Toronto Emergency Medical Services

EMS EMERGENCY MEDICAL SERVICES TORONTO

CHECK AGAINST DELIVERY

Remarks by Chief Bruce Farr on the release of the Alexander St Report – Oct 8, 2009

Thank you ladies and gentlemen, members of the media, for attending today.

It is not easy for me to be standing before you today with the news I am going to convey. I appreciate your patience in waiting for us to speak with you about the findings of the investigation that I asked be conducted by the Ministry of Health and Long-Term Care investigations unit.

First let me say to Mr. Hearst's family and loved ones that we at Toronto EMS extend our heartfelt sympathy to each of them. This is a very sad and difficult time.

Any time we lose a loved one, it is a very tough experience and especially in these circumstances. While we sadly cannot change our actions in this situation, we have learned from what transpired and have taken action to strengthen existing polices and procedures so that this situation can be

prevented in the future. We have also moved forward to take disciplinary action with those employees concerned.

I met with both Mr. Hearst's partner, Mr. Alejandro Martinez-Ramirez and Mr. Hearst's executor and friend, Mr. David Oshtrihon in my office this morning, before coming to speak with you. I have conveyed my sympathy and discussed the findings of the Ministry of Health's investigation with them.

Now, I would like to share with you the findings of the Ministry of Health Report. The key finding by the investigator from the Ministry, which is confirmed by our own internal investigation, is that, there was a preventable delay in the response time in the provision of EMS services that evening.

The delay was not caused by problems with procedures, but by decisions that were made by individuals at each step of the response chain process. The cumulative effect of those decisions led to the delay.

Let me outline to you what happened.

It requires me to speak to you about staff decisions at several points along the response chain.

The response process works like this:

a) someone calls 911

b) Emergency Medical Dispatcher, asks the caller questions following a medically approved script

Here is a sample of those questions:

1) What is the address of the emergency?
2) What is the phone number you are calling from?
3) OK, tell me what happened?
4) Is she or he awake and conscious?
5) Is she or he breathing?

c) the Emergency Medical Dispatcher then, “dispatches” paramedics to the call based on the information they uncover in their questioning

d) Paramedics arrive at the scene – usually within 8 or 9 minutes of the call (as they did in this situation)

e) Paramedics then assess the situation for safety, and proceed to assist the patient.

What went wrong on June 25th?

Procedures were in place, but were not followed. A series of unfortunate decisions were made at several points along the chain of information gathering, and decision making, including the following:

1. Emergency Medical Dispatchers did not follow procedure when interviewing the caller

2. although Paramedics arrived at the scene in 9 minutes they did not assess the call location for risk before choosing to wait for police to arrive

3. a supervisor did not follow procedure, when the call to "stage" was underway

I want to explain about "staging" or choosing to delay delivery of service. The "staging" policy was put in place by order of the Ministry of Labour in 2005. The policy was created in response to Ministry concerns about the health and safety of a paramedic. Paramedics felt particularly vulnerable during obvious situations like gun fire or stabbings – thankfully, those occasions are rare but they do happen. Paramedics had additional concerns about "unknown" source of injury situations – like the one at Alexander Street.

Toronto EMS' current staging policy, designed to protect the health and safety of our staff, requires our paramedics to make an assessment, based on the information from the Communications Center, as well as their own assessment of the call location.

In the case of Alexander St., the assessment of the call location did not occur.

Toronto EMS has over 1,100 dedicated paramedics, supervisors and dispatchers, who together, handle over 238,000 calls a year, and help thousands of people. Since 1975, we have built one of the finest Ambulance Services in the world. It is very difficult for them to hear that there was something more they could have done in this instance to prevent ambulance delay and provision of service - but those are indeed the facts.

The MOH report makes 13 recommendations, which include both training, and a review of policies and procedures. Our team will act to implement all of the recommendations and in fact, have already begun that important work.

Let me outline some of the specific action we have taken to date:

1. Issued a directive to all Toronto EMS Managers to review and reinforce existing Staging Policy.

2. Prepared remedial training programs for staff including those involved in the call.

3. Improved the supervision and management oversight of the staging process by implementing an alarm system in the Communication Center. The alarm will alert a number of key positions in the Communications Center, including a Manager who can immediately provide guidance to a "staged" crew.

4. Begun a comprehensive review of existing staging policy and procedure.

Let me assure Mr Hearst's family and all Torontonians, that we have learned from this incident, and will work to ensure this situation does not happen again.

Again, I would like to express my deepest sympathy to Mr. Hearst's family.