonprofit agencies, and individuals in providing legal, food, lodging, and transportation services to benefit missing and exploited children and their families
19. Provide information about model programs, services, and legislation that benefit missing and exploited children

Source: NCMEC at http://www.missingkids.com/missingkids

Federal law and missing children

Federal law requires police to report each case of a missing child under age 21 reported to them to the National Crime Information Center (NCIC). Contrary to what many believe, federal law prohibits police from establishing or maintaining a waiting period before accepting a missing child or unidentified person report. The National Child Search Assistance Act also mandates agencies to do the following:

- Enter, without delay, reports of missing children under age 21 into the state law enforcement system and NCIC and make it available to the state’s Missing Children Information Clearinghouse or other agency designated to get such reports,
- Update identifying information on each case in NCIC within 60 days,
- Pursue proper investigative and search action, and
- Maintain a close liaison with NCMEC for the exchange of information and technical assistance in appropriate cases (42 USC §§ 5779 and 5780).
CDE Quiz Mail-In Answer Sheet

Take this quiz for 1.0 CDE unit.

To be considered for CDE credit, this answer sheet must be received no later than 8/31/09. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements (up to 4 hours per year). Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE certificate to be submitted to the Academy with your application when you recertify.

1. Protocol 101 addresses which of the following:
   a.4. PPDS Protocol defines runaway as:
   a. any person whose location is not known, but there is no evidence that a criminal act has taken place
   b. the act of intentionally leaving without permission
   c. the act of taking and carrying away of one person by another by force, fraud, or persuasion
   d. any person who has been located and admits to being a runaway

2. The type of emergency, and subsequent applicable protocol, is determined at which level of questioning?
   a. Case Entry
   b. Key Questions
   c. Pre-Arrival Instructions
   d. Supplemental questioning by responding police

3. The acronym CYMBALS applies when describing:
   a. the suspect
   b. the victim
   c. suspect vehicle involved
   d. the chain of command in recovering a missing person

4. According to PPDS, when processing calls for abduction (kidnapping) what factors dictate the priority of most of the other actions taken?
   a. the time lapse between the event and the call
   b. the age of the victim
   c. the area in which the incident occurred
   d. whether the suspect has a known criminal background

5. Which of the following summarizes the reason to categorize someone as “at risk”?
   a. The individual is late coming home from work or school.
   b. The individual is a minor who left the home without permission.
   c. A caller to 9-1-1 hung up unexpectedly.
   d. The individual does not have the ability to care for himself or to make sound decisions based on the circumstances presented.

6. What is a factor differentiating the PPDS Protocols for missing and abducted people from the Joint Steering Committee document for missing children?
   a. Systematic inquiry
   b. Preliminary assessment based on questioning
   c. PPDS is a structured protocol while the Joint Steering Committee document provides recommended guidelines
   d. Data mining for information that would assist responding officers

7. The organization coordinating training in relation to the standards document issued by the Joint Steering Committee is:
   a. National Emergency Number Association (NENA)
   b. Association for Public-Safety Communications Officials (APCO)
   c. National Center for Missing and Exploited Children (NCMEC)
   d. American National Standards Institute (ANSI)

8. Following guidelines for missing children replace the need to issue an AMBER Alert.
   a. true
   b. false

9. Federal law prohibits police from establishing or maintaining a waiting period before accepting a missing child or unidentified person report.
   a. true
   b. false

10. The acronym CYMBALS applies when describing:
   a. 10. Federal law prohibits police from establishing or maintaining a waiting period before accepting a missing child or unidentified person report.
Dedicated Class. Academy course devoted to police instruction attracts enthusiastic following

By Audrey Fraizer

The first dedicated Police Instructor Academy held at the National Academies of Emergency Dispatch® (NAED) offices offered more than some attendees may have suspected.

“I’m lock, stock, and barrel into the police protocol,” said Jeff Pauley, a retired police officer from an agency in Maryland. “I wasn’t quite sure what to expect but now I am the poster child for a person who should introduce this to others. This is stellar stuff.”

Pauley was one of six who attended the seven-day session that combined the three-day Police Priority Dispatch System™ (PPDS) certification course with the four-day certified police instructor course.

Pauley applied because of his experience in law enforcement, including five years supervising in emergency dispatch. He knows first hand what standardized protocol can do for a communications center, although he said some of his former colleagues may not want to admit as much.

“Police can be slow to change the way they do things,” he said. “They have a system and if that’s working, it tends to stay that way.”

He said the PPDS protocol fascinates him. Its creation and continued development demonstrate a process that police can appreciate because of the meticulous research that goes into the product along with the very literal application of the instructions dispatchers provide to their callers.

Similar to Pauley, David Keefe, a high liability trainer at St. Petersburg College in Florida and reserve sergeant with the Florida Highway Patrol, came to the Police Instructor Academy eager to learn but with scant background in protocol use.

The time he spent in dispatch many years ago while working for a police department in Massachusetts, however, convinced him that something was needed to take the “winging it” out of emergency call response.

“After a few hours in class, I was convinced that this was great material,” he said. “Protocol provides a higher level of service and it gives dispatchers a reliable set of questions to ask no matter the emergency.”

Julie Harmon applied to the Instructor Academy with an understanding of what protocol means for the dispatch environment based on her experience using the Medical Priority Dispatch System® (MPDS) and her supervisor’s plans to couple that with the use of the Police Priority Dispatch System™ (PPDS) and the Fire Priority Dispatch System™ (FPDS).

“I’m lock, stock, and barrel into the police protocol. I wasn’t quite sure what to expect but now I am the poster child for a person who should introduce this to others.”

– Jeff Pauley
A quality assurance supervisor for the Capital Area Council of Government (CAPCOG) in Austin, Texas, Harmon makes sure that wireless carriers meet Phase II E911 accuracy for relaying precise location information to the public safety answering points (PSAPs). The CAPCOG in Austin is one of 24 regional planning commissions in Texas that coordinates government agencies to include emergency services, law enforcement training, criminal justice, and housing and economic development.

Harmon, a former dispatcher, will be the CAPCOG regional EPD instructor once he completes the course requirements.

“I know the anxiety over answering the phone when there aren’t any standards,” Harmon said. “You worry about asking the right questions and sending the right resources. With EPD, you know what to do and that really helps decrease the anxiety level. The same applies to the other protocols when we add them.”

Jaci Fox, quality assurance coordinator for the Medicine Hat 9-1-1 Regional Communications Centre in Alberta, Canada, considered the six students that took the course all valedictorians for what they achieved during their week of studies.

“A ny instructor would enjoy working with a group like this,” she said. “They were fabulous. I can't say enough about the caliber of instructors we’re sending out.”

The Medicine Hat Communications Centre was the first to achieve status as a Police Accredited Center of Excellence (ACE), and it’s the only center in the world to achieve ACE status in all three protocols. Fox has been using the police protocol for nearly six years.

Following the four days of in-house instruction, the Academy requires team teaching and observation prior to awarding full certification.

Interested in becoming certified with the National Academy as an instructor?

The Academy is looking for individuals to teach Medical, Fire, Police, and Quality Assurance courses throughout the world. Instructors must have current Academy certification and previous experience working in adult education, as well as an interest in supporting the Academy’s goals and Code of Ethics.

For more information, contact Ross Rutschman at 800-960-6236 ext. 214 or check out our Web site at www.emergencydispatch.org.

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## Did You Know

The National Academies of Emergency Dispatch® is always looking for qualified instructors to teach the medical, fire, and police protocols. Instructors must have previous experience working in adult education and must support the NAED goals and Code of Ethics. Police, fire, and medical instructors must be certified with the Academy and associated with an Accredited Center of Excellence (ACE) or a licensed training site.

### EMD QUALIFICATIONS

- **ALS Certification**
  - Previous training, experience, and certification or licensure as an ALS-level medical practitioner, preferably as a paramedic
  - EMS nurse or EMS physician
  - Five years of active field, medical, or clinical experience is preferred

- **Instructional**
  - Previous training in disciplines of adult learning theory, adult education, and instructional technology
  - Significant classroom instructional experience is preferred

- **Personnel Training**
  - Previous experience in EMS/prehospital care personnel training, preferably at the ALS level
  - Five years of experience is preferred

- **Medical Dispatching**
  - Previous work with medical dispatching and communications center operations
  - On-line experience with a system utilizing the Advanced FPDS™ is preferred

- **Computer Knowledge**
  - Previous experience with and knowledge of personal computers
  - Ability to perform basic personal computer operations
  - Experience with Microsoft® PowerPoint presentation software is preferred

### EPD QUALIFICATIONS

- **Experience**
  - Five years on-street experience as a full-time police officer
  - Ranking police officer certification is preferred

- **Instructional**
  - Previous training in disciplines of adult learning theory, adult education, and instructional technology
  - Significant classroom instructional experience is preferred

- **Personnel Training**
  - Previous experience in police personnel training
  - Five years of experience is preferred

- **Fire Dispatching**
  - Previous work with fire dispatching and communications center operations
  - On-line experience with a system utilizing the Advanced FPDS™ is preferred

- **Computer Knowledge**
  - Previous experience with and knowledge of personal computers
  - Ability to perform basic personal computer operations
  - Experience with Microsoft® PowerPoint presentation software is preferred

### EFD QUALIFICATIONS

- **Experience as a firefighter and one of the following:**
  - NFPA Fire Service Instructor I certification
  - NFPA Officer I certification
  - Five years as a full-time/paid firefighter or 10 years as a part-time/volunteer firefighter with a minimum of three years or more as a company line officer

- **Instructional**
  - Previous training in disciplines of adult learning theory, adult education, and instructional technology
  - Significant classroom instructional experience is preferred
There’s nothing that says let’s celebrate life like eating caramel-soaked french toast among friends and that’s exactly what happens every time Ventura County (Calif.) firefighters and paramedics save a life using cardiopulmonary resuscitation (CPR).

And in a recent celebration, Ventura County Sheriff’s Office 9-1-1 dispatcher Tonya King was there to join them at the tasty festivities.

“This is a great way to meet everyone involved in something that turns out positive,” said King, a former investigative assistant and corrections officer for the Ventura City Sheriff’s Department. “You get to hear all the pieces of the story, and in this line of work that doesn’t happen often.”

The first part of the story revolves around King and the CPR Pre-Arrival Instructions (PAIs) she relayed over the phone to a dad trying to revive his five-week-old son. Daniel Anthony, of Newbury Park, Calif., made the 9-1-1 call after his wife Lisa couldn’t arouse their baby, named Tommy, early one February morning. Tommy had stopped breathing because of (the couple later learned) an acute respiratory virus.

“Dad was remarkably calm,” said King. “He was so intent on listening to my (pre-arrival) instructions, he wasn’t even aware of when the paramedics came to the door.”

The story continues happily. Paramedics took over CPR once they arrived, and they transported the baby to the emergency room at Los Robles Hospital and Medical Center where doctors worked nonstop for days stabilizing and treating the infant while family members took turns staying with him day and night, never leaving his side. Tommy went home one week later, an apparently happy and healthy little boy.

The couple’s gratitude poured out in a letter Daniel later wrote on his Blackberry to the Ventura County Star, the county’s daily newspaper. The three-page letter that details Tommy’s care from the moment King took the call to his intensive care at UCLA concludes with his sincere gratefulness to everyone involved:

“The 911 operator, Fire Station 32, the paramedics, and the amazing people in the Los Robles ER. Everything had to be done perfectly to save Tommy’s life, and it was. We are surrounded by heroes and are forever in their debt.”

Katy Hadduck, the quality improvement nurse manager for the Ventura County Fire Department, saw the letter in the newspaper, and...
which prompted her to invite the couple to the french toast breakfast she has served during the past two years for firefighters and ambulance drivers every time a CPR save is made.

“They were quite excited about it,” said Hadduck, a former emergency service flight nurse from Colorado.

Knowing they would be attending the breakfast with the now 10-week-old Tommy and his sister, Hadduck pulled out all the stops, increased the number of invitations, and made quite a big party of the event. She baked extra batches of her ever-popular Firehouse caramel-soaked french toast.

King called the morning emotional.

“There was a lot of crying that day,” she said. “We were all hugs and attention for the baby. Everyone must have held him at least once.”

“Since the call in February 2008, King has received additional honors, including a CPR save pin from her department and, in June, she received the Ventura County Chapter of the American Red Cross Clara Barton Award. The Clara Barton Award is named after the humanitarian and activist who founded the American Red Cross in 1881, and the award was given in recognition of the CPR skills used over the phone to help save Tommy.

Ventura County 9-1-1 Clinical Program Supervisor Robin Shedlowsky didn’t miss a beat, either. She baked King a chocolate chip cookie the size of a pizza pan, which is what she does for any of her dispatchers making a CPR save or giving childbirth PAIs over the phone. King is also in the running for Shedlowsky’s “Caught in the Act of Caring Award,” which includes a certificate and gift card in honor of showing extraordinary compassion during an emergency situation.

“Our dispatchers get really excited about making a difference in someone’s life and I like giving the positive recognition,” said Shedlowsky.

King, of course, isn’t used to all the attention. She took the job in January 2007 because of the public service aspect she wants in her work and the chance to help people at their times of crisis.

“Even if you can’t save someone by what you’re doing, at least you can provide some comfort at a time someone may be feeling very alone,” she said.

Hadduck attributes Tommy’s survival to new procedures, intense CPR training, and the feedback she gives from the cardiac arrest cases she reviews—and she reviews all of them. Before 2006, county firefighters revived two or three cardiac arrest victims with CPR a year, Hadduck said. In 2006, that number rose to 10, and in 2007 it climbed to 15.

Shedlowsky praises the Medical Priority Dispatch System® (MPDS) protocols.

“They definitely make a difference,” she said.

Just read what Daniel has to say:

“Although every doctor had their own way of explaining how Tommy could have possibly survived, they agreed on one thing. Tommy’s care from the moment we found him until he was placed in the UCLA transport was what saved his life.”

“This is a great way to meet everyone involved in something that turns out positive. You get to hear all the pieces of the story, and in this line of work that doesn’t happen often.”

– Tonya King
Tanner Shoemaker is like other kids his age.

The 8-year-old looks forward to driving his four-wheeler, and a football game with Dad is the next best thing to visiting his grandfather on the weekend.

Perhaps not so usual is the time spent in school that Tanner enjoys, especially when it comes to studying subjects such as math and science and last year’s participation in a Washington County (Md.) sponsored program that emphasizes public safety.

This program was a hit with Tanner, said his dad Michael.

Not only does young Tanner think about a future career in the field since attending the program but the information he learned came in very handy the day his mother, Cindy, fainted and tumbled down 13 stairs in the family’s Hagerstown (Md.) home.

“He knows about his Mom’s condition and knew exactly what to do in case something happened,” said Michael Tanner. “He’s a quick study. He listens and the information goes in and stays. He’s like a mini computer chip.”

Cindy Shoemaker’s fainting is attributed to a condition called transient global amnesia (TGA). The rare neurological disorder can cause sudden, temporary episodes of memory loss. During an episode of TGA, those affected cannot recall where they are or how they got there. In Cindy’s case, she remembers waking up at the bottom of the staircase and realizing her husband was holding her head while Tanner talked to Kevin Willis, an emergency services dispatcher from Washington County 9-1-1.

Michael said his son made the call on his own without any prompting. He’d heard a noise while working outside and by the time he got in the house, Tanner was at his mother’s side making the 9-1-1 call. The only time he needed Dad’s help was during the call when Willis asked about the family’s pets and whether the dogs were put away in anticipation of arriving first responders.

“H e was very on top of things and did an exceptional job,” Willis said. “He is one brave kid. He made this a very smooth call to process.”

Tanner was able to give Willis his address and phone number, his mother’s age, and even the exact number of stairs she had fallen down. Tanner said his mother was confused and told Willis about similar episodes she had in the past.

Tanner admits he was a little scared at first. He knew he had to help his mother and that calling 9-1-1 was the action to take.

“Dad had taught me some of the stuff, about calling 9-1-1 and what could happen to Mom,” he said. “The rest I learned from Children’s Village.”

Jennifer Swisher, assistant chief of communications in Washington County, described Children’s Village as a miniature safety education complex in Hagerstown. Private and public school second graders visit the village for two days of public safety lessons presented by uniformed police officers and firefighters. Among other skills, they learn how to crawl out of windows in case of a fire, the stop-drop-and-roll technique, and the essentials of operating a smoke detector. Police explain pedestrian and bicycle safety and a highlight for many students is the drive around the miniature village behind the wheel of a battery-powered automobile.

Each student makes a 9-1-1 call, and that’s the part of the program that Tanner took to heart or, at least, that’s what Swisher thinks after listening to the call later on tape. She said he also had a very good dispatcher taking Tanner through the questions and getting the right information.

“Tanner was incredibly calm,” she said. “Kevin is very good with children and together they got through it.”

Washington County was so impressed with the duo that they invited Tanner to meet Willis and tour the center in early April, about a week after the incident occurred. Tanner received an emergency services T-shirt and a special hero certificate along with Willis’ efforts to recruit him for a dispatch job.

“We’re looking down the road, of course,” Willis laughed. “I was just excited to meet him and he deserves a lot of credit for what he did.”

Tanner said he likes the attention. The publicity in the local newspaper and the word going around school has friends calling to say congratulations. He said the communications center “was real cool” to visit and he received an award from Children’s Village that includes his choice of emergency vehicle to ride in. This time, it’s not the battery-powered model he’ll be driving but a ride alongside a police or firefighter in an actual emergency vehicle.

Then there’s his mom and dad who are proud of what he did on his own.

“It’s so reassuring to us that he can do this,” said Michael Shoemaker. “We’re so proud of him. There’s no telling what he’ll do once he gets older, but I’m sure it will be something that’s extraordinary. He’s that kind of kid.”
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— Tom Ling, Johnson County Central Dispatch

Now accepting applications for the 2008 course to be held in Kansas City, MO. Online applications begin August 11, 2008. Go to www.emergencydispatch.org or call 1-800-960-6236 for course curriculum and registration information.

Presented by Fitch & Associates on behalf of NAED

NENA has approved this course as credit toward recertification for the Emergency Number Professional designation.
What’s Your Story? Discovery program highlights good works of dispatchers

Do you have a compelling dispatch story to tell? If so, the producers of a new series documenting 9-1-1 calls want to hear it.

The 20-part series Call 911 premiered in July on Investigation Discovery, a cable network of Discovery Communications. The series chronicles 9-1-1 calls from sources such as newspaper headlines and the recent National Academies of Emergency Dispatch (NAED) Navigator Conference held in Baltimore, Md. The executive producer/director of the program, Tom Jennings, and his company, Tom Jennings Productions, have been collecting the stories for the past year for an idea that got its start when Jennings was producing a show for Animal Planet.

So, what’s the connection?

According to series producer Hani Shafi, Animal Planet was running a story about how pets have saved the lives of their housemates and Jennings was moved by a call made to a 9-1-1 communications center.

“The caller’s dogs were barking and over the course of the call you find out someone is breaking into the caller’s house,” said Shafi. “It was a very intense phone call. The dogs kept barking and the woman was getting more and more hysterical. Police got there just as the intruder was attacking her.”

The incident hit a nerve. The ability to get emergency help to a victim from a phone call made to a dispatch center reminded Jennings that dispatchers are an important part of the emergency response sequence. In this call, the dogs may have alerted the woman to someone breaking into her home but it was the dispatcher who sent the help she needed to stop the attack.

Jennings shot a television promo based on the call and later a pilot program featuring the actual people involved (save for the assailant, of course). Investigation Discovery (ID) liked the concept and decided to produce 20 episodes for the initial season. In total, the series will feature approximately 60 calls with three different calls in each 30-minute episode. The topics of the calls will range from medical emergencies, heroic feats, and people in distress with everything in-between.

Shafi said that the intention of Call 911 is to showcase 9-1-1 dispatchers at their best when they are lending a helping hand to people in need. The program does not focus on 9-1-1 mishaps, which is often the media’s focus. Instead, Call 911 features dramatic calls where the dispatcher plays a critical role in assisting someone during a crisis situation and the subsequent dispatch response.

There’s also the educational aspect, said Shafi.

The series’ primary focus is grabbing the viewer’s attention with dramatic 9-1-1 calls and the apparent behind-the-scene’s excitement of seeing the dispatcher’s response. However, the series also helps demonstrate when it might be inappropriate to call 9-1-1 such as a prank or for reasons outside of a life-threatening emergency like the infamous call about how to cook a Thanksgiving turkey highlighted on a late night talk show.

As of May, the production company had shot several episodes, with each featuring the actual call and interviews of those involved in the incidents. Examples include the rescue of a family trapped inside a burning apartment complex, the interception of a vehicle gone out of control following the driver’s cardiac arrest, and the caller whose dog alerted her to the home invasion.

“There’s a whole world behind-the-scenes of an emergency and the people answering the calls are just as important to the outcome as those who show up at the door in uniform,” said Shafi. “It’s all about the dispatchers doing their job and that’s what Call 911 will highlight. They are the unsung heroes.”

Not Your Everyday Call. Dispatcher goes into automatic drive in response to report of an officer down

After nearly 20 years in public service, a radio transmission no dispatcher wants to hear proves something that Joe McGrath already knew.

He responds well in an emergency.

The Oak Lawn (Illinois) Emergency Communications dispatcher, who started his public service career right out of high school, was having a regular sort of shift at the dispatch center. It was an evening, nearly 9 p.m., on Monday, Feb. 18, and he had just sent paramedics to a bad traffic accident and was now getting help for a woman who called 9-1-1 about her boyfriend’s suicide threat.

“There was nothing out of the ordinary,” he said.

Even a 9-1-1 call someone made to report his suspicions of a potential armed robbery seemed to be under control. According to the caller, someone who may be carrying a gun was walking toward the doors of a budget motel in Burbank, a suburb south of Chicago within the Oak Lawn Emergency Communications coverage area. An armed robbery could be in the making. McGrath gathered the information and radioed Burbank police to investigate.

And then all hell broke loose.

“Shots fired. Officer down,” came a shout over the radio.

A police officer who had responded to the potential armed robbery call had been shot. He was down, condition unknown, and another officer was wounded.

McGrath went into action. He focused his attention on the radio and, as he says, took control of the situation. He assumed radio priority and enlisted the assistance of two other dispatchers for ambulance and perimeter control. According to a later report of the incident, McGrath
cleared the air for emergency traffic only, relayed all critical information coming from the scene, assisted with the coordination of arriving units, and controlled the chaos with composed professionalism.

“It was instinct,” McGrath said. “I went ahead and did what was needed for an active incident.”

McGrath estimates three to four minutes until police had the situation under control. From an officer communicating over the radio, he knew that a bulletproof vest had saved the downed officer, despite two bullets to the chest. A second officer sustained a hand injury from a bullet that had ricocheted off a hard surface during the short gun battle. Both have since returned to active duty.

One suspect was killed while another was taken into custody.

McGrath was onto his next call.

“My part was over,” he said.

It was over until about a month later when McGrath and others from the center were honored for their response. The Village of Oak Lawn praised McGrath for being “calm, confident, and in control the entire time.” Village leaders also honored team leader Kathleen Hansen for her management during the crisis and telecommunicators Justin Haubenreiser and Linda George for their participation. Haubenreiser dispatched officers from neighboring towns while George dispatched medics for the officer down.

Despite the accolades, McGrath figures he could have done better.

“He’s that type of guy.

“I think about the calls and what I could have done,” he said. “Maybe I could have been clearer when talking to the police officer at the scene. I don’t know. It’s the Sunday quarterback in me.”

“Called into Action Dispatcher Joe McGrath, center, poses with fellow dispatchers and the Burbank police officers who responded to his radio call for help when an officer was shot during an attempted robbery. Pictured with McGrath are fellow dispatchers, team leader Kathleen Hansen, Justin Haubenreiser, and Linda George.

As far as Oak Lawn Emergency Communications Director Stacy Guercio is concerned, the team did everything perfectly. She wouldn’t change a thing.

“This type of call is a dispatcher’s worst nightmare,” she said. “An officer down isn’t something we get everyday and everyone handled it very, very well. They did an outstanding job.”

The situation was handled so well, she anticipates the call will be part of her training sessions for years to come.

McGrath has been with the Oak Lawn Communications Center for 10 years, and he’s a volunteer firefighter and paramedic for nearby Roberts Park Fire Protection District. Prior to dispatch, he was a firefighter for 10 years in Hometown, a city close to Oak Lawn and the place where he grew up.

He uses words like “challenge,” “variety,” and “never tedious” when explaining why he likes dispatching. But for the most part, he says it’s hard to put a finger on a specific reason.

“Public service is the only thing I’ve ever wanted to do,” he said. “When things are serious, I like buckling down to get the job done.”

Oak Lawn Emergency Communications is a major 9-1-1 center serving the Illinois communities of Oak Lawn, Evergreen Park, Burbank, Bridgeview, and Bedford Park. In addition, the Fire Protection Districts of North Palos, Roberts Park, and Central Stickney are served by the communications center.
An annual festival held in Haleyville, Ala., for the past 10 years celebrates an event that has since gone throughout most of America.

The small town in the northwest corner of the state is home to the very first 9-1-1 call ever made in the United States, placed at 2 p.m. on Feb. 16, 1968. According to the scrapbook of news stories that the Haleyville Police Department has collected over the years, Alabama Speaker of the House Rankin Fite made the call from the Haleyville City Hall which was answered by U.S. Rep. Tom Bevill (Alabama) on a bright red phone that’s still located in the police department. Bevill’s understated “hello” into the red receiver made history.

The town commemorates the occasion each year on the second weekend in June, which is several months after the actual call occurred. The city clerk attributes the reasons to weather.

“Most of the events are held outdoors, and when it’s cold that’s going to keep some people from coming,” said Haleyville City Clerk Debra Hood.

This is a big deal for Haleyville, and the warmer weather event attracts a huge crowd not only from neighboring cities, but also from neighboring states. Last year the festival drew an estimated 4,000 people, which is fairly substantial considering the city’s population of about 4,100 residents.

The barbecue, in fact, is a main attraction held over two days (this year it took place June 13 and 14). Since its start four years ago as part of the 9-1-1 celebration, the cookoff has grown to 40 professional teams (four to five members per team) in addition to the backyard barbecue enthusiasts who enter the contest.

A big draw is the State Championship 9-1-1 BBQ Cookoff, which is sanctioned by the Kansas City Barbeque Society (KCBS) and sponsored by the Haleyville Rotary Club. The KCBS sanctions about 300 barbecue contests coast-to-coast and—no pun intended—they can get fairly heated.

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According to Bruce Eddy, of the Haleyville Rotary Club, the barbecue has gotten so big that next year they may have to move it to another location to accommodate all the grills, cooks, audience members, and trophy stage.

“It’s a great fundraiser and it just keeps getting bigger,” he said.

About the only things missing from the big splash in Haleyville are the people central to the historic event. Congressman Bevill died in 2005, in Jasper, Ala. Rankin Fite retired from the state legislature in 1974 and died in November 1980. Fite was such a renowned politician in Marion County (Ala.) that the law office where he worked keeps a replica of his office in the building to memorialize his contributions.

But Rankin and Bevill were not the only ones involved. They simply placed and answered the call. Much of the actual credit goes to Bob Gallagher and Robert Fitzgerald, both former employees of the Alabama Telephone Company (ATC). Both are deceased.

According to a story by Megan Walde in the The Huntsville Times (Ala.), Gallagher was a go-getter kind of guy who wanted to beat American Telephone and Telegraph (AT&T) to the draw when it was announced that the Call to Fame Festival in Alabama honors first 9-1-1 call made in the United States.
country’s largest phone company was going to unveil its plans to implement a single telephone number for dialing various emergency services.

A story in *The Wall Street Journal*, dated Jan. 12, 1968, states that sources close to AT&T said the system would work in the following way: A person needing an ambulance, for example, will dial the standard phone number, regardless of what part of the country he is in, and tell the operator in the emergency center his location and the type of service needed. The operator then connects the caller into the phone of the ambulance service nearest his location.

Gallagher, who was reportedly upset that no one asked the smaller phone companies for their advice, went around AT&T and called upon Fitzgerald, the ATC chief central office engineer, to draw up the plans. Haleyville was in the process of upgrading its phone system and, subsequently, became the city of 9-1-1 choice.

Fitzgerald and his four technicians had the system in place in less than a month, and Fite dialed 9-1-1 from the red phone on the desk of Haleyville’s mayor.

Call Heard Across Country Congressman Tom Bevill answered the first call made to the number 9-1-1 on a red phone still on display in Haleyville, Ala.

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Haleyville celebrated that night beginning a tradition that the city continues today, although rather belatedly.

The 9-1-1 calls Haleyville residents make are now answered by the consolidated Winston County 911, a center that uses the Medical Priority Dispatch System® (MPDS). Residents can also still call the Haleyville Police Department direct to get an ambulance dispatched. The dispatchers in Haleyville have since stopped using the famous red phone, now kept in a glass display case at the station.

Forty years later, the three digits used to contact local emergency officials is accessible to 95 percent of the country’s population. Of those systems, 95 percent have been updated to the Enhanced 9-1-1 systems, which automatically route incoming calls to the nearest response center and automatically identify the location of the caller, without the caller even having to speak.

**Correction:** The quotes attributed to Ralph Dale in the May/June edition of The Journal should have been attributed to David Ralph, manager, Toronto EMS. We apologize for the error.
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