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ONTARIO'S WATCHDOG

OVERSIGHT 911

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

OMBUDSMAN REPORT ■ PAUL DUBÉ, OMBUDSMAN OF ONTARIO ■ MAY 2021

OVERSIGHT 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 Offices[2] 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 legislation[5] 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 report[7] 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 co-ordinate 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 co-ordination.

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 Orange 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.

Recommendation 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.

Recommendation 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.

Recommendation 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.

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.

Recommendation 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.

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.

Recommendation 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.

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.

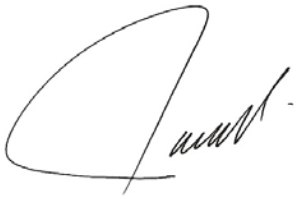
Response

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

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Ontario

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,

Helen Angus
Deputy Minister

Oversight 911

Ombudsman
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