ATTACHMENT A

Office of the Chief Coroner
Bureau du coroner en chef

# Verdict of Coroner's Jury
# Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
*Loi sur les coroners* – Province de l'Ontario

We the undersigned / Nous soussignés,

| | | |
|---|---|---|
| Carrie Elliott | of / de | Toronto |
| Sue Gargiulo | of / de | Toronto |
| Robert Huntley | of / de | Toronto |
| Rosemary Stackhouse | of / de | Toronto |
| Helena Hallett | of / de | Toronto |

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

| Surname / Nom de famile | Given Names / Prénoms |
|---|---|
| Hearst | James |

aged / à l'âge de 59 held at / tenue à Coroner's Court, Toronto, Ontario

from the / du 24th January to the / au March. 13. 20 20 12

By / Par Dr. / Dr Albert Lauwers Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
James Hearst

Date and Time of Death / Date et heure du décès
June 26th, 2009 at 0007 Hours

Place of Death / Lieu du décès
40 Alexander Street, Toronto

Cause of Death / Cause du décès
Atherosclerotic Heart Disease

By what means / Circonstances du décès
Natural

Original signed by: Foreman / Original signé par : Président du jury

Original signed by jurors / Original signé par les jurés

**FOR INFORMATION ONLY**
**NOT OFFICIAL**
**VERDICT/RECOMMENDATIONS**

The verdict was received on the / Ce verdict a été reçu le 13th (Day / Jour) day of March (Month / Mois) 20 12

| Coroner's Name (Please print) / Nom du coroner (en lettres moulées) | Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd) |
|---|---|
| DR. A-E. LAUWERS | 2012/03/13 |

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

 

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# Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
*Loi sur les coroners* – Province de l'Ontario

**Inquest into the death of:**
**Enquête sur le décès de :**

James Hearst

COPY

**JURY RECOMMENDATIONS**
**RECOMMANDATIONS DU JURY**

Legend

MOHLTC = Ministry of Health and Long-Term Care
EMS = Emergency Medical Services
TEMS= Toronto Emergency Medical Services
EMD= Emergency Medical Dispatchers
SOP = standard operating procedure
MPDS or PRO QA = Medical Priority Dispatch System
SCS = Systems Control Superintendent
"Staging" = A term used to describe a decision by paramedics not to enter a particular location until police arrive because they are concerned for their health and safety.
CACC =Central Ambulance Communications Centre
VisiCad= A computerized system used in CACC to record the call details and significant events for every call
Mobicad= A computerized system available in ambulances which reports recorded call details and significant events to paramedics
BLS = Basic Life Support
FTO = Field Training Officer

City of Toronto

1. We, the Jury on the Inquest of Mr. James Hearst, recommend that the City of Toronto ensure that there are no unjustifiable preventable delays in the provision of Emergency Medical Services to the people of Toronto, for any reason. In making this recommendation, we acknowledge the recent agreement between the City of Toronto and CUPE Local 416 whereby 100 per cent of paramedics will continue to work in the event of a collective bargaining dispute and will be subject to binding arbitration. We also acknowledge the recent agreement between the City of Toronto and CUPE Local 79 whereby 95 per cent of emergency medical dispatchers will continue to work in the event of a labour disruption pursuant to the terms of their current Essential Services Agreement.

2. The City of Toronto, in consultation with Toronto Police Services, should ensure that Toronto Police Services investigate the feasibility of developing a system that enables them to share information regarding scene safety issues with the Toronto Emergency Medical Services (TEMS) and the Toronto Fire Department.

Ministry of Health and Long-Term Care (MOHLTC)

3. The MOHLTC Emergency Health Services Branch should develop an educational memo for EMDs underscoring the need to ask the following question, verbatim, in every call: "Okay, tell me exactly what happened." This memo should make specific references to real life events, such as the circumstances surrounding the death of James Hearst, but avoid the use of any personal identifiers. This memo should be distributed to all ambulance communication centres in the Province of Ontario.

Toronto Emergency Medical Services

Management

4. The death of a patient during a "staging event" or the significant worsening of a patient's condition, where the dispatch priority of the call has been upgraded (e.g., to Echo from Bravo) should become the subject of an immediate incident review by the Duty Officer. This review should generate an incident report by all involved parties, including management, no later than 24 hours after the death has occurred. It should be the responsibility of the Commander and/or the Deputy Chief to ensure the Duty Officer has reviewed the event and completed the incident report.

5. TEMS should consider requiring the Duty Officer and the Systems Control Superintendent (SCS) to review the details of each and every staging event during their shift. Both the Duty Officer and the SCS should document the event during the same shift that the review of the staging has occurred. A delay in service to a patient is a critical event for

 

EMS and requires the highest level of attention. A summary of these staging events should be provided to the Chief of EMS for review each month.

6. TEMS should ensure that the Duty Officer Log Report contain the details of all staging events reviewed by that Duty Officer during that shift. The Duty Officer Log Report should also be updated contemporaneously (i.e., computer time-stamped) with events as they occur.

7. TEMS should develop a detailed, unified staging Standard Operating Procedure (SOP) that clearly outlines the responsibilities of all involved parties, including the paramedics, involved in every staging event. Specifically, the staging SOP should contain the duties and responsibilities of all involved paramedics, their Operations Supervisor, the call taking Emergency Medical Dispatchers (EMDs), the call dispatching EMDs, the Quadrant Dispatcher, the SCS, all senior emergency medical dispatchers, and the Duty Officer.

The SOP should also include or make reference to a comprehensive definition of the term "staging."

The SOP should be reviewed and updated to ensure it reflects current best practices and clearly identifies the involved parties by their correct titles.

8. TEMS should ensure that the Duty Officer assume ultimate responsibility within the CACC at all times during a staging event. This responsibility should include the performance of the following duties:

- Immediately upon receiving notification from the SCS of a staging event, the Duty Officer should review the details of the call history set out in VisiCad;
- The Duty Officer should assess the appropriateness of the staging based on the information provided;
- Where the reasons for the staging are not immediately apparent or are not properly articulated, the Duty Officer should communicate with the Operations Supervisor and, if necessary, with the paramedics, to ensure the reasons for staging are valid and have been clearly articulated;
- Where the reasons for the staging are deemed invalid or the manner in which the staging is being conducted is deemed to be inappropriate in any way, the Duty Officer should contact and personally direct the actions of the paramedics bearing in mind all of the circumstances including the provisions of the Occupational Health and Safety Act;
- The Duty Officer should personally assign the SCS to ensure that provisions of the staging SOP are being followed;
- The Duty Officer should ensure that all involved parties to a staging event are performing their assigned duties and responsibilities according to the staging SOP; and
- The Duty Officer should ensure that the Commander and/or the Deputy Chief have been notified of the staging event at the earliest possible opportunity.



9. TEMS should ensure that the SCS assumes responsibility for managing the staging event and ensure that all other involved parties are aware of their duties and responsibilities according to the staging SOP.

The SCS at a minimum should;

- Immediately upon being notified of the staging event, review all call details from the VisiCad with the call receiver to ensure the information being provided to the paramedics and their supervisor is accurate and comprehensive;
- Ensure all relevant call details have been included in the VisiCad call history, including any and all information regarding scene safety issues;
- Ensure the EMDs have confirmed with the paramedics their reasons for the staging event and ensure that these reasons have been included in the VisiCad call history;
- Assign a senior EMD to assist him/her on every call involving a staging event;
- Ensure that the Quadrant Dispatcher has notified the Operations Supervisor of the staging event, transmitted the call details to him/her, and recorded this notification in the VisiCad at the earliest opportunity;
- Ensure that the Operations (Paramedic) Supervisor is communicating with the paramedic crew as soon as possible and ensure this communication is recorded in the VisiCad call history;
- Ensure that the expected time of arrival of the police is updated regularly and all updates are included in the VisiCad call history;
- Ensure that the notification of the Duty Officer is noted in the VisiCad call history contemporaneously with the notification;
- Ensure that paramedics contact CACC every 10 minutes after the beginning of a staging event. If this does not occur, the SCS will immediately contact the paramedics to receive an update;
- Ensure the Duty Officer and the Operations (Paramedic) Supervisor are notified immediately in the event the paramedics do not communicate with CACC every 10 minutes during a staging event; and
- Ensure that any delegation of staging duties should be noted in the VisiCad call history.

10. In the event the Duty Officer is not able to personally perform his/her duties, he/she should personally assign the SCS to assume this role. This delegation should be recorded in the VisiCad call history. Even in the event of a delegation of authority, the Duty Officer must be available for consultation at all times during a staging event, either by being physically present in CACC or providing contact information (e.g., cell phone, email, etc.). TEMS should attempt to avoid any situation that would call for the Duty Officer and the SCS to be absent from CACC at the same

 

time.

11. TEMS should consider removing all ambulance re-supply functions from the Operations (Paramedic) Supervisor.

12. The City of Toronto should consider reinstating the third Senior Emergency Medical Dispatcher (EMD) on all shifts in the Central Ambulance Communications Centre (CACC).

Central Ambulance Communications Centre (CACC)



13. TEMS should ensure that the EMD dispatcher makes enquiries of the paramedics regarding the nature of the threat, scene safety issues, and the reasons for the staging event.

14. TEMS should ensure that the EMDs use the VisiCad system to document any reasons provided by the paramedics for the staging event.

15. TEMS should ensure that the EMDs use the VisiCad system to document and communicate the call details, including any reasons provided by the paramedics for the staging event, to the following persons: the call dispatching EMDs, the Quadrant Dispatcher, the SCS, the Senior EMDs, the Operations Supervisor, and the Duty Officer.

16. TEMS should ensure that EMDs dealing with any call backs from a scene where paramedics are staging make specific enquiries regarding changes to a patient's condition and any scene safety issues. In the event that the call details from the first call are unclear or the EMD receives any new information or any information regarding a change in the patient's condition, the EMD should re-launch the Medical Priority Dispatch System (MPDS) or PRO QA. The EMD should include any new information or any and all information regarding a change in the patient's condition or scene safety issues in the VisiCad call history.

17. TEMS should conduct periodic quality reviews of the performance of EMDs during call backs from the scene (i.e., any call that is not the first call from the scene) for the purposes of identifying any opportunities for enhancement in the education for the EMDs on how to approach call backs. This review should specifically address:

- Call backs from scenes in circumstances where paramedics were staged; and
- Development of more comprehensive guidelines regarding what types of changes in the patient's condition should trigger a re-launch of the Pro QA system of questions.

18. TEMS should require call taking EMDs to determine if someone is physically present with a patient, and their relationship to the patient, in every call where paramedics are staging and any call where there is thought to be "unknown trouble" (i.e., uncertainty regarding scene safety). The call taking EMD should include this information in the VisiCad call history.

19. TEMS should provide more comprehensive and regular training on communication challenges for EMDs including which types of questions may (e.g., clarifying, enhancing) or may not (e.g., freelancing, leading) be asked to obtain sufficient information to ensure the chief complaint has been properly identified. Any such training should make specific references to real life events, such as the circumstances surrounding the death of James Hearst, but it should avoid the use of any personal identifiers.

20. TEMS should clarify the SOP regarding police notification. In particular, there should be a distinction between unknown medical problem (e.g., confusing medical symptoms) and unknown trouble (e.g., uncertainty about scene safety issues). Toronto Police Services should not be routinely notified to attend unknown medical problem calls. In the event the EMD call taker selects "unknown problem" as the chief complaint and notifies the police to attend, the reasons for police notification should be clearly documented in the VisiCad call history.

21. TEMS should ensure that all SOPs are available electronically at all EMS computer terminals and be searchable by key words.

22. TEMS should require the EMD to immediately notify the Operations (Paramedic) Supervisor, of any unjustifiable preventable delays in service including, but not limited to, staging events.

23. TEMS should require the EMDs to participate in annual paramedic ride outs.

Paramedics

24. The TEMS orientation program for paramedics should be expanded to:

- allow for ride outs in the field that involve the paramedic being in the front seat of the vehicle;
- provide an opportunity for the paramedic to practise using the radio, pager, and the MobiCad, including the use of the devices while the ambulance is in motion;
- provide training on the staging SOP, including how to assess and secure a scene, where to park the ambulance, and how the staging SOP should be implemented in the field;
- make specific references to real life events, such as the circumstances surrounding the death of James Hearst,

 

but avoid using any personal identifiers;

- provide field training specific to staging events (e.g., mock stagings); and
- provide orientation of the CACC.

25. TEMS should ensure that newly qualified Basic Life Support (BLS) paramedics are accompanied at all times by a field training officer (FTO) for at least two work cycles (12 weeks). The FTO should be continually providing constructive feedback and further training to the paramedic. The FTO should also ensure the paramedic has been given an opportunity to perform all core duties for which they have been trained.

26. TEMS should make best efforts to ensure that newly qualified paramedics, in their first year of work, are paired with someone with greater than one years' experience as a paramedic.

27. The June 1, 2010, TEMS Standard Operating Procedure on Paramedic Safety and Staging should be updated to provide a more comprehensive explanation of what is meant by the direction to "assess the scene" and "secure the environment if assessment indicates there is no danger to self or others." In particular, instruction should be provided to paramedics on how paramedics are to assess and secure a scene.

28. The Toronto Emergency Medical Services (TEMS) should provide an update report to the Office of the Chief Coroner with regard to the implementation of the recommendations in one year's time.

Office of the Chief Coroner

29. The Office of the Chief Coroner should provide a copy of the verdict in the James Hearst Inquest to all base hospitals, municipalities, and Emergency Medical Services in the Province of Ontario.





 