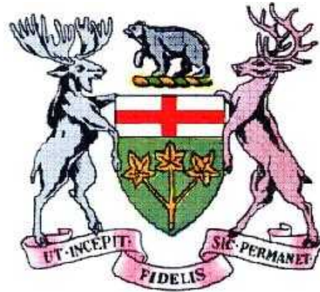

OCCURRENCE NUMBER 09IU-03-141

INVESTIGATION INTO THE EVENTS AFFECTING AMBULANCE SERVICE TO 40 ALEXANDER STREET TORONTO JUNE 25, 2009

MINISTRY OF HEALTH AND LONG-TERM CARE
EMERGENCY HEALTH SERVICES BRANCH
INVESTIGATION UNIT
September 2009

THIS REPORT HAS BEEN PREPARED BY THE

INVESTIGATION UNIT EMERGENCY HEALTH SERVICES BRANCH

MINISTRY OF HEALTH AND LONG-TERM CARE

AND IS AUTHORIZED FOR USE BY THE INTENDED RECIPIENTS

SERVICES:	Toronto Emergency Medical Services
	Toronto Central Ambulance Communication Centre
INCIDENT LOCATION:	40 Alexander Street, Toronto
DATE OF OCCURRENCE:	June 25, 2009
TYPE OF OCCURRENCE:	Quality of ambulance response

INTRODUCTION

The Chief/General Manager of Toronto Emergency Medical Services (TEMS) requested that the Investigation Unit of Emergency Health Services Branch, Ontario Ministry of Health and Long-Term Care, conduct a review of the circumstances surrounding the reported delay in the provision of emergency ambulance response to a resident of Toronto on June 25, 2009.

BACKGROUND

At 23:04:53 hours on June 25, 2009 the Toronto Central Ambulance Communications Centre (CACC) received a 911 call requesting emergency ambulance service for a male patient who had been found lying in a hallway on the main floor of an apartment building at 40 Alexander Street in Toronto. The male caller calmly advised the Emergency Medical Dispatcher (EMD) that the patient looked as if he had passed out and was lying in one of the hallways on the main floor.

The caller stated that he had approached the patient to ask if he was all right but did not receive a response. The caller said that he had had to move away from the patient to make the 911 call but there was someone with the patient.

The caller said that the patient appeared to be trying to stand up and that it looked as if the patient had fallen face down and hit his face; the caller said that the patient had a gash on his head. The caller said "*He looks like he might be drunk*"

The EMD committed the call information to the Computer Aided Dispatch (CAD) system as an Unknown Bravo call at 23:06:18 hours. The EMD advised the caller that an ambulance and the police were on the way.

At 23:06:31 hours the Toronto Police Service (TPS) created a call as a 'See Ambulance' Priority 2 event.

At 23:06:48 hours ambulance 1956, staffed by Primary Care Paramedic (PCP) #2 and PCP #1 was assigned to this ambulance call.

At 23:14:00 PCP #2 advised the dispatcher that they were staging at the intersection of Yonge and Alexander Streets and asked the dispatcher to notify her and her partner when the police arrived on scene.

At 23:14:13 hours an EMD contacted TPS communications and was told that the police had no one available at this time to send to 40 Alexander Street.

At 23:14:38 hours ambulance 1956 advised a second dispatcher that they were staging at the intersection of Yonge and Alexander Streets and were waiting for the police. At 23:17:33 hours ambulance 1956 was told that the police had not yet assigned anyone to the call.

At 23:19:16 hours an EMD telephoned EMS Operations Supervisor #1 to advise him of 1956 staging; the operations supervisor said he would "*keep an eye*" on the event.

At 23:19:36 hours an EMD received a phone call from the security company responsible for 40 Alexander Street. The security communicator said he was calling about a male who had fallen and was bleeding from the nose. The EMD was connected with an on scene security guard who stated that the patient was conscious and breathing but that the right side of the patient's face was turning blue. The EMD asked if this looked like bruising and the security guard said that it did. The security guard stated that the patient was not talking.

At 23:35:26 hours TPS unit 5112, staffed by Police Constable (PC) #1 and PC #2 was assigned to this call.

At 23:36:48 hours an EMD received a second call from the security company advising that the patient was no longer breathing and that CPR was in progress. The on scene security guard told the EMD that CPR had been in progress for ten (10) minutes.

The ambulance call was upgraded to an Echo response and at 23:38:20 hours the Toronto Fire Service (TFS) received a request to assist on scene via a computer interface with Toronto CACC.

At 23:38:46 hours TFS pumper 314, on duty at the fire hall located on Grosvenor Street just west of Yonge, was notified of this call.

At 23:38:46 hours PCP #1 advised the dispatcher that they received the upgrade for this call and asked if the fire department would attend. PCP #1 told the dispatcher he and his partner did not feel safe approaching the scene. The dispatcher confirmed that the fire department was responding. PCP #1 then asked if an Advanced Care Paramedic (ACP) would be attending.

An EMD assigned ambulance 8579, staffed by ACP #1 and ACP #2 to this call. Ambulance 8579 was near the intersection of Dundas and Pembroke Streets when assigned.

At 23:42:00 hours pumper 314 arrived on scene and firefighters #2, 3 and 4 entered the apartment building.

At 23:43:16 hours ambulance 8579 arrived on scene.

At 23:43:20 hours ambulance 1956 advised the dispatcher that they were on scene.

At 23:48:30 hours TPS unit 5112 arrived on scene.

The ACPs performed their VSA protocols and at 00:01:46 hours contacted the Base Hospital Physician (BHP). The ACP advised the BHP that on he and his partner's arrival the patient was VSA and the cardiac monitor showed the patient's heart was in asystole and remained so throughout their protocols.

At 00:07 hours the BHP declared the patient dead.

FINDINGS FOR AMBULANCE RESPONSE JUNE 25, 2009

1) At 23:04:43 hours the TPS 911 section received a call requesting emergency ambulance response to 40 Alexander Street in Toronto.

2) The TPS conferenced the call to Toronto CACC.

3) At 23:04:53 EMD #1 answered the 911 call and was told by a calm male that it appeared a male party had passed out in the hallway on the male floor of the building and that it looked as if he was waking up.

4) The Toronto CACC CAD uses a medical question/algorithm system known as the Medical Priority Dispatch System [MPDS] (Version 12) which uses a series of problem cards that the EMD would refer to in order to appropriately prioritize requests for ambulance service.

5) The male caller advised EMD #1 that it appeared the male patient had fallen and had struck his face; the caller said he had asked the patient if he was all right but did not receive a reply.

6) EMD #1 asked if the patient was unconscious; the caller said it looked as if the patient was trying to stand up and although the caller was not with the patient there was someone with the patient.

7) The caller called out to someone in the background and asked if the patient was okay; the caller told EMD #1 that the patient had a gash on his head and was trying to stand up.

8) The caller said "*He looks like he might be drunk*"

9) During his statement EMD #1 said "*I don't remember him getting anything when he called out. So I was really under the impression that this was a third-party caller and he did not have access to the patient. If I had known he had verbal contact with someone with the patient I would have interrogated him more.*"

10) In the Comments section of the CAD Call Details Report (CDR) EMD #1 documented "*HBD*". (HBD is an acronym for Had Been Drinking.)

11) During his statement EMD #1 said that he meant to document that the patient was 'possibly HBD'. "*The fellow said he looks like he might be drunk. I was under the impression I put possible that was a clerical error on my part. He mentioned that the guy was trying to stand up and it looks like the fellow had been drinking.*"

12) When asked if he should have documented the caller's exact words EMD #1 said "*That would certainly have been advantageous.*"

13) MPDS Card 17 deals with falls and some of the questions from this card are as follows:

- Is there any serious bleeding?
- Is s/he completely alert (responding appropriately)?
- What part of the body was injured? Is s/he having any difficulty breathing?
- Is s/he still on the floor (ground)?

14) MPDS Card 17 indicates that if the patient is unconscious or not alert the call should be prioritized as a Delta response.

15) A Delta response is identified as a serious, potentially life-threatening emergency call involving illness or injury.

16) Toronto Emergency Medical Services (TEMS) targeted response time for a Delta call is eight (8) minutes and fifty-nine (59) seconds.

17) EMD #1 did not ask the questions indicated from MPDS Card 17.

18) During his statement EMD #1 said he could not recall if he used Card 17.

19) MPDS Card 30 deals with traumatic injuries and some of the questions from this card are as follows:

- Is there any serious bleeding?
- Is s/he completely alert (responding appropriately)?

20) MPDS Card 30 indicates that if the patient is unconscious or not alert the call should be prioritized as a Delta response.

21) EMD #1 did not ask the questions indicated from MPDS Card 30.

22) During his statement EMD #1 said he could not remember if he used Card 30.

23) MPDS Card 31 deals with unconscious patients and some of the questions from this card are as follows:

- Is her/his breathing completely normal?
- Is s/he still unconscious?
- Is s/he completely alert (responding appropriately)?
- Is s/he changing colour?

24) MPDS Card 31 indicates that if the patient is unconscious or is not alert the call should be prioritized as a Delta response.

25) EMD #1 did not ask the questions indicated from MPDS Card 31.

26) During his statement EMD #1 said he could not recall if he used Card 31.

27) EMD #1 said "*I remember him saying three times that the fellow was trying to stand up. Clearly someone who is trying to stand up is awake. I just wasn't sure what was going on there.*"

28) At 23:06:18 hours EMD #1 committed the call information to the CAD as an Unknown type Bravo call.

29) A Bravo response is identified as a potentially serious and unknown emergency call involving illness or injury.

30) TEMS targeted response time for a Bravo call is ten (10) minutes and fifty-nine (59) seconds.

31) MPDS Card 32 is the unknown problem card and some of the questions from this card are as follows:

- Does s/he appear to be completely awake?
- Did you ever hear her/him talk (cry)?
- What is s/he doing – standing, sitting, or lying down? Is s/he moving at all?

32) MPDS Card 32 indicates that if the patient's life status is questionable (not alert, unconscious) the call should be prioritized as a Delta response.

33) EMD #1 did not ask the questions indicated from MPDS Card 32.

34) During his statement EMD #1 said "*I chose the unknown problems I didn't have enough information to go to a specific card. I will go to the appropriate card to determine questions depending on the original complaint. It sounded like he didn't have a good understanding of what was happening.*"

35) EMD #1 was asked why he did not ask the first question on Card 32 he replied "*One of the grounds for not asking the question is if the caller is too far away; because he could not make contact with him I bypassed that question on that grounds. I did not realize that it was within his capabilities to relay that question. I had no reason to think that he could direct that right beside this person. I didn't think that he would be able to get anything else. I didn't realize he may have been able to obtain information, but I was under the impression that he was out of communication.*"

36) As per the MPDS system the information provided by the caller that the patient had fallen, struck his head, was not communicating normally and was having difficulty standing indicated that this call request should have been prioritized as a Delta response.

37) During his statement EMD #1 said "*When I hear that this call was prioritized as a low priority call I object to that. At the point when I hung up I don't want to say I was okay with that but I was satisfied with the information that I had been provided.*"

38) EMD #1 was asked if he was satisfied that the patient was alert and he replied "*No I was not, which is why I did not commit to a yes or a no because I did not know at that time.*"

39) At the conclusion of the phone call EMD #1 told the caller that an ambulance and the police were on the way then said to the police communicator, who was listening to the conversation, "*We'll see you there radio*" and the female said good-bye.

40) During his statement EMD #1 said "*Radio is what we use to describe the Toronto Police Service, saying we'll see you there is just a way of acknowledging that they have the call and that they will be responding with us. It is satisfactory as an EMS call taker when I say radio will see you there; it's usually a couple of words between the two of us and when I say that it means they will be attending.*"

41) When asked in what situations are the police requested to attend calls EMD #1 said "*We send police to all of our unknown Bravo calls, no matter what is happening there that is standard operating procedure. Here are potential issues with a person who has been drinking, not necessarily for violence it just might be more appropriate to have the police there.*"

42) Section 09.8.6 of TEMS Standard Operating Procedures Chapter 09 Communications Section 8 Operations provides direction as to how and when to request police to attend calls by the call receiver. Unknown Bravo type calls are not listed as a reason to request police assistance nor are police to be automatically notified if there is reason to believe a patient had been drinking.

43) Section 09.8.6 states in part that the call receiver is to verbally request the police to attend a call and when the call is not a Delta call then such request is to be made prior to providing the caller with post dispatch or pre-arrival instructions to the caller. The call receiver is to provide the police with a brief explanation as to the reason for the request for assistance.

44) In the Comments section of the CAD Call Details Report (CDR) EMD #1 documented the following: *Main floor hallway; M 50's lying on the ground – unk problem – bleed from head – HBD*police notified*'

45) HBD is short form for had/has been drinking.

46) When asked if changing the details to someone who looks like he is drunk to someone who is HBD would change the dynamics of the call EMD #1 replied "*No it doesn't.*"

47) EMD #1 said that because the patient had been drinking there was a potential for violence and that this was the only possible scene safety issue he was aware of.

48) EMD #1 did not document that the patient had fallen, was not responding normally or that there were bystanders with the patient.

49) During his statement EMD #1 said "*I generally don't record information like that. It's not really the expectation because if we wrote that on every call it would end up being just too much information for the responding paramedics. It doesn't change our priority, if there's someone with the patient or not. In this case it would not change the priority, and it did not seem like anything significant. At least it didn't have the appearance of that. I did not attempt to describe I did not attempt to diagnose what had happened in my notes. I tended to be as general as I could because at this point I really didn't know what was happening.* "

50) Toronto CACC Directive 2005-07 dated August 10, 2005 deals with Paramedic Staging Procedures and reads in part as follows: *Per S.O.P. 9.8.11 "the call receiver has a significant responsibility to determine, through standard call receiving protocols and procedures, whether any threat to the responding paramedics exists and to ensure this information is available to the controlling EMD to provide to the paramedics.*

51) When asked if a patient who had fallen and struck his head could possibly exhibit the types of symptoms as described by the caller EMD #1 said "*These are certainly the symptoms you describe could be some of them. Loss of consciousness I was never 100% sure that there was a loss of consciousness. I didn't hear anything that led me to believe there was a loss of consciousness. Certainly, an altered level of awareness. There were a number of other things going on in my mind as to what exactly was going on.*

52) EMD #1 stated "*One of the things that they are specific about in our call taking training is not to question the integrity of our callers. If the caller gives us information we are expected to work with that information.*"

53) When asked if a call should be a lower priority when an EMD is not sure about what has occurred on scene and the exact status of a patient EMD #1 said "*No it is not taught that when you are not sure that it should be on a lower priority. In this situation I did not feel it was appropriate because in this situation the caller was too far away and according to our MPDS this would make it a Bravo.*"

54) TPS Communicator #1 documented the following in the TPS CAD Event Details Report (EDR): *Male passed in hallway on main floor…male late 50S…poss HBD…is awake…and trying to get up…was lying face down when comp saw him.*"

55) TPS prioritized this request as a 'See Ambulance Priority 2' call. A Priority 2 indicates that the call request is urgent but not life threatening.

56) 40 Alexander Street is within the area patrolled by 51 Division of TPS.

57) At the time this call was created all on duty 51 Division police personnel were assigned to higher priority police matters.

58) There is no documentation in either the CDR or EDR to indicate either real or potential violence or of any safety hazard on scene.

59) EMD #2, responsible for dispatching the area of Toronto that included 40 Alexander Street, identified that the closest most appropriate ambulance to respond to

this call was under the control of the North West Dispatcher and electronically transferred control of the call to EMD #3.

60) At 23:06:48 hours EMD #3 notified by radio ambulance 1956, staffed by Primary Care Paramedic (PCP) #1 and PCP #2, who were in the area of Yonge and Wellesley Streets, of this call. EMD #3 advised the paramedics they were responding for an unknown Bravo call and provided the address.

61) PCP #1 commenced employment with TEMS at the end of May 2008. Prior to commencing paramedic duties with TEMS PCP #1 successfully completed a three week orientation program with TEMS. At the time of this call PCP #1 had worked 144 – 12 hour shifts, having 1,728 hours of working paramedic experience with TEMS.

62) PCP #2 commenced employment with TEMS near the end of May 2009. Prior to commencing paramedic duties with TEMS PCP #2 successfully completed a three week orientation program with TEMS. At the time of this call PCP #2 had worked 4 – 12 hour shifts, having 48 hours of working paramedic experience with TEMS.

63) TEMS takes every reasonable effort to pair newly hired paramedics with more senior paramedics for the first three (3) months of employment, or approximately 40 – 12 hour shifts, after orientation. After that time there is no restrictions as to who may be partnered together.

64) At 23:06:54 hours an electronic message was transmitted to ambulance 1956 advising of a Bravo unknown call at the provided address.

65) At 23:06:56 hours an electronic message was transmitted to ambulance 1956 that read: *M 50'S lying on the ground – unk problem – bleed from head – HBD*Police notified*

66) At 23:14:00 hours PCP #2 advised the dispatcher by radio that they were staging at the intersection of Yonge and Alexander Streets and asked the dispatcher to notify them when the police had arrived on scene. The dispatcher acknowledged the information and advised ambulance 1956 to change their radio channel to Tac 1.

67) Part V of Regulation 257/00 reads in part that paramedics are required to provide patient care in accordance with the *Basic Life Support Patient Care Standards* (BLS Standards).[1]

68) Section A of the General Standards of Care contained in the BLS Standards deals with personal and patient safety and protection. Point 3 of this section reads in part as follows: *On arrival at scene, perform an assessment of the environment. Park the ambulance in a safe place, as close to the point of patient contact as possible. Identify obvious and potential hazards to the patient(s) and crew.*

69) Point 4 of Section A of the General Standards of Care reads as follows: *Secure the environment if assessment indicates there is no danger to self or others.*

[1] Subsection 11 (a) Part V Regulation 257/00 made under the *Ambulance Act*

70) Point 5 of Section A of the General Standards of Care reads as follows: *If danger exists, or there is uncertainty regarding personal and/or patient safety, request assistance from allied emergency services personnel/agencies. Initiate and/or maintain communication with ambulance dispatch.*

71) The Paramedic Conduct Standard contained in the BLS Standards reads in part as follows:

> *Behaviour unacceptable to the practice of a paramedic includes but is not limited to refusal or neglecting to serve citizens requiring services which are part of the normal performance of their duties given their current certification status.*

72) Toronto EMS Standard Operating Procedures Chapter 3 Operations Policy Number 03-06-13 Section 06 Paramedic Safety and Staging reads in part as follows:

> *The safety of all Toronto EMS staff is of utmost priority. When confronted with a situation where safety may be in doubt you are directed as follows:*

- *Assess the scene, applying all appropriate factors and using due consideration for personal safety (risk assessment)*
- *Do not attempt to enter a scene when you have specific information that leads to a reasonable concern that danger may exist*
- *Communicate your situation to the CACC immediately and request police, or other appropriate agency, for attendance/assistance.*
- *In the following circumstances paramedics are not to attempt to enter a scene until the appropriate agency has arrived and secured the scene:*
    - *calls involving the use of weapons at the scene*
    - *continuing violence at the scene*
- *Once it has been determined that danger may exist leave the immediate area and await the arrival of the appropriate agency/assistance before attempting to access the scene. Provide updates to CACC every ten (10) minutes if you remain staged. You will also be contacted by an EMS District Supervisor for further assistance.*

73) Neither PCP #1 nor PCP #2 arrived at the scene of 40 Alexander Street nor did they perform a risk assessment of the scene to determine if there was a real or potential threat to their health and safety.

74) A part of the TEMS orientation program is a situational awareness course which is to improve the paramedic's awareness, recognition and avoidance of potentially dangerous situations affecting the paramedic's safety in the work place. The course is designed to teach paramedics how to deal with potentially dangerous places, situations and people.

75) The situational awareness course provides training to an individual so that they learn how to obtain an accurate perception of the reality that is occurring around them. The course states that errors can occur when the individual's theory of the situation does not match the reality that is occurring or when the individual only looks at the portion of the data available that will support their theory of the situation.

76) The situational awareness course teaches the paramedic under high stress people revert to previous patterns of behaviour.

77) The situational awareness course teaches the paramedic to assess the scene , always plan ahead for the worst case scenario and therefore plan an escape route, and if the call obviously involves violence to plan a good staging area close to the scene but out of sight of the residence.

78) As part of the orientation program recruit paramedics must successfully complete a written examination. Part of the examination deals with TEMS Standard Operating Policies (SOP). Question 22 deals with SOP 03.6.13 – Paramedic Safety. This section reads as follows:

> *Paramedics are reminded that personal safety is the utmost priority. When confronted with a situation where safety may be in doubt, you are directed as follows:*
>
> *A. Attempt to enter the scene, assess for obvious danger that may exist and contact police if required.*
>
> *B. Request fire attendance/assistance on all responses.*
>
> *C. Do not enter the area, await arrival of police before leaving the station where there is a suspected unsafe situation.*
>
> *D. Do not attempt to enter a scene where obvious danger may exist. Advise C.A.C.C. and immediately request police attendance.*
>
> *E. D and C.*

The correct answer is D.

79) Ambulance 1956 parked on Yonge Street just south of Alexander Street in front of a restaurant.

80) 40 Alexander Street was not visible from the location where ambulance 1956 parked.

81) During their statements both PCP #2 and PCP #1 said they were familiar with the requirements of the BLS Standards and TEMS policy regarding scene assessments.

82) During her statement PCP #2 said the only information provided to her and her partner was that this was an unknown Bravo call for a male patient lying on the ground unknown problem, bleeding from the head, HBD and police were notified. She stated that she and her partner discussed if it would be appropriate to stage because neither of them was sure of there was a potential for violence and they decided it was appropriate and therefore informed the dispatcher that they would stage on Yonge Street at Alexander.

83) PCP #2 said that because it was night time and there were a lot of people out celebrating and partying to her it was important that the police were notified. She said "*What sparked their interest, what was going on just the fact that there was blood from the head had he been assaulted , was a fight going on, any weapons on scene what was going on to cause this situation that really made our decision to stage.*"

84) When asked if she was aware of any policy that would require a paramedic to radio the dispatcher and ask for more information in a case such as this PCP #2 said "*At this point right now yes at that time I was quite new and my experience with staging is not extensive. I am aware it is very important to keep in radio contact at that point in my career I was a little uncertain. I am not sure if there is a policy I can't recall with certainty if I asked dispatch if more was going on or if my partner did either if there is a specific policy not that I can say for certain.*"

85) When asked if she and her partner had talked about contacting dispatch to obtain more information PCP #2 said she could not recall with certainty of they had such a discussion.

86) When asked if she and her partner had driven to the scene to perform an assessment as required by the BLS Standards and TEMS policy PCP #2 said "*No. We felt that where we staged my partner and I felt it as appropriate because when the police arrived they would pass in front of us and we felt that was a good position for us. Also it being in the lobby that affected our decision we did not know who was there or who would come out.*"

87) When asked if she and her partner had considered driving past the address to see what was going on PCP #2 said "*I can't recall if we discussed that but we did not.*"

88) When asked if she and her partner had considered that the police could have approached the scene coming the wrong way from Church Street which meant she would not have seen them arrive PCP #2 said "*I guess we did not. We had hoped as well that dispatch would update us when they arrived on scene. We did not feel safe approaching at that time we felt that was the safest place for us to stage.*"

89) PCP #2 said that one of their first calls for the shift involved an aggressive male patient who had put his arm through a window and she and her partner staged just down the street from that patient's residence. She said the male exited the building and began to approach them in an aggressive manner. She said "*That shouldn't have affected where we staged for this call but perhaps it did.*"

90) PCP #2 said "*In regards to our staging position I was new very new and from my experience I did have always instilled upon me never park in front of the address and it is really important to always maintain your safety at all times and that played a role as well I suppose.*"

91) When asked if when staging she should be able to see the patient's residence PCP #2 said "*I was never taught that but my experience I was taught we were just sort of around the corner. There were not a lot of staging calls during my ride outs and that was how I learned.*"

(While a paramedic college student PCP #2 was placed with TEMS to accompany paramedics on shift which is what PCP #2 termed ride outs.)

92) PCP #2 was asked if there was a requirement for a supervisor to be notified if a paramedic crew stages she said she thought she was aware that supervisors were told but she was not sure if this notification was to be done by the dispatcher or the paramedic crew and she could not say with certainty if a supervisor was notified. "*In my previous experience there has not been a lot of calls I have staged on. I think I was aware a supervisor was notified.*"

93) PCP #2 was asked if a supervisor contacted either she or her partner she said "*Not that I recall no.*"

94) During his statement PCP #1 said when assigned to this call he and his partner were advised that this was an unknown Bravo call for a male in his 50s, bleeding from the face or head, HBD and that the police were notified. "*While we were driving to the scene we discussed there was not a lot of information on this call, there were tens of thousands of people out and we were discussing if we should wait for police and as there wasn't anything pointing to this being life or death so we decided to stage. While we were en-route we were discussing why was this guy bleeding from the face, was it an assault – there was no mention of any fall no mention of anything we just did not know what was going on.*"

95) When asked if he or his partner had driven to the scene to perform their assessment as required by the BLS Standards and TEMS policy PCP #1 said "*We felt that because it was in the lobby if it was an assault or a fight and if we had pulled up out front someone could have run out. We could not see the front of the building but because it was a one way street we knew the police would have to drive right by us. Anyone else attending the call would have gone right by us and then we would have known it was safe to approach.*"

96) PCP #1 was asked if it was unusual to be assigned to an unknown Bravo call for a male in his 50s with a bleeding facial injury who was HDB. PCP #1 replied "*It would be common.*"

97) PCP #1 said "*It wasn't just the HBD, it was Thursday night a lot of people were out; many times we get more information as we are en-route to let us know what is going on, is it a language issue for a Bravo unknown. We did not receive anything besides the initial facts.*"

98) PCP #1 said "*She* (his partner) *was worried, not worried trying to figure out as well what was going on. She was brand new I am just over a year so we don't have a huge amount of road sense. Things just were adding up – there was nothing leading us to believe it was a life or death situation given the information we were given, we thought it was safest to stage.*"

99) PCP #1 was asked if there was any TEMS policy for a paramedic to contact dispatch to ask for more information in this type of situation. He replied that he did not know all of the policies verbatim.

100) PCP #1 was asked why neither he nor his partner contacted the dispatcher to ask if there was any more information available. He replied "*Typically if dispatch knows more information they pass it along. The fact they didn't pass on any more I guess we took it as they didn't know any other information.*"

101) PCP #1 was asked if he considered a patient suffering from a head injury to have a possible life threatening injury and he replied "*If the bleed is serious the dispatcher will tend to include that if it is a serious Delta haemorrhage call but this remained a Bravo unknown.*"

102) PCP #1 was asked if either he or his partner went anywhere near the scene prior to the call being upgraded and he replied "*No, we were staged at the corner of Yonge and Alexander.*" He said they did not go near the scene "*…because the call information was telling us it was in the main lobby. I have never been to that building, we did not get what was going on, was it a fight or an assault. If we pulled up in front if it was a fight or assault we could have been in jeopardy. Because police were notified we felt it best to wait for them to see what was going on*."

103) At 23:14:13 hours an EMD contacted the TPS and notified the communicator that the ambulance responding to 40 Alexander Street was staging at Yonge and Alexander Streets; the police communicator advised that no one was available at this time to respond.

104) At 23:17:33 hours police communicator #2 documented the following in the EDR: *EMS staged at Yonge/Alexander*

105) At 23:14:38 hours ambulance 1956, using radio channel Tac 1, advised EMD #4 that they were staged at the intersection of Yonge and Alexander waiting for police.

106) At 23:17:22 hours EMD #4 notified ambulance 1956 that the police had not yet assigned anyone to this call.

107) At 23:19:16 hours EMD #2 telephoned EMS Operations Supervisor #1 and notified him of the staging event; the operations supervisor stated that he would "*keep an eye*" on the event.

108) Toronto CACC Directive 2005-10 dated September 28, 2005 reads in part: *The District Supervisor will, upon notification, respond to the scene, evaluate the circumstances, ensure the safety of the crew and provide necessary assistance or direction. The staged crew is to advise the responding District Supervisor of the circumstances and reasons for staging. In addition, staged Paramedics are required to contact One Desk via Tac 1, at intervals of not more than ten minutes to confirm their safety and provide any update to a change in status.*

109) EMS Operations Supervisor (OS) #1 did not respond to the scene.

110) During his statement OS #1 said *"The original policy came out in 2004, at that time the District supervisor when they were notified was to go to the scene or contact by the TAC channel where you can talk to the crew. And you were told to go to the scene and in 2004 and we did follow that originally. But the number of staging calls that now occur is between 500 to a thousand a year is my guess. You're also required to talk to*

the crew and get incident reports from them but many other problems arise. It is overwhelming to go to all of these calls so now the District supervisor will try to pull the call on the Mobi CAD, see the call details, you look at the details of it if it looks reasonable that the crew is standing by. You make a judgment as to whether it is a reasonable cause to stage from there you make a decision and that depends in your day to day duties. It would be nice to be able to sit and do things to policy, but sometimes you can't.

111) OS #1 stated *"Staging calls, I don't mark them on my log, it's just the numbers and just over the years it starts to wean off. Now when I receive a call I look at it. Try make a decision to go to the scene or not. I was at 41 station when I received a call and there were two to three staging calls plus a fire call and they were fairly close together and all these notifications were given to me. I don't remember pulling up the Alexander on the Mobi Cad. I don't remember pulling that call up. When I was first notified I believe they told me it was a 19 car in order for me to pull up that call I would have to go into a different quadrant screen to look it up and I cannot recall doing that. The other two were reasonable reasons for staging.*

112) There are no recordings on the Toronto CACC Master Audio Logging System (MALS) to indicate that either PCP #1 or PCP #2 were in contact with EMS Operations Supervisor #1.

113) When asked if he had contacted either PCP #1 or PCP #2 OS #1 said "*Nope no. When it came out in 2004 and it kind of weaned off. There are new priorities every week. Most of the Supervisors don't even log these staging calls I know I don't. No manager has ever called you into your office and asked about these staging calls. From 2005 to present we haven't been getting Incident Reports and obviously it has not been a problem with management.*"

114) When asked his opinion regarding the appropriateness of staging for this call OS #1 said "*I had bits of information after the event I kind of looked up some of the details for a male fell HBD laceration to the head and he was in the lobby or hallway area. That is to me a questionable call – male fell HBD is a very common call downtown and I know my crews on a call like that would probably not stage. That is not a problem building. My understanding is that was a new crew and experienced crew would not have staged.*"

115) At 23:19:36 hours EMD #5 received a conferenced 911 call from a dispatcher with the security company responsible for security at 40 Alexander Street. The security dispatcher stated he was calling about a male in the lobby at this address who had fallen, struck his nose and was bleeding from the nose. The security dispatcher also stated that the patient was turning blue in the face.

116) EMD #5 was connected to a security guard who was with the patient and the guard said the patient was conscious and breathing and he was turning blue on the head; EMD #5 asked if the patient's face was turning blue and the guard said yes the right side of the patient's head and face was blue. EMD #5 asked if this was bruising and the security guard said it looked like bruising. EMD #5 started to provide pre-hospital care instructions.

117) The security guard told EMD #5 that the patient was not really responding. EMD #5 said "*Okay, he doesn't respond*" and the guard replied that the patient was not talking now. EMD #5 continued providing pre-hospital care instructions.

118) EMD #5 did not document that the patient was not responding and when asked why this was not done he said *"I don't recall. After having a chance to listen to this with my supervisor I did not hear that statement by the security guard on scene if I had I would have investigated that with the security guard on scene.*"

119) EMD #5 did not document that there was a security guard on scene with the patient.

120) When asked why he had not documented that someone was with the patient EMD #5 said "*I did not think that was relevant*"

121) EMD #5 did not update the CDR regarding the chief complaint and left it as an Unknown type call.

122) During his statement EMD #5 said "*If the condition of the patient has worsened since the call was made originally if there has been some change to the patient then I would update that through the MPDS*."

123) EMD #5 was asked if there was a requirement to ask the questions outlined in the MPDS system again and he stated "*Well, we would ask if there had been any change to the patient's condition and then, if not then no I would not go through the MPDS again. I don't know if this is CACC Policy or not.*"

124) Toronto CACC Directive 2003-08 published April 23, 2003 deals with emergency scene call backs and reads in part as follows:

- Determine the reason for the call back. If information indicates that the patient's condition has changed, re-launch ProQa.
- Verify Case Entry information including Chief Complaint, Conscious, breathing
- Review Key question information, changing the answers where required
- Reconfigure the response when prompted
- Add any additional information in the Comments/Notes area
- Ensure appropriate quadrant dispatcher is aware of any changes in scene/patient/response level information

125) When asked if there had been a change to the patient's condition EMD #5 said "*Yes. That's because when I spoke to the guard and asked the guard if it was just bruising from a fall then I updated that in the notes. I didn't believe had to do the MPDS.*"

126) When asked why he did not ask any questions from the Fall card EMD #5 said "*Once I spoke to the guard on scene and the guard said the only change in a condition from the previous call was that there was discoloration and that the patient was conscious and breathing I didn't believe going through and MPDS was required.*"

127) EMD #5 stated "*The security guard had reported to me that the patient on scene had been turning blue so I wanted clarification with the guard on scene regarding that. The guard on scene said that the blue I asked if the blue was caused by bruising. I then asked the guard if the patient was conscious and breathing from which I recall the guard said yes he was. With regards to the specific turning blue no I don't think there are specific questions to ask I believe that the patient was conscious and breathing at that time.*"

128) At 23:21:05 EMD #5 entered the following in the CDR: *Second caller, pt turning blue.* At 23:22:27 EMD #5 documented: *Correction: side of pts face is blue from bruising*.

129) Ambulance 1956 electronically received the information that EMD #5 had entered into the CDR.

130) At 23:21:03 and 23:22:04 hours TPS communicator #3 entered the following information to the EDR: *Intelleguard* (sic) *sec dispatcher calling in saying that m is now turning blue----is cons and breathing tho* (sic).

131) During his statement PCP #1 said "*Got an update approximately 7 minutes later second caller patient turning blue at that time we looked at the update we didn't get anything from the radio. There was a car in front of us we were going to go the scene there was a car in front of us we didn't turn on the lights because that would have scared them. When the light turned green and the car moved we got another update correction side of patient's face turning blue from bruising so quickly again this was making it sound more like a possible assault no mention of a fall no breathing problem just bruising on his face in the main floor of the hallway. We discussed we need to wait for police to see what was going on here.*"

132) During her statement PCP #2 said "*There was an update the patient was turning blue, we started to go then an update turning blue from bruise. We did not know who was there, where was info coming from, how did he get a bleed from the head especially when police were notified we did not know what was going on*."

133) PCP #2 was asked if when she and her partner were notified that the patient was turning blue they were going to respond to the scene and she replied that they were but because they were advised the turning blue was only bruising they decided to remain at the staging location.

134) PCP #2 was asked if she and her partner had discussed the potential life threat caused by a head injury and she replied "I *can't recall certainly if we discussed that at that point. My partner and I were concerned we were really concerned with what had happened to him, no explanation of what had occurred which left us with the possibility of an assault. Why is he bleeding, what has happened to him to cause this bruise, where is it on his head, large or small, near laceration. We did discuss that, how did it happen.*"

135) PCP #2 was asked if she or her partner had considered asking the dispatcher if someone was with the patient and she replied "*I do not recall to be honest with you at that time I was driving I really had no idea what to do I wasn't sure where we should go. I*

kind of like I remember asking him (her partner) *what we should do. I cannot recall for sure if we discussed that.*"

136) At 23:35:26 hours TPS unit 5112, staffed by Police Constable (PC) #1 and PC #2 were assigned to this call; the police officers accepted the call at 23:35:32 hours.

137) This was the first time that 51 Division police officers were available to respond to this Priority 2 call.

138) At 23:36:48 hours EMD #6 received a third 911 call from the security dispatch centre and was told that the patient was no longer breathing and had no pulse. The call was conferenced to the on scene security guard who advised EMD #6 that CPR had been in progress for ten (10) minutes and that a medical student was on scene assisting with CPR.

139) EMD #6 upgraded the priority of the call to an Echo response and at 23:37:39 hours documented in the CDR: *Per security guard on scene.*

140) At 23:37:39 hours ambulance 1956 electronically received the following message: *Per security guard on scene*.

141) At 23:37:46 hours TPS communicator #4 began documenting the following in the EDR: *Sys that m no longer has a pulse…cannot find a pulse and m is not breathing*

142) At 23:38:19 hours ambulance 1956 electronically received the following message: *New Prio: 0-Echo.*

143) At 23:38:20 hours TFS communications was automatically and electronically notified of this call.

144) At 23:38:37 hours TPS Pumper 314 (P314), staffed by fire fighters #1, #2, #3 and #4 was notified of this call electronically and at 23:38:56 hours P314 received a radio transmission for this call.

145) At 23:38:46 hours PCP #1 advised EMD #7 by radio that ambulance 1956 had received the priority upgrade; PCP #1 asked if the fire department would be assigned as he and his partner did not feel safe approaching the scene; EMD #7 confirmed that the fire department would be attending. PCP #1 then asked if an Advanced Care Paramedic (ACP) would be attending. EMD #7 advised PCP #1to stand-by then assigned ambulance 8597 to this call for an Echo cardiac arrest.

146) In his statement PCP #1 said "*Approximately 16 minutes after that* (referring to first update) *as per security on scene patient is now not breathing, sent to fire, CPR on going 10 minutes. At this time my partner and I were very confused how this call started as an unknown became an Echo not breathing. My partner did not know what to say this was just her fourth or fifth shift. I ask CACC if fire was going. We did not know what was going on. I asked if ALS was available and as soon as the car in front of us was going we started to go my partner put the lights on*"

147) PCP #1 said "*When the call was first upgraded it was up on the Mobi CAD, the call card changed so when it first happened my partner and I looked at it and tried to*

figure out what was going on. The first information covers the other information so my partner grabbed her pager it was on the pager upgrade cardiac arrest. We still didn't understand what was going on, It started as an unknown now it was somebody not breathing. In my limited experience a call starts as a Bravo turns into an Echo we were not being told there was any life threat initially now CPR in progress.

148) During her statement PCP #2 said "*I was very torn about what was going on, I did not know what was going on on scene. Upgrade on my pager it is now an Echo. On the Mobi cad it was hard to tell what was changed. I believe my partner got on the air and requested ALS and we at that point CPR had been in progress 10 minutes. We were very concerned and immediately go. I got the upgrade on my pager. I remember the word Echo and I believe the Mobi CAD said CPR in progress. We immediately decided we should go.*"

149) PCP #2 was asked if she had heard her partner advised the dispatcher that they still did not feel safe approaching the scene and she said she could not recall his saying that.

150) Ambulance 8597, staffed by ACP #1 and ACP #2, were at the intersection of Dundas and Pembroke Streets when assigned to this call.

151) ACP #1 has been employed as a paramedic with TEMS since May 2002.

152) ACP #2 has been employed as a paramedic with TEMS since July 2003.

153) At 23:38:47 hours EMD #6 documented in the CDR: *Not not breathing per security on scene.*

154) At 23:38:47 hours ambulance 1956 electronically received the above noted message.

155) During his statement ACP #2 stated that he and his partner received all of the came call details as originally provided to PCP #1 and PCP #2. When asked if the information initially provided would have caused him to stage for this call ACP #2 said "*No probably not, unless there was any indication that the patient was assaulted.*"

156) When asked if, as in this situation there appeared to be a lack of information regarding the situation would he have asked the dispatcher for more information ACP #2 said "*Absolutely, absolutely. Whenever you have details where, which is frequent for an unknown problem, then of course you want to radio dispatch to find out any information that may not be related yet. The unknown type of problem are frequent downtown so for your own safety, obviously you want to try and get that clarification.*"

157) ACP #1 was asked if he would have staged for this call, given the information that had been provided to PCP #1 and PCP #2 he said he would not have.

158) ACP #1 was asked how common was it to be assigned to an ambulance call in downtown Toronto at night for an HDB male and he replied *Quite often, it is very common. Sometimes the police attend sometimes they do not – for them to respond to every one of our drunk calls they are very busy too.*

159) At 23:39:16 hours P314 acknowledged receipt of this call.

160) At 23:41:00 hours P314 was en-route to the call.

161) All of the crew of P314 stated that as they were crossing Yonge Street they noticed a TEMS ambulance parked south of Alexander Street at the east curb of Yonge Street, which placed it in front of a fast food restaurant) and that all of the lights on the ambulance were turned off.

162) In his Incident Report FF#4 wrote: *Realizing that they were staging, I tried to view the MWS for a reason, any violent situation that may have occurred. I could not find any reason for the staging.*

163) In his Incident Report FF#2 wrote: *After we proceeded through the intersection I noted the ambulance begin to follow us slowly along Alexander Street with no emergency lights or sirens on.*

164) PCP #2 was asked if she had seen P314 cross Yonge Street in front of the ambulance and she replied "*I am not sure if they came down and turned on to the one way street I don't remember I don't remember their passing us. I probably didn't see them.*"

165) PCP #1 was asked if he had seen P314 cross Yonge Street in front of the ambulance and he replied "*I don't recall seeing fire pass us, maybe that happened when we try to figure out what was going on.*"

166) When asked why after being advised at 23:38 hours that the patient was no longer breathing why she and her partner were still parked on Yonge Street almost four minutes later, when P314 passed them, PCP #2 said "*I know that when the Mobi cad came through it said the patient not not breathing CPR is in progress 10 minutes and once it was an Echo okay we got to go. To me it did not seem like we sat there, we were freaked out it was upgrade to an Echo what is going on. It is surprising, I am not sure if we waited for the light to turn green. At 23:38 the message not not breathing I remember seeing that thinking is he breathing or is he not breathing.*

167) PCP #1 said "*My partner was driving when I was on the radio she was waiting for the car in front of us to go, we were trying to find the address. I can't answer to the speed my partner was driving. We need to go this is serious now.*"

168) At 23:42:00 hours P314 arrived at the address.

169) FF#2 and 3 along with the FF#4 exited the pumper, obtained their medical equipment and headed for the front door of the building.

170) In his Incident Report FF#1 wrote *We arrived on scene followed by the ambulance that we had passed moments earlier. They missed the driveway and had to take time to back up and correct…When they pulled up under the awning I put them on scene. Due to our updated information I was surprised as to their lack of urgency.*

171) In his Incident Report FF#2 wrote: *While proceeding into the building I noticed the ambulance which had been staging on Yonge was pulling up behind P314. The lack*

of urgency on behalf of the EMS crew made me wonder if they had received the same information we had regarding the patient being VSA.

172) In his Incident Report FF#3 wrote *As we were approaching the main entrance I noticed an ambulance make a right turn onto Alexander St. with no lights activated. As they pulled up behind P314* (FF#2) *told the paramedics that we had an update that this was a possible VSA situation and that CPR was in progress.*

173) In his Incident Report FF#4 wrote that they had arrived at the address and *Upon exiting and approaching the building, the ambulance pulled up behind the truck*.

174) A surveillance camera mounted outside the address confirms that ambulance 1956 arrived on scene and stopped behind P314 after the pumper had arrived scene and the fire fighters had exited the vehicle. Ambulance 1956 can be seen driving slowly along Alexander Street; all emergency lights were activated.

175) At 23:43:16 hours ambulance 8579 notified the dispatcher that they had arrived on scene.

176) The elapsed time from when ambulance 8579 was assigned to this call until it arrived on scene was four (4) minutes and sixteen (16) seconds.

177) The elapsed time from when the first request for emergency service was received until an ambulance arrived on scene was thirty-eight (38) minutes and twenty-five (25) seconds.

178) At 23:43:20 hours PCP #2 notified the dispatcher that ambulance 1956 had arrived on scene with the fire department.

179) The elapsed time from when ambulance 1956 was assigned to this call until PCP #2 said they arrived on scene was thirty-six (36) minutes and forty-two (42) seconds.

180) The outside surveillance camera showed ambulance 1956 stop on the driveway in front of the building and PCP #1 walk to the back of the ambulance joined by PCP #2. As they arrived at the back of ambulance 1956 ambulance 8579 parked behind ambulance 1956. PCP #1 slowly walked towards the driver's side of ambulance 8579 while PCP #2 walked towards the passenger side of 8579. PCP #2 was then seen jogging to the back of 1956, opening the rear door, entering then exiting with a cardiac monitor in hand. PCP #1 assisted one the ACPs wheel the stretcher loaded with equipment from ambulance 8579 to towards the front doors and all four paramedics entered the building.

181) During his statement ACP #1 said "*I heard another car responding as well responding into the scene. When we turned from Church Street they were coming from the Yonge Street location and we pulled in at pretty much the same time. They pulled in and then we pulled in I remember the other crew getting out of their vehicle and they helped us with our equipment and we went into the building together.*"

182) During his statement ACP #2 said "*As we arrived on scene we saw the BLS unit arrive maybe 10 seconds as we pulled into the driveway they were just exiting their*

vehicle and we all proceeded inside where we found the patient lying in the hallway with CPR in progress.

183) During his statement PCP #1 said *My partner was like what do we do and ALS was pulling up behind us so we decided to take their direction. I honestly don't know why one of us didn't go in first instead of waiting for ALS. There was a sense of urgency.*"

184) During her statement PCP #2 said "*I know I was freaking out because this was my first potential VSA and getting my gloves on and then ALS arrived and I was standing there asking myself what stretcher we should use by the time I got out of the truck they were there.*"

185) At 23:48:30 hours TPS unit 5112 arrived on scene.

186) In their Incident Reports FF#2 and FF#3 wrote that when they made patient contact CPR was in progress. Both FF noted that the patient had a cut on his nose. The fire fighters took over patient care and while FF#2 continued CPR FF#3 attached the defibrillator to the patient. They wrote that after performing CPR for a minute or two they analyzed and obtained a no shock advisement.

187) The fire fighters performed the above actions prior to any paramedics making patient contact.

188) FF#2 and FF#3 wrote in the Incident Reports that the first paramedic crew they had seen outside the building arrived at the patient with the ACP crew and that the ACPs assumed patient care responsibilities.

189) A surveillance camera mounted inside the address confirmed the information provided by the firefighters.

190) Subsection 11 (b) of Regulation 257/00 made under the *Ambulance Act* states that when required patient care will be provided in accordance with the *Advanced Life Support Patient Care Standards* (ALS Standards).

191) Subsection 11 (c) of Regulation 257/00 made under the *Ambulance Act* states that all patient contact and care shall be documented in accordance with the Ontario Ambulance Service Documentation Standards (Documentation Standards).

192) Both the BLS Standards and the Documentation Standards indicates that patient contact and care will be documented using an Ambulance Call Report (ACR) in accordance with the Documentation Standards and the Ambulance Call Report Form Completion Manual.

193) The attending paramedic ACP #1 completed an ACR, which was signed by assisting paramedic ACP #2 and the ACR was completed in accordance with the legislated requirements.

194) According to the ACR the ACPs made patient contact at 23:45 hours.

195) According to the ACR neither PCP #1 nor PCP #2 participated in patient care.

196) Both ACO #1 and ACP #2 stated that both PCPs did assist with patient care.

197) Neither PCP #1 nor PCP #2 completed an ACR for this call.

198) The ACR identified that when the ACPs completed their first assessment the patient was in asystole.

199) The ACPs completed their VSA protocols in accordance with the ALS Standards.

200) The patient remained in asystole throughout the provision of the appropriate patient care provided by ACP #1 and ACP #2.

201) At 00:01:46 hours on June 26, 2009 ACP #1 contacted the on duty Base Hospital Physician (BHP) and provided him with the known history for the patient, the patient care provided prior to EMS arrival and the patient care provided by the ACPs. ACP #1 advised the BHP that CPR had commenced approximately ten (10) minutes prior to EMS arrival and that the patient had remained in asystole throughout the patient care provided by the ACPs.

202) At 00:07 hours on June 26, 2009 the BHP declared the patient dead.

203) When asked if he had detected the odour of an alcoholic beverage from the patient ACP #1 said "*I didn't smell anything and I was down by his mouth intubating him. Whether he had been drinking or not I don't know. He didn't reek of alcohol.*"

204) The investigating Coroner confirmed that the patient died as the result of a heart attack.

205) PCP #1, PCP #2, ACP #1 and ACP #2 all stated that none of the bystanders made any comments to any of the paramedics regarding a delay in ambulance response.

206) According to the reports and notes prepared by members of the Toronto Police Service three witnesses were located on scene and all were interviewed by the police. None of the witnesses provided any information in regards to the delay in ambulance response.

CONCLUSIONS

- On receiving the first request for emergency ambulance service for this patient EMD #1 did not follow Toronto CACC policy and procedures for the processing and prioritizing of this request thereby inappropriately prioritizing this request as an Unknown Bravo instead of a Delta response with an appropriate Chief Complaint.

(Findings 3, 4, 5, 6, 7, 9, 13, 14, 15, 6, 7, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, and 38)

- EMD #1 did not document all pertinent information within the Call Details Report concerning the patient's condition, what was occurring on scene or that there were bystanders with the patient.

(Findings 44, 45, 46, 47, 48, 49, 50, 51, 52 and 53)

↘ EMD #1 contravened Toronto CACC policies when he requested Toronto Police Service attendance at this call.

(Findings 39, 40, 41, 42 and 43)

↘ On receiving the second request for emergency ambulance service for this patient EMD #5 did not follow Toronto CACC policy and procedures for the processing and prioritizing of this request thereby inappropriately maintaining this request as an Unknown Bravo instead of a Delta response with an appropriate Chief Complaint.

(Findings 115, 116, 117, 121, 122, 123, 124, 125, 126, 127 and 128)

↘ EMD #5 did not document all pertinent information within the Call Details Report concerning the patient's condition, what was occurring on scene or that there were bystanders with the patient.

(Findings 118, 119, 120 and 121)

↘ PCP #1 and PCP #2 made a decision to stage, meaning to wait away from the scene to police arrival, without going to and assessing the scene as required by the *Basic Life Support Patient Care Standards* per s 11 (a) of Regulation 257/00 made under the *Ambulance Act* and as required by Toronto Emergency Medical Services Standard Operating Policy and training.

(Findings 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 86, 87, 91, 94, 95, 96, 97, 98 and 102)

↘ PCP #1 and PCP #2 made their decision to stage away from the scene based upon very little known information as to what had, or was, occurring on scene and made no attempt to request additional information from the dispatcher.

(Findings 82, 83, 84, 85, 88, 90, 91, 94, 95, 96, 97, 98, 99, 100, 131, 132, 133, 134, 135, 155, 156, 157 and 158)

↘ Operations Supervisor #1 was in contravention of Toronto Emergency Medical Services Standard Operating Policy in that he did not attend the scene nor did he make any contact with either PCP #1 or PCP #2 to discuss the reason for staging to determine if the reasons were appropriate.

(Findings 92, 93, 107, 108, 109, 110, 111, 112, 113 and 114)

↘ When this request for emergency ambulance service was upgraded to a Delta response for a patient in cardiac arrest PCP #1 and PCP #2 did not immediately or appropriately respond to the scene.

(Findings 138, 139, 140, 142, 145, 146, 147, 148, 149, 153, 154, 161, 162, 163, 164, 165, 166, 167, 168, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 183 and 184)

↘ The response by the Toronto Fire Services and the patient care performed by the fire fighters was done so in a prompt and professional manner.

(Findings 143, 144, 159, 160, 168, 169, 186, 187 and 188)

↘ There is no evidence to suggest that the response by the Toronto Police Service was inappropriate for the circumstances.

(Findings 39, 54, 55, 56, 57, 58, 103, 104, 130, 136, 137, 141, 185 and 206)

↘ The patient care performed by ACP #2 and ACP #1 was done so in a manner consistent with the requirements of the *Basic Life Support Patient Care Standards* and the *Advanced Life Support Patient Care Standards* as required in Part V of Regulation 257/00 made under the *Ambulance Act*.

(Findings 190, 193, 194, 198, 199, 200, 201 and 202)

CONCLUSION SUMMATION

There was a preventable delay in ambulance response and the provision of patient care for this patient.

From the time the first request for emergency ambulance service was received until an ambulance arrived on scene thirty-eight (38) minutes and twenty-five (25) seconds had elapsed.

This delay was caused primarily by the inappropriate decision made by PCP #1 and PCP #2 to park their ambulance (stage) away from the scene without obtaining sufficient information, either by assessing the scene or by requesting further information from the dispatcher.

EMD #1 contributed to this delay by not appropriately prioritizing this request and by failing to document pertinent information about the patient’s condition, clear scene information or that there were bystanders with the patient.

EMD #5 contributed to this delay by not upgrading the response priority on receipt of the second request for emergency ambulance service and by failing to document pertinent information about the patient’s condition, clear scene information or that there were bystanders with the patient.

Operations Supervisor #1 contributed to this delay by not attending the scene and by not reviewing the situation with PCP #1 and PCP #2 in order to determine the reasonableness of the decision to withhold patient care by staging until the arrival of the police.