



Emergency Services Committee Agenda

Wednesday, June 23, 2021

Tom Davies Square

Councillor Lapierre, Chair

4:00 p.m. Open Session Council Chamber / Electronic Participation

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1.	Call to Order	
2.	Roll Call	
3.	Declarations of Pecuniary Interest and the General Nature Thereof	
4.	Presentations	
4.1.	Emergency Services Committee Outlook 2021 Presentation	4
	This presentation by Joseph Nicholls, General Manager of Community Safety, provides information regarding the expected work of the Emergency Services Committee anticipated in 2021.	
4.2.	Ministry of Natural Resources and Forestry Updated Protection Agreement	35
	This presentation by Jesse Oshell, Deputy Fire Chief, provides information regarding the updated Ministry of Natural Resources and Forestry Protection Agreement.	
5.	Members' Motions	
6.	Correspondence for Information Only	
6.1.	Fire Services Update – June 2021	37
	This report provides information regarding the recent business activities, relevant statistics and good news stories within the Fire Services Division, Community Safety Department.	
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	This report provides information regarding the recent business activities, relevant statistics and good news stories within the Emergency Management Section, Community Safety Department.	
6.3.	Paramedic Services Update – June 2021	46
	This report provides information regarding the recent business activities, relevant statistics and good news stories within the Paramedic Services Division, Community Safety Department.	
6.4.	Community Paramedicine Program Update – June 2021	52
	This report provides an update on the City of Greater Sudbury's Community Paramedicine Program.	
6.5.	Oversight 911 – Ombudsman Report	57
	This report provides information regarding the Ontario Ombudsman's investigation report into how the Ministry of Health investigates and oversees patient complaints and incident reports about ambulance services.	

7. Addendum
8. Civic Petitions
9. Question Period
10. Adjournment

Outlook 2021



2019-2027 Strategic Plan Priorities

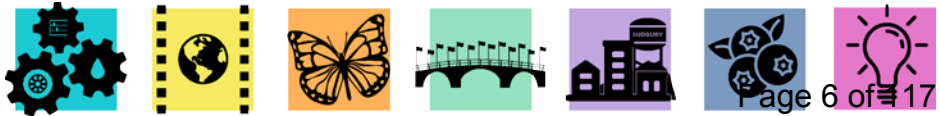
Overview

- ▶ Planning Committee
- ▶ Operations Committee
- ▶ Community Services Committee
- ▶ Finance and Administration Committee
- ▶ Emergency Services Committee






















Planning Committee

Outlook 2021

















 On Target  Complete  Delayed  Postponed to 2022



Planning Committee – Outlook 2021

















Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Heritage Impact Assessment Guidelines						
Residential Licensing - Supplemental Information						
Residential Parking Draft Zoning By-law						
Temporary Drive-In Theatre Draft Zoning By-law						
LaSalle Zoning – Public Hearing						
LaSalle Zoning – Post-Hearing Report and Recommendation						
Zoning By-law Update (Official Plan Phase 1) - Presentation of Draft					 	
Economic Recovery Land Use Planning Policy Report						

Planning Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Employment Land Strategy – Final Report						
Residential Parking – Public Hearing						
Presentation of Official Plan Review Phase 2 - Draft Official Plan Amendment						
Development Process Review						
Development Fee Review						
Material Stock Pile Review						
Housing Action Items Report						

 On Target
  Complete
  Delayed
  Postponed to 2022

Planning Committee – Outlook 2021

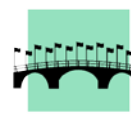
Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Phase 2 Official Plan Amendment – Public Hearing						
Climate Adaptation Strategy – Draft						
Community Energy and Emissions Plan – 2021 Update						
Public Art Master Plan – Draft						
Phase 2 of Commercial Parking Study - max/min/loading						
Home Retrofit Financing Feasibility Study – Draft						
Economic Recovery Land Use Planning Policy Report - Public Hearing						

Operations Committee















Outlook 2021

 On Target  Complete  Delayed  Postponed to 2022















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Operations Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Waste Collection Services – Progressive Enforcement and Compliance Methods						
Roadside Litter Container and Litter Collection Policy						
Winter Control Update – March 2021						
Winter Control Update – April 2021						
Traffic Signal Renewal Project Update						
Sidewalk Priority Index Update						
Wastewater De-chlorination Systems Project						

















Operations Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Water and Wastewater Capital Delivery						
Energy Operational Savings						
Transportation Demand Management Community Grant Update Report						
Waste Collection - Yellow Bag Program for Licensed Child Care Providers						
Mechanical Ice Breaker for Sidewalk Winter Maintenance – Pilot Project Update						
Wilderness Road - upgrades/winter maintenance						
Organic Food Waste Processing Update						















Operations Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Waste Collection Services – 2021 Participation Study						
Winter Sidewalk Maintenance Service Standards						
Winter Control/Spring Cleanup Update – May 2021						
LaSalle Truck Route						
Valley East Wastewater Treatment Plant						
Lift Stations Upgrade Program						
Valley Well Upgrade						
Water Tanks Rehabilitation						

Operations Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Wastewater Program - Lagoons, Lift Stations, Wastewater Treatment Plants						
Traffic Calming Report						
Gateway Speed Limit						
Water Wastewater Task Force Update						
Parking Restriction Policy						
Automated Speed Enforcement Report						
Lagoons Upgrade Project						
Blue Box Recycling Transition Update						

Operations Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Booster Stations Program						
Wastewater Treatment Plants Upgrade Program						
David Street Water Treatment Plant Upgrades						
Water Program - Valley Wells, David St Plant, Booster Station						
Strategy for Phasing out Single-Use Water Bottles in Municipal Facilities						
Road Safety Assessment						
Active Transportation Annual Report						

Community Services Committee

Outlook 2021






















Community Services Committee – Outlook 2021
















Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Long-Term Care Covid-19 Pandemic Response						
Bus Purchases						
GOVA Zone Contract						
Transit Technology Improvements						
YARDI Rent Café - review and update processes, templates						
Affordable Housing Strategy - Land Banking						
Home for Good Phase II - Peace Tower						
Divesture of Stand Alone Units						
Supervised Consumption Site - supporting Public Health						

On Target
 Complete
 Delayed
 Postponed to 2022







Community Services Committee – Outlook 2021

Project	2021					Status
	Q1	Q2	Q3	Q4	Other	
Coordinated Access among Service Providers - Homeless Individuals and Families Information System						
Social Services Relief Funding Phase 2 Projects (SACY Capital) and Addiction Mental Health Projects						
Ontario Health Virtual Care Project						
Expression of Interest for Trailer Parks						
GOVA Transit Major Mobility Hub - Downtown terminal, South End and New Sudbury hubs						
Sparks Street Affordable Housing Development						
Transitional Housing						
Final Report – Homelessness Consultation Projects						

Community Services Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
COVID Response - community support						
Population Health Safety Well-Being Report						
Social Procurement Policy						
Outdoor Court Revitalization						
Youth and Children Services and YMCA Sudbury						
New Horizons Grant - Java Music Program						
Children and Social Services – Indigenous Strategy						

Community Services Committee – Outlook 2021


















Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Potential Third Party Operator for Ski Hills						
Trail Improvements at Regional Parks - Bell Park, Delki Dozzi, Fielding						
Long-Term Care Customer Service Improvements						

Finance and Administration Committee

















Outlook 2021

















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Vertical Infrastructure Management Software						
Fleet Business Process Review Recommendations						
Facilities Maintenance Upgrades at Tom Davies Square and 199 Larch						
2021 Community Improvement Plan Intake Report						
Enhancing Community Broadband						
Enterprise Risk Management						
Long-Term Financial Plan Update						

















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Clearing of Yards and Property Standards By-law Reviews						
Assume Part III Prosecutions in POA from the Crown						
Information Technology Strategy Updates - Phase 2						
Annual Report						
Debrief on 2021 Budget Process and 2022 Budget Direction						
Negotiations with Christian Labour Association of Canada (CLAC)						
Agendas Online Replacement and Meeting Management Technology						
Asset management plans for core infrastructure, fleet and parking, asset management software						






















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Write off for POA amounts						
Review the current area rating model for property taxation						
Enhance the City's assessment protection policy						
AMI/AMR Water Meter Reading						
Taxi By-law Amendments						
Review of the capital budget policy and prioritization process						
Update on 2022 municipal and school board election						



Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Update to policy - use of municipal resources						
Stormwater Infrastructure Management Fee						
Negotiations with Ontario Nurses' Association						
Modern Employee Tools - email, collaboration, mobility						
Employee Survey						
Human Capital Management Plan – Phase 1						
Initiatives to support reductions in Lost Time Injury Frequency and Lost Time Injury Severity						
CUPE 148 interest arbitration						


















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Business Licensing By-law						
Parking Supply Analysis and Enhancements						
Evaluate alternate sites for animal control						
Psychological Health and Safety Policy and Program						
Negotiations with Sudbury Professional Fire Fighters Association						
Core Infrastructure Asset Management Plans						
Downtown Security Pilot Project						
RFP for enterprise security along with new process and collaboration						
Budget 2022						
















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Capital budget process consultation and five-year capital outlook						
Fleet work management system implementation						
Facility Renewal Strategy						
Electric Vehicle Strategy						
Business Intelligence Strategy and Plan						
Development Approvals Process update						
Land Management Information System – Phase 1						
Project Management Processes and Tools						
Dashboards and Analytics						






















Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
State of the Infrastructure Report						
Centralization of finance throughout organization						
Comprehensive review of preliminary 2022 assessment data						
Lead One-Stop Shop Tom Davies Square/Citizen Service Centre project						
Parking delivery technologies in the downtown						
Work from Home Program						
IT Server Infrastructure Replacement						
Shopping carts on municipal right of ways and sidewalks						

Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
CAO Quarterly Performance Update						
The Junction West						
Rural Northern Immigration Pilot Update						
COMPASS - Time and Activity Reporting						
Customer Relationship Management System – Phase 2						
Core Service Review Recommendations and Follow-up						

Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Downtown Business Incubator						
Greater Sudbury Development Corporation Quarterly Report						
Greater Sudbury Development Corporation Annual Report						
Community Promotion/Talent Attraction						
Greater Sudbury Development Corporation Economic Recovery Strategic Plan						
Kingsway Entertainment District						
Plan to Develop Community Engagement Strategy						
Ontario Job Site Challenge						
Communications and Customer Service Strategy Update						

Finance and Administration Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Library Governance Report						
Organizational Customer Service Training						
Museum Report Review						
Place des arts						
Tourism Event Support Program Review						
The Junction East						
Development Ambassador Pilot Position						
Indigenous Relations						
Advertising Report						

Emergency Services Committee

Outlook 2021



















 On Target  Complete  Delayed  Postponed to 2022



Emergency Services Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Divisional Update Reports - Paramedic Services, Fire Services, Emergency Management						
Tactical Paramedic Update						
Community Paramedicine Program Update Presentation						
Community Safety Facility Dog Report						
Paramedic Services 2020 Response Time						
Ministry of Natural Resources and Forestry Updated Protection Agreement						
Community Paramedicine Program Update						
Community Paramedicine Pilot Projects						

Emergency Services Committee – Outlook 2021

Project	2021				Supporting Pillar	Status
	Q1	Q2	Q3	Q4		
Standardization of Tankers						
Paramedic Services Palliative Care Program Implementation						
Community Safety Department Mental Health Programs						
Community Paramedicine Activities – COVID-19 Response and Health Promotion						
Fire Services – Volunteer Firefighter Recruitment/Retention Update						
Fire Services – Hazardous Materials Operations Level Update						
Paramedic Services – Tactical Medic Program Update						
Paramedic Services Trillium Gift of Life Referral Program						
Community Paramedicine – Long-Term Care Program Update						

Ministry of Natural Resources and Forestry Updated Protection Agreement

Presented To: Emergency Services Committee

Meeting Date: June 23, 2021

Type: Presentations

Prepared by: Jesse Oshell
Community Safety

Recommended by: General Manager of
Community Safety

Report Summary

This presentation by Jesse Oshell, Deputy Fire Chief, provides information regarding the updated Ministry of Natural Resources and Forestry Protection Agreement.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

Fire Services has allocated \$175,000 in the 2021 Operating Budget for the wildland fire season agreement with the Ministry of Natural Resources and Forestry.

Background

The City of Greater Sudbury and the Ministry of Natural Resources and Forestry maintain an agreement for the protection of Crown and Municipal land within the boundaries of the city. This agreement represents the largest Municipal Forest Fire Management agreement in the Province of Ontario covering 313,268 hectares of land. Each year the Ministry of Natural Resources and Forestry (MNRF) and Greater Sudbury Fire Services respond to a combined 400 or more wildland fires inside the City limits. These fires are predicated on the previous winter precipitation, speed of annual thaw, and spring rainfall amounts. Greater Sudbury experiences both dry and wet summer seasons which may significantly impact the total wildland fires. Annually, Fire Services budgets \$175,000 for the wildland fire season agreement with the MNRF.

In 2017, Fire Services and the Ministry of Natural Resources and Forestry each protected almost half of the municipality by sharing land area. This model put tremendous strain on Fire Services as it required significant resources, such as hose and pumps, along with manpower to access wildland fire locations which could often be located a kilometer or more off the travelled roadway. The dense brush and rocky terrain of a majority of the area did pose challenges to reaching the fire, locating adequate water supply, and having enough manpower for prolonged periods of time. Often, the services of the Ministry of Natural Resources and Forestry were required at additional cost due to calling them into an area which was protected by Fire Services, this is considered an additional service above the agreement.

In 2021, Fire Services and the Ministry of Natural Resources and Forestry updated the Municipal Forest Fire Management agreement and using historical fire response data and terrain mapping resources to best balance the Fire Service response with the MNRF response. Area and terrain which was only accessible by helicopter, for example, was assigned to the MNRF and local flat, road access areas were assigned to Fire Services. Using this approach and an achievable 500 feet off the travelled roadway as a guide, the agreement is an acceptable balance of resources and capability based on response for both services. This balance hopes to achieve financial stability for wildland response costs for the coming years.

The City of Greater Sudbury covers 3200 Kms² and Fire Services along with the Ministry of Natural Resources and Forestry respond from the borders of Nairn Centre on the west to those on the east with Markstay-Warren. North to Cartier and south to Estaire-Wanup. All points in between are covered for wildland fire protection between the Ministry of Natural Resources and Forestry and Fire Services. Approximately 90% of all roadways and 500 feet from the travelled portion are covered by Fire Services, in addition to the industrial properties of Vale in the city core. The flatland areas of Chelmsford, Azilda, and Valley East are also protected by Fire Services. All islands, water accessible properties, and indigenous lands are protected by the MNRF, along with all areas beyond 500 feet from the roadway or as defined by the agreement map. Many rural properties are also protected from wildland fires by the MNRF.

As part of the Ministry of Natural Resources and Forestry agreement, each year Fire Services provides training to our firefighters on the specific skills related to wildland firefighting. In addition to the core skills already in place with firefighters, a MNRF developed course is delivered, which prepares the firefighter to respond to rural and wildland scenarios where the ground conditions, type of material burning, weather patterns, and water supply all add complexity to the fire situation. Firefighters become proficient in the use of all the required tools, specialty pumps, hose, and the techniques to quickly and safely extinguish a wildland fire situation. In collaboration with our partners at the Ministry of Natural Resources and Forestry, material is delivered by MNRF staff, Fire Services Training Officers, and Station Captains. Training for these situations is a critical component of the annual wildland response.

Our collaboration with the Ministry of Natural Resources and Forestry continues to protect our community, providing skills and resources where and when needed. Whether on training or response, both services are working together when there is a need for a wildland response.

Fire Services Update – June 2021

Presented To: Emergency Services Committee

Meeting Date: June 23, 2021

Type: Correspondence for Information Only

Prepared by: Jesse Oshell
Community Safety

Recommended by: General Manager of Community Safety

Report Summary

This report provides information regarding the recent business activities, relevant statistics and good news stories within the Fire Services Division, Community Safety Department.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

This report aims to provide the City of Greater Sudbury Emergency Services Committee with an update on good news stories and relevant statistics as well as recent business activities within the Fire Services Division of the Community Safety Department.

Fire Services is responsible for delivering proactive public safety and response programs to prevent emergencies wherever possible and to preserve and enhance life, property, and the environment where response is required.

Key Performance Indicators

Major Fire Loss Incidents March 1, 2021 – April 30, 2021		
Date	Location	Estimated Loss
Monday, March 8, 2021	1073 Red Deer Lake Road, Wahnapiatae	\$ 325,000
Sunday, March 28, 2021	23 Poupore Road, Skead	\$ 300,000
Saturday, April 10, 2021	1036 Chapman Street, Sudbury	\$ 600, 000
Sunday, April 11, 2021	744 Bruce Street, Sudbury	\$ 450,000
Monday, April 19, 2021	545 Lorne Street, Sudbury	\$ 370,000
Wednesday, April 21, 2021	300 Christina Street, Hanmer	\$ 650,000

Data Source: Firehouse

Incident Type	Jan 1 – April 30, 2021	Jan 1 – April 30, 2020
Fires	98	78
Fire Alarms	278	316
Vehicle Collisions	136	146
Open Air Burning Response	101	99
Medical Assistance	467	260
Other Incidents (assisting other agencies, no incident found on arrival, etc.)	307	294
Total	1387	1193
TOTAL Estimated Loss for Fires	\$4,862,857	\$2,879,450

Data Source: Firehouse

Fleet

The Covid-19 Stay-at-Home order has hampered the deployment of several items in the division.

Tankers: Greater Sudbury Fire Services took delivery of twin International cab and chassis with an aluminum body HV607 Tankers in December 2020 from Dependable Emergency Vehicles. Training on the new tankers is complete with deployment in June 2021. These Tankers are assigned to Career Fire Station 4 Long Lake and Volunteer Fire Station 24 Wahnapiatae. They are a further step in the fleet standardization and are to be outfitted in the same setup as the two previous tankers.

Rescue Boat: The rescue boat was delivered in late 2020. Training by the manufacturer Inland Liferrafts is to take place as early as restrictions allow now that the waters have opened. The boat designated Boat-1 is being registered with Transport Canada. Once the registration numbers are assigned and received, the boat will be decaled and placed in Station 4 Long Lake.

Aerial Truck: The aerial truck was delivered in the fourth quarter of 2020. The radio has been installed and an alias has been assigned. The aerial is currently stored at the Lionel E. Lalonde Centre in Azilda. The truck has been used to train the ladder crew firefighters in Station 1 and relief firefighters in its driving and setup. Darch Fire performed warranty repairs, system upgrading, and equipment mounting and powering in May.

Technical Rescue Truck and Trailer: The technical rescue truck and trailer have been outfitted and delivered to Main Station for deployment. The HAZMAT tow vehicle mobile radio and decal package have been installed as has the detection equipment in the tow vehicle cap. The HAZMAT trailer has been equipped with a generator and new lighting.

The training ground's liquid petroleum gas vaporizer has been rebuilt by qualified contractors and passed its yearly testing. The propane kitchen simulator has been tested by Draeger and is approved for another season. This will allow the use of the simulator for the Training Section's evolutions

The installation and commissioning of the Nederman system (captures and vents vehicle exhaust from the tail pipe), is nearing completion. The COVID-19 restrictions have delayed its roll out. Once complete, the contractor will provide training to both Fire and EMS personnel on the operation and maintenance of the Nederman system.

Inventory of the bunker gear stored in our Copper Cliff storage was completed. The expired gear has been removed. Quantities and sizing of the remaining gear is on file and can likely accommodate the new hires for the Volunteer or Career recruitments.

The following annual requirements have been addressed:

- 2021 annual ground ladder testing is completed.
- 2021 annual hard suction hose testing has commenced.
- 2021 Volunteer and Career clothing orders are being processed.
- 2021 apparatus pump testing has commenced.

Fire Prevention

Fire Prevention Officers continue to complete mandated complaint, request and vulnerable occupancy fire and life safety inspections throughout the municipality.

Fire Prevention is currently developing a proactive low-rise inspection program that will focus on residential buildings with 2-4 units. This type of occupancy was chosen as statistics prove the majority of fire fatalities and injuries occur in low-rise residential buildings. A campaign will be developed to inform the public and specifically building owners of the new low-rise inspection initiative. This new initiative should reduce the number of fires, fatalities and injuries occurring in low-rise residential accommodations. Fire Prevention and Building Services are working collaboratively to develop procedures that provide clear direction to staff on specific responsibilities when violations are identified during an inspection (i.e.: illegal apartment).

Fire Prevention is pleased to announce that as of the end of the second quarter of 2021, the open files identified through an Office of the Fire Marshal Review, known as the P-1200 files, will all have been addressed and working towards compliance. This project has been ongoing for several years and the completion of the P-1200 open files will allow Fire Prevention to initiate the new low-rise proactive inspection program.

Public Education

Public Safety Officers have been working to develop standardized lesson plans for all fire and life safety topics. This will provide the guidance and information required to conduct a public education session with consistent messaging. The implementation of the standardized lesson plans will allow both Volunteer and Career Firefighters to be able to conduct fire safety presentations and public education to members of the community, reaching a greater audience.

The Public Safety Officers' focus over the last couple of months has been on addressing preventable fires through social media and new television commercials on kitchen fire safety, discarding of smoking materials, wildfire prevention and open air burning.

A new seniors based public education initiative is in the final stages of development and will be released by early summer. This new program will focus on assisting and educating seniors who reside within their own home on how to reduce the chances of fire from occurring and how to protect themselves in the event of a fire. Public Safety Officers are in communication with different agencies who would like to partner with Fire Services to promote this new initiative and assist with providing seniors with appropriate fire safety information.

Volunteer Firefighters have been assisting the Public Safety Officers by working collaboratively and providing virtual station tours to schools or classes within their community. This provides the children of the community with some basic fire and life safety information and makes them familiar with community first responders.

Training

Volunteer Firefighter training has resumed with a focus on skills development. Training Officers have been attending the in-station weekly training to provide assistance and support to the Volunteer Captains conducting the training. The in-station training has been well received by the Volunteer Firefighters, those that have attended are excited at the cooperation between Captains and Training Officers.

First Aid and CPR training for the Volunteer Firefighters has been initiated. Approximately one third of all the Volunteer Firefighters will receive first aid and CPR Lifesaver 101 training in 2021. The expectation is that all Volunteers will receive the training on a 3-year rotational basis. This approach will provide staggered expiry dates of certification and will reduce the impact on the Training Section to have a CPR/First Aid training completed in one year.

Tanker and aerial training is progressing well and all apparatus are anticipated to be in service in June.

Hazardous Materials (Haz-Mat) skills will continue to be developed over the remainder of 2021. The focus of the skills training will be gas detection.

Volunteer Firefighter Recruitment

In 2019, Fire Services adopted an open recruitment style where applications were accepted throughout the year and kept on file until a recruitment process occurred. Prior to the start of the current recruitment process, there were 64 applications already on file.

The 2021 volunteer firefighter recruitment process began on March 23, 2021 with the application stage closing April 30. Overall, Fire Services received 213 applications. In the interest of illustrating success/opportunity with recruitment efforts that saw banners at fire halls, signage in high traffic areas and the use of social media, it is noted that 70% (149) of the applications were received during the 2021 application stage.

The following confirms applications received in each Station:

District #2 - 33	District #3 - 31	District# 4 - 55	District #5 - 45	Outside of Volunteer Areas	Ineligible Applicants
Copper Cliff - 5 Waters - 13	Azilda - 12 Chelmsford - 13	Val Caron - 15 Val Therese - 19	Garson - 21 Falconbridge - 9	49	17
Lively - 9 Whitefish - 5 Beaver Lake - 1	Dowling - 5 Levack - 1	Hanmer - 18 Capreol - 3	Skead - 3 Coniston - 6 Wahnapiatae - 6		

In total, 147 applicants (approximately 69% of applicants) made it through to the physical testing portion of the recruitment. The remaining 17 were ineligible (i.e., no G Licence, no Grade 12, had a Criminal Record, moved from the community, or withdrew).

The following is the current volunteer firefighter recruitment schedule:

- Physical Testing (Lionel E. Lalonde) May 31 & June 1
- Online Interviews June 7 & June 8
- Employment Offer Letter to be Signed June 24
- First Weekend of Training (20 hours) June 25, 26, 27
- Second Weekend of Training (20 hours) July 3, 4

For the physical testing and interview, we have engaged CLAC for their support and participation. Where we have received a list of Captains and Senior Volunteer Firefighters, we are also considering engaging recent recruits that would be otherwise familiar with the recruitment process and can offer support and encouragement to applicants.

Upon successful completion of the required 40 hours of training, the new recruits will be assigned to their respective stations and required to attend the station for regular training and responses.

Career Firefighter Recruitment

A career firefighter recruitment is in process for hiring eight Career Firefighters to fulfill the Arbitration Award. The application process began on May 3, 2021 and closed on June 4, 2021.

Applicants who met the minimum requirements, were provided a link to pay the required administration fee in order to proceed in the process.

Candidates are required to successfully pass each of the following steps in order to proceed through to the next step.

- Proctored Online Aptitude Test
- Physical Testing
- Interviews
- Psychological Testing
- Offers of Employment / Reference Checks / Medical Checks / Criminal Reference Check
- Training Academy (9 weeks)

The eight successful candidates will graduate and report to a station as probationary firefighters in November.

Emergency Management Update – June 2021

Presented To: Emergency Services Committee

Meeting Date: June 23, 2021

Type: Correspondence for Information Only

Prepared by: Latoya McGaw
Community Safety

Recommended by: General Manager of Community Safety

Report Summary

This report provides information regarding the recent business activities, relevant statistics and good news stories within the Emergency Management Section, Community Safety Department.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

This report aims to provide the City of Greater Sudbury Emergency Services Committee with an update on information as it relates to recent business activities within the Emergency Management Section of the Community Safety Department.

The Emergency Management Section provides leadership, guidance, and direction to ensure the safety of residents in community emergencies. This Section is governed by the Emergency Management and Civil Protection Act (EMCPA). The Office of the Fire Marshal and Emergency Management (OFMEM) and the Greater Sudbury Emergency Management Advisory Panel provide further direction and advice to the Emergency Management Section. This section offers 24/7 support with a primary focus on the safety of our citizens through the effective management of community risks and emergencies.

Emergency Management

Emergency Response

COVID-19

The City of Greater Sudbury remains under a State of Emergency as was declared by Mayor Bigger on April 6th, 2020, due to the outbreak of coronavirus COVID-19, which constitutes a significant danger that could result in serious harm or death.

The Community Control Group (CCG) has been activated since March 16th, 2020 and continues to meet virtually on a biweekly basis to discuss operations and response in light of COVID-19, as well as future planning should there be case surges in the coming months and implementation of recovery plans.

As an added support to the CCG, Greater Sudbury Emergency Management Advisory Panel (GSEMAP) was repurposed as the Community Advisory Group (CAG) through which external emergency management stakeholders provide situational awareness and share information including public health guidance and facilitate information requests. The information gathered through these meetings are shared with the CCG as it provides a complete picture of needs, trends, and impact across the community.

Third Provincial Emergency Declaration

With the rapid increase in COVID-19 transmission, threat on the Province's hospital capacity, and the increasing risks posed to the public by the COVID-19 variants, the Ontario government in consultation with the Chief Medical Officer of Health and other health experts, declared a third provincial emergency under s 7.0.1 (1) of the *Emergency Management and Civil Protection Act* (EMPCA).

On April 8th, 2021 the government issued a province-wide Stay-at-Home order requiring everyone to remain at home except for essential purposes such as going to the grocery store or pharmacy, accessing health care services (including getting vaccinated), for outdoor exercise, or for work that cannot be done remotely. As Ontario's health care capacity is threatened, the Stay-at-Home order, and other new and existing public health and workplace safety measures will work to preserve public health system capacity, safeguard vulnerable populations, allow for progress to be made with vaccinations and save lives.

As more contagious variants continue to pose significant risks, the provincial declaration of emergency has since been extended until at least June 2nd, 2021.

COVID-19 Vaccine Implementation

In December 2020, after independent and thorough scientific reviews for safety and efficacy, Health Canada approved two vaccines for use in Canada: Pfizer-BioNTech (December 9th) and Moderna (December 23rd). An additional vaccine, Astra Zeneca was also approved by Health Canada in February 2021.

Public Health Sudbury & Districts (PHSD) unveiled a COVID-19 vaccination plan on January 15th, 2021 for its service area. The plan, Public Health Sudbury & District COVID-19 Vaccination Program Playbook, is the roadmap to vaccinate area residents against COVID-19. Vaccinations will follow the Ontario Vaccine Distribution and Implementation Plan and the recent COVID-19 vaccination updates issued by the Ontario government to implement the local vaccination program in three phases.

Phase 1 (January to March): Vaccines will be offered to seniors in long-term care homes and high-risk retirement homes, including staff and essential care givers; health care workers; adult (16+) First Nations, Métis, and Inuit populations; and adult chronic home care recipients (16+).

Phase 2 (April to August): Essential workers; adults aged 60+; staff and residents of additional congregate settings; at-risk populations; and remaining adults aged 16 to 59.

Phase 3 (September and ongoing): All remaining eligible populations who wish to be vaccinated.

The local vaccination program will be implemented in close partnership with community stakeholders to ensure access to vaccine is based on ethical principles and that the program is run efficiently.

The goal of the local vaccination program is to achieve a coverage level of at least 75% of eligible recipients in the service area, within the prescribed timeframe.

PHSD has completed vaccination in long-term care homes and other congregate setting for seniors. Certain high-risk healthcare workers and urban indigenous individuals are now eligible to receive their second dose of the COVID-19 vaccine at an interval shorter than four months. For urban Indigenous individuals who have already received their first dose, Public Health is working with Indigenous partners across the service area to ensure those individuals have the opportunity to receive their second dose sooner.

Beginning May 18th, all Ontarians 18 years or older in 2021 can book an appointment to receive the COVID-19 vaccine. Plans are underway to offer the vaccine to individuals between 12 and 17 years of age during the week of May 31st. These individuals are only able to receive the Pfizer- BioNtech vaccine at this time.

It is important to note that while the local plan is in place and being executed, it is subject to change based on the timing and availability of vaccines in the community.

Host Community Planning

Annually, the Office of the Fire Marshal and Emergency Management (OFMEM) seeks host communities' assistance in ensuring the health, safety and well-being of First Nations community residents in the event there is a need for evacuation due to flooding or forest fires.

As a result of COVID-19, many traditional host communities are unable to host evacuees due to the risk of illness and spread of COVID-19 in their communities.

OFMEM in light of COVID-19, developed a new framework that would help First Nations residents stay in their communities. The decision to evacuate a community during this time would only be made in exceptional circumstances (i.e., potential threat to life and limb) and if all other options such as sheltering in place if feasible, have been exhausted or unsuitable.

CGS Emergency Management Section continues to work with the OFMEM in identifying and assessing available accommodations in Greater Sudbury for First Nations evacuees. Should the need arise for First Nations community members to be evacuated to Greater Sudbury, the City in its efforts would play a supportive role in this initiative.

EMCPA 2020 Compliance Results

All municipalities in Ontario are required to establish and maintain an Emergency Management Program in accordance with the requirements under the Emergency Management and Civil Protection Act, R.S.O. 1990, c. E.9. The Act establishes the minimum standards and specifies the requirements for emergency management programs.

Recognizing that municipalities continue to actively engage their emergency management procedures and programs in response to the COVID-19 pandemic, the Ministry of the Solicitor General has suspended the requirement for an emergency exercise in 2020. This suspension will allow municipalities to focus on reopening their communities and local economies while keeping residents safe.

Municipalities are however expected to complete other key elements of their emergency management program which includes conducting an annual Hazard Identification and Risk Assessment (HIRA), identification of critical infrastructure, and review the municipal emergency response plan.

Greater Sudbury's Emergency Management Section has conducted activities to achieve compliance with the remaining requirements of the Act and Ontario Regulation 380/04. Our submission of the online compliance requirements was completed on December 31, 2020.

OFMEM has reviewed Greater Sudbury's submission and has determined that the municipality was compliant with the EMCPA in 2020.

Emergency Preparedness Week 2021

May 2 to 8 was recognized as Emergency Preparedness (EP) Week, a national awareness initiative that encourages residents to take action and be better prepared in the event of an emergency. The theme this year is "Be Ready for Anything".

Due to the COVID-19 pandemic, this year's activities were conducted virtually. A community survey on personal preparedness was launched on May 3rd and residents are encouraged to participate. The survey is available at [Emergency Preparedness: Be Ready for Anything | Over To You Greater Sudbury](#) until June 30th.

The results of the survey will help staff develop a baseline on our community's level of emergency preparedness, in turn guiding our public education program and internal operating procedures.

Paramedic Services Update – June 2021

Presented To: Emergency Services Committee

Meeting Date: June 23, 2021

Type: Correspondence for Information Only

Prepared by: Paul Kadwell
Community Safety

Recommended by: General Manager of Community Safety

Report Summary

This report provides information regarding the recent business activities, relevant statistics and good news stories within the Paramedic Services Division, Community Safety Department.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has direct connection with Goal #9 of the Community Energy and Emissions Plan, “Electrify 100% of Transit and City fleet by 2035”.

Financial Implications

There are no financial implications associated with this report.

Background

This report aims to provide the City of Greater Sudbury Emergency Services Committee with an update on activities, relevant statistics, and recent performance measures within the Paramedic Services Division of the Community Safety Department.

Greater Sudbury Paramedic Services is responsible for the delivery of a performance-based paramedic service that complies with legislative and regulatory requirements, ensuring safe and quality pre-hospital emergency medical care and transportation for those individuals suffering injury or illness. A performance-based paramedic service focuses on clinical excellence, response time performance, patient outcomes, patient satisfaction, continuous quality improvement, and a healthy work environment conducive to professional growth.

COVID-19

Both emergency childcare issues and other COVID-19 related challenges have minimally affected Paramedic Services staffing levels. Deployment of staff for emergency response to service our community has not changed. During the early stages of the pandemic, call volume had decreased by approximately 20%, however, call volume has since returned to pre-COVID levels. On May 13, 2021, the province wide stay-at-home order was extended until June 2, 2021. Currently, staff that are able to conduct work from home are continuing to do so, including managers and support staff.

Paramedic Operations

Provincial Hospital Surge Support with Interfacility COVID-19 Transfers

As hospitals throughout Southern Ontario experienced an increased demand for critical care beds to accommodate COVID-19 admissions to Intensive Care Units (ICU), Health Sciences North (HSN) stepped forward to be a part of the provincial critical care effort by accepting COVID positive Intensive Care patients from hospitals in Southern Ontario to HSN.

In collaboration with HSN, Paramedic Services provided the transportation and additional medical support to complete the transfers. As of May 5, Paramedic Services had transported six COVID-19 patients from hospitals in Southern Ontario to HSN. At this time, there are no transfers booked, but we are available to assist HSN, when requested.

Employer Provincial COVID-19 Antigen Screening Program

Greater Sudbury Paramedic Services was accepted to participate in phase one of the employer voluntary antigen screening pilot led by the Ministry of Health, Public Health Ontario, and Ontario Health. The objective of the pilot was to assess the value of rapid antigen testing utilizing the Abbott Panbio brand antigen test as a screening tool to support employee safety and business continuity in a variety of workplaces. Results of this pilot provided an increased understanding of how rapid antigen testing could be deployed more broadly to support provincial COVID-19 response activities.

During this pilot, paramedic staff were voluntarily tested for COVID-19 prior to shift commencement up to three times per week or when indicated. Results of the antigen test are provided within fifteen minutes following test completion. Abbott Panbio antigen tests are less sensitive than the polymerase chain reaction (PCR) test and as a result a regular lab tested PCR test is required to confirm positivity. The pilot was conducted over an eight-week period and was completed on March 31, 2021.

Following the Abbott Panbio Antigen Screening Pilot, the employer Provincial Antigen Screening Program (PASP), was launched. The PASP is a voluntary longer-term project providing employers in priority settings to add an additional safety measure in high-risk and essential workplaces to help reduce the spread of COVID-19. We commenced with PASP on April 6, 2021 and continue with our routine COVID-19 pre-shift screening practice. This project will continue until March 31, 2022, when the agreement expires with the Ministry of Health.

As of May 10, 2021, a combined 956 Abbott Panbio and PASP tests have been conducted identifying two antigen positive asymptomatic employees. These positive antigen results were followed by referral to the COVID-19 Assessment Centre for PCR testing. The Assessment Centre testing confirmed that the two employees were COVID-19 positive. The employees followed Public Health Sudbury and District (PHSD) protocols and have since been cleared by PHSD to return to work.

Screening for COVID

The Ministry of Health (MOH) and Emergency Health Services Branch (EHSB) is responsible under the Ambulance Act for publishing standards for patient care, documentation, safety, equipment requirements and transportation. These requirements are outlined in various paramedic practice documents: Standards, Training Bulletins, Manuals and Guides. During this pandemic, the EHSB has been updating COVID-19 Screening Tools for paramedics and Ambulance Communication Officers (ACO) as new knowledge is discovered about COVID-19. The ACO performs the initial COVID-19 screening of all 911 calls. Paramedics are advised of the outcome from the ACO screening, and with this information paramedics then don the necessary Personal Protective Equipment (PPE) required to protect themselves. Additional measures have been put in place to protect responding paramedics. These include instructions the ACO provides to the

callers to not approach the paramedics when they arrive, instructions for all those present to wear a mask, and to follow responding paramedic's instructions to maintain distancing. On arrival, paramedics also complete a second screening. The outcome of this screening further supports the decision of which level of PPE is to be used for patient care.

Mental Health Support

Paramedic Services recognizes the impact to all front-line workers during the COVID-19 pandemic. Support tools such as information and strategies on managing their mental wellness have been and will continue to be provided. Staff are routinely reminded to reach out to any member of the Peer Support Network (PSN) if they require additional support. Our PSN team continues to participate in professional development sessions with a local clinical psychologist. These sessions are instrumental in advancing the development of our PSN team, ensuring they are well prepared to assist their colleagues in times of need.

Recently, the Ministry of the Solicitor General (SOLGEN) reached out to the Ministry of Health (MOH) inviting Paramedic Services to participate in a mental health wellness program, providing first responders across the Province access to the First Response Mental Health's (FRMH) PeerConnect app; a proactive peer support and wellness online tool.

The PeerConnect app will support existing programs we currently have in place such as wellness tools, self-assessments, mental health programming, and peer support programs while also allowing for easier access to our peer supporters 24/7.

This tool is an Ontario-based solution that is already in use among several emergency medical services and first responder agencies in Ontario and across North America. There is no cost to Paramedic Services to participate in this project for the first year, and first responders have up to March 31, 2022 to use the app.

With the implementation of this PeerConnect app our goal is to provide communication and support for every Community Safety member, working towards the ultimate goal of a safe and supported work environment. PeerConnect is designed to increase access to mental health services and provide the resources we need to take care of our members. The app ensures member privacy, security of information, and organization controlled permissions.

We are committed to building a culture of care and support for all members within Community Safety. We understand the stresses and challenges faced by our staff, and we want to ensure that they have access to the people and tools they require in order to live fulfilled connected lives. We now have the tools to support our most valuable asset, our members. The anticipated date to launch the PeerConnect App is mid-June 2021.

Hiring

During the early stages of the pandemic, college programs were impacted due to restrictions imposed by Public Health and many paramedic services across the Province anticipated potential staffing challenges. To help mitigate this issue, the Ministry of Health Emergency Health Regulatory and Accountability Branch (MOH-EHRAB) amended the regulations to allow the hiring of Emergency Medical Attendants, which addressed the potential challenges that were anticipated by paramedic services.

Paramedic Services reviewed current staffing levels and as a result, recruited 22 regular part-time paramedics. During the hiring, orientation, and base hospital certification, Paramedic Services will be amending the processes to allow for physical distancing.

Expanded Ontario Naloxone Program

In December 2020, Sudbury Paramedic Services commenced participation in the Ontario Naloxone Program in collaboration with PHSD. This program has paramedics not only administering Naloxone as part of their standard paramedic care, but also distributing Naloxone kits to identified individuals where appropriate in the course of their duties or when requested from the public. This program permits 24/7 access to Naloxone in Sudbury, which was not previously available. This important initiative allows paramedics to promote harm reduction for those who misuse drugs with a goal of improving positive health outcomes in the community.

Since the implementation of this program on December 12, 2020, Paramedics have distributed 126 Naloxone kits and continue to support those in need.

Paramedic Services Performance Measures Defined

Paramedic Calls for Service

A measure of calls received by Greater Sudbury Paramedic Services by the Central Ambulance Communications Centre (CACC) to respond to emergencies. In simpler terms, the number of calls to 911 for Paramedic Services that resulted in Paramedics being dispatched.

Paramedic Unit Responses

A measure of units dispatched by the CACC to paramedics to service emergencies. This number will typically be higher than calls for service as some calls necessitate the use of multiple ambulances, Paramedic Response Units, or Platoon Superintendent Units.

Paramedic Patients Transported

A measure of patients being transported on both an emergency and non-emergency basis (Table 1).

EMS Calls for Service	9,572
EMS Unit Response	11,533
EMS Patients Transported	6,833

Table 1. Greater Sudbury Paramedic Services Statistics January 1- April 30, 2021

Logistics

Personal Protective Equipment

During the COVID-19 pandemic, inventory levels of Personal Protective Equipment (PPE) are being monitored to ensure all staff have the proper equipment to work safely. The Logistics staff continue to coordinate the procurement of supplies to ensure PPE levels are maintained and available to meet current and potential increased demands.

Electric Vehicles

Recently the Ministry of Long Term Care announced that Greater Sudbury will be participating in the Community Paramedicine Long Term Care (CPLTC) program over the next three years to provide services to individuals who are waiting for placement in a long-term care home. The Community Paramedics in these roles will require transportation to conduct home visits within our community. It was identified that this program allows the opportunity to utilize Electric Vehicles (EVs) to provide transportation for the Community Paramedics. Four Tesla Model 3s have been purchased and we anticipate the shipment to arrive by the end of May.

The introduction of EVs for this program aligns with the Community Energy and Emissions Plan (CEEP) to reduce carbon emissions and pollution in Greater Sudbury. During the three-year program, the EVs will be evaluated for performance, maintenance, infrastructure, and costing. At the completion of the program, an analysis of the EVs will be conducted to determine if EVs can be implemented within other operational areas of our fleet.

Professional Standards

Professional Standards is responsible for the delivery of quality assurance programming, consisting of clinical and service delivery auditing to improve patient safety and ensure high-quality clinical care, thereby reducing risks. Professional Standards also manages the electronic patient care record system and quality assurance. Clinical events are monitored and evaluated to identify training and education opportunities for the paramedics.

Reported number of clinical events: Date range is January 1 – April 30, 2021

Cardiac	Number of calls with at least 1, 12 Lead Acquired	1,453
	Total Cardiac related	487
	Number of STEMI	31
	A STEMI is a specific type of heart attack, which can be diagnosed by Paramedics in the pre-hospital setting.	

Neurological	Total Neuro-related	807
	Number of Acute Stroke (FAST positive, timeline criteria met)	80
	Average Age in Years	70
	An Acute Stroke Patient qualifies for specific time-sensitive treatments from the hospital to reduce and reverse damage caused by stroke.	

Sepsis	Number of Identified Sepsis cases	50
	Average age in years	73
	A Suspected Sepsis Patient meets a specific criteria (qSOFA) used to identify patients at risk of death due to systemic infection.	

Cardiac Arrest Medical and Trauma	Total Cardiac Arrest, Medical and Traumatic	133
	Total Treated Cardiac Arrest Medical and Traumatic	63
	Number of Medical Arrest with Return of Spontaneous Circulation at any time while in Paramedic Care.	11

Training

Enhanced Training Sessions

During the pandemic, Paramedic Training Officers' (PTO's) schedules have been adjusted to provide additional training time with staff. PTO's address training needs 16 hours a day, Monday to Friday and deliver real-time training and support to staff where needed with a specific focus on infection, prevention, and control. PTO's modified the delivery of training by conducting one-on-one sessions with paramedics. Topics of training included mask fit testing and reviewing of all COVID-19 related practices and processes. The PTO's continue to review COVID-19 safe work practices with all staff as they assist in the maintenance of keeping these practices and procedures in line with the most current standards. The Training Section has been involved in facilitating the latest hiring process which commenced this past March and will be transitioning into the new hire orientation phase in late May.

The PTO's have also been working with Community Paramedic (CP) Program in collaboration with an outside agency to provide various levels of training available to the quickly expanding CP Program and its newest staff.

Spring training will be delivered following strong safety protocols with some delivery face to face, however as the Province wide Stay-at Home order remains in effect, the majority of the training will be delivered virtually. This spring training session will see all frontline paramedics receiving online fundamental Community Paramedic Training. Paramedics will also be receiving the Stop the Bleed program designed to further enhance the Paramedics ability to manage bleeding emergencies.

Community Paramedicine Program Update – June 2021

Presented To:	Emergency Services Committee
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Meeting Date:	June 23, 2021
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Type:	Correspondence for Information Only
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Prepared by:	Melissa Roney Community Safety
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Recommended by:	General Manager of Community Safety
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Report Summary

This report provides an update on the City of Greater Sudbury's Community Paramedicine Program.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emission Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

This report aims to provide the City of Greater Sudbury Emergency Services Committee with an update on activities, relevant statistics, and recent performance measures within the Community Paramedicine Section of the Paramedic Services Division.

Community Paramedicine (CP) leverages paramedics to provide immediate or scheduled primary, urgent, and/or specialized healthcare to vulnerable patient populations by focusing on improving healthcare access across the continuum of care. The umbrella term “community paramedicine,” describes a growing field of paramedicine practice that emphasizes a more proactive and preventive approach to care that utilizes paramedics in expanded roles. CP represents an evolution of embedding emergency management principals into a paramedic’s scope practice to help patients recover after an acute medical event, prevent future exacerbations, provide support and preparation for medical decline, and continue to provide optimal responses when patient’s call for medical assistance.

COVID 19

Paramedic Services have been essential amid the COVID-19 pandemic. During this emergency situation, paramedics have been providing COVID-19 testing, administering COVID-19 vaccines both in clinics and in homes, transporting individuals to testing centres, and providing community paramedicine, among their regular emergency service responsibilities. Community paramedicine has been a crucial support for individuals during the pandemic, especially for isolated seniors and those living in remote areas.

Community Paramedics providing COVID 19 Vaccinations

Working collaboratively with Public Health Sudbury and Districts, Community Paramedics have been operating mobile vaccine to client (VTC) clinics delivering vaccine to those within the City of Greater Sudbury who are unable to make it to a mass immunization clinic. To date, our Paramedics have delivered over 600 first and second dose appointments to eligible clients in their home.

Mobile COVID-19 Testing – Collaboration with Health Sciences North

Paramedic Services continue to provide support to the community to address the changing demands created by this pandemic. Paramedics continue to support the Health Sciences North (HSN) COVID-19 Assessment Centre by conducting mobile in home COVID-19 testing for select individuals unable to attend the Assessment Centre in person either due to limited mobility or transportation challenges. Currently, Community Paramedics have assessed and tested over 6,094 symptomatic residents in the community, allowing equitable access to COVID-19 testing. In addition, we continue to collaborate with community partners, conducting surveillance and outbreak testing in settings of declared outbreaks and addressing specific needs of vulnerable populations within our community.

Care Transitions Community Paramedicine Program (CTCP)

The Care Transitions Community Paramedicine Program partners with Health Sciences North to utilize trained Community Paramedics (CP) to provide home visits and approved interventions under medical oversight to complex, high-risk patients to assist them in transitioning from acute care to community and/or self-supported in-home care.

The program's goal is to decrease emergency department visits and readmissions for identified high-risk patients with chronic disease (CHF, COPD, and diabetes) compared to their past utilization. Paramedics assigned to the CTCP continue to deliver services as outlined in the 2021 work plan during the pandemic.

From January 1, 2021 until April 30, 2021, there were 330 active patients enrolled within the program and only one patient reported the need to utilize our 911 service for the treatment of their chronic health condition. There was one referral to primary care and/or community service, thus improving the quality of life for this patient.

In an effort to reduce in person contacts during COVID-19, the CTCP increased the number of patient contacts over the phone. Home visits continued to be conducted to those that were deemed necessary or Just in Time (JIT). These JIT visits are for those situations of chronic illness exacerbation to allow CTCP paramedics to intervene prior to activation of 911 or an emergency department visit.

Visits Completed / JIT	625/58
Working Days	119
Active Patients	330
911 Calls Related to CTCP	6

Reporting date range is from January 1, 2021 – April 30, 2021

Health Promotion Community Paramedicine (HPCP)

The objective of this program is to maintain and expand health promotion, education, and injury prevention. This program will also assist citizens in chronic disease recognition and prevention, injury awareness/prevention strategies, referrals, and health system navigation assistance. The primary goals of this program are to mitigate emergency calls and hospital visits, keep our “at-risk” aged population healthy and at home. This is an attempt to aid our vulnerable populations and redirect them to more suitable community resources other than the emergency department.

During the pandemic, the HPCP program has collaborated with various community agencies in our provision of COVID-19 mobile testing to ensure our patients are tested and may remain safely in their place of residence.

- HSN COVID-19 Assessment Centre is screening phone calls from citizens to evaluate if COVID-19 testing should be conducted, scheduling in-home testing by the Community Paramedic Mobile Testing service for those in our community who are unable to physically attend the HSN COVID-19 Assessment Centre and are members of the mobile testing group who provide the in-home COVID-19 testing.
- We have established a priority referral process to HPCP from North East Local Health Integration Network (NELHIN)/ Maison McCulloch Hospice for those who are in the community who require COVID-19 testing for admission to either a long-term care facility or hospice.
- A group of Primary Care Physicians may be utilized by phone to function as CP medical oversight physicians to offer guidance / follow-up if required for those patients the CPs test and assess and who are deemed to require further intervention.
- Sudbury and District Nurse Practitioner Clinic (SDNPC) with Dr. Alex Anawati and Canadian Mental Health Association (CMHA) have collaborated with HPCP where HPCPs provide on demand COVID-19 testing every morning at the Withdrawal Management at 336 Pine Street.

Since the program began on March 15, 2020, 6,094 tests have been performed by Community Paramedic Mobile Testing service.

We have continued with our paramedic referral programs and Community Mobilization Sudbury-Rapid Mobilization Table (CMS_RMT).

We have begun a gradual re-entry into CP clinics, utilizing virtual technology and less in-person contact. This program is another McMaster development in concert with Ontario Health. Preparation for this new version of CP@Clinic began in February 2021 with a start date of February 28, 2021. Staff took part in Ontario Telemedicine Network (OTN) training to utilize video technology in addition to telephone consultation.

Between the dates of February 28, 2021 - April 30, 2021 the following contacts were made:

Number of residents called by CP to book a virtual CP@Clinic appointment	120
Number of residents who booked a virtual CP@ Clinic appointment	7
Number of TOTAL videoconference CP@Clinic appointments completed	4
Number of UNIQUE videoconference CP@Clinic appointments completed	3
Number of TOTAL telephone CP@Clinic appointments completed because residents did not have technology/internet/know how	38
Number of UNIQUE telephone CP@Clinic appointments completed because residents did not have technology/internet/know how	31

New Community Paramedicine Programs

Ontario Health North Remote Clinical Monitoring Pilot

Greater Sudbury Paramedic Services has been awarded \$142,000 in funding that the Ministry of Health has approved in dedicated short-term allotments to support provincial and regional initiatives that provide COVID-19 patients with remote clinical care and monitoring in the community. The objective of this funding is to ensure COVID-19 patients and other vulnerable patients receive appropriate clinical care and monitoring in the community, including escalation to a medical assessment or acute care where necessary. By supporting remote clinical care models, this funding is also intended to reduce the risk of infection among health care workers. Paramedic Services has collaborated with three other paramedic services and health care agencies in the northeast and designed a program, which will be delivered as a regional model. Paramedic Services commenced a five-month pilot program in December 2020, which was extended until June 2021. This program is staffed with one Community Paramedic 12 hours per day. Since December 2020, 26 COVID-19 positive patients have been enrolled in the remote patient monitoring service within our community.

This program has helped to support 155 discharged patients and continues to support 7 COVID-19 positive patients in their homes and 12 others who suffer from chronic health conditions. The benefits to the above are medical oversight, the comfort that someone is keeping an eye on patients' wellbeing with phone consultations and daily visits, and reduced exposures for both patients and the community.

Ministry of Health - Home and Community Care High Intensity Supports Program and Community Paramedic Expansion

Greater Sudbury Paramedic Services has been awarded \$189,000 through the Ministry of Health's initiatives to expand Home and Community Care and Community Paramedicine. The goal of the funding is to provide support to regional health partners to implement plans, execute the High Intensity Supports at Home Program, and expand Community Paramedicine to support the health system response to the COVID-19 pandemic and seasonal influenza. Home and community care can help address reduced bedded capacity by assuming care responsibility for hospital Alternate Level of Care (ALC) patients with a long-term care (LTC) destination and other patients with similar needs on LTC waitlists. This will ensure high needs patients continue to receive care when beds are in short supply. Paramedicine can be leveraged as 'capacity enhancers' to work alongside home and community care and other services. Target populations are clients requiring supplemental Community Paramedic services, beyond home and community care or seniors with similar needs in the community at high risk of hospital admission and becoming designated ALC (i.e., those with frequent hospital admissions, emergency department visits, and those recently discharged at high risk of readmission).

From January 1, 2021 to April 30, 2021, our High Intensity Community Paramedics have enrolled 25 patients resulting in 52 home visits, 147 telephone consultations, and 10 physician consultations totaling 209 interactions.

Community Paramedicine - Long Term Care (CPLTC) Program

The CPLTC program will be delivered by Greater Sudbury Community Paramedics in partnership with the North East Local Health Integration Networks (NE LHIN) and Ontario Health Teams, where applicable. The purpose of the program is to keep individuals who are on the long-term care wait list, or who are soon to be eligible for long-term care, stabilized in their illness trajectory and in their own home for as long as possible. The program will do this through preventive and responsive care, such as home visits and remote client monitoring.

There are three categories of people eligible for CPLTC:

- Those on the wait list for long-term care;
- Those who have been assessed as eligible for long-term care by a LHIN Care Coordinator (but not yet on the wait list); and,
- Those who are soon to be eligible for long-term care

The services that the Greater Sudbury CPLTC are providing will correspond with the specific needs of people on the waitlist and the overall program goals which are to be accessible, responsive, proactive, and safe.

The types of services funded by this program will include:

- 24/7 access to community paramedicine services for defined non-emergency procedures in people's own homes addressing urgent, episodic care needs. For example, diagnostic procedures, assessment and testing during routine home visits; at-home treatment under supervision of a physician, where required; or at-home treatment of minor conditions (e.g., falls, lacerations, bruises).
- Prompt, flexible, and proactive response to an individual's changing circumstances or medical conditions, and if necessary, connecting them to the right health care provider and social services at the right time in order to avoid escalation and crisis.
- Routine-based remote monitoring or virtual supports to prevent emergency incidents or escalation in medical conditions, including, but not limited to monitoring of blood pressure, heart rate, oxygen saturation, blood glucose, weight, and temperature alerts.
- Immunizations, vaccinations, and other injections (e.g., tetanus).
- Certain other controlled medical procedures and treatments at home under appropriate medical oversight.
- Ongoing monitoring of changing or escalating conditions to prevent or reduce emergency incidents.
- Provide connections for participants and their families to home care and community supports.

This program is a fully funded three year pilot and will provide four additional Community Paramedics per day in the community providing 24/7 access to Community Paramedicine services for defined non-emergency procedures in individual's own homes addressing urgent, episodic care needs. The staffing requirements for this project included hiring ten full time Paramedics, a Scheduler, and a Clinical Lead. Paramedic training for this group was completed between April 26 and May 6, leading to the program phase one launch on May 10, 2021.

Oversight 911 – Ombudsman Report

Presented To: Emergency Services Committee

Meeting Date: June 23, 2021

Type: Correspondence for Information Only

Prepared by: Joseph Nicholls
Community Safety

Recommended by: General Manager of Community Safety

Report Summary

This report provides information regarding the Ontario Ombudsman’s investigation report into how the Ministry of Health investigates and oversees patient complaints and incident reports about ambulance services.

Relationship to the Strategic Plan, Health Impact Assessment and Community Energy & Emissions Plan (CEEP)

This report refers to operational matters and has no direct connection to the Community Energy and Emissions Plan.

Financial Implications

There are no financial implications associated with this report.

Background

On April 30, 2018, the Ontario Ombudsman notified the Ministry of Health that an investigation would be launched into how the Emergency Health Services Division investigates and oversees patient complaints and incident reports about ambulance services. The Ombudsman’s report, providing 53 recommendations, has been attached for information only.

Resources Cited

Ontario Ombudsman Report – Oversight 911, May 2021

<https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/Ombudsman-Report-Oversight-911-May-2021-EN-accessible.pdf>

OVERSIGHT 911

Investigation into how the Ministry of Health oversees patient complaints and incident reports about ambulance services



OVERSIGHT 911

911



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Office of the Ombudsman of Ontario

We are:

An independent office of the Legislature that resolves and investigates public complaints about Ontario public sector bodies. These include provincial government ministries, agencies, boards, commissions, corporations and tribunals, as well as municipalities, universities, school boards, child protection services and French language services.

Our Values:

Fair treatment
Accountable administration
Independence, impartiality
Results: Achieving real change

Our Mission:

We strive to be an agent of positive change by promoting fairness, accountability and transparency in the public sector and promoting respect for French language service rights as well as the rights of children and youth.

Our Vision:

A public sector that serves citizens in a way that is fair, accountable, transparent and respectful of their rights.



Ombudsman Report

“Oversight 911”

Investigation into how the Ministry of Health oversees patient complaints and incident reports about ambulance services

Paul Dubé
Ombudsman of Ontario

May 2021

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Executive Summary

- 1 Most people hope they will never need to dial 911. However, each year hundreds of thousands of Ontarians must make this call when faced with medical emergencies. Each time someone calls, a complex series of steps executed by multiple organizations allows an ambulance to quickly respond and provide medical care and transportation. Typically, this process is seamless and patients receive the high-quality care that they deserve and expect. However, sometimes problems occur, and in some cases lead to tragedy. That is why it is imperative that the province maintain robust oversight of the system for emergency medical services. Proper and thorough investigations are an essential component of a robust oversight system.
- 2 The Ministry of Health oversees the \$1.5-billion emergency medical services system. One of its key responsibilities under the *Ambulance Act* is to establish standards for ambulance services and ensure compliance with those standards. It also has a statutory duty to monitor, inspect and evaluate ambulance services, as well as to investigate complaints.
- 3 The role of an Ombudsman is to enhance governance by promoting, among other things, accountability and transparency. My Office had identified issues in the past with the way in which the Ministry oversees and investigates complaints about ambulance services. In our review of individual complaints, we noted problems with the way information about the scope of the Ministry's review was communicated, the quality of its investigative report writing, and with its written communication to complainants. We worked with senior Ministry staff to address these specific issues. More recently, an individual approached us with serious concerns about the Ministry's oversight of emergency health services. After assessing this complaint, I informed the Ministry in April 2018 that I was launching a systemic investigation into its oversight of ambulance services. We received an additional **72** complaints after we announced the investigation.
- 4 When a person calls 911 about a medical emergency, their call is dealt with by a dispatcher at one of 22 dispatch centres throughout the province. Paramedics from one of 61 different Emergency Medical Service (EMS) providers are dispatched to provide medical care and transport the patient to hospital. The Ministry relies on three regionally-based Field Offices to oversee and liaise with the EMS providers and dispatch centres. The Ministry's Investigation Services Unit investigates complaints about the provision of ambulance services and monitors investigations undertaken by EMS providers and dispatch centres. A similar structure exists for the provision of air ambulance service.

- 5 My investigation identified serious issues with the Ministry’s oversight and investigation framework. Ministry investigators conceive of their role and mandate as being very limited, which means that many complaints about ambulance services are not investigated. When the Ministry does investigate, we found that investigators operate with almost no policies or procedures to guide their investigation or decision-making process, and there are often long delays before investigative reports are released. The reports themselves are difficult to understand, without clear recommendations to fix identified issues. Even worse, the Ministry does almost nothing to follow up on investigation findings to ensure that problems are actually addressed so that they do not recur. We found that a lack of training, high levels of staff turnover and understaffing within the unit exacerbated each of these issues.
- 6 My investigation also identified serious issues with the Ministry’s process for reviewing incident reports, which EMS providers, dispatchers, and others must prepare in response to certain events. On average more than 250,000 of these reports are sent to the Ministry’s Field Offices each year, but there are only a handful of staff responsible for reviewing their content. They are often months behind, and since there are no policies or procedures about what they should be looking for, almost nothing is flagged to Ministry investigators for further review. There is also no mechanism for tracking and analyzing the issues raised in these reports. As a result, this fundamental oversight mechanism does little to identify and correct issues in order to ensure patients receive safe and reliable ambulance services.
- 7 In addition, there are numerous obstacles that prevent complaints about ambulance services from ever making it to the Ministry. With so many organizations involved in the provision of ambulance services, patients and their loved ones don’t always know they can ask the Ministry to investigate their concerns. Even if they specifically seek out complaint information online, they will likely struggle to find useful and clear information about how to complain to the Ministry. When individuals do manage to contact the Investigation Services Unit, their experience can be far from ideal. Complainants are given little to no information, leaving them with only a hazy idea of what will be investigated or the process for doing so. At times, investigators don’t even contact complainants to get details about their concerns or to provide a copy of the final investigative report.
- 8 My investigation concluded that the Ministry of Health’s administrative process for investigating and overseeing patient complaints and incident reports about ambulance services is unreasonable and wrong under the *Ombudsman Act*. This report makes **53** recommendations to address these serious issues.

- 9 Emergency ambulance service is a fundamental part of our health care system and can mean the difference between life and death. The quality of our health care system depends on the establishment and maintenance of operational standards that protect patients. A key to ensuring that appropriate standards are established and met within our health system, including emergency ambulance services, is having an adequate oversight regime. The Ministry must do a better job of ensuring that providers meet the standards established by the *Ambulance Act*, and that complaints about possible contraventions are rigorously investigated and addressed. The Ministry recognizes the shortcomings in the current system, and has committed to implementing all of my recommendations.

Investigative Process

Previous complaints about the Ministry

- 10 Emergency health services rarely generate complaints to my Office. Between January 1, 2016, and the announcement of this investigation on May 1, 2018, we received only four.
- 11 However, over the past five years, my Office worked closely with the Ministry on two of these complaints that raised extensive concerns with its investigative and oversight function.
- 12 In one case, our review identified issues with the information that was available to the public about the scope of Ministry investigations and the role of its investigators, but we did not substantiate any non-compliance with the *Ambulance Act*. As a result, the Ministry improved its website to better explain its mandate and role. In another case, our review identified issues with the clarity of the Ministry's report writing, and our Office shared best practice suggestions with the Ministry for improvement.
- 13 More recently, an individual provided us with information about serious, ongoing concerns about the Ministry's oversight of emergency health services. They spoke with us on condition of anonymity and highlighted issues with understaffing of key Ministry positions, inadequate oversight of service providers, and concerns around the effectiveness, thoroughness and objectivity of Ministry investigations. Although much of the evidence provided was anecdotal, what we heard was consistent with issues that Ombudsman staff had seen firsthand while reviewing individual complaints about the Ministry in previous years.

- 14 Rather than wait until we had several more complaints or a serious incident involving a patient, I decided that an investigation was necessary in the public interest. My Office considers several factors in deciding whether or not to conduct a systemic investigation, for instance, whether:
- Our Office has authority to consider the matter;
 - Other appropriate resolution mechanisms exist to address the issue;
 - There is evidence available suggesting there is a systemic component;
 - The issue is serious and potentially impacts a large number of Ontarians;
 - The matter relates to public sector administration and not broad public policy that should be dealt with through elected representatives; and
 - An investigation would represent a judicious use of our limited resources.
- 15 In this case, the need for an investigation was compelling, as the identified issues were serious and potentially affected more than 1 million people. Moreover, my Office's expertise in investigation and oversight techniques uniquely positioned us to review the Ministry's own processes and make recommendations for improvements.

Scope of investigation

- 16 On April 30, 2018, I notified the Ministry that I was launching an investigation into how it investigates and oversees patient complaints and incident reports about ambulance services. The next day, I publicly announced the investigation and invited affected members of the public to contact my office. During the course of this investigation, we received **72** complaints related to the oversight of emergency health services.
- 17 Investigators from our Special Ombudsman Response Team, assisted by members of our Legal, Investigations, and Early Resolution teams, carried out the investigation. Investigators reviewed tens of thousands of pages of documents, including more than 200 of the Ministry's investigation files and thousands of incident reports, as well as relevant policies, briefing notes, internal communications, and other information provided by the Ministry at our request. They also reviewed documents provided by complainants and community stakeholders.
- 18 The team conducted 60 interviews with complainants, Ministry staff, and other stakeholders, including EMS providers, air ambulance providers, dispatch centres, hospitals, and various industry associations. The bulk of this field work was completed prior to the COVID-19 pandemic.

- 19 However, in early 2020, the Ministry, EMS providers, and other stakeholders were confronted with the unprecedented challenge of responding to the pandemic, and this affected the timing of the Ministry's response to our findings and the finalizing of this report. Despite these circumstances, we received excellent co-operation throughout the course of the investigation from the Ministry and other public sector bodies.

Coroner's jury recommendations

- 20 While our investigation was ongoing, a coroner's inquest also reviewed aspects of Ontario's 911 system. The coroner's jury heard evidence about the circumstances of two fatal tragedies, one involving a 2013 boat crash that left three people dead and the other involving a woman who died of an asthma attack. In November 2018, the jury made 27 recommendations to improve emergency services in the province.¹
- 21 The jury recommended, among other things, that the government create an independent body to provide oversight to all 911 operations by investigating, responding to, and resolving complaints. It also recommended numerous technological improvements to ensure easier communication between the public and various emergency services. Because inquest juries do not provide reasons in support of their recommendations, it is impossible to know why the jurors decided that the Ministry's Investigation Services Unit did not adequately oversee 911 operations and should be replaced by a different investigative body. However, it is clear that the jury – much like my Office – determined that there were major flaws in the existing oversight of Ontario's emergency services.
- 22 To address the jury's recommendations, the Ministry formed a working group with the Ministry of the Solicitor General. We were told that the working group is researching and analyzing best practices in the provision of emergency services.

Emergency Medical Services in Ontario

- 23 Each year, paramedics attend to more than **1 million** patients at a total cost of more than **\$1.5 billion**. This basic service requires the co-ordination and co-operation of numerous organizations devoted to providing timely pre-hospital care.

¹ Verdict of Coroner's Jury (November 1, 2018), Office of the Chief Coroner, online: <<https://www.mcscs.jus.gov.on.ca/english/Deathinvestigations/Inquests/Verdictsandrecommendations/OCCInquest911Deaths2018.html>>.

Calling 911 – Dispatch

- 24 When a person calls 911 with a medical emergency, their call will be dealt with by an Ambulance Communication Officer (a “dispatcher” or “call-taker”) working at a Central Ambulance Communication Centre (a “dispatch centre”). In an emergency, this is how the public accesses Ontario’s pre-hospital care system.
- 25 There are 22 land ambulance communication centres in Ontario. Half are operated directly by the Ministry and half are operated by transfer payment agencies under performance agreements with the Ministry.

Ambulance and paramedic services

- 26 Paramedics are responsible for responding to medical emergencies, and where necessary, transporting patients by ambulance to hospital. Paramedics work for Emergency Medical Services (EMS) providers. There are more than 8,000 paramedics working at 61 EMS providers in Ontario. Municipalities and District Social Services Administration Boards are responsible for the provision of land ambulance services within their boundaries, while the province is responsible within certain First Nations communities and remote areas.
- 27 The quality of medical care provided by paramedics is overseen by base hospitals, which are designated by the Ministry of Health under the *Ambulance Act*. Each EMS paramedic must be certified by a base hospital. Base hospitals also allow doctors to delegate certain “controlled acts” (i.e. medical procedures) to paramedics and oversee compliance with advanced life support standards.
- 28 Ornge, a non-profit corporation governed by an independent board of directors, provides air ambulance services under a performance agreement with the Ministry. Ornge operates a dispatch centre, a fleet of helicopters and airplanes, as well as some land ambulances to provide this service.

Ministry of Health

- 29 Under the *Ambulance Act*, the Ministry of Health has overall responsibility for the provision of pre-hospital care and provides oversight of this sector through its Emergency Health Services Division. This division is responsible for the certification of EMS providers and dispatch centres, as well as inspections, service delivery, reporting, and investigations.

- 30 The Ministry relies on three regional Field Offices² to oversee the EMS providers and dispatch centres responsible for land ambulance service delivery. The Air Ambulance Oversight Unit is responsible for overseeing air ambulance services provided by Ornge. These programs fall under the Emergency Health Program Management and Delivery Branch of the Ministry.
- 31 The Ministry is also responsible for investigating complaints related to the provision of pre-hospital care. The Investigation Services Unit, a part of the Emergency Health Regulatory and Accountability Branch, is tasked with directly investigating complaints about the provision of ambulance services, as well as monitoring investigations undertaken by EMS providers, dispatch centres, and others. This unit was the primary focus of my Office’s investigation.

Ineffective and Inadequate Investigations

The Ministry’s investigative process

- 32 At the time of our investigation, the Investigation Services Unit was comprised of one manager positions and five investigator positions, and only three of the investigator positions were filled. This small team is responsible for conducting or overseeing approximately 200 investigations each year. Investigators are typically designated Provincial Offences Officers, which allows them to lay provincial charges under the *Ambulance Act*. These charges are prosecuted by provincial prosecutors at the Ministry of the Attorney General.
- 33 The unit is responsible for investigating complaints related to whether or not EMS providers and dispatchers have complied with the *Ambulance Act*, as well as its regulations and standards. Complaints can arise from any source, but typically come from members of the public or industry stakeholders.
- 34 There are no up-to-date policies or procedures that govern the unit’s investigative process, but we were told that after the unit receives a complaint, the first step is to determine its jurisdiction to investigate and whether there has been a direct or potential negative impact on patient care. Next, the unit must decide whether the EMS service or the Ministry will conduct the investigation. Complaints that are directly investigated by the Ministry are referred to as “investigation files.” Cases where the Ministry allows EMS providers and dispatch centres to conduct their own investigations, with the Ministry reviewing the investigation’s progress, quality and conclusions, are known as “watch files.”

² The provincial regions are: Central East, Southwest, and North. Central East is the most populated region, encompassing the Greater Toronto Area all the way to Ottawa. The Southwest region is responsible for Hamilton, London, Windsor and the Niagara area. The Northern region begins around Parry Sound and includes the remainder of northern Ontario.

Investigation files

- 35 In an investigation by the Ministry's Investigation Services Unit, an investigator will contact the involved organizations to obtain relevant documentation. Sometimes the investigator will conduct interviews with paramedics or dispatch staff, but this is sometimes deemed unnecessary. We were told that complainants are not always interviewed about their experience.
- 36 After gathering this information, the investigator determines whether there have been any contraventions of the *Ambulance Act* and its regulatory standards, which are then documented in a draft investigation report. The draft report is "peer-reviewed" by other investigators before being sent to a manager. The manager reviews the draft and may change findings and conclusions before it is finalized. Investigators told us that by this point, the report "belongs" to the Ministry and they have little involvement in the final version of the report.
- 37 When the report is ready for release, it is sent to the Field Office that oversees the EMS provider or dispatch centre. The Field Office then forwards the report and a covering memo to the organization under investigation. We were told that when the report contains actionable items, the organization has 10 days to develop a plan to address those concerns, and 40 days to actually implement that plan. However, this practice is not clearly set out in any policy or procedure, and some staff told us they were unsure if this process was still in effect.

Watch files

- 38 When the Ministry allows an EMS provider or dispatch centre to investigate a complaint, the "watch file" is still assigned to a Ministry investigator for review. Different investigators we spoke with had different understandings of what "watching" a file means. Some request all relevant documentation and conduct a full review, while others said they just read the final report prepared by the EMS provider or dispatch centre to see if it "makes sense." If the Ministry investigator identifies a concern, they can speak to their manager and launch a Ministry investigation, although we were told that this is an extraordinary and rare step, with each Ministry investigator having a different understanding of when or how this might occur.
- 39 If the Ministry investigator is satisfied with the EMS provider or dispatch centre's report, the watch file is closed. We were told there is no Ministry follow-up on the report's findings, and the investigator does not receive any information about whether, when, or how the service provider addresses any identified issues.

Issues with investigations

- 40 My investigation identified serious gaps in the Ministry’s investigative process from beginning to end. These included its investigative mandate, a tendency not to interview witnesses, the lack of a system to manage investigations or a consistent report structure, and long delays in releasing reports.

Limited investigative mandate

- 41 Providing pre-hospital care is complicated, involving many individuals at different organizations, all working in a stressful environment. Because complaints can arise from the conduct of any of these individuals, the Investigation Services Unit might be expected to have a broad and expansive mandate. Instead, the Ministry interprets its mandate restrictively, focusing only on whether there was a contravention of the *Ambulance Act* and related standards that can be supported by written or audio-recorded documentary evidence. This is a major limitation, as most patient complaints relate to the conduct of paramedics and customer service, which the Ministry says isn’t subject to specific regulatory standards and is often impossible to substantiate in a written record or audio recording.

- 42 One Ministry employee we interviewed acknowledged that this means that “a lot of times, we can’t speak directly to [the patient’s] complaint,” such as when the complaint relates to a paramedic’s attitude. We were told that these are treated as unprovable “he said/she said” issues, even when other witnesses are present, as those witnesses are typically connected to patients or paramedics. One senior Ministry employee told us the Ministry is “trying to get away from...things of a more subjective nature [such as] ‘I sat in the ambulance and the paramedic was arguing with a firefighter outside and I heard them argue and I had to wait an extra five minutes and it was cold in the ambulance.’”

We were told that this type of complaint would be outside the scope of the Ministry’s mandate.

- 43 We asked the Ministry why it has taken this position when the *Ambulance Act* states:

4 (1) The Minister has the duty and the power, [...]
(d) to establish standards for the management, operation and use of ambulance services and to ensure compliance with those standards; [and]
(e) to monitor, inspect and evaluate ambulance services and investigate complaints respecting ambulance services.

The Ministry was unable to provide a clear explanation.

- 44 Moreover, the Basic Life Support Patient Care Standards contain an entire section regarding paramedic conduct and professionalism, aptly titled “Paramedic Conduct Standard.” These standards are drafted by the Ministry and incorporated by reference into Part V of O. Reg 257/00 of the *Ambulance Act*, which establishes the standard of patient care, reports and documentation to which paramedics must adhere. Among other matters, this conduct standard outlines in detail the parameters of paramedics’ conduct and misconduct, including matters such as courtesy and professionalism. We learned that this section was determined to be so significant that it was moved to the first section of the Standards during a revision in July 2016. Despite these provisions, the Ministry takes the position that these complaints are “employment issues” that should only be dealt with by paramedics’ employers.
- 45 Given the important oversight role entrusted to the Ministry, where lives are literally on the line, it is inappropriate to take such a narrow approach to complaint investigation and oversight. The Ministry should ensure that the Investigation Services Unit interprets its investigative mandate in a broad and purposive manner, consistent with the oversight scheme of the *Ambulance Act* and related standards. It should specify that issues related to conduct of paramedics may come within the Ministry’s jurisdiction and instruct staff to investigate these matters to determine whether an allegation could amount to a breach of the Paramedic Conduct Standard in the Basic Life Support Patient Care Standards.

Recommendation 1

The Ministry should ensure that the Investigation Services Unit interprets its investigative mandate in a broad and purposive manner, consistent with the oversight scheme of the *Ambulance Act* and related standards.

Recommendation 2

The Ministry should direct its investigators that issues related to paramedic conduct come within the Ministry’s investigative mandate to determine whether an allegation could amount to a breach of the Paramedic Conduct Standard in the Basic Life Support Patient Care Standards.

- 46 The Ministry also takes a narrow approach to investigations in other instances. One of the main criticisms we heard from other stakeholders about the Ministry’s process is that it fails to acknowledge or take into account nuanced or grey areas. For example, we were told there is a provision that says paramedics must always carry a patient to the stretcher. Whenever a paramedic failed to do so – even if the patient didn’t want to be carried or it wasn’t necessary or practical in

the circumstances – the Ministry determined that the paramedic had violated the Act. One described this as an example of Ministry investigators acting as “rule trolls,” preoccupied with the letter of the law and not allowing for nuance.

- 47 In addition, the Ministry perceives itself as unable to investigate contraventions of local directives or policies for EMS providers or dispatch centres, even if they involve serious consequences. For example, a Ministry employee told us that they were aware of cases involving an EMS provider where it was alleged that patients were given much higher doses of fentanyl (an emergency pain reliever) than they should have received. Large doses of fentanyl can kill people by stopping their breathing, and it was alleged that the only reason those patients lived is because they already had a machine breathing for them. We were told this serious allegation fell outside the Ministry’s investigative mandate because such medication errors are dealt with in the EMS provider’s policy, rather than the *Ambulance Act* and its related standards.³ While the EMS provider took steps to prevent this human error from happening again, an oversight gap remains. We were told repeatedly by Ministry staff and management that the Ministry is only responsible for investigating contraventions of the *Ambulance Act* and its standards – and therefore cannot enforce local EMS policies.
- 48 Although the Ministry is aware of this serious gap and its possible ramifications, it has taken no steps to ensure that it has the necessary authority to review complaints where the conduct is governed by a local directive or policy. The Ministry should consider legislative or regulatory changes to the *Ambulance Act* that would ensure the Investigation Services Unit has authority to consider and enforce all local directives and/or policies when investigating complaints under the *Ambulance Act*. For example, the legislation and its regulations could incorporate local policies by reference in the same manner as they do the Basic and Advanced Life Support Patient Care Standards.

Recommendation 3

The Ministry should consider legislative or regulatory changes to the *Ambulance Act* that would ensure the Investigation Services Unit has authority to consider and enforce all local directives and/or policies when investigating complaints under the *Ambulance Act*.

³ As indicated in paragraph 27, paramedics are delegated authority from physicians at base hospitals to complete controlled acts like medication administration. It is the responsibility of the base hospitals in conjunction with individual EMS providers to establish policies regarding these controlled acts and to oversee this aspect of paramedic conduct. If a paramedic is found to have contravened these local policies, it is the base hospital in conjunction with the EMS provider – not the Ministry – that can revoke the paramedic’s ability to work.

Lack of interviews

- 49 Because the Ministry interprets its role so narrowly, we learned that its investigators do not routinely interview witnesses when the complaint relates to certain conduct of paramedics or dispatchers. Although each investigator has their own process, there was general agreement that witnesses would not be interviewed if the complaint came down to a “he said/she said” assessment of credibility, because adverse findings based on contradictory testimony were unlikely.
- 50 We found one case where the patient complained to the Ministry about a paramedic’s refusal to treat them due to the patient’s allegedly aggressive behaviour. The incident was witnessed by several family members and a second set of EMS paramedics, who were able to treat the patient and transport her to hospital without incident. Although the Ministry did launch an investigation, the investigator did not interview any of the patient’s family, because this evidence “would have to be taken with a grain of salt and even if they all said the same thing, all the paramedics said the exact opposite, so it’s a wash.” As they described it:

There were four paramedics on scene, there were four family members, so I feel like the truth probably lies somewhere in the middle and I can’t present either as fact; So I didn’t [interview the family members].... I don’t tend to speak to every witness that’s there....Especially if they’re related to the patient.”

After reviewing the dispatchers’ and paramedics’ documentation and speaking with the paramedics, the Ministry investigator concluded that the paramedics had not contravened the *Ambulance Act* or its standards.

- 51 My Office reviewed this same investigation file and interviewed the patient who made the initial complaint. Our assessment determined that there would have been considerable value in Ministry investigators interviewing the patient’s family, not only because they had valuable evidence to share, but also because it would have demonstrated to the complainant that the Ministry was conducting a thorough and objective investigation.
- 52 We also learned that some Ministry investigators don’t interview the paramedics and dispatchers involved in a complaint. They told us documentary evidence is more reliable and already contains the information needed to determine whether there was a contravention of the *Ambulance Act*. Still, interviews can provide crucial information and context that is lacking in the documentary evidence. One Ministry employee told us about an investigation where it was discovered that dispatchers were not applying an air ambulance triage standard because they had not been taught about the standard. This was a significant systemic issue

that was only discovered by interviewing the involved staff. The Ministry staff doubted whether the systemic training issue could have been identified without conducting interviews, noting, “that’s where the value is in interviewing people. [But] there’s nothing that says...[we] have to so...[investigators] don’t.”

- 53 Documentary review is important in the investigative process, but interviews often provide key information and context not found in the paper record. The Ministry’s Investigation Services Unit should seek to interview every complainant who brings an issue to the Ministry for investigation. The Investigation Services Unit should also interview other witnesses, including family members and bystanders, when relevant to the complainant’s concerns. This will help ensure a thorough, balanced, fair, and objective investigation. In addition, the Ministry’s Investigation Services Unit should interview paramedics, dispatchers, and other relevant professionals in every instance where they may have material information, regardless of the availability of documentary evidence.

Recommendation 4

The Ministry’s Investigation Services Unit should seek to interview every complainant who brings an issue to the Ministry for investigation, wherever practicable.

Recommendation 5

The Ministry’s Investigation Services Unit should interview relevant third-party witnesses, such as family members and bystanders, when relevant to the complainant’s concerns, wherever practicable. If a complaint is brought by someone other than the patient, the Ministry should ensure the patient is interviewed, where practicable.

Recommendation 6

The Ministry’s Investigation Services Unit should interview paramedics, dispatchers, and other relevant professionals, wherever practicable, in every instance where they may have material information related to a complaint, regardless of the availability of documentary evidence.

Investigation management system

- 54 The Ministry’s Investigation Services Unit does not have a centralized method for documenting and storing information from investigations. Because there is no case management system, individual investigators must devise their own strategy for recording and storing interview notes, as well as other relevant documents and information. This meant that when my Office requested complete investigation files from the Ministry, we were provided documents in all sorts of

formats, setting out the same type of information in many different ways. We also quickly realized that some documentation we expected to receive, such as notes of telephone conversations, was entirely missing.

- 55 We were told that at one time, investigators were given special notebooks for each investigation file, in which they documented their work by hand. When an investigation was completed, the notebook was scanned and stored on a shared drive with other investigation documents. However, in early 2018 these notebooks ran out and the Ministry determined they were too costly to reorder. Nothing was ever developed to replace these notebooks. If the Ministry is to meet the public's expectations of 21st-century investigations to ensure proper oversight, it will have to evolve from 19th-century tools.
- 56 The Ministry has tried to develop workarounds to replace some of the functionality that a good case management system would provide. Staff told us about two spreadsheet-like resources that the Ministry has developed to track very basic investigation and post-investigation information. Only a few people have access to these spreadsheets, and they are not robust enough for systemic analysis or research. They also do not allow investigators to upload or attach documents or notes.
- 57 Many people we spoke with were frustrated by this gap. One employee expressed frustration that the Ministry's case management system was much less sophisticated than those employed by the EMS providers' investigation teams.
- 58 The ad hoc approach to tracking information related to investigations also means that Ministry investigators are unable to track potential trends or systemic issues and easily determine if the complaint they are investigating has arisen previously. Staff acknowledged these shortcomings, telling us:

[W]e don't have the resources or the ability to run a query, run trend analysis – what are the issues that are coming in?...Are they systemic? Are they local? Are they provincial?...we don't have the ability to do that...the manhours that would be required to go through and do that manually are just – we don't have the resourcing.”

- 59 A robust case management system would allow Ministry investigators to thoroughly and consistently document investigations, track complaint statistics, and monitor trends over time. In addition, it would make it easier for the Ministry to assemble necessary materials for prosecutions under the *Ambulance Act* and help ensure that the Ministry's documentation practices can withstand scrutiny.

Recommendation 7

The Ministry should develop and implement an investigations case management system that allows investigators to fully document each investigation, including all contacts, notes, interviews and relevant documentation for each investigation file.

Recommendation 8

The Ministry should ensure that the case management system allows staff to identify and track specific issues or trends that arise in its investigations.

Inconsistent format of reports

- 60 Our review also identified concerns with the structure and content of the Ministry's reports on investigations. These reports do not contain any information about the Ministry's investigative process such as what documents were reviewed and who was interviewed. This can lead to concerns about the thoroughness and credibility of the findings. Our review also determined that there was no standardized format or structure for reports. This inconsistency means that if two investigators wrote reports about the same complaint, they may include different information in a different order. This is understandably confusing to EMS providers and dispatch centres that deal with dozens of Ministry reports each year.

Recommendation 9

The Ministry should adopt a clear, standardized format for investigative reports that includes information about the investigative process and the specific evidence reviewed.

- 61 Most concerning, we learned that the Ministry's reports do not make recommendations, but instead outline "actionable items" and "observations." What these terms mean is open to considerable debate. We received no consistent definitions from Ministry staff about what these mean. When asked why the Ministry doesn't make recommendations, one employee told us that the Ministry shouldn't have any role in directing the EMS provider or dispatch centre: "It's not our service, they're not our employees." As a result, the Ministry's investigative reports are limited to making findings of facts and determining whether those facts resulted in a contravention of the *Ambulance Act*.

- 62 This approach means that EMS providers and dispatch centres are left to determine how best to address identified issues on a case-by-case basis without any guidance or expertise from the Ministry. One stakeholder we spoke with was frustrated by this approach, since the Ministry is in the best position to see how other EMS providers have successfully resolved similar issues.
- 63 There were many theories about why the Ministry doesn't make recommendations. Some Ministry investigators, EMS providers, and other stakeholders thought the Ministry's motivation might be financial, as it provides 50% of EMS funding and its recommendations could lead to additional costs. Others suggested that because the Ministry's primary focus is on stakeholder relations, it might not want to be seen directing independent EMS providers as to how to conduct their business.
- 64 Regardless of the reason, the Ministry is in the best position to recommend specific improvements to issues identified in its investigative reports. The Ministry should ensure that its reports make specific recommendations to EMS providers when issues are identified.

Recommendation 10

The reports published by the Ministry's Investigation Services Unit should make specific recommendations to resolve any issues that are identified.

The waiting game

- 65 The Ministry's investigative process is also not timely. We saw many instances where its small Investigation Services Unit - responsible for more than 200 investigations per year - took more than a year to release a report on a simple complaint. We were told that the majority of this delay is caused by the many layers of review and bureaucracy that each report goes through after being written by the investigator. If there is a backlog at any step of this process, reports begin to pile up. This was a serious issue during the course of our investigation, when the Ministry went months without releasing any reports due to management staffing shortages.
- 66 Nearly everyone we spoke with in the Ministry was frustrated by this delay. One person told us they had received "a multitude of calls over the last 4 to 5 months asking where a report is, why it isn't out." They pointed out that the reports contain important findings that need to be addressed in a timely fashion, and said they feared the Ministry was "losing credibility" with stakeholders. EMS providers and dispatch centres were equally frustrated, noting that it is hard to take action

on a complaint – especially if it involves employee re-education – when the incident occurred long ago.

- 67 Given the importance of the Ministry’s investigative function, the Ministry should ensure that all steps of the investigative process are properly resourced so they can be completed in a timely manner. The Ministry should also establish clear benchmarks for how long each step in the investigation and review process should take, continuously monitor its progress against this standard and take remedial action when necessary.

Recommendation 11

The Ministry should ensure that all steps of the investigative process are properly resourced so that they can be completed in a timely manner.

Recommendation 12

The Ministry should establish clear benchmarks for how long each step in the investigation and review process should take. The Ministry should continuously monitor its progress against this standard and take remedial action when necessary.

Following up to ensure change

- 68 When a Ministry investigation identifies issues that an EMS provider needs to address, there should be some process in place to ensure that appropriate action is taken. Similarly, where the EMS provider conducts its own investigation and identifies an issue, the Ministry should ensure that the provider fixes the concern. The purpose of investigating a complaint and identifying issues is largely defeated unless this follow-through occurs. However, our investigation found that the Ministry has no clear, effective method for following up with service providers to make sure corrective action is taken.
- 69 In response to our request, the Ministry provided a 2013 memo that purported to set out a follow-up and tracking process for issues identified in its reports. In short, the service provider has 10 days to inform the Ministry how it intends to address any issues, and 40 days to confirm that corrective action has been taken. This “10/40” follow-up process was familiar to most people we spoke with, but there was substantial disagreement about who is responsible for tracking and assessing these remedial actions.

- 70 Looking to the 2013 memo for clarification isn't helpful, as the Ministry section tasked with this role in the process no longer exists, and there was disagreement among those we spoke with about whether the document was still in effect. Some Ministry staff told us that follow-up tracking is now the responsibility of the Investigation Services Unit, while others said that it was done by the Field Offices. In practice, it seems that no one has taken full responsibility. We learned that the database for recording follow-up information has limited functionality, making tracking and trend analysis nearly impossible. The primary follow-up that occurs is on a piecemeal basis by individual Field Offices, although this is not necessarily timely or effective. One senior Ministry employee told us that the Field Offices do not have the expertise or resources to effectively review and track the 10/40-day follow-ups.
- 71 Even more concerning, we learned there is absolutely no follow-up conducted when the Ministry's investigators open a watch file and allow an EMS provider to conduct its own investigation. After the EMS provider finishes its report, no one in the Ministry's investigative unit or Field Office takes any steps to ensure that corrective action is taken. In fact, those we interviewed weren't even sure if the 10/40-day process applied in this circumstance.
- 72 The Ministry's follow-up process for air ambulance investigations is equally concerning and unclear. Unlike land ambulance providers which are co-ordinated through Ministry Field Offices, the air ambulance services provided by Ornge report to the Ministry through the Air Ambulance Oversight Unit. This Unit, created in July 2012, is in a different branch of the Ministry and was created to directly oversee Ornge in response to serious concerns identified in a 2012 special report of the Auditor General.⁴ The unit was intended to ensure that Ornge was rigorously overseen by Ministry employees who have special expertise in air ambulance services, and operated similarly to Field Offices.
- 73 However, we were told that chronic understaffing and work-related delays in the Ministry's Air Ambulance Oversight Unit necessitated the use of creative workarounds by Ornge that effectively cut the oversight unit out of the process. For instance, the Ministry's Investigation Services Unit started sending its investigative reports directly to Ornge, instead of relying on the Air Ambulance Oversight Unit to manage this communication. We were told these steps were taken because the Air Ambulance Oversight Unit had so few staff that it was unable to review reports and forward them to Ornge in a timely manner. As a result, the Ministry's own specialized oversight unit was not involved in assessing corrective action taken by Ornge in response to the Ministry's investigations.

⁴ Auditor General, *Special Report: Ornge Air Ambulance and Related Services* (March 2012), online: <http://www.auditor.on.ca/en/content/specialreports/specialreports/ornge_web_en.pdf>.

- 74 Identifying actionable items is of little value if there is no system in place to ensure that the issues are addressed. The Ministry should develop and implement a procedure for following up on all issues identified during investigations, including those conducted by EMS providers, dispatch centres, and Ornge. The process should clearly define roles, responsibilities, and timelines, as well as establish criteria for satisfactorily addressing actionable items. The procedure should set out the steps that will be taken and consequences for when the Ministry is dissatisfied with the service provider's remedial action.
- 75 For land ambulance services, the process should be administered by a centralized unit, such as the Investigation Services Unit, that has broad subject-matter expertise and the capacity to track and conduct trend analyses throughout the province. Ministry Field Offices may not be suited for this oversight responsibility, given their role as regional liaisons for EMS providers and their focus on fostering collegial and collaborative relationships.
- 76 For air ambulance services, the Air Ambulance Oversight Unit should be tasked with carrying out this specialized oversight mandate. In each case, the Ministry should ensure that the oversight units have the human resources and technology infrastructure necessary to conduct this work.

Recommendation 13

The Ministry should develop and implement a procedure for following up on all issues identified during investigations, including issues identified in investigations conducted by EMS providers, dispatch centres, and Ornge. The procedure should clearly define roles, responsibilities, and timelines, as well as establish criteria for satisfactorily addressing actionable items. The procedure should set out the steps that will be taken and consequences for when the Ministry is dissatisfied with the service provider's remedial action.

Recommendation 14

For land ambulance services, the new follow-up procedure should be administered by a centralized unit, such as the Investigation Services Unit, that has broad subject-matter expertise and the capacity to track and conduct trend analyses throughout the province. For air ambulance services, the Air Ambulance Oversight Unit should be tasked with carrying out this specialized oversight mandate. In each case, the Ministry should ensure that the oversight units have the human resources and technology infrastructure necessary to conduct this work.

Findings against individuals

- 77 Our investigation also found that the Ministry fails to track findings against individual paramedics and dispatchers who are found to have contravened the *Ambulance Act* and other applicable standards.
- 78 Under the present system, concerns about misconduct by paramedics that are identified in a Ministry investigation are usually dealt with directly by the ambulance service that employs them. Employers have no obligation to communicate with the Ministry about what steps, if any, they take in response to findings against paramedics. Although the Ministry has the option to pursue charges under the *Ambulance Act* in certain circumstances, this is an extraordinary remedy and we were told of only two instances where this had occurred. Findings against dispatchers are dealt with in a similar manner, although in some cases the employer is another branch of the Ministry.
- 79 Privacy legislation⁵ prevents employers from sharing misconduct findings with others, but Ministry investigators need this data to spot troubling trends, such as individuals committing the same error multiple times. We were not provided with a satisfactory explanation for the Ministry's failure to obtain and track this information, as it already requires paramedics and dispatchers to be licensed by the province and has a database where this information could be easily stored. We were told that the database system is equipped to record this information and can begin doing so immediately. The Ministry should immediately begin using this functionality to track all findings against paramedics and dispatchers, and any disciplinary action taken.
- 80 This information should be available to Ministry investigators, who may be able to use the data to spot problematic trends during the course of an investigation. Given the public interest in ensuring paramedic and dispatcher competence and safety, the Ministry should also consider legislative changes that would allow for broader sharing of misconduct findings to ensure that employers are aware of any previous findings against prospective paramedics and dispatchers.

Recommendation 15

The Ministry should require that EMS providers, base hospitals, and dispatch centres provide notification of any discipline resulting from an investigation. The Ministry should ensure this information is recorded in the Ministry's licensing databases.

⁵ This includes the *Freedom of Information and Protection of Privacy Act*, which generally applies to provincial organizations, the *Municipal Freedom of Information and Protection of Privacy Act*, which generally applies to municipal organizations, and the *Personal Health Information Protection Act*, which applies to custodians of health information.

Recommendation 16

The Ministry should ensure that information about misconduct by paramedics and dispatchers is available to relevant Ministry staff, including the Investigation Services Unit.

Recommendation 17

The Ministry should research and consider legislative changes that would allow it to obtain and share adverse findings against paramedics and dispatchers with relevant organizations, including prospective EMS employers.

Sharing information and best practices

- 81 Improving its follow-up and tracking procedure would also allow the Ministry to better co-ordinate and share information and best practices among EMS providers, dispatch centres, and Ornge. At present, investigative findings are only shared with the involved organization. Many people we interviewed were frustrated by this restricted approach to sharing information and concerned about this lost opportunity. One senior stakeholder told us that they would appreciate greater guidance and a more proactive approach: “There are 52 [sic] ambulance services in Ontario; this is probably not the first time [the Ministry has] investigate[d] this type of thing. What are other services doing to address this?”⁶ Others told our Office that even general information about complaint trends could help them take preventative steps and stop an issue before it becomes a complaint. Although the Ministry would need to be cognizant of its privacy obligations, there could be opportunities to share general or anonymized findings and best practices with other stakeholders to improve ambulance services throughout the province.

Recommendation 18

While remaining cognizant of its privacy requirements, the Ministry should share general or anonymized findings and best practices with relevant stakeholders so that other service providers can take proactive steps to address any similar issues in their organization.

⁶ There are currently 61 ambulance services in Ontario.

Procedural fairness in reporting

- 82** Under the Ministry’s process, the organization complained about – as well as the specific paramedic or dispatcher whose conduct is being scrutinized – might have little to no involvement in the investigation process prior to a report being finalized. This is because Ministry investigators often do not interview relevant staff or share preliminary findings with those involved. Instead, the organization is presented with the final report and a list of actionable items without having had the opportunity to review the factual foundation of the report and provide input.
- 83** In one case we reviewed, the Ministry investigated a complaint about the quality of dispatch services in a particular area. The Ministry’s Investigation Services Unit reviewed the concern and released a report containing many findings and 13 actionable items. The EMS provider was not given any opportunity to respond to the report prior to its finalization, and once it did receive the report, it identified concerns with many factual findings and the resulting actionable items. We were told that, after receiving this feedback, the Ministry revised many findings in the report and eliminated 11 actionable items. We were told the EMS provider contested the report’s findings because it believed the Ministry was acting outside its authority and had misinterpreted relevant documents. If the EMS provider had been allowed to review the report before it was finalized, these issues could potentially have been avoided.
- 84** Many investigative bodies, including my own Office, are required by legislation to provide organizations with an opportunity to review and comment on preliminary investigative findings and recommendations prior to the finalization of any report. This gives the organization under investigation an opportunity to correct any factual errors and discuss disagreements in interpretation while the investigation is ongoing. This process helps ensure procedural fairness and creates a written record to support any changes to a report’s findings or recommendations.
- 85** Accordingly, the Ministry should ensure that the organizations under investigation are given the opportunity to review a preliminary version of any report that contains negative findings or recommendations about them. The organization should have the opportunity to respond to the preliminary report in writing, and the Ministry should consider this response before finalizing its report. When relevant, the Ministry should consider including the organization’s written response in the final report.

Recommendation 19

The Ministry should ensure that all organizations under investigation are given the opportunity to review a preliminary version of any report that contains negative findings or recommendations about them. The organization should have the opportunity to provide its response in writing, and the Ministry should consider this response before finalizing the report. When relevant, the Ministry should consider including the organization’s written response in the final report.

- 86** We also heard of more than one case in which the Ministry apparently changed a report based on an organization’s reaction, rather than new factual information that supported a different conclusion. In one investigation, a complaint was made to the Ministry about how paramedics treated a pregnant woman while in labour at home. The EMS provider and base hospital both felt the paramedics used relatively good judgment during the interaction and had no clinical concerns. However, the Ministry’s independent investigation identified a number of instances of wrongdoing by paramedics. We were told that after the EMS provider and base hospital were given the final report, they objected and that the Ministry “changed the recommendations [actionable items] based on the pushback.” The Ministry did not alter its underlying finding that relevant standards had been contravened.
- 87** Many of those we interviewed acknowledged the fundamental power imbalance between the poorly resourced Investigation Services Unit versus large EMS providers and dispatch centres. In allowing organizations to review and provide feedback on the factual foundation of draft reports, the Ministry should ensure that reports are only modified when new information is brought forward that warrants changing a reported finding or actionable item.

Recommendation 20

The Ministry should ensure that any changes to its preliminary reports are based on a thorough review of the available evidence. The reason for such changes should be thoroughly documented in writing in the Ministry’s investigative file.

No investigative policies

- 88 The Ministry has no active policy, procedure, or protocol setting out how the Investigation Services Unit reviews complaints about ambulance services. While some Ministry staff told us they rely on an outdated and unofficial protocol from 2009, some were completely unfamiliar with this document and others said it no longer applied. Effectively, the Ministry's Investigation Services Unit operates without any policies or procedures to guide it, and practices are developed informally, case by case and investigator by investigator.
- 89 The effects of this inconsistency are profound. Ministry staff couldn't explain to us why a certain type of complaint was sometimes a watch file and sometimes a Ministry investigation. There was also disagreement about the Ministry's role in a watch file. We learned that some investigators conduct interviews in almost every case, while others rarely do so. We heard that this uncertainty is especially difficult for new investigators, who don't have a resource they can turn to when learning how to do their job. It also means that the Ministry is highly dependent on the knowledge of its existing employees. As one employee put it:
- If we all got hit by a bus tomorrow and new investigators were hired, no one would know how to access or do anything, there's nothing to say "this is how we do [our investigations]."
- 90 The Ministry's approach is in contrast to other organizations that have developed detailed, publicly available investigation policies to govern their internal investigations, such as the Toronto Paramedic Service.
- 91 The Ministry is aware of this problem and took some steps to develop a modern investigation protocol. However, work on this document stalled due to staffing issues and competing priorities. Given the importance of clear policies, the Ministry should prioritize drafting a comprehensive investigation protocol and ensure that all staff are trained on the new procedures.

Recommendation 21

The Ministry should develop and finalize an investigation protocol. The protocol should outline, among other things, the Investigation Services Unit's complaint handling and investigation processes. The protocol should clearly outline the criteria to be used in determining whether the Ministry will conduct an investigation into a complaint or refer it to the involved EMS provider or dispatch centre for investigation, as well as the Ministry's role when overseeing another organization's investigation.

Recommendation 22

The Ministry’s investigation services protocol should be provided to all Ministry investigators. The Ministry should ensure that existing and new investigators receive comprehensive training on the protocol.

Culture issues

- 92 Underlying the specific concerns identified in the Ministry’s investigative process are broader culture issues related to its approach to staffing and oversight.

Lack of training, expertise

- 93 Many individuals we spoke with raised concerns about the training and expertise of Ministry investigators. These concerns came from Field Offices, EMS providers, dispatch centres, Ornge, and the Ministry investigators themselves.
- 94 Investigators are not required to have any prior experience in emergency health services, although many have worked previously as paramedics or dispatchers. Some stakeholders feel that investigators are out of touch with the modern reality of pre-hospital patient care. One doctor we interviewed said that although investigators might be able to recite the appropriate standard that applies to a particular case, “the standards are much more judgment and nuance.” Put another way, he questioned: “How do you evaluate someone if the person you’re evaluating has twice the knowledge base that you do?”
- 95 Senior Ministry officials told us that this procedure has changed and that Ministry investigators now rely on subject matter experts to determine whether patient care was appropriate, and investigative staff are no longer responsible for making this assessment themselves. However, the investigation files we reviewed did not reflect this new process.
- 96 Many told us they had even greater concerns about the Ministry’s oversight of Ornge’s air ambulance services. This is because none of the Ministry staff assigned to oversee and investigate Ornge had experience or subject matter expertise in air ambulance service and apparently didn’t seek out experts for support. The Auditor General highlighted this same issue in her 2012 special report⁷ on Ornge, but no evident progress has been made.

⁷ *Special Report: Ornge Air Ambulance and Related Services* (March 2012), Office of the Auditor General of Ontario, online: http://www.auditor.on.ca/en/content/specialreports/specialreports/ornge_web_en.pdf.

- 97 These expertise concerns are compounded by the lack of robust training and mentoring available to new investigators. When we asked for information about what training investigators receive after starting, we were told “not a whole lot”, and that some investigators take personal initiative to review old investigation files in an attempt to learn the ropes. We consistently heard that investigators received no training, with one employee noting that the Ministry is “not setting up investigators for success”:

They’re basically saying welcome aboard and here’s your first 10 files... have a nice day.

- 98 The Ministry’s Investigation Services Unit is only as effective as its investigators, and it is critical that staff have the experience and training necessary to oversee EMS providers, dispatch centres and Ornge. The Ministry should develop a formal training and mentorship program for new investigators, and this training program should be documented in a formal orientation guide, available to all investigators.
- 99 In addition, the Ministry should ensure that investigators have access to and are encouraged to rely on subject matter experts in the course of their investigations. While investigators must have a solid foundation in paramedic and dispatch practices, their ultimate expertise is in investigation, not the provision of emergency health services. The greater use of subject matter experts will ensure that investigative reports are factually accurate and increase the legitimacy of the Ministry’s findings among EMS providers and dispatch centres.

Recommendation 23

The Ministry should develop a formal training and mentorship program for new investigators. This training program should be documented in a formal orientation guide and made available to all investigators.

Recommendation 24

The Ministry should ensure that investigators have access to and are encouraged to rely on subject matter experts in the course of their investigations.

Turnover and understaffing

- 100 Compounding the investigator credibility issues caused by a lack of training and expertise are the extreme turnover and understaffing that have plagued the Ministry’s Investigation Services Unit and other key oversight roles.

101 The high volume of staff turnover and vacant positions was readily apparent during our investigation. Many of those we interviewed hadn't been in their position long or had already moved on to different roles by the time we spoke with them. Since we launched our investigation, there have been name changes to the Division and Branch, changes in Assistant Deputy Minister, and several manager position shifts.

102 As one employee put it: "In the two and a half years I've been here, I've had four directors, three senior Managers, and a year where it was vacant. I've had 4 Managers." These issues extend to the Air Ambulance Oversight Unit, where most of its positions were vacant for years at a time. For a while, only one out of eight positions was filled. We were told that this put the sole employee under "a lot of pressure" and made it impossible to do a thorough oversight job. We were told that the resulting delays and lack of response were why Ornge unilaterally cut the oversight unit out of its investigation process.

103 Staff turnover has been especially high in senior oversight roles, including key director positions. One senior Ministry employee explained that there has been:

[L]iterally a revolving door within the branch for the past five years...we've probably had five different directors, we've probably had five or six different senior managers. In the position of Manager, Investigations, we've probably had five or six different individuals...it does nothing to lend stability."

Another person said the investigative staff and leadership are constantly "flipping over like laundry."

104 We were told that because managers were always new to their position, no one felt confident establishing new policies or processes even when they were clearly needed. Investigators told us that working under many different managers has made their job more difficult and contributed to attrition. We also heard that the way investigators are asked to do their work is continually changing as new managers cycle in and out.

105 The high turnover affects the Ministry's relations with its stakeholders. One told us they are constantly having to teach new Ministry staff about their processes and "answer the same questions over and over." Another said the Investigation Services Unit "is in chaos" because of turnover.

106 Many people gave us potential explanations for these issues, including below-market compensation, allegations of a difficult work environment, and a perception that the oversight system was ineffective, making employees feel that their work doesn't matter. The Ministry must do more to understand and address

these issues, as effective oversight requires engaged employees who stay in positions long enough to develop expertise. The Ministry should conduct a review of staffing turnover and vacancies in its investigative and oversight positions with the goal of better understanding their underlying cause. Once identified, the Ministry should take steps to address these issues. The Ministry should also ensure that all oversight positions are filled in a timely manner, as vacancies are detrimental to the timely and effective review of ambulance services.

Recommendation 25

The Ministry should conduct a review of staffing turnover and vacancies in its investigative and oversight positions with the goal of better understanding their underlying cause. Once identified, the Ministry should take steps to address these issues.

Recommendation 26

The Ministry should ensure that all oversight positions are filled in a timely manner, as vacancies are detrimental to the timely and effective review of ambulance services.

Siloed approach

- 107** We also learned that units within the Ministry's investigative and oversight structure work in "silos," with limited information sharing or communication. This approach extends to various system participants who do little to share and coordinate information regarding patient complaints, patient care issues, trends, statistics, or potential systemic concerns. The effect is an emergency health system whose participants operate in narrow, confined areas with little coordination.
- 108** In 2017, the Emergency Health Services Branch was split into two distinct branches. The Emergency Health Program Management and Delivery Branch oversees and manages emergency health program delivery, and is home to the three regional Field Offices, as well as the Air Ambulance Oversight Unit. The Emergency Health Regulatory and Accountability Branch is responsible for emergency health oversight and regulation, and houses the investigation and inspection units. We were told that communication has been "challenging" and in many cases ineffective since this split occurred.

- 109 Many people told us this structure leads to confusion over individual roles and responsibilities, and delays in the investigative and oversight process. Within the Ministry, staff feel they cannot freely request or access information from other areas. One employee described it like having a “brick wall” between staff. In some instances, staff were told not to make any contact between Field Offices and the Investigation Services Unit without prior approval, adding unnecessary delay to a vital oversight function.
- 110 We also heard there is little communication between the Investigation Services Unit and other units within the Ministry that could provide assistance during investigations. For example, the Certification and Patient Care Standards Unit is responsible for drafting emergency health standards and manuals. This unit also prepares and administers the paramedic licensing examination. Despite the unit’s obvious expertise in these areas, we were told that investigators seldom contact its staff for input on the interpretation of paramedic standards.
- 111 Effective oversight of the emergency health system requires co-operation and communication amongst all participants. The Ministry should ensure that its staff and stakeholders have a clear understanding of the roles and responsibilities of each unit involved in emergency health services oversight. In addition, the Ministry should consult with staff in relevant units to determine what obstacles prevent effective communication, and take steps to address these concerns. Specifically, it should ensure that the Investigation Services Unit is able to communicate freely with other Ministry units in carrying out its investigative mandate. Investigators should not require special permission before initiating contact with Field Office staff.

Recommendation 27

The Ministry should ensure that its staff and stakeholders have a clear understanding of the roles and responsibilities of each unit involved in emergency health services oversight.

Recommendation 28

The Ministry should consult with staff in relevant units to determine what obstacles prevent effective communication and take steps to address these concerns.

Recommendation 29

The Ministry should ensure that the Investigation Services Unit is able to communicate freely with other Ministry units in the course of carrying out its investigative mandate. Investigators should not require special permission before initiating contact with Field Office staff.

Piles of Paperwork (Incident Reports)

- 112 We also learned of serious issues with the Ministry’s process for creating and reviewing “incident reports,” which EMS providers, dispatch centres, and Ornge must prepare in many different circumstances.
- 113 Each year, organizations send Ministry Field Offices some 250,000 incident reports for review. These reports are intended to document unusual occurrences and inform the Ministry of issues that may require further review. But my investigation found that they are largely a meaningless paperwork exercise that fails to increase oversight or accountability.

Drafting and submitting incident reports

- 114 The *Ontario Ambulance Documentation Standard*⁸ sets out the circumstances in which incident reports must be prepared and forwarded to the Ministry by land ambulance service providers.
- 115 An EMS provider is required to submit an incident report when they receive a complaint, conduct an investigation (including an investigation into a patient complaint), and when there is an “unusual occurrence,” such as sudden death or an issue that might require police investigation. EMS providers must send these reports to their Ministry Field Office within a specified time, depending on the seriousness of the incident. The most serious incidents must be reported “as soon as possible within 24 hours,” while minor reports can be sent in “90 calendar days.” A minor report could be for a flat tire on an ambulance that is waiting to be dispatched, while a serious incident could be a major patient medication error.
- 116 Incident reporting requirements are similar for dispatch centres, Ornge, and base hospitals, although they are contained in different documents.⁹
- 117 Our investigation also found considerable differences in how organizations interpret their incident reporting obligations. Until recently, one EMS provider was submitting incident reports only for “vital signs absent” patients, even though the documentation standard does not require incident reports in that circumstance, and does require them for many others. We were told that one EMS service had not submitted incident reports for patient complaints or internal investigations,

⁸ *Ontario Ambulance Documentation Standards*, Version 3.0; dated April 1, 2017.

⁹ Dispatch centres are governed by the *Manual of Practice for Ambulance Communications Officers of Central Ambulance Communications Centres*, while Ornge is governed by the *Amended Performance Agreement* between the Province and Ornge. Base hospitals are governed by the terms of their *Service Agreements* with the Ministry.

and the Ministry was fully aware of this because the EMS service had discussed it with Field Office staff. Although the documentation standard requires incident reports in these cases, we were told that Field Office staff did nothing to ensure the provider's compliance.

- 118** Different organizations also have inconsistent understandings of how quickly they should submit incident reports. Some submit them as soon as they are prepared, while others send “batches” on a periodic basis, regardless of the timeline requirements set out in the documentation standard. We were told this “batch” system was set up in consultation with the Field Offices, which were unprepared to deal administratively with a daily influx.
- 119** We also heard that some organizations do not immediately report complaints and incidents. For example, we were told about one EMS provider that only sends incident reports to the Field Office “within a week or two” of having commenced an investigation, unless it involves a “catastrophic” issue. We heard this is because it does not want to “blow the whistle in advance” despite the reporting requirements of the documentation standard, and the EMS provider would rather understand an issue before notifying the Ministry.
- 120** Despite being aware of these inconsistencies, the Ministry has taken very few steps to clarify or enforce the reporting requirements. When we asked the Ministry about this gap, one employee told us that “it’s not...[the Ministry’s] role to provide an interpretation of the law to an outside organization,” and that organizations should obtain their own legal advice about their incident reporting obligations. We also heard about a Field Office that does nothing to assess whether incident reports are being submitted according to mandated timelines and that experience has shown the timelines are not followed. We were told the Ministry has never held organizations accountable to the incident reporting requirements and that “this is one of the biggest gaps” in the oversight process.
- 121** The Ministry and the public it protects need to be certain that it is receiving timely incident reports in every case where one is required. The Ministry should take steps to ensure that all organizations obligated to submit incident reports understand and accurately interpret these requirements, including the types of incidents that must be reported. The Ministry should specifically clarify that all complaints and internal investigations into complaints must be reported via incident report, as well as the timeline for doing so. It should ensure that it tracks and audits each organization’s compliance. If an organization fails to submit reports as required, the Ministry should take remedial action, including and up to an investigation by its Investigation Services Unit.

Recommendation 30

The Ministry should take steps to ensure that all organizations obligated to submit incident reports understand and accurately interpret these requirements, including the types of incidents that must be reported and the timeline for doing so. The Ministry should specifically clarify that all complaints and internal investigations into complaints must be reported in an incident report.

Recommendation 31

The Ministry should ensure that it tracks and audits each organization's compliance with the incident reporting obligations. If an organization fails to submit reports as required, the Ministry should take remedial action including in appropriate cases conducting an investigation.

- 122** Incident reports are submitted to Field Offices by numerous methods in many formats. Some organizations use an online database service that allows Field Offices to directly download them. Others use email, fax, and courier services. Some incident reports are typed, while others are handwritten. To add to the confusion, different organizations format their reports differently, meaning that the same information is in different areas, depending on the report. Ministry witnesses told us this makes it difficult to find relevant information and review reports efficiently.
- 123** Many Ministry staff told us that a standard, consistent template for incident reports would make review and assessment easier. EMS providers, dispatch centres, and other stakeholders were also supportive of the idea, although we were cautioned that some would have difficulty adapting to systems intended for larger, more resourced organizations. These concerns, while valid, should not prevent the Ministry from seeking to standardize the incident reporting template and process. It should work with relevant stakeholders to develop and implement a standardized incident report template to be used by all ambulance service providers. In addition, the Ministry should work with stakeholders to develop a method for submitting incident reports electronically, regardless of an organization's size or resources.

Recommendation 32

The Ministry should work with relevant stakeholders to develop and implement a standardized incident report template to be used by all emergency health service providers.

Recommendation 33

The Ministry should work with stakeholders to develop a method for electronically submitting incident reports regardless of an organization's size or resources.

Reviewing incident reports

- 124** The criteria for submitting an incident report are very broad, resulting in a massive number of incident reports each year. The Ministry estimated that it receives 250,000 incident reports each year. This is partially because many routine events must be reported as “incidents” by each employee involved. For instance, if two ambulances, each staffed by two paramedics, respond to a call and find that the patient is already deceased, at least four separate incident reports would be prepared to document that event.
- 125** We learned that the Central East Field Office alone was receiving 12,000 incident reports each month, all of which are reviewed by one employee. We were told this is an “overwhelming” amount for one person to review, adding up to a nine-inch stack of reports representing only one month of incidents from one service provider.
- 126** The enormous volume of incident reports means that Field Offices are constantly backlogged, often by many months. One Ministry employee estimated that it takes an average of three months before an incident report is reviewed. Unless an EMS Chief, dispatch manager, or other senior employee flags a particular incident to the Ministry’s attention using another method, a significant amount of time may pass before the Field Office gets around to reviewing a particular incident report. A senior Ministry official we spoke with described the process as “having to find Waldo,” since there were thousands of routine reports for every report that may require additional attention. There is no way or criteria for Field Offices to triage or sort incident reports quickly, so routine reports are mixed in with more serious ones.
- 127** We heard numerous stories of incident reports slipping through the cracks. We learned of a case where a paramedic was fired after an internal investigation found he had abandoned a patient. We were told the EMS provider sent the Ministry the initial incident report about this issue, but received no indication that the Ministry was interested in investigating the case. The EMS provider conducted its own investigation without sharing the final report or results with the Ministry or the affected patient. We were unable to confirm whether the Ministry assessed the initial incident report and determined that no further action was required, or if it was lost in the shuffle of thousands of other reports. Unfortunately, Field Offices do not keep sufficiently detailed records of their incident report reviews to answer this type of question.

- 128** We also spoke with a major EMS provider that noticed its Field Office hadn't accessed any of the service's incident reports for many months. The EMS provider discovered this because it uses an online system that tracks when incident reports are accessed. Eventually the EMS provider had to contact the Manager of the Ministry's Investigation Services Unit to resolve the issue with the Field Office. We were told that the Investigation Services Unit doesn't have any way to independently track whether Field Offices are reviewing incident reports in a timely fashion, so this serious issue would not have come to its attention without the help of the EMS service.
- 129** The frustration extends to Field Offices. We were told that the Field Office review process creates "a real bottleneck" and that the Investigation Services Unit should have "access to information [from the reports] earlier on." One employee suggested that incident reports be directly sent to the Investigation Services Unit for review, which he felt would decrease delay and allow investigators to directly determine which reports require further inquiry.
- 130** Even if an incident report is reviewed by the Field Office in a timely manner, many told us that the reports are not detailed enough to enable Field Offices to properly assess whether a Ministry investigation is necessary. Ministry staff agreed that there is often little meaningful information in incident reports. One employee told us that incident reports "are pretty anemic. They are quite bare." Another bluntly said that he doesn't understand the point of reviewing thousands of reports each month because "incident reports are not good at informing the Field Office of issues they need to look at."
- 131** One former employee told us about an incident where an EMS provider contacted the Investigation Services Unit with information about an investigation the service had been working on for months. The EMS provider said it had discovered that some paramedics failed to complete important, required paperwork about their service calls. According to the provider, this problem came to light when a woman called from China to request information about the death of her son. When the EMS provider went looking for records of the incident, it ultimately determined that its paramedics had failed to complete important documentation. The EMS provider knew that this type of issue needed to be reported to the Ministry, but when it filed an incident report, it only said that "a woman called from China asking about her son..." The Field Office, given the lack of context, did not understand the seriousness of the issue and did not think it warranted further investigation.
- 132** In addition, we repeatedly heard that Field Office employees have no guidance on what they should be looking for in incident reports. We were told that there are no written policies setting out how incident reports should be reviewed and when they should be escalated to the Ministry's Investigation Services Unit. Staff told

us that they rely on their experience to identify issues that might require further Ministry review. Experience is a valuable asset, but it does not lead to consistent outcomes. For instance, we heard that instead of escalating reports and incidents to the Investigation Services Unit, some Field Office Managers conduct their own “mini” investigations and work directly with EMS providers and dispatch centres to deal with issues. Some suggested this was part of the Ministry’s unofficial position to work collaboratively with stakeholders instead of taking a stronger oversight role.

- 133** We also heard of a case where, due to staffing changes, an administrative assistant with no subject matter expertise was tasked with reviewing the incident reports for a particular Field Office. The Ministry acknowledged that the administrative assistant could only “sort and file” the incident reports, and perhaps identify “glaring” contraventions.
- 134** However, our investigation found that even glaring concerns in incident reports might not be forwarded to the Ministry’s Investigation Services Unit. A senior Ministry official told us that in his experience, the unit had never received a flagged incident report from a Field Office. Other staff did remember receiving reports during their tenure, but said the reports were often three to six months old by the time they were forwarded by the Field Offices. We heard that the Investigation Services Unit is rarely – if ever – notified about an issue through an incident report forwarded by Field Office staff.
- 135** EMS providers, Ornge and dispatch centres are also frustrated by the lack of response they receive to their incident reports. Staff at Ornge said they never receive feedback or questions about the reports they submit and questioned the value of the process. An EMS provider told us it received zero feedback from the regional Field Office in three years. They were not sure why the service was bothering to submit reports, noting that “they just go to the abyss.”
- 136** Clearly EMS providers, dispatch centres, Field Offices and the Ministry’s Investigation Services Unit are aware of issues with the incident reporting process. Almost everyone we spoke with had concerns about the process and ideas about how to improve it. The top suggestions were reducing the number of incident reports, increasing the amount of detail provided, and developing specific policies setting out the review and escalation process. After our investigation was launched, the Ministry began a review of the incident reporting process, but progress has been slow and we were told there was still no “business case” for more extensive changes.
- 137** Given the serious issues with the incident reporting process, the Ministry must prioritize modernization efforts. Most critically, the Ministry should evaluate the incident reporting requirements, in consultation with stakeholders, with the goal of reducing the total number of incident reports submitted. It should also develop

a method for quickly triaging reports based on the type of incident being reported and the severity of the issue. In addition, it should take steps to ensure that incident reports are being reviewed in a timely manner by individuals with expertise in emergency medicine and dispatch procedures. The Ministry should review whether incident reports can be more efficiently and effectively reviewed by Field Offices or the Investigation Services Unit, and ensure that the chosen unit is sufficiently resourced to handle the workload.

- 138** The Ministry should also develop clear guidelines regarding the review of incident reports. The guidelines should specify what the reviewer is supposed to assess, as well as how and when to escalate particular issues. The Ministry should ensure that EMS providers, dispatch centres, base hospitals, and Ornge provide sufficient information in their incident reports to facilitate this review. Further, the Ministry should develop a database that will allow incident reports to be tracked and reviewed for systemic issues within individual organizations and throughout the province. It should analyze the volume and type of incident reports submitted and use this information to guide future policy development, training, and potential investigations. These changes will help change the incident reporting process from an inefficient and ineffective make-work exercise into a key method through which the Ministry can oversee the delivery of ambulance services.

Recommendation 34

The Ministry should evaluate the existing incident reporting requirements, in consultation with stakeholders, with the goals of ensuring that incident reports are a meaningful oversight mechanism and reducing the number of incident reports written and submitted to the Ministry that do not add value from an oversight perspective.

Recommendation 35

The Ministry should develop a method for triaging incident reports quickly, based on the type of incident being reported and the severity of the issue.

Recommendation 36

The Ministry should develop procedures to ensure that incident reports are being reviewed in a timely manner by individuals with expertise in emergency medicine and dispatch procedures.

Recommendation 37

The Ministry, in consultation with internal and external stakeholders, should undertake to review and develop a process so that incident reports can be more efficiently and effectively reviewed by Field Offices or the Investigation Services Unit. The Ministry should also ensure that the chosen unit is sufficiently resourced and provided the necessary training to handle the workload.

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The Ministry should develop clear guidelines regarding the review of incident reports. The guidelines should clearly specify what the reviewer is supposed to assess, as well as how and when to escalate particular issues.

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The Ministry should ensure that EMS providers, dispatch centres, base hospitals, and Ornge provide sufficient information in their incident reports to facilitate meaningful review.

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The Ministry should develop a database that allows incident reports to be tracked and reviewed for systemic issues within individual organizations and throughout the province. In addition, the Ministry should analyze the volume and type of incident reports submitted and use this information to guide future policy development, training, and investigations.

Issues with Complaint Handling

- 139** Our investigation also found numerous obstacles that prevent complaints about ambulance services from ever making it to the Ministry in the first place. There are many organizations involved in the provision of ambulance services, each with their own internal complaint processes. Many people might access these without realizing that the Ministry is an option. The Ministry has no procedure in place to ensure that these complaints are reported to its Investigation Services Unit.
- 140** Even when individuals do manage to contact the Ministry's Investigation Services Unit directly, their experience can be far from ideal. Complainants often receive no information about the Ministry's mandate or investigative process, leaving them with no idea of what can and cannot be investigated. Ministry staff told us that complainants are often not contacted at all by investigators, or given a copy of the final investigative report.

Too many places to complain

- 141** When someone wants to make a complaint related to ambulance service, it's not easy to figure out where to turn. Some people complain directly to EMS providers or dispatch centres, while others contact the Minister of Health's office or their local MPPs, base hospitals, or stakeholder organizations like paramedic unions. Even Field Offices, which have no public facing presence, sometimes receive public complaints.
- 142** One emergency health professional put it bluntly:
- It's a dog's breakfast in Ontario. People basically don't know who to complain to, who to talk to. Sometimes they contact the paramedic services. Sometimes they contact the [Ministry]. Sometimes they contact the base hospital. Sometimes they contact the services and the service passes on the complaint to the base hospital. Sometimes the services pass on the complaints to the [Ministry].
- 143** There is no consistency in what these organizations do with the complaints they receive. EMS providers are supposed to flag all complaints to the Ministry through their regional Field Office. Our investigation found that this did not always occur, and even when it did, there were often lengthy delays before the information made it to the Investigation Services Unit. Instead, EMS providers typically investigated these complaints themselves without any oversight or guidance from the Ministry.
- 144** When complaints are made to other organizations, including dispatch centres, there is no clear obligation that they be reported to the Ministry. Many complaints never make it to the Ministry's Investigation Services Unit for review, limiting the effectiveness of its oversight.
- 145** Because there is no obligation to report complaints directly to the Investigation Services Unit, internal politics and organizational relationships can prevent effective oversight. We were told by a stakeholder about one incident where a patient died while waiting in the ambulance for a hospital bed. We were told the issue was repeatedly brought to the attention of the Field Office, which responded that it had discretion in determining whether to send a complaint to the Investigation Services Unit for review – and that this concern would not be forwarded. Months later, the stakeholder independently approached the Investigation Services Unit, which led to a Ministry investigation. Soon after, the stakeholder's employer asked that the complaint be withdrawn, as they "didn't want to rock the boat." The stakeholder complied and the Ministry closed its investigation; we understand it was later reopened.

- 146 Because complaints are received by many different organizations without central oversight, the Ministry is unable to track the overall number of complaints made provincewide. When we asked how many complaints the Ministry received each year, the Ministry came up with an answer – 121 in 2016 and 97 in 2017 – but said this number was limited by the quality of its data. The Ministry, EMS providers, dispatch centers and base hospitals do not maintain comprehensive statistics about ambulance service complaints. Where piecemeal statistics are kept, they are not shared among the relevant stakeholders. This means the Ministry is unable to track or analyze trends throughout the province.
- 147 Even when individuals send their complaint to someone at the Ministry of Health, there is no assurance that it will go to the Investigation Services Unit. The Ministry is vast, with thousands of employees in many different offices. Our investigation found there is no procedure in place to ensure that complaints that reach the wrong part of the Ministry are quickly forwarded to the Investigation Services Unit.
- 148 The Ministry’s oversight of ambulance services is significantly compromised if most complaints never make it to the Investigation Services Unit. The Ministry has little insight into what people are complaining about or what trends may exist in the province. It should establish a procedure clearly indicating that EMS providers and dispatch centres are required to report all complaints directly to the Ministry’s Investigation Services Unit. The Ministry should also make certain that other internal and external bodies that are likely to receive complaints about ambulance services have information about how to directly refer those complaints to its Investigation Services Unit.
- 149 In addition to ensuring complaints are forwarded to investigators, the Ministry should establish a consistent framework for tracking and reviewing these complaints, and ensure that the Investigation Services Unit is properly resourced to undertake this work. This process will ensure that investigators are alerted to complaints and that the Ministry can conduct comprehensive complaint trend analyses throughout the province.

Recommendation 41

The Ministry should establish a procedure clearly indicating that EMS providers and dispatch centres are required to directly provide the Ministry’s Investigation Services Unit with information about all complaints received in a timely manner.

Recommendation 42

The Ministry should make certain that all internal and external bodies that are likely to receive complaints about ambulance services have information about how to refer those complaints directly to the Ministry’s Investigation Services Unit.

Recommendation 43

The Ministry should establish a consistent framework for tracking and reviewing complaints about ambulance services.

Recommendation 44

The Ministry should ensure that the Investigation Services Unit is properly resourced to review, track and analyze complaints about land ambulance services.

- 150 The Ministry’s oversight of Ornge’s air ambulance service suffers from many of the same issues as its other areas of oversight. Unlike the Ministry, Ornge’s website provides clear information about how to make a complaint with the organization. Investigations into these complaints are undertaken by an internal Professional Standards Unit. However, the Ministry is not routinely advised of these complaints or the outcomes of Ornge’s internal investigations unless the Ministry is independently aware of the complaint and has asked Ornge for the result. This is the case even though Ornge’s 2012 performance agreement requires that it notify the Ministry of complaints received and provide information about its investigations into these complaints. Because this requirement is not enforced, Ornge is left to police itself with little to no independent oversight.
- 151 The Ministry should establish a procedure clearly indicating that Ornge is required to provide the Ministry’s Air Ambulance Oversight Unit directly with information about all complaints received and investigations undertaken in a timely manner. The oversight unit should co-ordinate with the Investigation Services Unit to establish a clear framework for tracking and reviewing these complaints, consistent with the framework for land ambulance services. The Ministry should ensure these units are properly resourced to undertake this work.

Recommendation 45

The Ministry should establish a procedure clearly indicating that Ornge is required to directly provide the Ministry’s Air Ambulance Oversight Unit with information about all complaints received and investigations undertaken in a timely manner.

Recommendation 46

The Air Ambulance Oversight Unit should coordinate with the Investigation Services Unit to establish a clear framework for tracking and reviewing air ambulance complaints, consistent with the framework for land ambulance services.

Recommendation 47

The Ministry should ensure that the Air Ambulance Oversight Unit and Investigation Services Unit are properly resourced to review, track and analyze complaints about air ambulance services.

The Ministry's own website

152 It is likely that complainants turn to other organizations because it is so hard to figure out how to complain directly to the Ministry's Investigation Services Unit. There is no page on the Ministry's website dedicated to providing information about the unit and its investigative mandate. Instead, some basic information is included on an omnibus page for "Emergency Health Services". The page only contains a general email address for websitecontact.moh@ontario.ca.

153 One complainant to our Office – a registered nurse who wanted to complain about her own experience with an EMS provider – told us it took her approximately four hours of Internet research before she was able to locate the contact information for the Ministry.

154 This is not news to the Ministry. One senior Ministry official told us:

I have an appreciation that the Ministry's website, and trying to navigate through, is difficult...It is [difficult] for me. I can't imagine what it would be like for an individual [who is] not part of the Ministry.

These concerns are shared by stakeholders. A major EMS provider told us that a clear, accessible online presence for the Ministry would be beneficial, noting that even EMS staff have struggled to find contact information on the website: "A more transparent website, even if it's just for the service providers, would help. Better customer service."

155 The challenges in filing a complaint with the Investigation Services Unit almost certainly have a chilling effect on the number of public complaints received. As a priority, the Ministry should update its web content to include a specific webpage with information about the public complaint process for emergency health services. This webpage should contain information about how to make a complaint and the contact information necessary to do so.

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Customer service concerns

- 156** When complainants do find their way to the Ministry's Investigation Services Unit, the way they are treated and the information they receive is often far from ideal.
- 157** Investigators do not always reach out to complainants. There is no policy or standardized practice. We found that when contact is made, there is substantial inconsistency in the information provided to complainants. Some investigators provide an outline of the investigative and reporting process, but this practice is not universal. Investigators also differ in whether they provide detailed information about the unit's investigative mandate and which aspects of a complaint fall outside its authority. This is particularly problematic because many public complaints, including some regarding conduct of paramedics, relate to issues that fall outside the Ministry's current interpretation of its mandate.
- 158** Our investigation also found that different investigators have different approaches to complainant communication during the investigation. Some stay in touch, while others proceed with the case and initiate no further contact with complainants.
- 159** Complainants are also unlikely to hear from the Ministry when the investigation is completed. They are not provided with a copy of the investigation report unless they specifically request it in writing from the investigator's manager. We were told that, in the absence of contact from the Ministry, it is up to the complainant to somehow know when an investigation might be complete so they can request the report.
- 160** One Ministry employee, when asked whether there were any outcome discussions with complainants, commented: "How could there be?" Even the investigators don't know the outcome, they pointed out. We were told that once investigators complete a report and send it to their manager, they often never hear about the file again. Investigators typically have no idea if their report is changed or whether the identified issues have been addressed. Because of this, investigators have no finalized information that they can share with a complainant.

- 161 This process falls far short of how similar organizations communicate with complainants. For example, the Toronto Paramedic Service's Professional Services Unit endeavours to have investigators speak with all complainants within 48 hours of receiving a complaint. Complainants are provided with information about the general investigative process and what to expect, as well as a notice that their complaint has been forwarded to the Ministry. Each complaint is assigned a file number and an initial intake letter is sent as a matter of routine. The letter acknowledges receipt of the complaint, summarizes information from the complainant, and provides contact information for the assigned investigator. When the investigation is complete, the complainant receives a closing letter describing the outcome, although they do not receive the investigation report. Ornge's internal investigation process also includes similar types of communication with complainants.
- 162 Individuals who contact the Ministry with complaints about ambulance services should be contacted directly about their concern and provided with information about the outcome. The Ministry should develop a customer service policy that specifically outlines when complainants will be contacted and what information they will be given. The Ministry should, as a matter of course, provide complainants with a copy of the investigative report that relates to their concern, subject to any necessary redaction to protect third party personal information or maintain the integrity of the investigative process. Complainants should not have to request the report in writing from the investigations manager. In addition, the Ministry should ensure that its website contains clear information about the steps in the complaint process, the role and mandate of the Ministry, and the different possible outcomes of an investigation.

Recommendation 49

The Ministry should develop a customer service policy that specifically outlines when complainants will be contacted by investigators and what information they will be provided.

Recommendation 50

The Ministry should, as a matter of course, provide complainants with a copy of the investigative report that relates to their concern, subject to any necessary redaction. Complainants should not have to formally request the report in writing from the investigations manager.

Recommendation 51

The Ministry should ensure that its website contains clear information about the steps in the complaint process, the role and mandate of the Ministry, and the different possible outcomes of an investigation.

- 163 The Ministry's complaint process also fails to articulate a mechanism for complainants to escalate their concerns if they are dissatisfied with Ministry investigations. We were told that the Ministry decides on an ad hoc basis how to deal with these requests. Depending on the issue, it might send the case for review by a third party, or review its own investigation. It does not provide complainants with information about what issues the new review will consider or what the possible outcomes may be. The escalation pathway appears to depend on how persistently individuals pursue their concerns.
- 164 Rather than dealing with unhappy complainants on a case-by-case basis, the Ministry should create a policy for dealing with requests by members of the public who are dissatisfied with investigations conducted by the Ministry's Investigation Services Unit. The Ministry should ensure that the policy sets out the scope and limitations of this review process, as well as a requirement that this information be communicated to complainants who request a review.

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The Ministry should create a policy for dealing with requests by members of the public who are dissatisfied with investigations conducted by the Ministry's Investigation Services Unit. The Ministry should ensure the policy sets out the scope and limitations of this review process, as well as a requirement that this information be communicated to complainants who request a review.

Opinion

- 165 Few Ontarians who dial 911 understand the complexity of the system they are engaging. Few will know or care which EMS service comes to their aid, the names of the paramedics who assist them, the base hospital they report to, or the Field Office that oversees them. Even fewer will know whether the care they receive at the hands of those paramedics meets the standards set by the province.

- 166** As members of the public, our interactions with the pre-hospital emergency health system are largely based on trust. We trust that the Ministry of Health, charged with funding and regulating all aspects of ambulance service, controls and oversees this \$1.5-billion system. We trust that everyone involved in providing our ambulance service – from the ambulance dispatch to the paramedic – adheres to the law and that the Ministry is vigilant in holding these system participants to account. We trust that if we have concerns, there will be a clear, transparent process through which they can be addressed. Sadly, much of this trust is misplaced.
- 167** My investigation found numerous issues with the adequacy and effectiveness of the Ministry’s oversight of emergency health services. Although the Ministry has an entire unit devoted to investigating complaints about ambulance service, we found that its mandate is limited and there are serious shortcomings in its investigative process. Even when issues are identified and reported, there is no effective mechanism in place to ensure that the service provider addresses them.
- 168** Moreover, the system intended to alert the Ministry to complaints, incidents, and unusual occurrences is dysfunctional and unsuited to its intended purpose. The Ministry is buried in hundreds of thousands of incident reports each year with no effective way of reviewing them to identify those requiring further investigation. Incident reports are supposed to assist the Ministry in overseeing the emergency health services system, but this process renders it virtually meaningless.
- 169** Most concerning, my investigation found nearly insurmountable obstacles that prevent the public from complaining about emergency health care. The Ministry has no clearly defined process for complaining about ambulance services. Instead, the public is left to use whatever Ministry contact information they are able to locate and hope that the complaint is forwarded to the right unit. If a complaint does make it to the investigative unit, the Ministry does little to ensure that complainants understand the unit’s mandate or process. Most complainants aren’t even told the outcome of their case.
- 170** Although there are multiple organizations involved in providing and overseeing emergency health services, it is the Ministry that has primary responsibility for ensuring that the emergency health care patients receive is consistent with the law and service standards. It has neglected patient safety by failing to adequately monitor EMS providers, dispatch centres and Ornge.
- 171** Accordingly, it is my opinion that the Ministry of Health’s administrative process for investigating and overseeing patient complaints and incident reports about ambulance services is unreasonable and wrong under s.21(1)(b) and (d) of the *Ombudsman Act*.

- 172 I am committed to monitoring the Ministry's efforts to address my concerns and to ensuring that concrete action is taken to address these issues.

Recommendation 53

The Ministry should report back to my Office in six months' time on its progress in implementing my recommendations, and at six-month intervals thereafter until such time as I am satisfied that adequate steps have been taken to address them.

Recommendations

- 173 I make these recommendations with the aim of improving the oversight of emergency ambulance services, and thus patient safety, in Ontario:

1. The Ministry should ensure that the Investigation Services Unit interprets its investigative mandate in a broad and purposive manner, consistent with the oversight scheme of the *Ambulance Act* and related standards.

2. The Ministry should direct its investigators that issues related to paramedic conduct come within the Ministry's investigative mandate to determine whether an allegation could amount to a breach of the Paramedic Conduct Standard in the Basic Life Support Patient Care Standards.

3. The Ministry should consider legislative or regulatory changes to the *Ambulance Act* that would ensure the Investigation Services Unit has authority to consider and enforce all local directives and/or policies when investigating complaints under the *Ambulance Act*.

4. The Ministry's Investigation Services Unit should seek to interview every complainant who brings an issue to the Ministry for investigation, wherever practicable.

5. The Ministry's Investigation Services Unit should interview relevant third-party witnesses, such as family members and bystanders, when relevant to the complainant's concerns, wherever practicable. If a complaint is brought by someone other than the patient, the Ministry should ensure the patient is interviewed, where practicable.

- 6. The Ministry’s Investigation Services Unit should interview paramedics, dispatchers, and other relevant professionals, wherever practicable, in every instance where they may have material information related to a complaint, regardless of the availability of documentary evidence.**
- 7. The Ministry should develop and implement an investigations case management system that allows investigators to fully document each investigation, including all contacts, notes, interviews and relevant documentation for each investigation file.**
- 8. The Ministry should ensure that the case management system allows staff to identify and track specific issues or trends that arise in its investigations.**
- 9. The Ministry should adopt a clear, standardized format for investigative reports that includes information about the investigative process and the specific evidence reviewed.**
- 10. The reports published by the Ministry’s Investigation Services Unit should make specific recommendations to resolve any issues that are identified.**
- 11. The Ministry should ensure that all steps of the investigative process are properly resourced so that they can be completed in a timely manner.**
- 12. The Ministry should establish clear benchmarks for how long each step in the investigation and review process should take. The Ministry should continuously monitor its progress against this standard and take remedial action when necessary.**
- 13. The Ministry should develop and implement a procedure for following up on all issues identified during investigations, including issues identified in investigations conducted by EMS providers, dispatch centres, and Ornge. The procedure should clearly define roles, responsibilities, and timelines, as well as establish criteria for satisfactorily addressing actionable items. The procedure should set out the steps that will be taken and consequences for when the Ministry is dissatisfied with the service provider’s remedial action.**

14. For land ambulance services, the new follow-up procedure should be administered by a centralized unit, such as the Investigation Services Unit, that has broad subject-matter expertise and the capacity to track and conduct trend analyses throughout the province. For air ambulance services, the Air Ambulance Oversight Unit should be tasked with carrying out this specialized oversight mandate. In each case, the Ministry should ensure that the oversight units have the human resources and technology infrastructure necessary to conduct this work.

15. The Ministry should require that EMS providers, base hospitals, and dispatch centres provide notification of any discipline resulting from an investigation. The Ministry should ensure this information is recorded in the Ministry's licensing databases.

16. The Ministry should ensure that information about misconduct by paramedics and dispatchers is available to relevant Ministry staff, including the Investigation Services Unit.

17. The Ministry should research and consider legislative changes that would allow it to obtain and share adverse findings against paramedics and dispatchers with relevant organizations, including prospective EMS employers.

18. While remaining cognizant of its privacy requirements, the Ministry should share general or anonymized findings and best practices with relevant stakeholders so that other service providers can take proactive steps to address any similar issues in their organization.

19. The Ministry should ensure that all organizations under investigation are given the opportunity to review a preliminary version of any report that contains negative findings or recommendations about them. The organization should have the opportunity to provide its response in writing, and the Ministry should consider this response before finalizing the report. When relevant, the Ministry should consider including the organization's written response in the final report.

20. The Ministry should ensure that any changes to its preliminary reports are based on a thorough review of the available evidence. The reason for such changes should be thoroughly documented in writing in the Ministry's investigative file.

21. The Ministry should develop and finalize an investigation protocol. The protocol should outline, among other things, the Investigation Services Unit's complaint handling and investigation processes. The protocol should clearly outline the criteria to be used in determining whether the Ministry will conduct an investigation into a complaint or refer it to the involved EMS provider or dispatch centre for investigation, as well as the Ministry's role when overseeing another organization's investigation.

22. The Ministry's investigation services protocol should be provided to all Ministry investigators. The Ministry should ensure that existing and new investigators receive comprehensive training on the protocol.

23. The Ministry should develop a formal training and mentorship program for new investigators. This training program should be documented in a formal orientation guide and made available to all investigators.

24. The Ministry should ensure that investigators have access to and are encouraged to rely on subject matter experts in the course of their investigations.

25. The Ministry should conduct a review of staffing turnover and vacancies in its investigative and oversight positions with the goal of better understanding their underlying cause. Once identified, the Ministry should take steps to address these issues.

26. The Ministry should ensure that all oversight positions are filled in a timely manner, as vacancies are detrimental to the timely and effective review of ambulance services.

27. The Ministry should ensure that its staff and stakeholders have a clear understanding of the roles and responsibilities of each unit involved in emergency health oversight.

28. The Ministry should consult with staff in relevant units to determine what obstacles prevent effective communication and take steps to address these concerns.

29. The Ministry should ensure that the Investigation Services Unit is able to communicate freely with other Ministry units in the course of carrying out its investigative mandate. Investigators should not require special permission before initiating contact with Field Office staff.

30. The Ministry should take steps to ensure that all organizations obligated to submit incident reports understand and accurately interpret these requirements, including the types of incidents that must be reported and the timeline for doing so. The Ministry should specifically clarify that all complaints and internal investigations into complaints must be reported in an incident report.

31. The Ministry should ensure that it tracks and audits each organization's compliance with the incident reporting obligations. If an organization fails to submit reports as required, the Ministry should take remedial action including in appropriate cases conducting an investigation.

32. The Ministry should work with relevant stakeholders to develop and implement a standardized incident report template to be used by all emergency medical service providers.

33. The Ministry should work with stakeholders to develop a method for electronically submitting incident reports regardless of an organization's size or resources.

34. The Ministry should evaluate the existing incident reporting requirements, in consultation with stakeholders, with the goals of ensuring that incident reports are a meaningful oversight mechanism and reducing the number of incident reports written and submitted to the Ministry that do not add value from an oversight perspective.

35. The Ministry should develop a method for triaging incident reports quickly, based on the type of incident being reported and the severity of the issue.

36. The Ministry should develop procedures to ensure that incident reports are being reviewed in a timely manner by individuals with expertise in emergency medicine and dispatch procedures.

37. The Ministry, in consultation with internal and external stakeholders, should undertake to review and develop a process so that incident reports can be more efficiently and effectively reviewed by Field Offices or the Investigation Services Unit. The Ministry should also ensure that the chosen unit is sufficiently resourced and provided the necessary training to handle the workload.

38. The Ministry should develop clear guidelines regarding the review of incident reports. The guidelines should clearly specify what the reviewer is supposed to assess, as well as how and when to escalate particular issues.

39. The Ministry should ensure that EMS providers, dispatch centres, base hospitals, and Ornge provide sufficient information in their incident reports to facilitate meaningful review.

40. The Ministry should develop a database that allows incident reports to be tracked and reviewed for systemic issues within individual organizations and throughout the province. In addition, the Ministry should analyze the volume and type of incident reports submitted and use this information to guide future policy development, training, and investigations.

41. The Ministry should establish a procedure clearly indicating that EMS providers and dispatch centres are required to directly provide the Ministry's Investigation Services Unit with information about all complaints received in a timely manner.

42. The Ministry should make certain that all internal and external bodies that are likely to receive complaints about ambulance services have information about how to refer those complaints directly to the Ministry's Investigation Services Unit.

43. The Ministry should establish a consistent framework for tracking and reviewing complaints about ambulance services.

44. The Ministry should ensure that the Investigation Services Unit is properly resourced to review, track and analyze complaints about land ambulance services.

45. The Ministry should establish a procedure clearly indicating that Ornge is required to directly provide the Ministry's Air Ambulance Oversight Unit with information about all complaints received and investigations undertaken in a timely manner.

46. The Air Ambulance Oversight Unit should coordinate with the Investigation Services Unit to establish a clear framework for tracking and reviewing air ambulance complaints, consistent with the framework for land ambulance services.

47. The Ministry should ensure that the Air Ambulance Oversight Unit and Investigation Services Unit are properly resourced to review, track and analyze complaints about air ambulance services.

48. As a priority, the Ministry should update its web content to include a specific webpage with information about the public complaint process for emergency health services. This webpage should contain information about how to make a complaint and the contact information necessary to do so.

49. The Ministry should develop a customer service policy that specifically outlines when complainants will be contacted by investigators and what information they will be provided.

50. The Ministry should, as a matter of course, provide complainants with a copy of the investigative report that relates to their concern, subject to any necessary redaction. Complainants should not have to formally request the report in writing from the investigations manager.

51. The Ministry should ensure that its website contains clear information about the steps in the complaint process, the role and mandate of the Ministry, and the different possible outcomes of an investigation.

52. The Ministry should create a policy for dealing with requests by members of the public who are dissatisfied with investigations conducted by the Ministry's Investigation Services Unit. The Ministry should ensure the policy sets out the scope and limitations of this review process, as well as a requirement that this information be communicated to complainants who request a review.

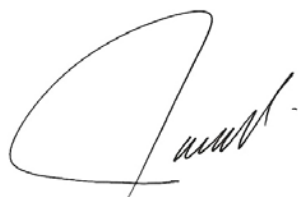
53. The Ministry should report back to my Office in six months' time on its progress in implementing my recommendations, and at six-month intervals thereafter until such time as I am satisfied that adequate steps have been taken to address them.

Response

- 174** The Ministry of Health was given an opportunity to review and respond to my preliminary findings, opinion and recommendations. All comments received were taken into consideration in the preparation of my final report.
- 175** On behalf of the Ministry, the Deputy Minister accepted each of my 53 recommendations and committed to ensuring that ambulance oversight is more transparent and accountable. She also advised that the Ministry is already in the process of responding to 16 of the recommendations, including those related to investigation protocols, follow-up processes, and investigator orientation and training. The Deputy Minister further indicated that the Ministry has undertaken

the recruitment of six additional positions within the Investigation Services Unit and four additional positions in the Air Ambulance Oversight Unit. A copy of the Ministry's response is appended to this report.

- 176 I appreciate the co-operation received from the Ministry and all stakeholders in this investigation, especially in light of the challenging circumstances imposed by the COVID-19 pandemic. I am encouraged by the Ministry's positive reply to my report and its commitment to improving the accountability and transparency of its ambulance oversight. The Ministry has agreed to provide my Office with semi-annual status updates, and we will monitor its progress in implementing my recommendations.



Paul Dubé
Ombudsman of Ontario

APPENDIX: Ministry of Health response

Ministry of Health
Office of the Deputy Minister

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Tel.: 416 327-4300
Fax: 416 326-1570

Ministère de la Santé
Bureau du sous-ministre

777, rue Bay, 5^e étage
Toronto ON M7A 1N3
Tél. : 416 327-4300
Télec. : 416 326-1570



182-2021-162

March 30, 2021

J. Paul Dubé
Ontario Ombudsman
Bell Trinity Square
483 Bay Street, 10th Floor, South Tower
Toronto, Ontario M5G 2C9

Dear Mr. Dubé:

Thank you for the opportunity to review your office's preliminary investigation report on how the Ministry of Health's (the ministry) Emergency Health Services Division investigates and oversees patient complaints and incident reports about ambulance services. We appreciate the review your office conducted and wish to advise the ministry accepts all of your recommendations in the report and will be working towards their implementation.

I am pleased to advise the ministry is well positioned to respond to 16 recommendations, shortly after the report release and before the first six-month report back requirement. Recommendations relative to Investigation Protocols, Follow Up, Policy/Procedure, Orientation and Training are being finalised for immediate implementation. Respecting resourcing, the ministry has already undertaken the recruitment of six additional positions within the Investigations Unit and four additional positions within the Air Ambulance Oversight Unit. The ministry is committed to ensuring the investigative process is more transparent and accountable.

I want to thank you and your team for your continued support and collaboration during the Special Ombudsman Response Team Investigation. Steven Haddad, Director, Emergency Health Regulatory and Accountability Branch, will be the primary point of contact for all future requests, Steven can be reached at Steven.Haddad@ontario.ca or (437) 522-9596.

The ministry looks forward to the release of the final report, working with our partners to develop an implementation plan and commits to communicating with your office respecting our progress relative to all recommendations in the timelines delineated within Recommendation #53.

Sincerely,

A handwritten signature in blue ink, appearing to read "Helen Angus".

Helen Angus
Deputy Minister



OVERSIGHT 911




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