Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
372621	Addressing	Fire-Rescue units were dispatched to BSO sally Port. Actual call was at FLPD sally port	FLPD units requested FR for a prisoner who appeared to be having a seizure. The units were at the FLPD Sallyport. The dispatcher entered a call for the Main Jail – the units were at the FLPD jail. The dispatcher failed to verify the location needed, however, this information should have been clear as the unit's status had him 1019.
392726	Addressing	The address of the emergency was in Pompano and caller insisted it was in Pompano.	The caller dialed 911 and reported a fire at her place of work – giving an address of 2959 N Power line Rd in Pompano. This address is not valid in CAD. The operator spent a tremendous amount of time trying to obtain a valid location and the caller could not provide anything further. The call was entered for Wilton Manors, as this is the only city that the CAD would validate against the address provided. The issue in this case is two-fold. CAD did not accept the location for the city of Pompano. Regardless of what measures the operator tried to take to obtain a location (Lat/Long, google business search, etc.), CAD would not accept the address entered. In this case, the operator should have by-passed the address for the city of Pompano. She failed to do that. However, that takes this to the obvious issue. The CAD did not accept a valid location. This is a direct technology issue. Had CAD been programmed to accept this address, this incident would not have occurred.
396860	Addressing	20 minute delay in dispatching correct address	The critical mistake in this case occurred with the 911 operator. The ANI/ALI dump did not match what the caller stated. The operator also did not have the caller repeat the address, which would have given her a second chance to visually verify what was being stated to what was reflected. Had the operator verified the call location, the correct address would have been immediately submitted to the CAD report and assigned.
400800	Addressing	Call stated she was bleeding. Wrong address given, delayed arrival - DOA.	The dispatchers error was that when she rebid for Phase 2 information in order to generate a call for service, she used the update address provided by the ANI/ALI, which proved incorrect, instead of plotting the LAT/LONG information that would have taken the call to the location nearby where she was located. While the operator did follow policy with regards to trying all efforts to locate this caller, her error was relying upon ANI/ALI data that was not useful and not plotting the LAT/LONG data.
421765	Addressing	Fire-Rescue dispatched in wrong City. Responding units informed dispatcher of correct location (Pompano).	This issue occurred because the operator did not utilize all resources to assist in finding a location to which the caller was clearly confused. The caller provided a business name, and partial street address. Despite his stating that he was in Fort Lauderdale, probably because the business name has "Fort Lauderdale" as part of its title, his assumption is understandable. The caller had a Phase 1 cell phone, which does not offer their location. However, the operator did not rebid the cell phone, and when the caller was unable to advise N or S Federal Hwy, she should have checked the mapping against a rebid cell. If that was unable to be done due to the caller disconnecting, she should have google searched the business name. Clearly she recognized that there was a choice in location, and her choosing N was inexplicable.

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
394498	Call Handling	Lady called 911 twice for her 7 year old having a seizure . NO ANSWER. 911 called back while she was putting her child in her car to take her to the hospital POV	At this time, the incident as outlined did occur – however, all operators were accounted during the timeframe and those on the phones were unavailable for call assignment, resulting in the caller disconnecting. The disconnected call was redialed and a call for service generated.
372629	Event Classification	Dispatched to Pedestrian vs Boat. Upon arrival there was an assault in progress.	The caller reported that someone hit him with a boat this morning. The caller stated that there were injuries and FR was needed. The operator classified this as an accident and sent FR and DLE to respond. The caller's comments suggested that this was an accident and not an assault, and there was no indication that there was any altercation occurring at the time of this call (no background noises or other audio concerns heard). The operator began EMD and treated this as an accident event. The manner in which the caller expressed the circumstances led the operator to believe that this was somehow a traffic related accident with a speed boat versus the male. The commentary, however, makes absolutely no clear sense whatsoever, and the operator should have interrogated more clearly and thoroughly to determine exactly what occurred. The operator simply took the caller's description of events and entered the call without any interrogation strategy or logic whatsoever. This is why the call was classified in the manner in which it was – however, having stated that, the caller was not arguing with anyone during the call and did not express that this incident was an assault.
375956	Event Classification	A single rescue unit was dispatched to a medical emergency. 1 min later a structure fire was dispatched at same address	The caller immediately requested a "fire truck". The operator asked for an address and entered this for a sick person, failing to inquire as to the reference or any other qualifying information. This is a gross violation of policy and a basic procedure that is inexcusable. Once the call was created, the operator continued with interrogation and only then found out that this was due to a fire event and not a medical call.
392017	Event Classification	Dispatched as an MVA. Assault upon arrival.	The caller provided a location and stated that a man got hit with a "bike", and he is lying on the sidewalk. The caller gave a city and the call was generated at 1808:16. When the operator asked if he was on a bike or on foot, the caller stated "no, he got hit in the head with a pipe." The call was then updated to reflect this new information. The operator asked for suspect information, and the caller could not provide anything and stated that she had to leave. The issue is that the CAD event was updated by the 911 operator 2 minutes prior to it being verbalized by the dispatcher.
392731	Event Classification	Sent to elevator extrication, Actual garbage truck fire.	Occurred as outlined. The caller clearly stated his vehicle as on fire. The operator typed a signal for an elevator rescue, despite her interrogating to a vehicle fire.
410346	Event Classification	Sent to a hemorrhage, actual call was a gas leak	The caller reported that a broken gas line. The operator entered the signal as a S67 (hemorrhage) instead of S25 (gas leak)

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
384231	Event Creation	Ft. Lauderdale hospital nurse claimed to have called 911 and no response was generated	The initial 911 call was received at 0322:43. The caller reported that a patient at FL Hospital was needed to be sent to the emergency room. The operator asked "for a second" and then, after some time, asks where the patient is needed to be sent. The operator is speaking to someone in the background (not certain who she is speaking with), the operator then proceeds to communicate that the caller must speak with the BC. The operator then says she will take the information and obtains the address, the caller's name, and confirms the condition of the patient, who is having chest pains. The operator begins with EMD protocols. This call concludes at 0328:24. THERE IS NO CAD EVENT FOUND TO HAVE BEEN GENERATED. When the caller calls back, the operator comments that she had created an original call, however, there is no evidence of any CAD events in the system despite multiple efforts to try to determine how the call may have been entered. It is reasoned that the operator may have believed she generated a call, however, for whatever reason, the call did not execute in the system. At 0404:58, the caller calls back and asks about the status of FLFR. The operator is the same operator who received the first call. She states that she would check to see what happened with the first call, as the call had been created (again, however, no call was ever found). An event was then created – case FL/346 – and FLFR assigned.
392727	Event Creation	Fire-Rescue was dispatched to an assault. FR was sent to address of armed rapist, not the address of victim	The caller reported that she had been sexually assaulted earlier in the day at gunpoint. The caller said that she was in front of Betty's at Sistrunk and 22nd Ct. The caller then stated that the suspect was at 14th and 6th St and that this incident occurred hours previously. The operator took the suspect's description and the caller's description and entered a call for DLE and FR. The CAD entry requires that the place of occurrence is used as the first location for jurisdictional accuracy. The caller's location was then entered as the Caller's Address field (2nd address). The event was correctly classified as a delayed sexual assault. The address field was actually the location of occurrence, which, again, is proper for DLE interrogation requirements to zone the incident correctly. With a dual created event, the CAD would then create the FR incident for the place of occurrence (and not the caller's address). The only way to prevent this from occurring would be to have the operator create two independent calls for service, which is not efficient nor is it outlined as a policy expectation. Regardless, the information of the caller's location was updated into the FR event and would have been visible to the FR dispatcher, but this information was presented after FR had been assigned to the event. The FR dispatcher provided the location of occurrence to FR units assigned at 1421 hours (this was the only location he had at the time). R46 then asked about the comments in the notes that he was viewing. The Dispatcher then acknowledged that the patient was at another location. In this case, the issue occurred due to the 911 operator creating a dual call for service for DLE and FR (which is appropriate) however, for an incident in which the caller's location is not the same as the place of occurrence. The 911 operator did document this discrepancy, however, did so after the call was initiated.
414420	Event Creation	Police on scene of PD involved MVA and stated FR had a 20 min response time. RMS shows 8 min	There was a delay in the call creation for FLFR by 9 minutes and 3 seconds. This delay was unbeknownst to the dispatcher, who believed that she had entered a call for FR once FR was requested by WMPD. The process that the dispatcher used to enter the call was via cloning. She obviously made an error in the cloning process, which resulted in the call not actually being generated. The dispatcher, however, believed that it was, and didn't realize that FR did not have the call until questioned for an ETA.

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
427362	Event Creation	Dispatched to abdominal pain and informed PD was on scene. Upon arrival PD was not on scene and actual call was breaking and entering.	FLPD never requested FR to respond to this event. The call was originally submitted for DLE only and was involving a domestic dispute between the caller and a teenage grandchild. For some reason, the DLE dispatcher believed this call to be a FR need, and cloned the original DLE call for FR, inexplicably making this an abdominal call. Upon receipt, the FLFR dispatcher believed, since this call came via FLPD, that FLPD was on scene and that the scene was secure. That was never spoken.
393693	Event Interrogation/ Management	Dispatch cancelled Fire-Rescue believing it was a duplicate call. It was not	There were two calls placed for the same location. The first call was at 1607:43 involving a possible S7 male found on the floor apparently deceased. The second call was at 1744:33 involving an elderly female found on the floor not moving. The second 911 operator entered the call for service, then quickly sent a message to the dispatcher advising that this call was a duplicate to the original and to "disregard." This message caused the dispatcher to cancel FR units incorrectly. This error is inexcusable. The time difference between the two calls makes any chance of these calls being connected highly unlikely. This error could have resulted in the patient not receiving care in a timely fashion.
396877	Field Status Updates	Dispatched units that were out of service to an emergency call.	For the first concern, B2 clearly stated that he was out of service. This was not executed by the dispatcher, which resulted in the unit remaining on duty for call assignment. This is unacceptable. In fact, the dispatcher had to re-ask the unit what his last transmission was, which resulted in B2 repeating his out of service status. This is even more illogical that the dispatcher had the unit repeat the status and still not confirm his unit status in CAD. This is a flagrant error.
374235	Holding Call Management	FR was dispatched to a possible over dose. Upon arrival this was found to be a suicide attempt. On scene units were unable to get PD to respond	There are a number of issues found with this call. First – the operator should have classified this as a 32/S32 – especially since the caller stated that the intent of the pills was to do something "bad". Had this classification been used correctly, it is possible that DLE and FR would have responded differently to the events described. Second – the FR dispatcher was asked to have DLE respond. A CAD message was sent, however, directives have been outlined that all inter-discipline notifications between DLE and FR should be done via Gold Elite radio alerting instead of relying upon CAD messaging. The dispatcher, however, did take action in this case. Third – the DLE dispatcher was the most egregious of the violations found. The FR Dispatcher clearly indicated that FR needed DLE to respond, she did not relay this message to the DLE Sgt, and answered on the Sgt's behalf that the call was holding. This is completely unacceptable.
400778	Holding Call Management	Poss misinformation given to PD sergeant while unit was staging.	The DLE dispatcher never alerted the Sgt of this pending call – she simply downgraded the priority level. The Sgt was only alerted to the call after the Division requested the Sgt to make contact. This is unacceptable. The Dispatcher has clear policies with regards to handling calls in which a unit cannot be immediately assigned. The dispatcher has not authority whatsoever to determine that the call will hold.

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
366058	Interposition Communications	Female floating in water. PD gets call 30 min before Fire.	The call was received via non-emergency line. The caller states that he is fishing and states that a body appears to be in the water. The caller stated south of Oakland Park Blvd about ½ mile south of the roadway on the beach. The operator entered Oakland Park Blvd and N Ocean Blvd for DLE only as a suspicious incident. The operator never entered a call for FR – most likely because the caller reported that the object looked like a body but he was not sure and it might not be a human. DLE units were dispatched at 0729:11. The Marine Unit was notified at 0731:09. The Marine Unit made contact and advised S7 at 0746:53. At 0754:48, Marine requested FLFR to respond as they were transporting the S7 to the boat ramp at 1784 SE 15th ST. The Marine Unit commented that they were going to keep working the patient as she didn't appear to be in the water for very long. FLFR case was generated at this time. The original 911 operator did not generate a call for FR based upon the comments made by the caller in which he expressed he wasn't sure what the object was floating in the water. However, as the caller made it known that the object might have been a body, it was prudent to send FR to the initial call. Per SOP, operators are to use the higher of any classification when faced with an event that can be classified in more than one manner. When FLFR did received the call we received it as a drowning at 1784 SE 15th Street (15th Street Boat Basin Boat Ramp). We did not receive information as to whether the person was in or out of the water. We did not receive any information that the victim was on the PD boat and being transported to this location. Due to this lack of information the district BC started Fire Boat 49 as it appeared the person was still in the water and needed to be rescued, which cause another delay in patient contact.
371495	Interposition Communications	FLFD & FLPD received different info. This led to the patient pulling out a gun and FR personnel restraining him prior to shots fired.	The call taker interrogated the caller and asked the caller if there were any weapons in the home. The caller was very distraught and also very hard to understand. He advised the call taker that he had two pistols. Due to the caller being very hard to understand, the call taker initially documented that there were no weapons at 16:23:23, but upon further interrogation at 16:26:46 the caller re-advises that there are 2 pistols in the home, "One gun on the bed and the other in the chair in the living room" as documented by the call taker at 16:27:08. The caller then advises that he tried to use one of the guns on himself yesterday but failed. This information was also documented in the call. While PD dispatcher gave the FLPD officers the nature of the call at the time of dispatch and the update that there were weapons inside the home, the PD dispatcher failed to advise the officers the exact location of the weapons and that the caller tried to use one of the guns on himself the day before, but failed. For these reasons, I am also forwarding this to our QA department for further review.
371529	Interposition Communications	FLPD sent to a possible drowning. FD started 40 min later	04:19:58 - Call was entered into CAD as a Signal 13I, which prompts a police response only. No Fire Rescue case was generated by the call taker. The female then told the call taker that the man is wet and is in the water. The call taker at no point asked the caller if anyone was injured or if the paramedics are needed. The fact alone that the male was still in the water should have prompted the call taker to create a Fire Rescue call in CAD for service. There was a 30 minute and 54 second delay in Fire Rescue receiving this call due to the call taker not generating a Fire Rescue case when the initially 911 call was received.

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
372641	Interposition Communications	Dispatched to an unknown medical call. Upon arrival found an assault in progress. PD was requested by FD code 3. Dispatch delay in requesting PD & did not request them code 3	DLE received this call at the same time as FR. DLE Dispatcher does not advise the Sgt of the pending incident until 1254:45 hours and asks the FR dispatcher to advise if PD was needed after the Sgt directs to have FR advise if DLE was needed. This update came before the FR request for a DLE Code 3 response. The Sgt is then updated that FR requests DLE reference to an unruly patient. She does not provide a Code response. The SGt directs to have a unit respond. The dispatcher attempts to get units responding at that time, with a unit assigned at 1301:26. This timeframe is concerning in that it does not demonstrate any level of urgency. Eventually the dispatcher provides the Code 3 response and units continue to go enroute. The delay in first notifying the Sgt is unacceptable. This call sat pending for 8 minutes before the Sgt was even told of the event. This is not going to be tolerated, as dispatchers have a very specific timeline to alert a Sgt of a pending incident that cannot be immediately assigned. The delay to get units assigned once it became known that DLE was needed is also unacceptable. The Sgt was aware that DLE was needed and directed to send units at approximately 1258, however, units were not assigned until 1301. The FR Dispatcher did not rely the Code 3 direction immediately, despite this being given.
387715	Interposition Communications	FD personnel being assaulted on-scene and requested PD code 3. 6 min delay in dispatching PD and did not dispatch PD code 3	Call was assigned to units at 2129:43 in regards to a stroke. Unit arrived at 2136:07 hours. E3 requested a DLE response at 2144:43 hours. There was no response. E3 then stated they he needed DLE code 3 in regards to a subject trying to assault him. Dispatcher acknowledged and stated that she would notify DLE. A DLE call was generated at this time by the FR dispatcher – case 34/10449 – with comments that a subject was trying to assault the unit. . The DLE event was generated at 2146 hours, as a subject attempting to assault the unit. By 2149 hours, the DLE dispatcher inexplicably closed the DLE call without commentary. By 2152 hours, the DLE Dispatcher assigned units to this location in regards to the subject threatening FR units, who requested a DLE response. This call – 34/10450 – was created by the DLE dispatcher at 2151:31 hours, and perhaps was a response to the error that was realized by closing out the original call. This call was given out as a code 1 response. FLFR B8 then transmitted over the DLE talk group and asked if DLE was enroute code 3 to the location. The DLE dispatcher stated that they are responding Code 1. Units were directed to upgrade to code 3. We have two critical errors found – the first is the FLFR dispatcher who did not respond to the code 3 response with any sense of urgency. Second, the DLE Dispatcher inexplicably cancels the FR call. There is no direction or authority of why this occurred.
396844	Interposition Communications	FD request PD code 3. PD did not arrive to the scene in a timely fashion	This call was an on-view by E35 who reported that DLE was needed 19th AV/47th ST for a domestic in progress. Immediately a new call was received and the dispatcher began assigning that call while creating a call for DLE to have them respond to this event. The DLE call had it outlined that a code 3 response was needed at NE 19th AV/NE 47th ST. As the incident moved, and the location was changed, the FR dispatcher updated the DLE entry only, but did not go over the radio to announce the change in location. Subsequently, the DLE dispatcher did not respond to the update in a timely fashion. As a result, DLE units went arrival to the original location, and naturally could not find FR. Right after DLE stated that they could not locate FR, B13 transmitted the new location of 1301 E Comm. In this case, the points of failure occurred as the scene was moving and the updated location was provided. This new information should have been broadcast via radio to the DLE dispatcher directly. The comments were updated in the CAD entry, but the information was not received timely. Additionally, the DLE dispatcher should have responded to the updated comments that should have been presented to him once the comments were amended. He did not respond to the updates and the new location of the event was not communicated until the BC transmitted directly

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
408076	Interposition Communications	Units on scene of and assault in progress. PD was requested several times and did not arrive in a timely fashion	The request for DLE was handled immediately and the original CAD incident that DLE had been assigned was updated. DLE had originally been enroute to a nearby intersection, and not the exact address of the what was reported by FR. The DLE units cleared the scene when they didn't see anything occurring, and they did not respond to the location provided by FR. A new call was then created specific to the FR address, and DLE was enroute again. Communication on ETA was established and provided to FR field, as well as a confirmation for a code 3 response. The omission found was the exact location entered by the FR dispatcher was not verbalized to DLE timely, resulting in their closing out their first call. While they were in the area, they seemingly did not see FR or the event occurring. The DLE dispatcher should have responded to the updated information in the CAD entry, and verbalized the new location.
400773	Staffing	No TAC operator available for structure fire & DC2 not given requested info by BSO duty officer	On 3/27, Central staffing was grossly below minimum the of 33 / 36 to 24 / 27. Three employees were on pre bid AL (1 of the FR discipline) and 5 employees on SL (1 of which was of the FR discipline). As a result, the TAC position was unable to be filled, resulting in the need to utilize the FR TAC at North for any FR TAC needs. There is staffing shortages experienced at all three PSAP locations. A recent academy graduation released 9 new hires to the three PSAP locations. There is currently two academies in session now, totaling 21 new hires. To speed the process of training once the academies graduate, all academy hires are being cross trained on both 911 and dispatch assignments simultaneously in order to both meet the requirements of 911 performance as well as meet their dispatch probationary requirements sooner. This will enable operations to meet not only a headcount shortage for overall staffing, but a skill set shortage for dispatch assignments. Normal operations and current staffing can meet staffing demands, however, when unexpected and extreme sick leave occurrences are realized, as was the case on this date, it places an unreasonable burden to operations that is difficult to overcome. At times, despite utilizing all mandatory overtime assignments, sufficient staffing is still not possible, which was the case here. There is no reason why the Duty Officer cannot communicate this reality when questioned, and he was addressed and directed that he is to provide accurate information when asked. Delaying a response won't change the reality of that response
381889	Time Checks	R247 was dispatched to a call. No tones went off in the station and dispatch never verified they were responding	R247 was initially assigned per the run card, and, therefore, station tones should have alerted. Beyond that, the second issue occurred when the dispatcher placed R247 in an Enroute status without the unit transmitting that status. The Enroute status turned off the timer associated with the dispatch status. Had the dispatcher not changed the status, the Dispatcher would have been alerted much sooner to the fact that R247 was not responding to the call.
382340	Unit Assignment	Dispatch requested BSO for mutual aid- heavy rescue. This was not requested by FLFR	There was not a need for mutual aid, as the run card was seemingly filled with FL units upon initial assignment. The dispatcher may not have been aware that Station 47 units serve as TRT, despite E47 directing that they have already been assigned and rang out. The dispatcher moved to have BSOFR support the TRT need. Had a need for mutual aid been required, the dispatcher should have alerted the BC of the mutual aid need and awaited direction. However, that is not what occurred in this case. The BC was providing direction to the dispatcher which included directing the dispatcher to standby when she asked about TRT. There was communication about Station 47 units responding and perhaps the dispatcher was under the assumption that these units were not available, however, she initiated a mutual aid request without clear direction or approval.

Ticket #	Category	Description of Complaint	Response Summary by Regional Communications
394154	Unit Assignment	BC upgraded MVA to rollover. Took 4:42 to dispatch units.	Upon dispatch assignment, the FLFR dispatcher provided the event as a S4H. B16 asked if this was a roll over. Then said that BSOFR was also assigning a roll over, and that this was probably one in the same. The response should be updated and a patched channel established. Dispatcher copied and said that she was speaking with the BSOFR dispatcher to see if they had the same location. Dispatch then said that she had this as a vehicle "flipped" and to standby, she would talk to County. Div2 asked to start a response at 0718 hours. Div2 then repeated to send the rest of the units to a S4E and to get a TAC channel. B2 then asked if there was a roll over on SR 84, dispatch stated affirmative and she was getting additional units ready for dispatch. Dispatch then assigned additional units to the call at 0721 hours.
396644	Unit Assignment	Mutual Aid rescues dispatched into FL without notifying Fire-Rescue	The mutual aid units were secured without notification to the BC/DV and in violation of SOP. The run cards were not filled by FLFR units, who were not available at the time, and instead of soliciting direction from the BC, the dispatcher made the MA assignment automatically. A QA will be done and this policy thoroughly reviewed with the dispatcher. The dispatcher reverted back to old policy which allowed an immediate MA assignment once a run card could not be filled.
377722	Verbal Communications	Dispatcher cancelled FD - stated FD was being cancelled by on-scene PD unit. We responded back and PD denied CX us.	The caller reported that FR was needed at the Broward Central Terminal due to a patient that was breathing but unresponsive. The CAD event was generated at 0550:12 hours and assigned at 0550:22. This call was only generated for FR – so DLE never had this case. As this was in a public environment – this call should have been created for both DLE and FR. This will be addressed with the initiating operator. DLE did have a unit that took a special detail at this location and would have been present at this time, however, that unit did not have any call assignment as a DLE call had not been created. At 0555:19, dispatch stated that units could clear per PD. There is absolutely no evidence that DLE ever transmitted this direction. As there was no active DLE call at all, there is no documented evidence that DLE was ever in patient contact. Further, audio from DLE does not support any transmission from DLE to cancel FR. There seems to be a significant error on the part of the FR dispatcher. It is assumed that she received a message to cancel for another event and erroneously advised units on this call to cancel. Again, there is no evidence that FR was ever authorized to clear.
421769	Verbalizing Event Details	Dispatched to fall injury. Upon arrival PD doing CPR. Dispatch was notified of cardiac arrest an did not update FR	The dispatcher provided the initial comments of "passed out". Units were enroute at 1750:49. The comments about the patient "not breathing" were updated at 1749:40 hours. This comment was not verbalized.
425625	Verbalizing Event Details	Dispatch received an update of people trapped over 6 min before E46 arrival. Never verbalized or started appropriate response.	The CAD entry was generated based upon an accident with injuries on a highway, and the operator proceeded with EMD. Through EMD, the status of the patient being trapped was recognized and documented. The Dispatcher, however, did not verbalize this update. The update regarding the entrapment occurred at 2330:11 hours. R246, however, places themselves arrival at 2334:22 hours. At 2336:20 hours, E46 verbalized arrival. The CAD updates for the entrapment were not verbalized. Within 4 minutes and 11 seconds, R246 went arrival. E46 arrived 1 minute 58 seconds later. The updates were provided to the dispatcher and a lack of verbalization is unacceptable.