

21 February, 2019

Executive Summary
Fatality Structure Fire, Polk Co. FL 23 Nov. 2018

At the request of the Polk County Florida Sheriff's Office Telecommunications Division, representatives of The International Academies of Emergency Dispatch (IAED) Fire Standards Council reviewed records of the 911 call processing detail of a fatality structure fire that occurred in Polk Co. FL on 23 Nov. 2018. The purpose of this review was to determine compliance with general 911 industry best practices as well as any applicable agency, local, state, national and international standards applicable to Fire/Rescue Calltaking/Dispatch.

The records reviewed include both phone and radio traffic from the incident in question, Fire ProQA 911 call taking software data as well as a side by side timeline of the phone and radio traffic created by Polk Co. and taken directly from CAD and the voice recorder.

This document will serve as the IAED step by step review and critique of this 911 call. Review is a list form in chronological order. Recommended actions are listed below each step. General over-all recommendations are listed at the bottom of the document.

Note: all times listed as approximate due to not having direct access to agency voice recorder. IAED Independent timing matches listed agency timing within fractions of seconds.

1. An AQUA QI software review of the call determines the calltaker was partial compliant over-all with the Fire Priority Dispatch System (FPDS) v6.1 (*1 Major Deviation noted in # 6 below) and executed the call with no other deviations.
Recommended Action: See # 6. Below.
2. Call was classified (call typed) at an appropriate **69 Echo 6** (Structure Fire, single residential) level and made available for dispatch approximately 42 seconds after the call was answered. Time to obtain address and phone number was approximately 17 seconds. These call processing times fall well within the recommended parameters of the applicable 2019 NFPA Call Processing Time Standard (60 seconds). (see reference a. below).
3. The calltaker had the option to select the *Caller in Danger not Trapped* instructions while still in Case Entry when she was told by the caller that "her house was on fire, was alone and she was using a walker". This is permissible per FPDS Case Entry Rules (see reference b. below). It should be noted this was not required by the protocol pathway and its use is a subjective judgement based on the calltakers interpretation of the danger as expressed by the caller. It should also be noted that while in Case Entry, the caller did not state she was inside the structure so a reasonable argument can be made that the danger at that point was unknown. This is statistically very atypical in our experience. *In our opinion, even if this pathway had been selected it would not have changed the outcome of the call, primarily due to the callers later discovered inability to exit the structure.*
Recommended Action: Create and instruct Continuing Education topic for all calltakers concerning possible and appropriate usage of the *Caller in Danger not Trapped* link,

instructions and pathway in Fire ProQA. This should be addressed as a quarterly topic as it will be a seldom used pathway and could well be lifesaving in the right circumstance.

4. Once call was made available for dispatch, calltaker followed the appropriate structure fire call pathway and determined the caller was in the structure. This information became apparent approximately 1 minute 19 seconds after the call was made available for Dispatch. *In review of the call phone traffic audio, it is our opinion a substantial portion of this time was consumed by calltaker data entry/information update tasks (calltaker typing in background with phone conversation gaps).*

Recommended Action: Obtain or create and instruct multi-tasking training topics for all calltakers. Refresh on a quarterly basis.

5. The calltaker obtained the exact location of the caller, confirmed she was alone and attempted to give the caller instructions to exit the structure approximately 32 seconds after it became known the caller was inside the structure. The caller consequently advised she was unable to exit the structure due to her level of disability/immobility.
6. Once the calltaker determined the caller was unable to exit the structure, the calltaker should have selected the *Trapped in Structure Fire* protocol link per FPDS Case Entry Rules (see reference c. below) and given those instructions. The calltaker did not follow that link immediately, she instead followed the *Return to Key Questions* link and finished the Key Questions referencing where the fire was and if anyone was injured. (*Failure to follow protocol link, Major Deviation). Following the *Return to Key Questions* link delayed the provision of the *Trapped in Structure Fire* instructions by approximately 25 seconds. *In our opinion, even if the Trapped in Structure Fire link had been selected and the instructions given 25 seconds earlier, it would not have changed the outcome of the call. This primarily due to the caller's inability to follow any of the instructions even to the point of being unable to get low to the floor.*

Recommended Action: Provide this calltaker constructive feedback and coaching about the use of the *Trapped in Structure Fire* link and pathway in this particular call and all similar calls. This should include Fire ProQA simulation to assist in making the pertinent points. Create and instruct Continuing Education topic for all calltakers concerning possible and appropriate usage of the *Trapped in Structure Fire* link and pathway in Fire ProQA. This should be addressed as a quarterly topic as it will be a seldom used pathway and could well be lifesaving in the right circumstance.

7. The calltaker in this case presents at some points in the call with somewhat of a flat affect (minimal amount of voice inflection) in her dialogue with the caller. This flat affect can affect the perceived rate with which any call is processed. While this might have created a perception of a slower rate with which this call was processed, the call processing time for this call was well within a normal range. On the other end of the spectrum, it is well documented that excessively rapid speech can in fact, cause confusion and non-compliance from a caller under significant stress. There was no indication that this flat affect created a negative customer service situation with this caller or effected the outcome.

Recommended Action: Provide this calltaker constructive feedback and training about the importance of voice inflection when communicating with a 911 caller, particularly a caller under significant stress. A flat affect or lack of voice inflection can create a negative customer service situation with many callers. It can be perceived as a lack of caring by the calltaker.

8. The calltaker in this case used the term "paramedics" more than once when describing the response to this call. While paramedics may well have been part of the response to this call, the primary response was obviously by the Fire Department. This was not a call processing error, it was a verbal error and did not negatively affect this call or caller. It should be noted however, as this kind of verbal error can be picked up on by a caller and result in a negative customer service situation

Recommended Action: Provide this calltaker constructive feedback and coaching about the correct use of terminology both in this particular call and all calls. This kind of verbal error can create a negative customer service situation with many callers. It can be perceived as a lack of attention by the calltaker.

9. The calltaker-caller relationship between this calltaker and caller was quite good in spite of the significant stress both were under. Throughout the call, the calltaker displayed empathy for the caller and her situation and constantly reassured and tried to calm the caller. We believe the caller recognized that and responded in as positive a fashion as could be expected for the situation.
10. The calltaker at more than one point in the call tried very acceptable non-protocol driven methods to try and assist the caller.
- Cover face with wet cloths
 - Maintaining constant contact with the caller and verifying exact location inside the structure
 - Attempting to obtain husbands, neighbors phone number
 - Informing the caller of Fire Department actions

This was necessitated by the caller being unable to exit the structure or follow the *Trapped in Structure Fire* instructions. The calltaker should be commended in that respect for utilizing independent thought and actions in a seldom encountered situation not covered by the Fire Protocol instructions.

11. Although not strictly a calltaking function, this calltaker put information into the call that allowed the dispatcher to air to units numerous times that the caller was trapped in the structure.

Conclusion:

Although the outcome of this incident was tragic, after a thorough review of this incident we do not believe there is anything the calltaker could have done differently to change the outcome. The caller's inability to exit the structure or move around in the structure or follow the *Trapped in Structure Fire* instructions severely limited what the calltaker could do to assist her. Although the technical processing of this call was not perfect, it was quite good given the extraordinary circumstances that presented themselves. The calltaker should be strongly commended for her empathetic, caring interaction with a caller that would soon be deceased while still on the phone with the calltaker.

References:

- a. NFPA 1221 Chapter 7.4 Operations, 2019 Edition, Section 7.4.3 through 7.4.3.1 and 7.4.3.2
- b. Fire Priority Dispatch System (FPDS) v6.1 Case Entry Rule # 4.
- c. Fire Priority Dispatch System FPDS v6.1 Case Entry Rule # 5.

Over-all Recommendations:

- a. Update agency Fire Priority Dispatch System (FPDS) protocols from v6.1 to v7.0 as soon as it is operationally possible. FPDS 7.0 contains an expanded set of tools and instructions for dealing with callers trapped in structure fires and other life-threatening situations.
- b. Provide mandatory quarterly training for all calltaking staff on low frequency high risk call types. These would include events such as Trapped in Structure Fire, Sinking Vehicle, Vehicle in Floodwater, Building Evacuation, Structure Collapse, Trench Collapse, Trapped by Wildland Fire and others. Any one individual calltaker has the distinct possibility of working for an extended period of time and never having to process one of these low-frequency high-risk incidents in the normal course of their duties. Skillsets for these incidents will degrade even when using a logic-based calltaking software such as ProQA.
- c. Provide yearly training for all calltaking staff on caller management, and the importance of using voice inflection when dealing with 911 callers. A calltakers presentation can positively or negatively affect the outcome of a 911 based on the relationship between the calltaker and the caller.
- d. Provide yearly training for all calltaking staff to develop and maintain multi-tasking skillsets. The ability to multi-task efficiently can save valuable time in situations that are truly life threatening to a caller. It can also vastly improve the calltaker/caller relationship with all calls.

If you have any questions, please feel free to contact us at any time,

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On behalf of the IAED Fire Council of Standards and Fire/Rescue Special Operations Group

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