Ombudsman
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Oversight 911
Backgrounder – Issues with the Ministry of Health's ambulance investigation system

Emergency services in Ontario:

- Each year, paramedics attend to more than 1 million patients at a total cost of more than $1.5 billion.

- When a person calls 911, their call is dealt with by an Ambulance Communication Officer working at one of 22 dispatch centres.

- Paramedics respond to medical emergencies and transport patients by ambulance. There are more than 8,000 paramedics working for 61 Emergency Medical Services (EMS) providers across the province.

- Air ambulance services are provided by Ornge, a non-profit corporation governed by a board of directors. These are overseen by the Ministry's Air Ambulance Oversight Unit.

- The Ministry has three regional Field Offices that co-ordinate EMS providers and dispatch centres.

Complaints and investigations:

- The Ministry's **Investigation Services Unit,** part of the Emergency Health Regulatory and Accountability Branch, investigates complaints about ambulance services, and monitors investigations undertaken by EMS providers, dispatch centres, and others.

- Complaints about paramedics, EMS services or dispatch are investigated by the Ministry, or locally via the EMS provider or dispatch service that is the subject of the complaint.

- Complaints about Ornge are submitted via its website and investigations are undertaken by its internal Professional Standards Unit. The Ministry is supposed to be advised of these complaints, but the Ombudsman found that isn't always the case.

- At the time of our investigation, this unit was comprised of one manager and five investigator positions, not all of which were staffed. It is responsible for conducting and overseeing some 200 investigations each year.

Ombudsman's findings and recommendations:

The oversight system for land and air ambulances is complex, confusing and severely under-resourced. There is little training for investigators, few procedures for how investigations should be completed or reviewed, little to no follow-up to ensure problems are fixed, and a lack of central oversight for the disparate bodies within the system.

- The Investigation Services Unit has interpreted its investigative mandate too narrowly; it should be interpreted broadly, to ensure important issues are not missed. **(Recommendations 1 and 2)**

- Ministry investigators rarely interview witnesses for conduct complaints. Investigators should seek to interview every complainant, as well as other relevant witnesses, to ensure investigations are fair and objective. **(Recommendations 4, 5 and 6)**

- The Investigation Services Unit does not have a centralized method for documenting and storing information from investigations. There is no consistency across investigators for what information to include, and no way to track trends or systemic issues. A central case management system should be developed, along with a standardized format for investigative reports. **(Recommendations 7, 8 and 9)**

- The Ministry's investigative reports only outline "actionable items" and "observations," leaving EMS providers, dispatch centres and Ornge to determine how to address issues. Instead, the Ministry's reports should make clear recommendations, establish criteria for addressing them, and follow up on them with the organizations. **(Recommendations 10, 13 and 14)**

- The Ministry's investigative process is slow, due to lack of resources and layers of bureaucracy. It should ensure proper resourcing, benchmarks for timing, and constant monitoring of progress. **(Recommendations 11 and 12)**

- The Ministry fails to track when paramedics have contravened the *Ambulance Act* and other applicable standards. Information about discipline findings should be recorded in a central database, and the Ministry should consider changes to legislation to allow adverse findings to be shared with relevant organizations. **(Recommendations 15, 16 and 17)**

- The Ministry has no clear protocol for complaint handling and investigations. To ensure consistency, it should set clear criteria for determining when and how the Investigation Services Unit should investigate complaints, and ensure investigators are adequately trained. **(Recommendations 21, 22, 23 and 24)**

- There is a siloed approach within the Ministry's investigative and oversight structure, with limited information-sharing. It should ensure staff and stakeholders understand their roles, and improve communication between agencies and staff. **(Recommendations 27, 28 and 29)**

- The 250,000-plus incident reports sent by EMS providers to Ministry Field Offices each year to document "unusual occurrences" are largely a meaningless paperwork exercise that fails to increase oversight or accountability. The gravity and timeliness of issues reported varies widely between providers. The reporting system should ensure reports are meaningful, consistent, triaged efficiently, tracked and regularly audited. **(Recommendations 30-40)**

- Complaint handling processes are convoluted and inconsistent, with no central oversight between organizations, and communication with complainants is inadequate. Most complaints never make it to the Ministry's investigations unit, and it has little insight into complaint trends across the province; Ornge is largely left to police itself. A clear process should be established to ensure all complaints are received centrally, and a framework developed to track and review complaints consistently. **(Recommendations 41-48)**

- Investigators don't always communicate with complainants, and there are no policies or standard practices about what information should be provided. A customer service policy should be developed that includes providing complainants with a copy of the investigation report related to their concerns and a method for escalating their complaints if needed. **(Recommendations 49-52)**

The Ministry of Health has agreed to all of the Ombudsman's recommendations, including that it report back to his office every six months on their status **(Recommendation 53)**.