

DEPARTMENT OF TRANSPORTATION**National Highway Traffic Safety Administration**

[Docket No. NHTSA–2010–0089]

Public Meeting on Draft Recommendations for Safely Transporting Children in Specific Situations in Emergency Ground Ambulances

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Notice of Public Meeting.

SUMMARY: The National Highway Traffic Safety Administration (NHTSA) will hold a Public Meeting to obtain comments on the attached Draft Recommendations for Safely Transporting Children in Specific Situations in Emergency Ground Ambulances. These recommendations were developed by a Working Group comprised of subject matter experts to provide guidance to local, State, and national emergency medical services (EMS) personnel and organizations to safely transport children from the scene of a crash or other incident in ground ambulances.

DATES: The Public Meeting will be held on August 5, 2010 from 1:30–4:30 p.m. EST.

ADDRESSES: *Location of meeting:* Department of Transportation, 1200 New Jersey Avenue, SE., Washington, DC 20590. NHTSA recommends that all persons attending the Public Meeting arrive at least 45 minutes early in order to facilitate entry into the DOT building. If you wish to attend or speak at the Public Meeting on August 5, 2010, you must register by 5 p.m. ET on July 26, 2010 by following the instructions in the *Procedural Matters* section of this Notice. NHTSA will consider late registrants to the extent time and space allows, but NHTSA cannot ensure that late registrants will be able to speak at the meeting.

If you are unable to attend the Public Meeting in person in Washington, DC, NHTSA will also conduct a live, Internet-based “Webinar” of the meeting on August 5, 2010. For those interested in registering to participate in the Webinar, please send an e-mail message indicating this to sandy.sinclair@dot.gov by no later than 5 p.m. ET, on July 26, 2010 with “Webinar Attendance” in the e-mail “Subject” line.

Instructions for written comments: If you are interested in submitting written comments on the draft recommendations, you may submit

comments identified by DOT Docket ID Number NHTSA–2010–0089 by July 26, 2010 using one of the following methods:

- *Federal eRulemaking Portal:* Go to <http://www.regulations.gov>. Follow the online instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* Docket Management Facility, M–30, U.S. Department of Transportation, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery or Courier:* West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., ET, Monday through Friday, except Federal holidays.

Please Note: All comments received will be posted without change to <http://www.regulations.gov>, including any personal information provided. Please see the information provided under “Privacy Act.”

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review the complete User Notice and Privacy Notice for Regulations.gov at <http://www.regulations.gov/search/footer/privacyanduse.jsp>.

Docket: For access to the docket to read background documents or comments received, go to <http://www.regulations.gov> at any time or to West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Alexander Sinclair, Telephone: 202–366–2723, Occupant Protection Division (NTI–112), Office of Impaired Driving and Occupant Protection, Research and Program Development, Traffic Injury Control, NHTSA, DOT, 1200 New Jersey Avenue, SE., Washington, DC 20590. E-mail: sandy.sinclair@dot.gov.

SUPPLEMENTARY INFORMATION:**I. Background**

Estimates suggest that ground emergency medical services (EMS) responds to approximately 30 million emergency calls each year.¹

¹ Levick, NR. Emergency Medical Services: A Transportation Safety Emergency. Paper presented at: American Society of Safety Engineers Professional Development Conference; June 24–27, 2007; Orlando, Florida, USA. Available at: <http://www.objectivesafety.net/2007ASSE628Levick.pdf>. Accessed December 9, 2008.

Approximately 6.2 million patient transport ambulance trips occur annually,² of which approximately 10 percent of those patients are children.³ While data sources regarding ambulance crashes involving child ambulance occupants in the U.S. are limited, it is estimated that each year up to 1,000 ambulance crashes involve patients who are children. A review of local, national, and international media coverage of ambulance crashes involving injuries to children of all ages suggests such crashes are dangerous and can result in injuries ranging from minor to fatal. Injured children may be patients or passengers accompanying a parent or caregiver; they may be receiving transport from the scene of a crash or a medical emergency, or may be involved in an inter-facility transport.

The issue of variation in emergency child transport guidelines was first identified in a 1998 publication which reported the results of a survey examining State requirements regarding the use of safety restraints for children in ambulances. The study revealed that 35 States did not require patients of any age to be restrained in ambulances. Of those States requiring the use of child safety restraints, requirements varied between requiring that the child be placed in a child restraint system on an ambulance cot, in a child seat, or both.⁴ Depending upon the medical condition of the child (e.g., uninjured/not ill, and being transported with an injured parent or caregiver; injured/or ill but not requiring continuous and/or intensive medical monitoring; or injured/ill and requiring continuous and/or intensive medical monitoring), these three methods of transporting children in ground ambulances may not be the safest means of doing so.

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) and the National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation convened a national consensus committee in 1999 to review EMS child transportation safety practices following the 1998 publication of the State survey and to develop guidelines for safely transporting children in ground ambulances. The HRSA/NHTSA committee, composed of

² Levick, NR. 2002. New Frontiers in optimizing ambulance transport safety and crashworthiness. *The Paramedic*. 2002;4:36–39.

³ Winters, G and Brazelton, T. Safe Transport of Children. *EMS Professionals*. July–August 2003;13–21.

⁴ Seidel J.S., Greenlaw J. Use of restraints in ambulances: A state survey. *Pediatric Emergency Care*. 1998;14(3):221–3.

representatives from national EMS organizations, Federal agencies, and transportation safety engineers, developed a document entitled, *The Do's and Don'ts of Transporting Children in an Ambulance*, which was published in December 1999.⁵ This document provides general guidance for EMS practitioners in the field on how to transport children safely in an ambulance.

Since the publication of *The Do's and Don'ts of Transporting Children in an Ambulance*, protocols and practices currently utilized by EMS practitioners have remained inconsistent. States, localities, associations and EMS providers have developed legislation, guidelines or protocols regarding this issue. However, these guidelines and protocols vary across jurisdictions and often provide limited, or in some cases inappropriate, guidance.

Currently, there are no Federal standards or standard protocols among EMS and child passenger safety professionals in the U.S. for how best to transport children safely in ground ambulances from the scene of a traffic crash or medical emergency to a hospital or other facility. The absence of consistent national standards and protocols regarding the transportation of children in ground ambulances complicates the work of EMS professionals and may result in the improper and unsafe restraint of highly vulnerable child passengers. As a result, EMS agencies, advocates and academicians have turned to NHTSA for leadership on this issue.

II. Draft Recommendations

To address this issue, NHTSA initiated "Solutions to Safely Transport Children in Emergency Vehicles" in September 2008.⁵ The major objectives of the project were to: (1) Build consensus in the development of a uniform set of recommendations to safely and appropriately transport children (injured, ill, or not sick/uninjured) from the scene of a crash or other incident in a ground ambulances; (2) foster the creation of best practice recommendations after reviewing the practices currently being used to transport children in ground ambulances; and (3) provide consistent

national recommendations that will be embraced by local, State and national EMS organizations, enabling them to reduce the frequency of inappropriate and potentially unsafe transportation of ill, injured or not sick/uninjured children in ground ambulances.

To achieve the objectives described above, NHTSA formed a Working Group of experts with the experience, background, and knowledge of the current practices for the emergency transportation of child passengers in ground ambulances. The members of the Working Group were drawn from many prominent national organizations and entities involved in the health care of children and the transportation of children and others in ground ambulances, including the International Association of Firefighters, the National Association of State EMS Officials, the American Academy of Pediatrics, the American College of Emergency Physicians (ACEP), the National Association of Emergency Medical Service Physicians (NAEMSP), the National Volunteer Fire Council, the National Association of Emergency Medical Technicians, the American Ambulance Association, the National Emergency Medical Services for Children's Resource Center (EMSC NRC), and the Emergency Nurses Association (ENA). Members from NHTSA, HRSA and other entities within HHS also participated in the discussions and deliberations of the Working Group. The Working Group met monthly via teleconference beginning in 2009 to develop the draft recommendations for the safe transportation of children in ground ambulances. In addition to holding the monthly teleconferences, the Working Group was also convened for a one-day meeting in Washington, DC on July 22, 2009.

The ultimate goals of the draft recommendations developed by the Working Group are to: (1) Prevent forward motion/ejection of all children being transported in ground ambulances; (2) secure the torso ejection of all children being transported in ground ambulances; and (3) protect the head, neck and spine of all children transported in ground ambulances. By ensuring that these goals are met in all situations involving the transportation of children in ground ambulances from the scene of a traffic crash or medical emergency, the Working Group believes that the safety of such children will be greatly improved.

The draft recommendations for the safe transportation of children in emergency ground ambulances are organized into five categories reflecting common situations:

1. Child who is uninjured/not ill;
2. Child who is ill and/or injured and whose condition *does not require* continuous and/or intensive medical monitoring and/or interventions;
3. Child whose condition *requires* continuous and/or intensive medical monitoring and/or interventions;
4. Child whose condition *requires* spinal immobilization and/or lying flat; and
5. Child or children who *require* transport as part of a multiple patient transport (newborn with Mother, multiple children, etc.).

The full text of the recommendations and the draft report will be placed in the Docket.

III. Participation in the Public Meeting

The Public Meeting will be open to the public with advance registration for seating on a space-available basis. Individuals wishing to register to assure a seat in the public seating area should provide their name, affiliation (if any), telephone number and e-mail address to Mr. Alexander Sinclair using the contact information in the **FOR FURTHER INFORMATION CONTACT** section at the beginning of this notice no later than July 26, 2010. Should it be necessary to cancel the Public Meeting due to an emergency or some other reason, NHTSA will take all available means to notify registered participants by e-mail or telephone.

The Public Meeting will be held at a site accessible to individuals with disabilities. Individuals who require accommodations such as sign language interpreters should contact Mr. Alexander Sinclair using the contact information in the **FOR FURTHER INFORMATION CONTACT** section no later than July 26, 2010. Any written materials NHTSA presents at the Public Meeting will be available electronically on the day of the Public Meeting to accommodate the needs of the visually impaired.

Once NHTSA learns how many people have registered to speak at the Public Meeting, NHTSA will allocate an appropriate amount of time to each participant, allowing time for necessary breaks during the time allotted for the meeting. [**Please note:** NHTSA anticipates the Working Group will present some of the recommendations and respond to technical questions during the Public meeting.]

For planning purposes, each speaker should anticipate speaking for no more than approximately ten (10) minutes, although NHTSA may need to adjust the time for each speaker depending upon the total number of speakers. To accommodate as many speakers as

⁵ Health Resources and Services Administration (HRSA) and National Highway Traffic Safety Administration (NHTSA). *The Do's and Don'ts of Transporting Children in an Ambulance*. December 1999. Available at: www.dhhs.state.nc.us/dhsr/EMS/pdf/nhtsa_childtransport.pdf. Accessed January 21, 2009.

⁵ Operational support for the project was provided by Maryn Consulting Inc. under NHTSA contract DTNH22-08-C00085 by Maryn Consulting, Inc.

possible, NHTSA prefers that speakers not use technological aids (e.g. audio-visuals, computer presentations, etc.). However, if you plan to do so, you must contact Mr. Sinclair by July 26, 2010 using the contact information in the **FOR FURTHER INFORMATION CONTACT** section of

this notice. Speakers must also make arrangements to provide their presentations to NHTSA in advance of the Public Meeting to facilitate set up. During the week of August 2, 2010, NHTSA will post information on its Web site at <http://www.nhtsa.gov>

indicating the amount of time allocated for each speaker and each speaker's approximate order on the agenda for the Public Meeting.

Jeffrey P. Michael,
Associate Administrator, Research and Program Development.

DRAFT RECOMMENDATIONS FOR SAFELY TRANSPORTING CHILDREN IN SPECIFIC SITUATIONS IN EMERGENCY GROUND AMBULANCES

**Situation 1
For a Child who is uninjured/not ill⁶**

<p>The Ideal</p> <p>If the Ideal is not Practical or Achievable.</p>	<p>Transport using a size-appropriate child restraint system that complies with FMVSS 213 in a vehicle other than a ground ambulance.</p> <ol style="list-style-type: none"> 1. Transport in a size-appropriate child restraint system that complies with FMVSS 213 appropriately installed in the front passenger seat (with air bags off) of the emergency ground ambulance; or 2. Transport in the forward-facing EMS provider's seat (currently rare in the industry) in a size-appropriate child restraint system that complies with FMVSS 213 inside ambulance; ⁷ or 3. Transport in the rear-facing EMS provider's seat in a size-appropriate child restraint system that complies with FMVSS 213 (convertible or combination seat but not infant only seat, using a forward facing belt path) or in an integrated child restraint system seat (certified by manufacturer) to meet the injury criteria FMVSS 213; or 4. Consider delay⁸ of transport of the child with appropriate adult supervision until additional vehicles are available (patient is transported in EMS vehicle separately); or 5. Per the judgment of EMS personnel on the scene (and in consultation with medical control, when possible), consider delay of transport (to the extent the patient's safety and medical condition are not in any way compromised), patient care continued on scene (monitoring) until an additional vehicle is available for transport.
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**Situation 2
For a Child who is ill and/or injured and whose condition does not require continuous and/or intensive medical monitoring and/or interventions⁹**

<p>The Ideal</p> <p>If the Ideal is not Practical or Achievable.</p>	<p>Transport child in a size-appropriate child restraint system that complies with the injury criteria of FMVSS 213—secured appropriately on cot.¹⁰</p> <ol style="list-style-type: none"> 1. Transport child in the EMS provider's seat in a size-appropriate child restraint system that complies with the injury criteria of FMVSS 213 or an integrated seat in the EMS provider's seat that is certified by the manufacturer to meet the injury criteria of FMVSS 213; or 2. Transport child on cot¹¹ using three horizontal restraints across the child's torso (chest, waist, and knees) and one vertical restraint across each of the child's shoulders.
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**Situation 3
For a Child whose condition requires continuous and/or intensive medical monitoring and/or interventions¹²**

<p>The Ideal</p> <p>If the Ideal is not Practical or Achievable.</p>	<p>Transport child in a size-appropriate child restraint system that complies with the injury criteria of FMVSS 213—secured appropriately on cot.¹³</p> <p>Secure the child to the cot¹⁴; head first, with three horizontal restraints across the torso (chest, waist, and knees) and one vertical restraint across each shoulder. If the child's condition requires medical interventions, which requires the removal of some restraints, the restraints should be re-secured as quickly as possible as soon as the interventions are completed and it is medically feasible to do so. In the best interest of the child and the EMS personnel, the vehicle operator is urged to consider stopping the ambulance during the interventions. If spinal immobilization of the child is required, please follow the recommendation in the following table.</p>
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**Situation 4
For a Child whose condition requires spinal immobilization and/or lying flat¹⁵**

<p>The Ideal</p> <p>If the Ideal is not Practical or Achievable.</p>	<p>Secure the child to a size-appropriate spineboard and secure the spineboard to the cot,¹⁶ head first, with a tether at the foot (if possible) to prevent forward movement. Secure the spineboard to the cot¹⁷ with three horizontal restraints across the torso (chest, waist, and knees) and a vertical restraint across each shoulder.</p> <p>Secure the child to a standard spineboard with padding added, as needed, (to make the device fit the child) and secure the spineboard to the cot,¹⁸ head first, with a tether at the foot (if possible) to prevent forward movement. Secure the spineboard to the cot¹⁹ with three horizontal restraints across the torso (chest, waist, and knees) and a vertical restraint across each shoulder.</p>
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**Situation 5
For a Child or Children requiring transport as part of a multiple patient transport (newborn with Mother, multiple children, etc.)²⁰**

<p>The Ideal</p>	<p>If possible, for multiple patients, transport each as a single patient according to the guidance shown for Scenarios 1 through 4.</p>
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DRAFT RECOMMENDATIONS FOR SAFELY TRANSPORTING CHILDREN IN SPECIFIC SITUATIONS IN EMERGENCY GROUND
AMBULANCES—Continued

If the Ideal is not Practical or Achievable.	For mother and newborn, transport the newborn in an approved size-appropriate child restraint system that complies with the injury criteria of FMVSS 213 in the rear facing EMS provider seat with a forward-facing belt path that prevents both lateral and forward movement (convertible or integrated child restraint system and not an infant only seat), leaving the cot ²¹ for the mother. When available resources prevent meeting the criteria shown for situations 1 through 4 for all child patients, including mother and newborn, transport using space available in a non-emergency mode, exercising extreme caution and driving at reduced (i.e., below legal maximum) speeds. If additional units may be needed based upon preliminary reports, backup units should be put on standby.
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Prepared under NHTSA Contract DTNH22-08-C00085, EMS Solutions for Safely Transporting Children in Emergency Vehicles, with Maryn Consulting, Inc.

⁶ Please consult Appendix C, General Considerations and Selecting Child Restraint Systems for Ground Ambulance Transport, for guidance on how to select equipment that may be used to meet the requirements of each of the recommendations. EMS providers are encouraged to check with equipment manufacturers for detailed information on the proper use and installation, results of crash testing, and possible limitations of any equipment that may be considered for use to fulfill the recommendations for the safe transportation of children in emergency ground ambulances.

⁷ There may be considerations of adding specific conditions for this use, e.g., crash tested seat meeting FMVSS 213 and adequate space in front of the seat.

⁸ The Working Group recommends that all EMS agencies plan, in advance, with other public health, public safety, and other partners for those situations where uninjured or not ill infants and children may be on the scene—as primary patients or not—so such events can be successfully mitigated and the uninjured infants and children can be transported as safely and as quickly as possible.

⁹ See Footnote 1.

¹⁰ ¹¹ All children transported on a cot shall be restrained to the cot with the 5-point cot restraint system that includes three horizontal restraints across the torso (chest, waist, and knees) and one vertical restraint across each shoulder.

¹² See Footnote 1.

¹³ See Footnotes 5 and 6.

¹⁴ Ibid.

¹⁵ See Footnote 1.

¹⁶ See Footnotes 5 and 6.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ The Working Group recommends that all EMS systems “pre-plan”, i.e., plan in advance for those situations where multiple infants and children may be on the scene—as primary patients or not—so such events can be successfully mitigated. Pre-planning for such events must also involve other public health, public safety and other partners to be most successful. An example of such an event is one that involves multiple patients, i.e., infants and/or children who need to be transported (to include labor with the mother and one or more newborns).

²¹ All children transported on a cot shall be restrained to the cot with the 5-point cot restraint system that includes three horizontal restraints across the torso (chest, waist, and knees) and one vertical restraint across each shoulder.

[FR Doc. 2010-17513 Filed 7-16-10; 8:45 am]

BILLING CODE 4910-59-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Noise Exposure Map Notice New Smyrna Beach Municipal Airport, New Smyrna Beach, FL

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice.

SUMMARY: The Federal Aviation Administration (FAA) announces its determination that the Noise Exposure Maps submitted by the City of New Smyrna Beach for New Smyrna Beach Municipal Airport under the provisions of 49 U.S.C. 47501 *et seq.* (Aviation Safety and Noise Abatement Act) and 14 CFR Part 150 are in compliance with applicable requirements.

DATES: *Effective Date:* The effective date of the FAA’s determination on the noise exposure maps is July 8, 2010.

FOR FURTHER INFORMATION CONTACT: Ms. Lindy McDowell, Federal Aviation Administration, Orlando Airports District Office, 5950 Hazeltine National

Drive, Suite 400, Orlando, FL 32822, 407-812-6331.

SUPPLEMENTARY INFORMATION: This notice announces that the FAA finds that the Noise Exposure Maps submitted for New Smyrna Beach Municipal Airport are in compliance with applicable requirements of Title 14 Code of Federal Regulations (CFR) Part 150, effective July 8, 2010. Under 49 U.S.C. section 47503 of the Aviation Safety and Noise Abatement Act (the Act), an airport operator may submit to the FAA Noise Exposure Maps which meet applicable regulations and which depict non-compatible land uses as of the date of submission of such maps, a description of projected aircraft operations, and the ways in which such operations will affect such maps. The Act requires such maps to be developed in consultation with interested and affected parties in the local community, government agencies, and persons using the airport. An airport operator who has submitted Noise Exposure Maps that are found by FAA to be in compliance with the requirements of 14 CFR Part 150, promulgated pursuant to the Act, may submit a Noise Compatibility Program for FAA approval which sets forth the measures the airport operator has taken

or proposes to take to reduce existing non-compatible uses and prevent the introduction of additional non-compatible uses.

The FAA has completed its review of the Noise Exposure Maps and accompanying documentation submitted by the City of New Smyrna Beach. The documentation that constitutes the “Noise Exposure Maps” as defined in Section 150.7 of 14 CFR Part 150 includes: Figure 6.1, 2009 Noise Contours; Figure 6.2, 2014 Noise Contours; Figure 5-1, Runway 02 Flight Tracks; Figure 5-2, Runway 07 Flight Tracks; Figure 5-3, Runway 11 Flight Tracks; Figure 5-4, Runway 20 Flight Tracks; Figure 5-5, Runway 25 Flight Tracks; Figure 5-6, Runway 29 Flight Tracks; Figure 5.7, Helicopter Flight Tracks; Figure 5.8 Local Flight Tracks; Table 5.1, 2008 Annual Operations; Table 5.2, 2008 Annual-Average Day Fleet Mix (Itinerant Operations); Table 5.3, 2008 Annual Average Day Fleet Mix (Local Operations); Table 5.4 2013 Annual Operations; Table 5.5, 2013 Annual-Average Day Fleet Mix (Itinerant Operations); Table 5.6, 2013 Annual Average Day Fleet Mix (Local Operations); Figure 5.10, Percentage Runway Utilization; and Table 5.11,