July 12, 2016

Patient safety event reviews and Section 51 of the BC *Evidence Act*

Q and A:

What is a "patient safety event"?

It is something which may have resulted, or did result, in unnecessary harm to a patient while under our care. PHSA does everything possible to learn from the event. One of the things we do is conduct a patient safety event quality of care review.

What is a patient safety event quality of care review?

In health care, when a patient safety event occurs the goal is immediate management, disclosure and analysis of the event through a structured process, focused on system improvement, that aims to identify what happened, how and why it happened, and whether there are any ways to reduce the risk of recurrence and make care safer. PHSA conducts patient safety event quality of care reviews in accordance with Section 51 of the BC *Evidence Act* (these are often referred to as "Section 51 reviews").

What is Section 51?

Section 51 of the *Evidence Act* specifically addresses health care evidence prepared for or arising during a quality of care review conducted by a committee charged with the responsibility for conducting such a review. Section 51 prohibits the disclosure of information and documentation prepared for or during the course of such a review. All records, summaries, reports and opinions prepared for such a committee during the quality review are prohibited from being disclosed externally. As well, documents prepared for a quality review committee or by the review committee for the hospital's board cannot be admitted into evidence in civil proceedings, nor can witnesses or members of the committee give evidence about the review.

Why does PHSA carry out reviews under the protection of legislation?

Section 51 of the *Evidence Act* is intended to promote full, open and candid discussions amongst health care professionals with the goal of ensuring the best learning form the event, which in turn will foster the greatest opportunity for continuous quality improvement. Section 51 is intended to foster full participation and the best process for learning from the patient safety event. Quality reviews generate recommendations for potential improvements that may benefit future patients. For example, policy changes may be recommended or specific education sessions for healthcare professionals.

Why wouldn't health care professionals want to share everything they know?

PHSA healthcare professionals are committed to doing the very best they can for their patients. However as an organization we cannot meaningfully ask hospital and clinic staff to consider and address some queries – such as were mistakes made, are there things we should do differently, what would be a better practice in the future, could we have done anything better, or what have we learned – without assuring the participants that their open and honest answers, speculations, ideas and opinions will be appropriately respected and safeguarded. We know that many professionals would not be permitted to participate in such reviews by their insuring bodies without the protections Section 51 provides. Section 51 allows PHSA to reassure participants we are carrying out the review to improve future patient care, not to penalize. The broader the participation and more thorough the inquiry, the more we stand to learn and the more patients ultimately benefit.

What if an outside body needs the information to conduct its own investigation?

Patient safety event quality of care reviews conducted under Section 51 do not preclude health care professionals from cooperating in other reviews by outside investigative bodies, such as the coroner, police or regulators, nor do they shield health care professionals or PHSA from potential civil suits.

Does PHSA tell patients or their families about the review?

A patient (or his or her family, in the case of a patient death) may be informed about the following after a Section 51 review:

- the fact a quality of care review was conducted and when it occurred;
- any information contained in the patient chart;
- a high level summary of the resulting actions or recommendations coming out of the review;
- any other clinical factual information contained in documentation which was not prepared for the review; and
- medical facts.

Can anyone else see the results of the review?

All records created during the proceedings of a review, as well as opinions expressed by the participants in the review, and the findings and conclusions of the review committee (subject to what is set out below), cannot be disclosed beyond the health authority board of directors and, in some instances, health care professional governing bodies.

"De-identified" information (information that has confidential information removed from it) and learnings coming out of a patient safety event review can be used for education purposes. They can be shared among other health authorities and health professionals to improve patient safety throughout the entire health system. Additionally, a high level summary of the resulting actions to come out of the patient safety event review can be shared with a third party, within certain limits. Other than as set out above, once a review is commenced under Section 51, it is not lawful for any other information to be disclosed by PHSA or any participant in the review.

July 6, 2016 – Dario Bartoli Investigation - FOI

The City of Surrey has fulfilled an FOI request for a letter sent by Surrey Fire Chief Len Garis to BCEHS regarding the response provided when the 9-1-1 call was received following the December 2014 assault of 15 year old Dario Bartoli.

The teenager was seriously injured and his subsequent death has been well reported in the media. His mother June Iida has since begun a campaign for improving safety after dark in public parks.

Background:

- 15 year old Dario Bartoli of Surrey was seriously injured in an assault at a South Surrey location in the early morning of Saturday, December 13, 2014.
- Surrey RCMP called BCEHS, which responded by sending a Basic Life Support (BLS) ambulance crew without lights and sirens. The ambulance arrived 21 minutes later, and after spending another 13 minutes on scene, rushed the patient by ambulance to Peace Arch Hospital in three minutes, where the patient subsequently died a few hours later.
- A month later on January 20th, 2015, Surrey Fire Chief Len Garis wrote Linda Lupini in her capacity as executive vice president of BCEHS and PHSA to point out BCEHS did not dispatch a Surrey Fire Department fire rescue unit to the scene for what should have been prioritized as a Code 3 call. He stated Surrey RCMP then called the fire department directly for a fire rescue crew to attend after BCEHS had not.
- A Patient Care Quality Office (PCQO) investigation was conducted in order to learn how to ensure better response in similar situations in the future.
- Since the incident, BCEHS has worked to provide a consistent dispatch protocol when it comes to dispatching fire first responders, and the circumstances surrounding the dispatch decisions made in this incident are now used as a case study in dispatch training by BCEHS. This has been implemented with the endorsement of the mother.
- Further discussion ensued between Ms. Lupini and Chief Garis and both agree the dispatch concerns expressed in the letter are have been addressed.
- In April 2015, after Dario's death, the patient's mother, June Iida publicly launched the Dario Bartoli Movement, an initiative aimed at 'protecting local youth and securing the community' through the use of security cameras, and having parks lit after dark.
- The City of Surrey has received an FOI request for communications from the period around Dario's death, which includes the letter from Chief Garis.
- The City has responded to the FOI.
- The PCQO investigation report indicates that the Surrey RCMP dispatch called BCEHS dispatch at 2:49 a.m. that morning.
- The Medical Priority Dispatch System (MPDS) was used to assess the call, s.22 s.22

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Confidential Background:

- PCQO conveyed deepest condolences to the mother, June Iida and supplied the Patient Care Record, Event Chronology and Event Register to her.
- The mother also met personally with Dr. William Dick, Vice President of Medical Programs, BCEHS, Kathy Steegstra, Provincial Executive Director, Patient Care Communications and Planning, and Mary MacKillop, Director of Patient Care Quality Office, PHSA.
- In December 2015, about a year after Dario's death, s.22
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The Provincial Health Services Authority - Communications Department recommends that the following key messages be communicated publicly:

Key Messages:

- This young person's death was devastating and our hearts go out to his family and friends.
- BCEHS dispatchers and paramedics work hard every day to make the right decisions to save lives.
- An internal review of our ambulance response was done, and representatives from BCEHS met with Dario Bartoli's mother to go over what we learned.
- Since the incident, BCEHS has worked to provide a more consistent dispatch protocol when it comes to dispatching fire first responders
- The circumstances surrounding the dispatch decisions made in this incident are now used as a case study in dispatch training by BCEHS.

If asked about s.22

- If you're asking about a matter directly involving the personal privacy of one of the employees at BCEHS, and not part of our medical response investigation, then I'm not able to discuss it.

If asked about the letter

- Yes, the Chief of the Surrey Fire Department did reach out to BCEHS regarding the response in this case - which I think shows how seriously we all take patient safety.
- They proactively called on us to work with them on improving and coordinating emergency responses.
- BCEHS continuously works toward improving its patient-centre care to British Columbians, and the lessons learned from incidents like this one provide us with the opportunities to improve.
- BCEHS and the Surrey Fire Department have consulted further since the letter was sent, and both agree the concerns expressed have been rectified.

If asked about response times in Surrey since the incident

- We have seen some improvement in response times in Surrey since new resources were added in the Lower Mainland earlier this year.
- We also know we need to further improve response times in Surrey, and we're looking at ways to do that.
- We are currently reviewing in detail the Action Plan proposed earlier this year by BCEHS to improve our ability to respond quickly to emergencies across B.C.
- The emergency response needs of all communities, including Surrey, will be considered as we decide where to invest in new ambulance resources.

Surrey Response Times (Monthly Breakdown) Jan 2015-June 2016

		Alpha/Omega		Bravo/Charlie		Delta/Echo	
Call Location	Year - Month	Events	Median Event Resp Time (mm:ss)	Events	Median Event Resp Time (mm:ss)	Events	Median Event Resp Time (mm:ss)
Surrey	2015 Jan	929	19:03	1,750	12:40	1,044	9:56
	2015 Feb	826	17:35	1,533	12:47	887	9:47
	2015 Mar	983	17:51	1,662	12:16	964	9:27
	2015 Apr	972	19:11	1,731	12:40	980	9:49
	2015 May	947	19:28	1,781	13:26	1,039	10:02
	2015 Jun	1,008	20:53	1,751	13:35	1,039	9:43
	2015 Jul	972	19:57	1,696	13:09	1,103	9:56
	2015 Aug	964	19:39	1,878	13:28	1,075	9:57
	2015 Sep	889	23:19	1,708	14:11	1,062	10:14
	2015 Oct	957	21:39	1,812	14:19	1,058	10:38
	2015 Nov	922	20:47	1,762	13:51	1,029	9:59
	2015 Dec	1,019	20:41	1,839	14:21	1,088	10:32
	2016 Jan	1,060	19:46	1,899	13:20	1,178	10:01
	2016 Feb	1,032	18:27	1,848	13:01	1,061	9:33
	2016 Mar	1,089	18:38	2,004	13:03	1,146	9:50
	2016 Apr	996	18:17	1,867	13:03	1,184	9:33
	2016 May	1,057	18:32	1,933	13:03	1,134	9:52
	2016 Jun	1,089	18:35	1,784	13:02	1,148	9:43
	Total	17,711	--	32,238	--	19,219	--

Contact Information			
Contact	**Name**	**Title**	**Phone**
Program:	Linda Lupini	Executive Vice President, BCEHS and PHSA	**Tel:** 604-675-7403
Communications	Lesley Pritchard	Manager, Media Relations and Issues Management, PHSA	**Tel:** 604-675-7472 **Cell:** s.17 **PHSA Media Pager:** 604-871-5699
Spokesperson(s)	Linda Lupini		
Family member involved (if consent form signed)			

Creation & Revision History	
Date	Name
27 April 2016	Trevor Pancoust
July 5, 2016	Fatima Siddiqui
July 6, 2016	FS

July 15, 2016 – Surrey Letter FOI – Teenager (DB) Injured

The City of Surrey has fulfilled an FOI request for a letter sent by Surrey Fire Chief Len Garis to BCEHS regarding the response provided when the 9-1-1 call was received in the December 2014 assault of a teenager. The teenager was seriously injured and subsequently died.

A redacted version of the letter was released and reported in the media on July 11 2016.

Background:

- Media have previously reported 15 year old Dario Bartoli of Surrey was seriously injured in an assault at a South Surrey location in the early morning of Saturday, December 13, 2014.
- A month later on January 20th, 2015, Surrey Fire Chief Len Garis wrote Linda Lupini in her capacity as executive vice president of BCEHS and PHSA to point out BCEHS did not dispatch a Surrey Fire Department fire rescue unit to the scene for what should have been prioritized as a Code 3 call. He stated Surrey RCMP then called the fire department directly for a fire rescue crew to attend after BCEHS had not.
- A Section 51 Patient Care Quality Office (PCQO) investigation was conducted in order to learn how to ensure better response in similar situations in the future.
- Since the incident, BCEHS has worked to provide a consistent protocol when it comes to dispatching fire first responders, and the circumstances surrounding the dispatch decisions made in this incident are now used as a case study in dispatch training by BCEHS. This has been implemented with the endorsement of the patient's mother.
- Lupini and Garis both agree the dispatch concerns expressed in the letter have been addressed.
- In April 2015, media reported Dario's mother, June Iida, publicly launched the Dario Bartoli Movement, an initiative aimed at 'protecting local youth and securing the community' through the use of security cameras, and having parks lit after dark.
- The City of Surrey received an FOI request for communications from the period around Dario's death, which includes the letter from Chief Garis.
- The City responded to the FOI request by releasing a redacted letter to the applicant.
- After pre-recording an interview with BCEHS Executive Vice President Linda Lupini on July 7 2016, CKNW reporter Janet Brown publicly broadcast July 11 2016 she (Janett) had sought the FOI.
- Brown reported on the contents of the letter and aired audio of comments by Lupini.
- In a morning interview on CKNW, the reporter also suggested an inquiry be held into the death.

Confidential Background

- Surrey RCMP called BCEHS, which responded by sending a Basic Life Support (BLS) ambulance crew initially without lights and sirens, until the call was upgraded. The ambulance arrived 21 minutes later, and after spending another 13 minutes on scene, rushed the patient by ambulance to Peace Arch Hospital in three minutes, where the patient subsequently died a few hours later.

The Provincial Health Services Authority - Communications Department recommends that the following key messages be communicated publicly:

Key Messages:

- This young person's death was devastating and our hearts go out to the family and friends involved in this case.
- BCEHS dispatchers and paramedics work hard every day to make the right decisions to save lives.
- An internal review of our ambulance response was done and since the incident, BCEHS has worked to provide a more consistent dispatch protocol when it comes to dispatching fire first responders
- The circumstances surrounding the dispatch decisions made in this incident are now used as a case study in dispatch training by BCEHS.
- Yes, the Chief of the Surrey Fire Department did reach out to BCEHS regarding the response in this case - which I think shows how seriously we all take patient safety.
- They proactively called on us to work with them on improving and coordinating emergency responses.
- BCEHS continuously works toward improving its patient-centre care to British Columbians, and the lessons learned from incidents like this one provide us with the opportunities to improve.
- BCEHS and the Surrey Fire Department have consulted further since the letter was sent, and both agree the concerns expressed have been rectified.

If asked about response times in Surrey since the incident

		Alpha/Omega		Bravo/Charlie		Delta/Echo	
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Contact	**Name**	**Title**	**Phone**
Program:	Linda Lupini	Executive Vice President, BCEHS and PHSA	**Tel:** 604-675-7403
Communications	Lesley Pritchard	Manager, Media Relations and Issues Management, PHSA	**Tel:** 604-675-7472 **Cell:** s.17 **PHSA Media Pager:** 604-871-5699
Spokesperson(s)	Linda Lupini		
Family member involved (if consent form signed)			
Creation & Revision History			
Date 27 April 2016 July 5, 2016 July 15, 2016		Name Trevor Pancoust FS TP	

September 28, 2016 – Surrey Delayed Ambulance Response

On Monday, September 26, 2016, BC Emergency Health Services (BCEHS) received a 9-1-1 call to respond to a midday motor vehicle accident in South Surrey involving two patients.

The call was coded as routine (Code 2, not life-threatening), and Surrey Fire Department first responders attended, however ambulance paramedics did not arrive to care for, and transport, these patients until roughly 3½ hours later.

Surrey Fire Department has criticized the delayed response in the media. BCEHS calls the delay "unacceptable" and is investigating.

Background:

- BC Emergency Health Services received a call at 11:51 a.m. on September 26th requesting an ambulance to respond to two patients injured in a motor vehicle incident near 160th Street and King George Boulevard.
- In total, 11 ambulances were dispatched to scene during this call, however nine of them were diverted.
- The shortage of available ambulance resources was also exacerbated by a total of 18 offload delays at hospital emergency departments.

Timeline:

- Based on information provided by the caller to 9-1-1 this was categorized by dispatchers as a Code 2 call, meaning based on the information received, the injuries were not considered life threatening.
- At 11:54 a.m., local fire first responders were dispatched.
- At 12:07 p.m., first responders reported s.22
- Between 12:18 p.m. and 12:52 p.m., Surrey Fire Department made four requests regarding the estimated time of arrival for an ambulance and paramedics. On the final request, dispatch advised ETA was 30 minutes.
- Due to at least two significant incidents occurring elsewhere and other higher priority calls during this time period, there was a temporary shortage of available ambulances.
- Over a two-hour period that followed (between 13:28 p.m. and 15:13 p.m.), nine ambulances were dispatched to the scene one after the other, only to be redirected to other calls.

- At 15:17 p.m., a 10th ambulance was dispatched and arrived at 15:29, to take one patient to hospital.

- An 11th ambulance was dispatched at 15:31 p.m. and arrived a short time later to take the second patient to hospital.

Key Messages:

PHSA Communications recommends the following key messages be communicated publicly:

- The time that it took for an ambulance to respond to this call is not acceptable.

- At this stage we do know there was a spike in 9-1-1 calls requiring ambulances during that period, and a number of ambulance crews were busy offloading their patients at hospital emergency departments.

- While we work on longer term solutions, we have introduced an immediate interim escalation plan to better manage ambulance resource challenges in rare occasions like this one, and to respond to patients in situations like this more quickly.

- BC Emergency Health Services will further review all the circumstances that led to this.

- We also want to find a way to reduce offload delays at hospitals, to keep more ambulances on the road, and prevent excessive delays in response. This is one of the priorities contained in the BCEHS Action Plan released in February, 2016.

- Regardless, waiting this length of time was no doubt stressful for these patients, their families and bystanders and we apologize to these patients.

- While we are not able to share private patient information with the public without consent, we are anxious to answer any questions they may have.

- Patients can also contact the Patient Care Quality Office to act as a third party to look into their concerns.

Contact Information			
Contact	**Name**	**Title**	**Phone**
Program	Linda Lupini	Executive Vice President, PHSA and BCEHS	**Tel:** (604) 675-7403
Communications	Lesley Pritchard Trevor Pancoust	Manager Media Relations & Issues Management, PHSA Director Communications, BCEHS	**Tel:** (604) 675-7472 **Tel:** (604) 660-6998
Spokesperson(s)	Linda Lupini	Executive Vice President, PHSA and BCEHS	
Creation & Revision History			
September 28, 2016		Trevor Pancoust	

January 23, 2017 – Andrew Cho Ambulance Response Time

Vancouver resident Andrew Cho has gone to media to question why it took an ambulance up to an hour to attend his downtown apartment on the evening of Friday, January 6, 2017 after he suffered sudden onset paralysis.

Background:

- CTV Vancouver and Global BC have done news stories about Cho's experience.
- The stories stated the 29-year-old Cho felt dizzy while out for dinner with friends earlier that evening on January 6, 2017 and went home, where he experienced paralysis and fell to the floor.
- He told reporters by using his chin and mouth, he was able to reach his mobile phone just inches away and dialed 9-1-1 using voice command.
- After calling 9-1-1, fire rescue crews attended and stayed with Cho until an ambulance could arrive.
- Patients with life-threatening symptoms including cardiac arrest, chest pain, breathing difficulties, severe bleeding or unconsciousness generally receive a high-priority (lights and sirens/code 3) response.
- This request was coded as non-life-threatening (no lights and sirens), and occurred during a period of time when BC Ambulance Service responses were delayed for some non-life-threatening cases due to factors including:
    - Poor road conditions due to ice and snow
    - An increased number of 9-1-1 calls for falls, for which ice on the ground is believed to be a contributing factor
    - The influenza outbreak
    - The ongoing opioid crisis
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- BCEHS provided interviews to CTV and Global BC regarding how BCEHS typically responds to calls like this one, and indicated the factors at play that evening may have affected response time.
- The reporters were also advised PCQO will provide the Cho family directly with answers to their questions.

Confidential Background:

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The Provincial Health Services Authority - Communications Department recommends that the following key messages be communicated publicly:

Key Messages:

- Our thoughts are with Andrew and all his family and friends during this extremely difficult time.
- We are taking this incident very seriously and have initiated a review with the Cho family through our Patient Care Quality Office.
- We will be working directly with the Cho family to review the particulars of this event.
- BCEHS is committed to providing the best and most appropriate patient care throughout BC.
- We work with our fire first responder partners in Vancouver to reach patients as quickly as possible.
- BCEHS sends the closest available ambulance as quickly as possible.
- We have been experiencing very high call volumes this winter due to weather conditions, the flu season, and the ongoing opioid crisis.
- We have a growing, aging population and that is also increasing demand by about six per cent a year.

If asked why some calls are dispatched with lights and sirens and others are not:

- BCEHS prioritizes ambulance calls based on the information received from the caller and an internationally recognized system known as the Medical Priority Dispatch System.
- In this system, patients with life-threatening symptoms including cardiac arrest, chest pain, breathing difficulties, and severe bleeding or unconsciousness generally receive a lights and sirens (Code 3) response.
    1. That's because research shows that unlike other circumstances, a few minutes can make the difference between life and death.
    2. The system is designed to make life-threatening calls a priority, and this sometimes leaves non-life-threatening patients waiting longer, depending on the availability of ambulances.
- Driving without lights and sirens is also safer for patients, the public and paramedics.

Contact Information			
Contact	**Name**	**Title**	**Phone**

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Contact	**Name**	**Title**	**Phone**
Program	Jodi Jensen	Chief Operating Officer, BCEHS	**Tel:** 250-387-1512
Communications	Lesley Pritchard	Manager, Media Relations and Issues Management, PHSA	**Tel:** 604-675-7472 **Cell:** s.17 **PHSA Media Pager:** 604-871-5699
Spokesperson(s)			
Family member involved (if consent form signed)			
Creation & Revision History			
Date May 31, 2016		Name Trevor Pancoust	

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #

PREPARED FOR: Doug Hughes, Assistant Deputy Minister- **FOR INFORMATION**

TITLE: BC Emergency Health Services (BCEHS) Adverse Event – Dario Bartoli

PURPOSE: To provide an overview of the BCEHS adverse event and subsequent investigation relating to the death of Dario Bartoli in December 2014.

BACKGROUND:

- On December 13, 2014, BCEHS dispatch received a call from Surrey RCMP for two teenagers who had been victims of an assault with a crowbar. One of these teenagers was fifteen-year old Dario Bartoli.
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- The ambulance arrived 21 minutes later, and after spending another 13 minutes on scene, rushed Mr. Bartoli by ambulance to Peace Arch Hospital in three minutes. Mr. Bartoli unfortunately succumbed to his injuries several hours later.
- A month later on January 20, 2015, Surrey Fire Chief Len Garis wrote Linda Lupini, in her capacity as executive vice president of BCEHS and PHSA, to point out BCEHS did not dispatch a Surrey Fire Department fire rescue unit to the scene for what should have been prioritized as a Code 3 call. He stated Surrey RCMP then called the fire department directly for a fire rescue crew to attend after BCEHS had not.
- The City of Surrey has received an FOI request for communications from the period around Dario's death, which includes the letter from Chief Garis. It is believed the request is from a member of the media.

DISCUSSION:

- A Section 51 Patient Care Quality Office (PCQO) investigation was conducted in order to ensure a better response in similar situations in the future.
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- It should be noted that given the severity of Mr. Bartoli's injuries, there is no evidence that arriving any sooner would have had a significant impact on the clinical outcome of this case.
- Since the incident, BCEHS has worked to apply a consistent dispatch protocol when it comes to dispatching fire first responders.The circumstances surrounding the dispatch decisions made in this incident are now used as a case study in BCEHS dispatch training.
- BCEHS has also reached out to Mr. Dario's mother, June Iiada, who has met with Dr. William Dick, Vice President of Medical Programs, BCEHS, Kathy Steegstra, Provincial Executive Director, Patient Care Communications and Planning, and Mary MacKillop, Director of Patient Care Quality Office, PHSA.

- The PCQO also recently attempted to make contact with Ms. Iiada on the anniversary of her son's death but were unsuccessful.

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ADVICE:

- BCEHS continuously works toward improving its patient-centre care to British Columbians, and the lessons learned from incidents like this one provide us with the opportunities to improve.
- BCEHS has identified strategies for improving the speed and effectiveness of the dispatch system in their *BCEHS 2020 Business Case* (shared with the Ministy in April 2016).
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- BCEHS and the Surrey Fire Department have undergone further consulations since Chief Garis' letter was sent, and both parties agree the concerns expressed have been rectified.
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Program ADM/Division: Doug Hughes, Health Services Policy Division
Telephone: (250) 952-1049
Program Contact (for content): Brendan Abbott, A/Executive Director, Acute and Provincial Services
Drafter: Paige Muttersbach, Manager, Acute Care Programs, Acute and Provincial Services
Date: May 2, 2016
File Name with Path: