CITY OF FORT LAUDERDALE
City Commission Agenda Memo **#16-0955**
CONFERENCE MEETING

TO: Honorable Mayor & Members of the Fort Lauderdale City Commission

FROM: Lee R. Feldman, ICMA-CM, City Manager

DATE: August 16, 2016

TITLE: 911 Public Safety Communications Center Service Resumption Update

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A multidisciplinary team of City staff members representing the Information Technology, Police, Fire Rescue, Human Resources, Public Works and Finance Departments has met regularly since January to evaluate the feasibility of resuming 911 Emergency Public Safety Communications services in the City. The departments have agreed that this would be a significant undertaking with regard to inter/intra-departmental coordination; project management and costs, However, with the cooperation of Broward County, the restoration of a City 911 Public Safety Communications Center is feasible.

The City of Fort Lauderdale Fire Rescue Department responds to 55,000 emergencies per year. The Police Department responded to approximately 204,000 calls for service in calendar year 2015. Actual incoming phone call volume corresponding to the calls for service is not available from Broward County but is typically significantly higher than the total number of calls for service.

The City of Fort Lauderdale joined the Broward County Regional Communications system in August 2014. At that time, Fire-Rescue and Police personnel began to experience severe shortcomings with the Regional Communications system. In an effort to identify the specific issues Fire-Rescue and Police were experiencing in the field and to manage the volume of complaints received, the County began using a Trouble Ticket tracking system. The intent was to identify and report specific issues the field personnel were experiencing, so that the Broward Office of Regional Communications and Technology and the Broward Sherriff's Office Regional Communications Division could identify their problems and develop solutions.

Problems were reported with each function provided by the Broward County to include: Call Taking, Dispatching and Supervision. They range in severity from Dispatchers not answering officers' calls on the radio to Call Takers sending public safety personnel to the wrong address or not providing current updates of vital information to units responding to incidents.

The following summary reports of Fort Lauderdale Trouble Tickets from the ticket

tracking system is compiled in one document (Exhibit 1).

In addition, complaint samples from Police and Fire-Rescue are included and labeled as Exhibit 2 and Exhibit 3. *The data shown through the ticketing system is merely a snapshot of errors/problems encountered in the field and in no way is a representation of the true number of errors made by Broward County Regional Communications since August 2014.*

City 911 Public Safety Communications Center Staff Considerations:

1. Staff has limited hours available to plan and implement a 911 Emergency Public Safety Answering Point (PSAP). Fulltime project management is essential for the successful design, procurement, construction, staffing and training for a new communications center. Salary and benefits for Communications Center staff must be highly competitive to hire the best quality candidates.

2. Location:

   Option 1 - Restore 911 PSAP operations in the Police Department Headquarters building. The previous PSAP space has been repurposed for IT offices, thus staff and furniture will need to be relocated. The data center and Motorola equipment room have been preserved and are available for reuse. The building is over 50 years old and therefore does not have a Category 5 wind rating. This is considered a temporary solution if a new Police Headquarters will begin construction in the next 2 years.

   Option 2 - Lease space in the area of Executive Airport. The committee has located a site at the Hotwire building, formerly Bank Atlantic, at W. Cypress Creek Road and NW 21st Avenue. The location is close to the City's Emergency Operations Center and therefore conducive for laying fiber optic cable between the locations that will increase communications resilience with the technology placed there. The space has the potential to conform to the 911 Public Safety Communications Center security requirements; has sufficient staff space; parking, and meets the data center needs. A wind study is needed to determine the stability and impact resistant status of the roof. The property management firm will require that the City agree to a long term lease (potentially 10 years). Eventually, 911 operations could be relocated to a future Police Headquarters building.

   Option 3 – Remodel Fire Station 53 - Emergency Operations Center (EOC). This is a City owned CAT 5 wind rated building. The 911 PSAP could be built at this location however, Fire Training and the EOC would need to be relocated to another facility. Consideration could be given to leasing the Hotwire building for those operations.

3. Backup 911 PSAP: the City must identify a Backup or "flee to" location as an alternate site for Fort Lauderdale 911 PSAP operations to immediately resume

should the primary location be compromised. The City's previous Communications Center utilized a Broward County facility for this purpose.

4. Broward County Authorization and relinquishment of service: It is required that Broward County review the City's 911 PSAP operations plan and upon approval, agree to allow the City to resume these functions.

5. Intergraph Computer Aided Dispatch (CAD) system: The City operated its communication and 911 PSAP center using the Intergraph CAD system from the year 2000 to August 2014. The City owns the software licenses for the CAD system so, it is recommended to re-initiate maintenance services and pay any related fees to have a "current" status. Intergraph also has the technology to interface and share incidents with 3rd party CAD systems such as Broward County's system for interoperability.

6. Interlocal Agreement with Broward County: The City Attorney's Office will be requested to review the current agreement as well as the State and County 911 plans and requirements. The Interlocal Agreement requires 180 day advance notice to Broward County to terminate and withdraw from the system.

7. Personnel: Hiring, Training and Retention: Due to the large number of positions required in a 911 PSAP the size of Fort Lauderdale's, it is recommended the hiring, training and 911 PSAP daily operation be outsourced initially. After the center is functional and performing to specified standards the City would consider taking over the operation. This strategy will reduce and/or eliminate the burden on Departments to process candidates for hire, conduct extensive CAD training, conducting individual performance monitoring, individual re-training, disciplining and termination processing of unsuccessful hires the first year of operation.

8. RFP Preparation: A Request for Letters of Interest (RLI) was released to assist the 911 Communications Team by collecting information on the scope of available comprehensive services in the 911 Communications PSAP industry. The RLI closed on July 29, 2016. Based on the Letters of Interest received, it has been determined managed service agencies exist with the possibility of providing a turn-key solution. We will begin preparation of an RFP (Request for Proposals) for an agency to manage (based on our specifications) all operations, including but not limited to, hiring, training, set-up, design, procurement, construction, and full facility management. This is based on the understanding that after a pre-determined amount of time, the City may adopt management of the 911 PSAP.

Cost Projections:

These estimates represent the first year operating and capital outlay. Subsequent years would be lower. It is not possible to determine exact costs without coordinating with specific vendors to determine the requirements of their individual solutions. Therefore,

these estimates are based on past experience procuring certain equipment, market estimates and projections. Actual costs can be determined after vendor selections and contract negotiations. In addition, certain vendors may offer the opportunity to finance costs over multiple years thereby reducing these estimates.

Communications Center and 911 PSAP Estimated 1st Year Startup Cost Summary			
Description	Option 1 Estimate: FLPD	Option 2 Estimate: Leased Building	Option 3 Estimate: Fire Station 53
Personnel	$6,500,000	$6,500,000	$6,500,000
PSAP Consultant (1st year cost)	TBD	TBD	TBD
Facility (Primarily Staff Relocation Related)	$40,000	$350,000	$1,220,000
Intergraph CAD Related Software Maintenance Renewal	$250,000	$250,000	$250,000
CAD Related Hardware	$600,000	$600,000	$600,000
Interfaces, Enhancements, and Upgrades	$600,000	$600,000	$600,000
NG911 Phone System, ANI/ALI, Recording, etc	$475,000	$475,000	$475,000
Fire Rescue - FireRMS/First Look Pro/TripTix Software	TBD	TBD	TBD
Fire Rescue - Mobile Data Computers & Accessories	$300,000	$300,000	$300,000
Fire Rescue Interfaces (Zetron, etc)	$75,000	$250,000	$250,000
Data Center Buildout	$185,000	$250,000	$2,000,000
Staff Workstations / Furniture	$600,000	$600,000	$600,000
911 Telephone System and Trunk Lines	TBD	TBD	TBD
Dispatch Consoles, consolettes & associated peripherals	$1,170,000	$1,170,000	$1,170,000
P25 Radio System Infrastructure	$1,100,000	$1,100,000	$1,100,000
*TOTAL ESTIMATED COST PROJECTION	$11,895,000	$12,445,000	$15,065,000
*Projected total(s) are based on a sum of the determined estimates. To be determined (TBD) values will increase the projected total(s).			

Strategic Connections

This item is a *Press Play Fort Lauderdale Strategic Plan 2018* initiative, included within the Public Safety Cylinder of Excellence, specifically advancing:

- Goal 9: Be the safest urban coastal City in South Florida through preventative and responsive police and fire protection.
- Objective 2: Provide quick and exceptional fire, medical, and emergency response.

This item advances the *Fast Forward Fort Lauderdale 2035 Vision Plan:* We are Community.

Attachment(s)
Exhibit 1 – Summary Reports of Trouble Tickets by Category
Exhibit 2 – County Regional Communications Police Complaint Sample
Exhibit 3 – County Regional Communications Fire-Rescue Complaint Sample

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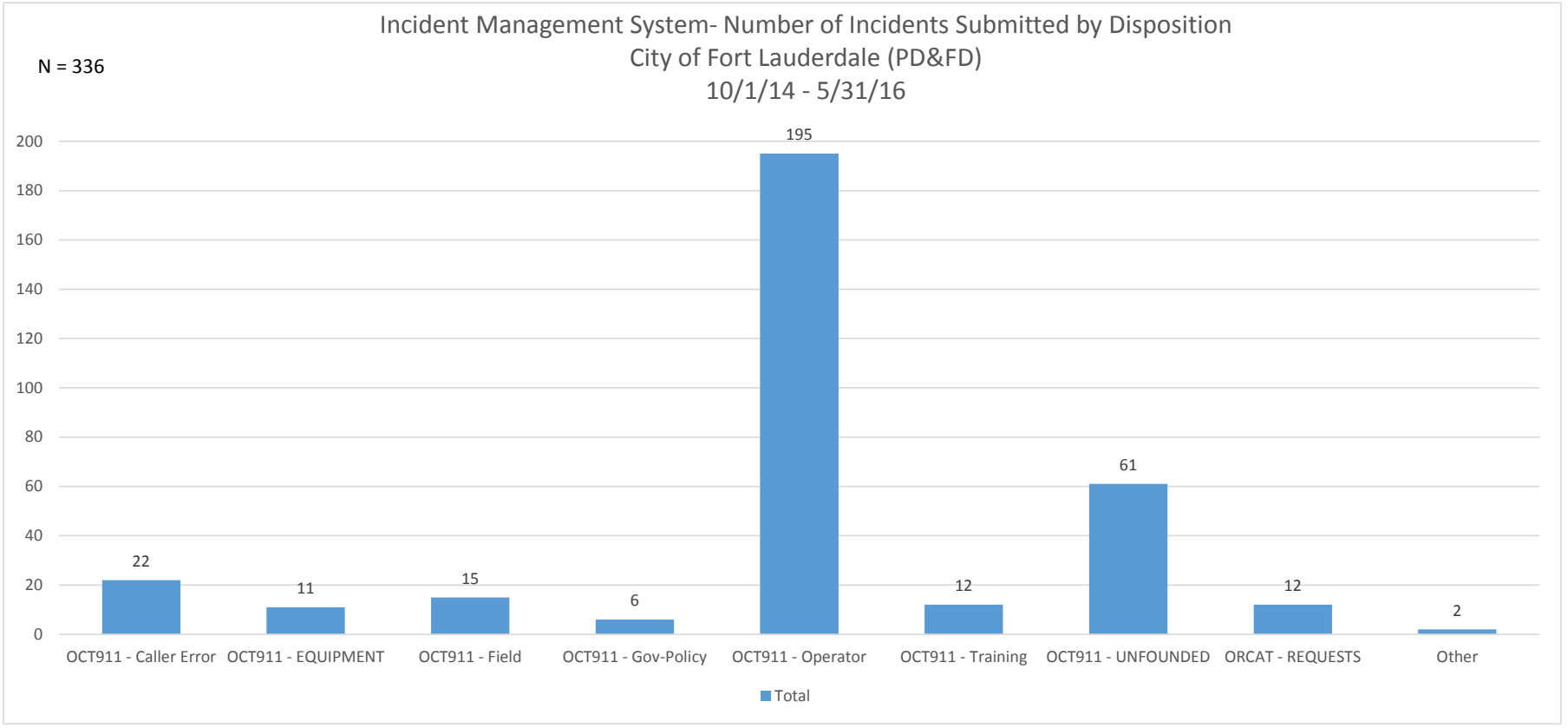
Prepared by:	Asst. Police Chief Michael G. Gregory, Police Department Division Fire Chief Stewart Ahearn, Fire Department Donna Perez, Information Technology Services Michelle Flores, Information Technology Services
Department Director:	Mike Maier, Information Technology Services

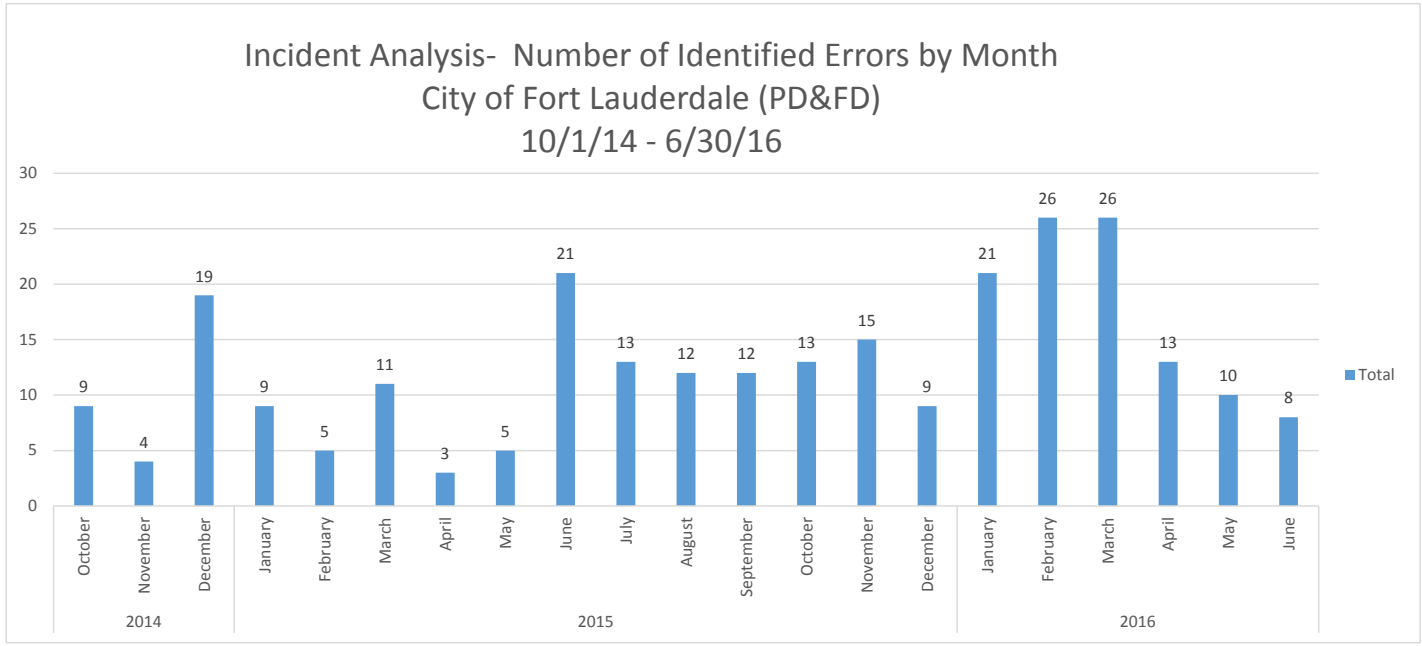
Open Date & Time	(Multiple Items)
Group Name	BSO 911

Row Labels	Count of Subject Description
OCT911 - Caller Error	22
OCT911 - EQUIPMENT	11
OCT911 - Field	15
OCT911 - Gov-Policy	6
OCT911 - Operator	195
OCT911 - Training	12
OCT911 - UNFOUNDED	61
ORCAT - REQUESTS	12
Other	2
Grand Total	**336**



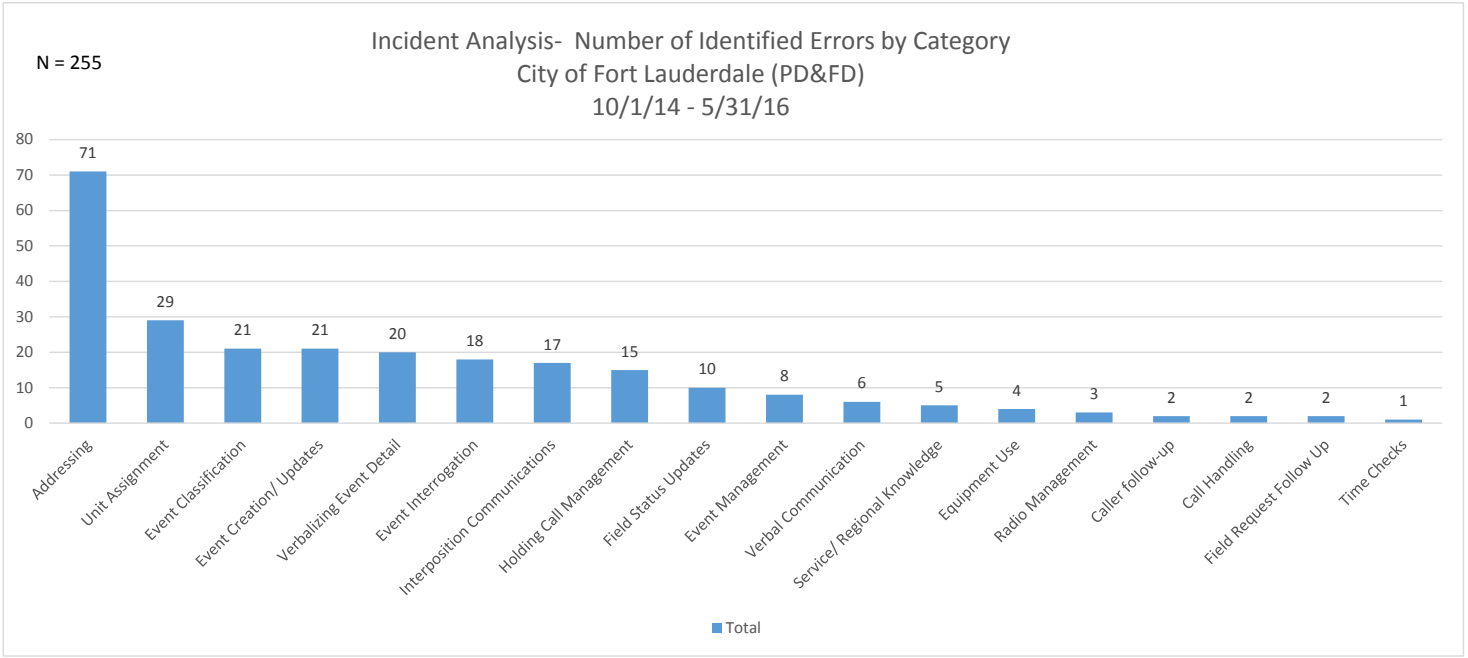
Division	(Multiple Items)
Subject	OCT911 - Operator

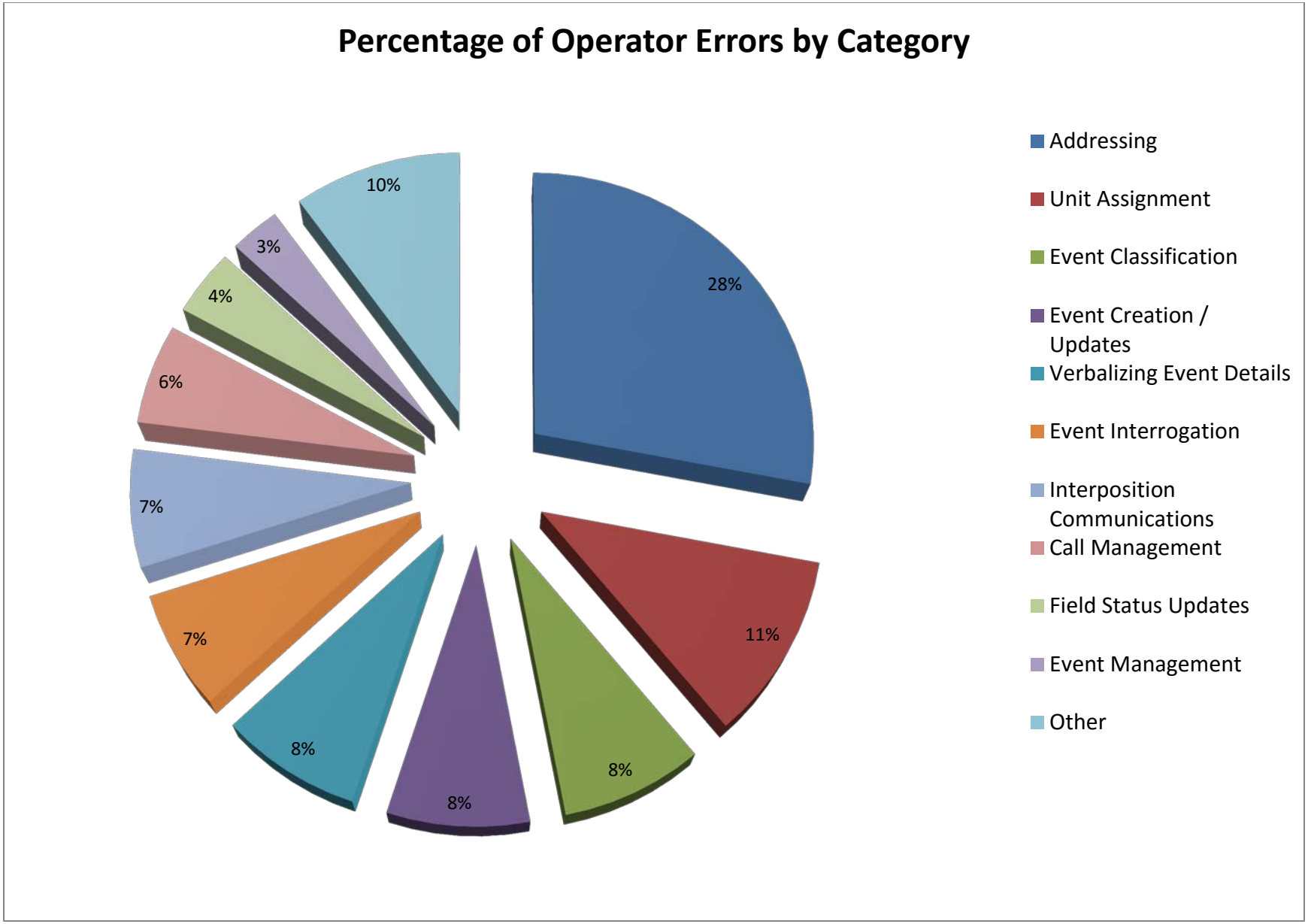
Row Labels	Count of Incident
2014	**32**
October	9
November	4
December	19
2015	**128**
January	9
February	5
March	11
April	3
May	5
June	21
July	13
August	12
September	12
October	13
November	15
December	9
2016	**104**
January	21
February	26
March	26
April	13
May	10
June	8
Grand Total	**264**



Subject	OCT911 - Operator
Opened	(Multiple Items)

Row Labels	Count of Service Category
Addressing	71
Unit Assignment	29
Event Classification	21
Event Creation/ Updates	21
Verbalizing Event Detail	20
Event Interrogation	18
Interposition Communications	17
Holding Call Management	15
Field Status Updates	10
Event Management	8
Verbal Communication	6
Service/ Regional Knowledge	5
Equipment Use	4
Radio Management	3
Caller follow-up	2
Call Handling	2
Field Request Follow Up	2
Time Checks	1
Grand Total	255




Percentage of Operator Errors by Category
28%
11%
8%
8%
8%
7%
7%
6%
4%
3%
10%
Addressing
Unit Assignment
Event Classification
Event Creation / Updates
Verbalizing Event Details
Event Interrogation
Interposition Communications
Call Management
Field Status Updates
Event Management
Other

Operator Error Category	Sub-Categories
Addressing	Address Verification or Discrepancy Clarification
	Data Entry error of proper direction, address, or street type
	Failure to use tools to locate caller, validate city, or identify location
	Incorrect Use of Common Names
	Selection of incorrect city or zone
Event Classification	Data Entry error
	Improper call classification or failure to use the higher signal
	Inaccurately capturing In-progress, Just Occurred, Delayed; incorrect event priority
	Data Entry error
	Improper call classification or failure to use the higher signal
	Inaccurately capturing In-progress, Just Occurred, Delayed; incorrect event priority
Event Creation / Updates	Event not created timely
	Failure to create a call for service
	Failure to create a call for service for a specific discipline
	Failure to create a call when notified by the field
	Failure to identify duplicate event or improper duplication of event
	Failure to include pertinent/ clear details or updates
	Inaccurate information entered in the event fields/ comments
	Incorrect validation of signal, event details, or address prior to cloning
Holding Call Management	Ensuring field assignments of holding events
	Failure to provide Sgt timely updates
	Holding the call without supervisory approval
Event Interrogation	EMD protocol failure
	Incorrect line of questioning or failure to assess the call nature/details
	Injury interrogation
	Interrogation prior to transferring to non-emergency or disconnecting
Interposition Communications	Acquiring/ Assignment to a TAC Dispatcher or Talkgroup
	Failure to acknowledge / take action on message
	Failure to send update
	Failure to use Gold Elite to communicate
	Information sent was unclear or inaccurate

Operator Error Category	Sub-Categories
Verbalizing Event Detail	Address updates/ clarification not verbalized
	Failure to verbalize all pertinent event comments or updates
	Failure to verbalize premise incident history, safety/ hazard flags
	Inaccurate information provided to field
Field Requests/ Follow Up	Failure to acknowledge information provided by field
	Failure to complete field requests
	Failure to provide addition resources or backup
	Failure to send required page
	Failure to update field that request was completed/ result of request
Radio Management	Critical incident handling protocol (10-3, 10-24)
	Failure to confirm communications were received by Field
	Relayed inappropriate information for main channel
	Talkgroup / channel management
	Traffic management/ Timely Acknowledgements
	Unit not responding procedures
Unit Assignment	Appropriate Fire units not assigned / dispatched
	Appropriate Law units not assigned / dispatched
	Appropriate Marine units not assigned / dispatched
	Assigned units to Duplicate Incident
	Failure multiselect or notify multi Jurisdictions
	Failure to communicate pertinent event details to Supervisor
	Failure to dispatch units timely
	Failure to notify supervisor of emergency call
	Failure to verbalize unit assignment
	High priority call announcement / tone alerting critical events
	Signal Upgraded and correct assignment not sent
Field Status Updates	CAD not updated with information from the field
	Failure to update CAD unit statuses accurately and timely
Time Checks	Failure to perform time checks on correct interval and signal
Event Management	Improperly clearing/ freeing units from calls
	Improperly closing incidents
	Incorrect disposition used

Operator Error Category	Sub-Categories
Service/ Regional Knowledge	Adherence to countywide page procedures
	Improperly redirecting units to BCF Info or Info
	Incorrectly directed caller on services, procedures, or referrals to another entity
	Knowledge of Regional service area/ participating agencies- Coral Springs/ Parkland
	Knowledge of Regional service area/ participating agencies- Plantation
	Knowledge of Regional service area/ participating agencies- Seminole
	Knowledge of Services provided by Regional Communications and Local Agencies
Equipment Use	Engaged Adapter/ Volume Controls
	Use of the CAD system
	Use of the Power911 system
	Use of the Radio console
Verbal Communication	Address updates/ clarification not verbalized
	Failure to verbalize all pertinent event comments or updates
	Failure to verbalize premise incident history, safety/ hazard flags
	Inaccurate information provided to field
Dispatcher Relief	Relief Dispatcher unaware of pending requests / active events
	Relief occurring during priority event
Caller follow up	Failure to call back disconnected caller
Call Handling	Failure to announce call transfer
	Failure to stay landline with caller during in progress event
	Schedule compliance

Incident Date	Incident Number	Incident Location	Operator Error Category	Incident Details	Regional Assigned Ticket #	Response from Broward County Regional Communications
5/16/2016	34-1605-073796	48xx N Federal Hwy	Unit Assignment	An in progress armed robbery that was entered as a suspicious incident; The call was never alert toned		
4/15/2016	34-1604-056830	sr7 @Sawgrass Expwy	Interposition Communications	Officer was OJ when he encountered a traffic crash. Officer was switched channel to channel while trying to report and gets updates to/from department of jurisdiction.	**411502**	The unit did not transmit the accident OJ on District 1. The District 1 dispactcher created a call for Fort Lauderdale Police Department as an on-view for the unit, however, she did not generate a call for CKPD. The unit did switch to DLE HQ and proceeded to have the request made there. The dispatcher, however, could have generated this call for CK without the switching talkgroups. We will review this with the operator invovled and with all staff.
5/25/2015	34-1505-083188	29xx Ocean Blvd	Event Classification	The call was not dispatched with the information consistent with the information that was given by the call taker on the 911 tape.		
5/4/2016	34-1605-067047	10xx NW 25 Ave	Event Management	Complainant has been having ongoing noise issues with his neighbor. He complained that we never responded to his latest call. Reviewing the CFS, module shows the call was cancelled by complainant. He is insistent that he did not cancell the call.		
4/16/2016	34-1604-055861	NW 14th Ave @ NW 6 St	Unit Assignment	Dist. 2 was engaged in a foot chase of a suspect from a stolen vehicle. The chase was heading towards the boarder of another district. A Sgt. and Capt monitoring Dist 2 came over the air and advised dispatch to alert tone the call over the other channels. An alert tone was not heard by either requesting supervisor and they feel there was ample time to do so.	**407608**	We find error as outlined in the concern. The QA unit will be reviewing all components of this event.
4/28/2016	34-1604-061199	6xx NW 19 Ave	Event Classification	Call for a shooting at Lincoln Park. The call was not dispatched on all channels, only on District 2.		
4/22/2016	34-1604-060268	25xx NW 20 Street	Verbal Communication	Ofc. Responded to the incident location to what sounded like a burglary in progress at 2127 hours. A perimeter was set. Prior to arrival, the Ofc. Requested information to verify and clarify if the victim was home (occupied 21?). The dispatcher repeated the call - the victim was watching the suspect attempt to gain entry into his home. The dispatcher sent the request to the call taker. The Ofc. never received any further information. The victim stated he notifed the call taker that he was at home wastching the subject actively trying to gain entry into his house. The information was never provided to the Ofc.		
4/12/2016	34-1604-055250	5700 block North Federal Hwy	Addressing	Officer requested dispatch to have another Officer respond and dispatch was sending him to the 2700 block of N. Fed Hwy. Dispatch was unaware of the Ofc's location after he had advised of the traffic stop over the Police radio and had told them previously he was going to be at 2121 NE 53rd St. They were requesting an Officer from the south sector to respond when the Officer was at the North sector.	**406463**	In this case, the dispatcher never lost the unit's location and had the location updates documented timely in CAD. The only error made was requesting a South unit instead of a North unit. The dispatcher did not have any issues with tracking the unit's location. The issue with her asking for a South unit instead of a North unit may have been a mis-speak by the dispatcher and could have caused the unit to believe that she did not have a correct location, however, this was not the case. This event will still be evaluated and reviewed with the dispatcher by the Quality Assurance team.
3/16/2016	34-1603-038657	40xx Galt Ocean Drive	Event Classification	Officers were dispatched to back up the fire department on a medical call regarding a person suspected of being on FLAKKA. Fire alleges that they requested PD Code 3 on three occasions. Officer states he was not advised about the Code 3 request until he read about it in the CAD notes in inquired.	**398731**	This matter is unfounded in that FR did not request Code 3 multiple times. A Code 3 reponse was requested only once, and was immediately confirmed to DLE when they saw this update. FR had made contact with the patient prior to unit's arrival, and had asked for an ETA, but never elevated the response until just prior to DLE being requested to respond in this manner.
2/29/2016	34-1602-031853	Originated in Lighthouse Point	Interposition Communications	On 02/29/16, the Dispatcher advised that Lighthouse Point Police Department was in pursuit of a stolen vehicle that was involved in several burglaries and that it was southbound on I-95 at SW 10th Street. Supervisor Cedric Hugley came on the District 2 channel and was giving us updates. The updates were delayed and it was not real time intelligence. The radios were asked to be patched with Lighthouse Point Police Department and was advised that it could not be done. The following jurisdictions were involved in assisting Lighthouse Point Police: Broward Sheriff Office (Oakland Park, Lauderdale Lakes and Aviation Unit), Lauderhill Police Department, Florida Highway Patrol, and Fort Lauderdale Police Department. All agencies appeared to be operating on their own assigned radio channel and the real time intelligence was being disseminated as delayed. Detective Jared Gross located the second stolen vehicle and advised that he was in pursuit on District 2 channel and the other jurisdictions were not aware as they did not have our communication as real time intelligence. The communication that was being passed along amongst all jurisdictions were communicated in person out in the field with the other agency such as apprehending two suspects from the second stolen vehicle bailout. Officer Travis Weston responded to the first bailout location in the 3800 Block NW 19th Street (Lauderdale Lakes jurisdiction) and requested several times for BSO Lauderdale Lakes to respond and it took several minutes before anyone showed up. I believe that the teamwork would have been much better if all communication was limited to one channel to avoid any confusion and gather real time intelligence as it was happening.	**397943**	There is no policy on this, per se, However, this is an established practice. Again, this falls to the Duty Officer for coordination and patching. This is being identified as an "Operator" issue, in that the event occurred due to the operator (Duty Officer) not establishing a primary point of control and management. This issue will be addressed with ALL Duty Officers at all sites reitering this expectation and procedure for implementation.

Incident Date	Incident Number	Incident Location	Operator Error Category	Incident Details	Regional Assigned Ticket #	Response from Broward County Regional Communications
2/26/2016	34-1602-030151	6xx NE 5th Ave	Interposition Communications	The particular dispatcher that was broadcasting has a tone/speech pattern that is often difficult to understand via police radio. This particular dispatcher has become well known as difficult to understand, so much so, that when his voice is initially heard officers talk about how difficult the evening will be. On this incident in particular there are two issues that we would like addressed. 1) Both the responding officers and supervisor were unable to understand the information being dispatched on the first transmission (and subsequent) 2) The site manager was unwilling switch out the dispatcher to help meet the operational needs of the district.	**396083**	The audio was reviewed. The dispatcher provided all call details and responded to all units appropriately. This is a veteran, decorated dispatcher who has been recognized in the past for exemplary performance. His speech patterns are not unintelligible and removing a dispatcher from working an assignment in which he is trained is not a viable option.
3/2/2016	34-1602-025238	64xx NE 18th Ave	Radio Management	Officer was sent to an in progress domestic violence call along with a back-up who had to XY from another sector. After arriving on scene of the in progress domestic violence the dispatcher began to read, in great detail, a long list of holding calls thus shutting down the officer's conduit of communication.	**396085**	This call was entered at 1827:36 hours. The dispatcher alerted the call to all channels and then confirmed the Sgt was aware of 1829:40 hours. The Sgt took the call and a back up was assigned. The Sgt was asked if he could copy on “2”. The first unit responding to this call then arrived, and the Sgt told the dispatcher to “go ahead.” The dispatcher proceeded to read calls pending. IN this case, the dispatcher attempted to give the Sgt pending calls as required by SOP. However, once the first unit arrived on a priority call, all radio traffic needed to stop and the air held for the unit’s declaration of the status of the call. The dispatcher was adhering to one policy when he violated another. SOP 2.6.1H directs that all units arrival to a priority call must have the air held automatically. That did not occur. This issue will be documented and the operator will have this policy outlined clearly for remedial purposes.
Multiple	Multiple	Multiple	Radio Management	It has been noticed lately that when checking an alarm and coming across an opened door, some dispatchers are alert toning the fact that there is open door/window or alert toning when asked to hold the air while checking an alarm or for any other reason. This can pose an officer safety issue for needed air time or by a loud alert tone giving away the element of surprise of an officer who is outside an open door of a home where a potential subject may be. Can we please have this eliminated so that alert tones are not done to notify people to not use the air.	**396777**	There are no incidents to review, so this is ticket will be responding to policy and practice SOP 2.2F. This policy outlines the use of the different tone alert requirements. To suspend the use of any alerts would be a matter for ORT as it would have county-wide implications.
Multiple	Multiple	Multiple	Event Classification	Being a narcotics canine I am requested several times during a shift. Having an in car radio I am able to scan the other districts and I have noticed on some instances that someone from another district will ask for a narcotics canine and if I am on a call, a traffic stop, or assigned to a call, the dispatcher will simply respond that I am busy instead of going all channels. This poses several issues for both requests and legal reasons. We have a time limit to respond to calls for requests which is 15 minutes. If I am unaware of a request, I cannot respond within the time frame of the traffic stop. Also, I have been writing calls off completing paper able to respond and I am never notified. Can we please address this so that all requests go all channels at the time of request	**396777**	The second component is a concern regarding the availability of narcotic canines when the unit is not available for call assignment. In these cases, any specialized unit is required to still be notified of a request and the unit will make a determination of when or if they can respond. A dispatcher should not be advising a unit making a request for a specialized unit that the unit is not available unless that is what the unit themselves have communicated. We can address this with all staff.
2/8/2016	34-1602-020154 155, 156, 157, 158	1048 NE 3 Ave	Event Creation/Updates	Multiple missing person calls were received. Initially Ofc. Shields volunteered to handle. She then responded to an in progress call and advised dispatch to remove her from the calls. The calls were never put back into the queue, and subsequently appear to have been closed out by dispatch. As a result missing children were never entered into FCIC/NCIC. This was discovered when a call was placed to recover the children this morning, and they were not in the system.	**392247**	After a discussion between the Site Manager and this employee, the employee has confirmed that she intentionally closed all calls in pending because it was “common practice” at FLPD that when a unit stated that they would handle precisely these types of calls, the unit was responsible for all follow up and that it was acceptable for the dispatcher to code them out without further dialogue. However, at 0507:35, 34A43 was cleared from the cases, and was enroute to an unrelated S10. All calls were returned to pending queue.
2/22/2016	34-1602-027642	N/A	Event Creation/Updates	Officers were on a scene with a fleeing subject who allegedly had a warrant. An officer ran the subject on Teletype and he came back with a hit for a felony warrant. The officer attempted to get the operator to confirm the warrant, but the operator refused because the officer did not have the subject in custody (he was fleeing). We were awaiting the information so that we could deploy K9 who was on scene. The operator should have advised the officer that a status check could be completed, at very minimum, as opposed to refusing to confirm. Please look into and advise of findings.	**395699**	The TTY operator asked if the subject was in custody, and the unit said “no”. The unit stated that she was chasing the subject and “trying to figure this out.” The TTY operator stated that she cannot confirm on a warrant in which the subject was not in custody. The TTY operator’s direction is correct. There is a long standing procedure that only subjects who are detained or in custody will be confirmed for anything in the system. In this case, the TTY operator absolutely advised the unit that the subject had a possible warrant for felony narcotics. She was just not able to confirm if the warrant was still active unless the subject was detained or in custody. There is no violation of policy in this case.
2/20/2016	34-1602-026891	43xx N Ft Lauderdale Bch Blvd	Addressing	Officers were dispatched to a woman screaming for help. Upon officers arrival to the area they discovered that the numerical address did not exist and no one matching the description of the person in need could be found. Further investigation revealed that the call was in a city other than Fort Lauderdale.	**395701**	The caller’s LAT/LONG showed that he would have been north of Commercial on Ocean Blvd, which would have been a numerically higher number than what he offered at 4301. Based upon this, the caller did provide an incorrect address. The location provided could not have been 4301 based upon his LAT/LONG coordinates. In using 4301, only FL is valid for a city of choice, LBTS is not. What is most confusing is that the caller stated that units were on scene prior to disconnecting. There are no calls found for LBTS in this timeframe, so it is unsure if a unit happened upon the scene or would have been from another agency.

Incident Date	Incident Number	Incident Location	Operator Error Category	Incident Details	Regional Assigned Ticket #	Response from Broward County Regional Communications
2/19/2016	34-1602-026300	32xx N Fed Hwy	Addressing	Officers were dispatched to a report of a person attempting to commit suicide with a knife. Officers were lead to believe that the caller was with the suicidal subject. Officers circulated the area looking for the subject without success. After officers cleared the area and closed out the call they were advised that they drove past the suspect and needed to return. This is when the officers learned that the caller was not on the scene and was calling from an office miles away.		
2/22/2016	34-1602-027900	Riverland RD & SR 7	Event Classification	How does the narrative of this call justify it being classified as a S-37 and not a S-41/S-0 just occurred?	**394443**	The call dials 911 and reports that an altercation involving teenagers – one of which is walking with a long knife "type thing". A description is given to the operator, and the caller comments that a cell phone was stolen and someone is now being chased. The caller repeats that a type of weapon is seen. The operator's comments reflect the issue reported, however, the signal absolutely fails to capture the incident as described. SOP oulines clearlyt that an operator will use the highest classification when confronted with an event that could be considered more than one type of event. In this case, the caller is clearly describing a robbery type event in which the subject was armed. There should not have been any confusion as to what the signal should have been.
N/A	N/A	Maguire's	Event Creation/Updates	Two car break ins at Maguire's tonight. Response time for PD over two hours. Also, dispatch talked one car owners who appeared not to have anythind stolen to not file a report.	**393375**	There is no evidence at all that this incident occurred with any member of Regional Comm. The caller called into Regional Communications 3 times. There were no outgoing calls made to the caller from either of our dispatch/call taker positions. No audio was found that would suggest that any of our call takers/dispatchers advised or insinuated that the caller should not file a police report. If it is possible, please have the complainant provide a phone number that called the caller or the phone number the caller dialed when he was allegedly advised to not file a report. The call was holding at the discretion of the 34D15. Dispatch notified/attempted to notify 34D15 of the call 4 times.
2/10/2016	34-1602-021508	43xx N Fed Hwy	Unit Assignment	An vehicle accident came in through the call center at 2056. At this time a PSA (34Z17) had been in service for 2 hours and was not dispatched to this call, causing the call to hold and driver to wait longer than needed.	**392482**	Occurred as outlined. 34Z17 was available from the previous assignment at 1904 hours. This event was generated at 2056 hours. There is no reason why this call was not assigned at the Z unit as required.
1/22/2016	34-0122-011558	24xx S Fed Hwy	Event Creation/Updates	When this call was dispatched, the dispatcher advised of the culprits running to a Uhaul, not understanding if it was a business or truck. It was unclear so Ofc. Scola pulled up the call. After seeing that the Burglary was to the Mercedes dealership, Ofc. Scola only had to read to line 4, to read a fantastic BOLO of the culprit vehicle. Uhaul Sprinter Van, tag AG80157. Sprinter vans are extremely recognizable, and the tag was a bonus. Dispatch failed to broadcast this vital information, so Ofc. Scola did. And when she did, Officer Walters was in eye shot of the Sprinter Van! The van only had about a mile before hitting I-95, and could've potentially gotten away. Only to come back later and steal expensive Mercedes' to further the victimization of a Ft Lauderdale business. This ended well with all 6 in custody, but it could've easily been worse.	**391306**	In this event, the dispatcher provided all of the information that was in the CAD entry with the exception of stating that it was a "sprinter van" and the tag number. She did mention that subjects were GOA in a Uhaul on more than one occasion. This omission should have been spoken as it was on the CAD entry upon unit assignment.
1/23/2016	34-1601-011581	6xx NE 4 Ave	Unit Assignment	A subject opened Reportee's bedroom window and fled. This call may have had a 15 minute time delay but it was held for an additional 7 minutes. While this call was holding, Sgt. Fortunato was sitting directly across from the address, unaware that the call was pending because dispatch never dispatched it. The air was being held at that time for an alarm, but this constitutes an alert tone and breaking 10-33. This was a great officer safety issue, the burglary subject could have run up on Sgt. Fortunato with him completely unaware the culprit had just committed a burglary.	**391304**	This delay in unit assignment is unacceptable. The air was initially held appropriately for the 49A. SOP directs that the air can be held for a 3 minute interval for incidents such as what occurred in this case. However, the air was cleared within 2 minutes. Therefore, all subseuential traffic should have been managed in accordance with policy. SOP outlines that priority 4 events have a 3 minute window for assignment. This call was not assigned until 7 minutes after initiation. Further, this call was a more urgent matter than the 22N complaint, and should have taken higher precedence than routine traffic and the assignment of the disturbance call. The delay in managing this event is inexcusable.
5/30/2015	34-1506-091798	BGH	Event Interrogation	Today I responded to Walgreens at 1515 E Sunrise Blvd in ref. to a shoplifting in progress. The call stated that the manager was not comfortable making contact with two young adult males and he called police. The call taker took the information at hand and told the reportee "we'll send someone" and hung up. My question is, is there not a policy to keep someone on the phone during an in progress call, even if it's a misdemeanor? By the time I got to the Walgreens coming from the north the subjects were gone in a vehicle and probably drove right by me. I asked the manager Eric Pearson why he didn't stay on the phone and he said he was not given that option. He advised of a similar incident last week where he watched the suspect go to the Publix parking lot, but the call taker did not stay on the phone with him. It would be helpful, at least when the call is still in progress if contact was maintained.	**N/A**	The County has investigated your complaint and has determined that policy was violated in the described incident. The BSO employee will be addressed and referred for remedial training.

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6/12/2015	34-1506-092946	7xx E Evanston Cir	Unit Assignment	The call was received at 1355hrs advising of a s-0 subject chasing his sister. Several units from bravo shift handled the call. A charlie shift unit 34C62 did a prisoner transport for the incident to JAC. At some point around 1756 the call was re-dispatched as in progress with units going code 3. The incident was not going on. The aggressor was not on scene and the female at the home said no one called that the incident was solved earlier in the day by police response.		
6/25/2015	34-1506-010082	17xx W Las Olas Blvd	Verbalizing Event Detail	The problem presented with this call was that we were never advised by dispatch while enroute (information acquired after arrival from the victim, who later advised that she had notified the communication center at the commencement of the original call) that the house was occupied during the burglary which would have elicited a different response from the responding officers to ensure the safety of the occupant. Please review so that we may avoid in the future.		

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.

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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)

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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.

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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.

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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

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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.