



BORN

Out-of-Scope Births in Ontario: A Provincial Analysis to Inform System-Level Change

September 1, 2026 | Version 1.0



User Acknowledgement

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Data Acknowledgement

BORN Ontario strives to better understand how our data can be used to inform health system partners on the intersection between social determinants of health, Indigeneity, and perinatal and child health outcomes. Furthermore, due to limited availability and use of reliable sociodemographic and patient- and family-context data, this report is limited in its ability to offer insights related to the equity of health outcomes impacted by social determinants of health. This pursuit is ongoing, and we appreciate your support and ideas related to enabling our efforts to provide insights that will lead to more equitable outcomes and programming.

Land Acknowledgement

BORN Ontario acknowledges that the land on which we gather, and the living environment from which our data are collected, is the traditional territory of the Haudenosaunee and Anishinaabe, the original peoples of Turtle Island. These territories are covered by traditional and shared agreements including the Two Row Wampum, the Dish Wampum, the Nanfan Treaty of 1701, and Haldimand Proclamation of 1784. BORN Ontario recognizes that geography is not universally agreed upon and acknowledges the importance of ongoing land claims and negotiations.

Equity Acknowledgement

BORN is committed to using expansive language (e.g. 'maternal and perinatal care'). BORN recognizes that the term 'maternal' is gendered and does not encompass the experiences of all pregnant/birthing/parenting individuals.

Disclaimer

Parts of this material are based on data and information compiled and provided by CIHI. However, the analyses, conclusions, opinions, and statements expressed herein are those of the author, and not necessarily those of the CIHI.

Suggested Citation

Cite the Better Outcomes Registry & Network (BORN) Ontario as the source of the data on any document where you use the data (i.e., written documents, PowerPoint slides, Excel spreadsheet, etc.) using the following format:

BORN Ontario. Out-of-Scope Births in Ontario: A Provincial Analysis to Inform System-Level Change 2012 – 2025. Ottawa, Ontario; 2026.

The following disclaimer must be used when disseminating or publishing any output based on aggregate data received from BORN: “All inferences, opinions, and conclusions drawn in this publication are those of the authors, and do not necessarily reflect the opinions or policies of BORN Ontario.”

Comments on the report and suggestions for reporting in the future are welcome. Please send these to: science@bornontario.ca

Notes for Interpretation:

1. Data were extracted from the BORN Information System (BIS) on 1 Jan, 2026. Note that data submission to the BIS is both voluntary and open to updates and amendments. These analyses are based upon a representative snapshot of the BIS on the date of data extraction.
2. Missing values were excluded from percentage calculations. Percentages were based on non-missing responses only ($N = \text{denominator} - \text{missing values}$).
3. Fiscal year was defined by infant date of birth. Each fiscal year ranges from April 1 of one year to March 31 of the following year, inclusive.

Acknowledgements

This report could not have been produced without substantial effort from Deborah Barnard, Liam Bruce, Alysha Dingwall-Harvey, and Dr. Katherine Muldoon. We appreciate the broader support from the larger team including Dr. Jessica Reszel, Sarah Tarpey, BORN Ontario Maternal Newborn Outcomes Committee (MNOC), Provincial Council for Maternal and Child Health (PCMCH) Perinatal Newborn Committee (PNC), Mireille Cloutier, and Alicia St. Hill.

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Premature infants face increased risks of morbidity and mortality when delivered at facilities that lack personnel specifically trained in neonatal care, as well as the specialized equipment and resources required to recognize and meet the complex needs of infants born at lower gestational ages (GA). Out-of-scope births (i.e. infants born at a lower level of care (LOC) for their GA) often require urgent transfer to higher level neonatal intensive care units (NICUs), introducing further risks for morbidity. This report builds on previous work by BORN Ontario for the Provincial Council for Maternal and Child Health (PCMCH) Perinatal Newborn Committee (PNC) and BORN's Maternal Newborn Outcomes Committee (MNOC). It examines the prevalence, trends, and contributing factors of out-of-scope births in Ontario among infants born at less than 32 weeks gestation. It is intended to identify patterns and trends rather than determine causation or evaluate statistical differences between groups.

KEY FINDINGS:

- Declining prevalence of out-of-scope births: From 2012 to 2025, the prevalence of out-of-scope births has decreased.
 - <32 weeks GA: 23.3% to 15.0%
 - <28 weeks GA: 30.4% to 19.8%
- Regional variation: Substantial differences remain across Ontario Health (OH) regions. In 2024/2025, the prevalence of out-of-scope ranged from 32.0% in OH North West and 10.1% in Toronto.
- Higher frequency of emergent complications:
 - Conditions requiring immediate delivery, including placental abruption (18.6% vs. 9.7%) and eclampsia (1.3% vs. 0.6%), were more common among out of scope births.
 - The median time from admission to delivery was 1.6 hours (IQR: 0.7-4.1) for out-of-scope births and 45.4 hours (IQR: 7.2-139.5) for in-scope births.
- Missed opportunities for perinatal interventions: Out-of-scope births had lower use of:
 - Antenatal steroids (48.7% vs. 84.6%)
 - Magnesium sulphate (45.9% vs. 69.3%)
 - Deferred cord clamping (31.0% vs. 59.7%)
- Higher prevalence of adverse newborn outcomes: Infant mortality (22.7% vs. 12.1%) and severe neurological injury (8.4% vs. 5.6%) were more frequent among infants born out of scope.

IMPLICATIONS

Many out-of-scope births result from unavoidable, rapidly evolving clinical emergencies. However, the increased prevalence of neurological injury and mortality highlights opportunities to improve system-level readiness and neonatal outcomes. Potential strategies include:

- Strengthening early recognition and maternal transfer pathways
- Reassessing regional LOC designations in response to demographic and service capacity changes
- Implementing standardized evidence based stabilization bundles for unavoidable out-of-scope births

Research has shown that premature infants face a higher risk of morbidity and mortality when they are delivered in facilities that lack the on-site resources required to support their stabilization and ongoing care (Amer et al., 2018). In these situations, infants often require urgent transport to neonatal intensive care units (NICUs) capable of providing the necessary Levels of Care (LOC). Infants being transported are at greater risk of physiological instability because they are exposed to environmental stress during transport. The transport process also increases the risk that critical equipment may become dislodged, including intravascular lines used to deliver fluids and medications and airway stabilizing equipment such as endotracheal tubes. These complications can increase the risk of morbidity and mortality.

To address this issue, the Provincial Council for Maternal and Child Health (PCMCH) convened a group of experts in 2010 to review the existing system and determine the optimal provincial model of care for maternal and newborn services. This advisory committee standardized definitions for neonatal LOC in clinical settings and provided recommended criteria for each level. These criteria identify the required human resources (e.g., physicians, nurses, respiratory therapists), as well as specialized equipment, laboratory, and radiology services necessary to provide care for this complex patient population (PCMCH, 2023). In 2021, Critical Care Services Ontario (CCSO) provided further neonatal information based on Neonatal Intensive Care Units (NICU) LOC and to reflect evolving practice recommendations.

This report builds on previous analyses conducted for PCMCH and BORN's Maternal Newborn Outcomes Committee (MNOC) to provide a deeper understanding of the prevalence and patterns of out-of-scope births across Ontario. The goal is to gain further insight into where these births occur, how frequently they happen, and the factors that contribute to them, thereby supporting ongoing efforts to align maternal and newborn care with recommended LOC.

This report uses data from BORN Ontario, authorized as the province’s prescribed maternal, newborn, and child registry. Data was linked with the Canadian Institute for Health Information’s Discharge Abstract Database (CIHI-DAD) to improve ascertainment of maternal transfer status and adverse infant outcomes. Throughout this report, LOC always refers to neonatal LOC.

We conducted a descriptive analysis of very preterm births (<32 weeks’ GA) occurring from April 1, 2012 to March 31, 2025. Births were classified as out-of-scope if they occurred at <30 weeks’ GA in hospitals designated as neonatal LOC 1, 2a, 2b, or 2c, or if they occurred at 30+0 to 31+6 weeks’ GA in LOC 1, 2a, or 2b facilities.

Among in-scope births, we further distinguished between those involving a transfer during labour (i.e., births where the individual initially presented out-of-scope but was transferred and delivered in-scope) and those that were in-scope from the outset.

Note that guidance documents from PCMCH and CCSO reference several criteria for each LOC and NICU classification, including identified risks in pregnancy, twin pregnancies, infant birth weight, and GA. For the purposes of this report, we solely used the GA criteria for each LOC to define in-scope and out-of-scope births.

Legend

Delivered out-of-scope, not transferred to appropriate LOC before birth

Transferred to appropriate LOC before birth (in-scope)

First presented to appropriate level of care (in-scope)

GA at birth = 30 or 31 weeks		Level of care, birth hospital				
Level of care, first hospital presented to in labour	Level	Level 1	Level 2a	Level 2b	Level 2c	Level 3
	Level 1					
	Level 2a					
	Level 2b					
	Level 2c					
	Level 3					

GA at birth <30 weeks		Level of care, birth hospital				
Level of care, first hospital presented to in labour	Level	Level 1	Level 2a	Level 2b	Level 2c	Level 3
	Level 1					
	Level 2a					
	Level 2b					
	Level 2c					
	Level 3					

We investigated the prevalence of antenatal steroid and magnesium sulphate use, pregnancy complications, distance travelled, time from admission to birth, deferred cord clamping, infant mortality (up to one year of age), and severe neurological injury. Severe neurological injury was defined as intraventricular hemorrhage $\geq$ grade 3 and/or periventricular leukomalacia (Beltempo et al., 2026).

Calculations were stratified by OH region of residence, hospital transport region, and hospital OH region. In most analyses, the hospital of interest was the hospital where the pregnant individual first presented in labour. For individuals transferred during labour, this was the hospital they were transferred from. For those not transferred, it was the birth hospital.

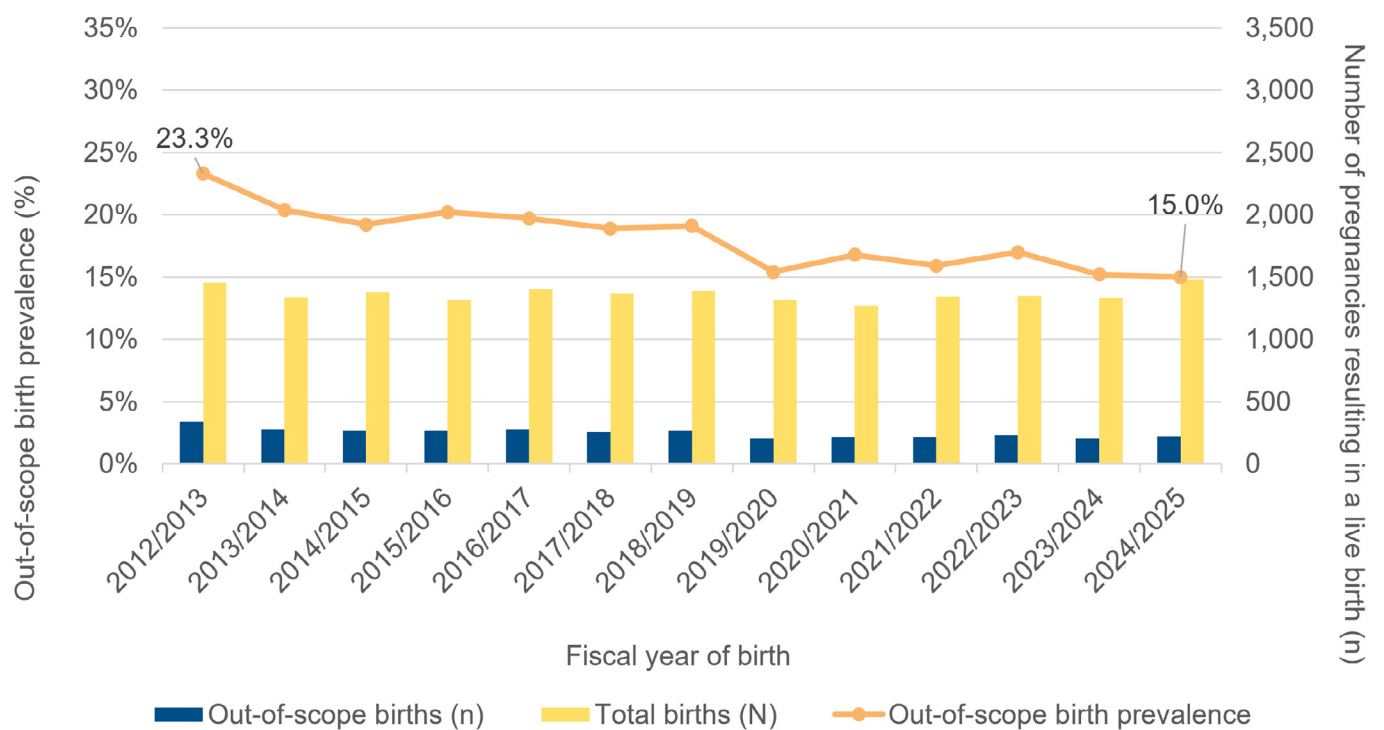
For subgroup analyses, we examined provincial trends in out-of-scope births among extremely preterm births (GA <28 weeks). These births are only in-scope at a level 3 hospital.



4.1 PROVINCIAL OUT-OF-SCOPE BIRTHS

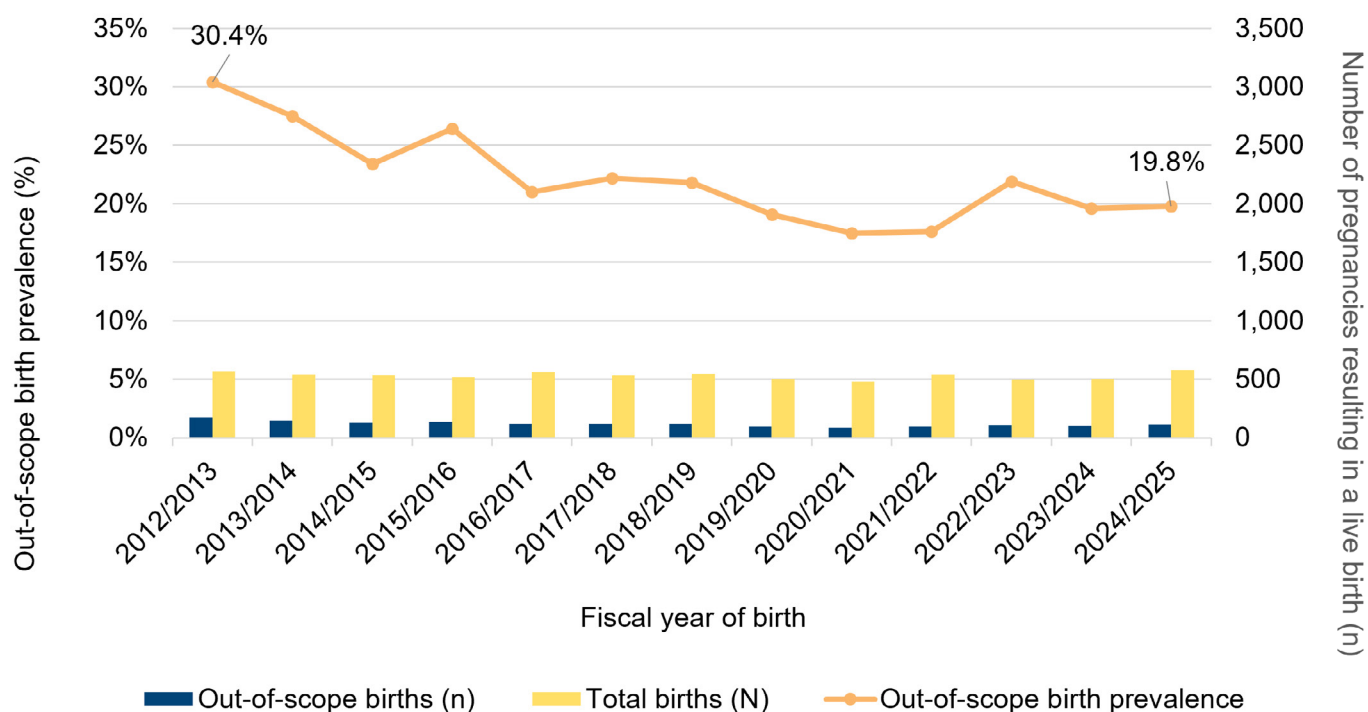
- Out-of-scope births have declined over the past 13 years for both <32-week and <28-week GA groups.
- The prevalence of out-of-scope births among <32 weeks' GA decreased from 23.3% to 15.0%
- The prevalence of out-of-scope births among <28-week GA subgroup declined from 30.4% to 19.8%
- See Appendices [A1](#) and [A2](#) for the data tables, [Appendices B1–B6](#) for OH distributions, and [Appendices C1–C4](#) for Transport Region distributions.

Figure 1a: Prevalence of out-of-scope births less than 32 weeks' gestation, Ontario, 2012/2013 - 2024/2025.



4.1 PROVINCIAL OUT-OF-SCOPE BIRTHS (continued)

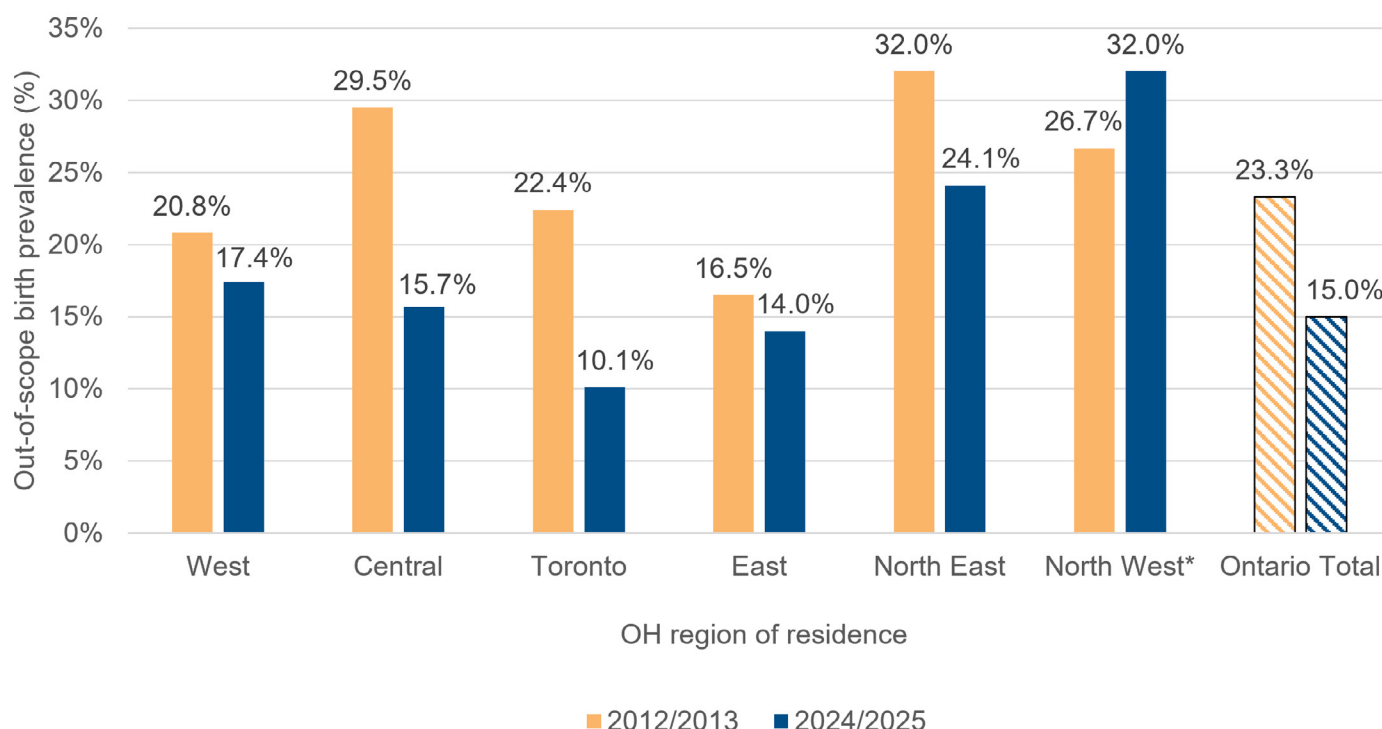
Figure 1b: Prevalence of out-of-scope births less than 28 weeks' gestation, Ontario, 2012/2013 - 2024/2025.



4.2 OUT-OF-SCOPE BIRTHS, PER ONTARIO HEALTH (OH) REGION OF RESIDENCE

- The prevalence of out-of-scope births in Ontario varies by OH region.
- In 2024/2025, 32.0% of infants <32 weeks' GA in OH North West¹ were born out-of-scope, compared with 10.1% in OH Toronto.
- OH Central experienced the largest decrease (from 29.5% in 2012/2013 to 15.7% in 2024/2025), and all regions saw decreases in the prevalence of out-of-scope births except OH North West, where the prevalence increased.
- Regional-level action may be needed to further lower the provincial prevalence. Each OH region may need to review whether sufficient resources are in place to support timely maternal transfer to the appropriate LOC.

Figure 2: Prevalence of out-of-scope births less than 32 weeks' gestation, by OH region of residence, 2012/2013 compared to 2024/2025²

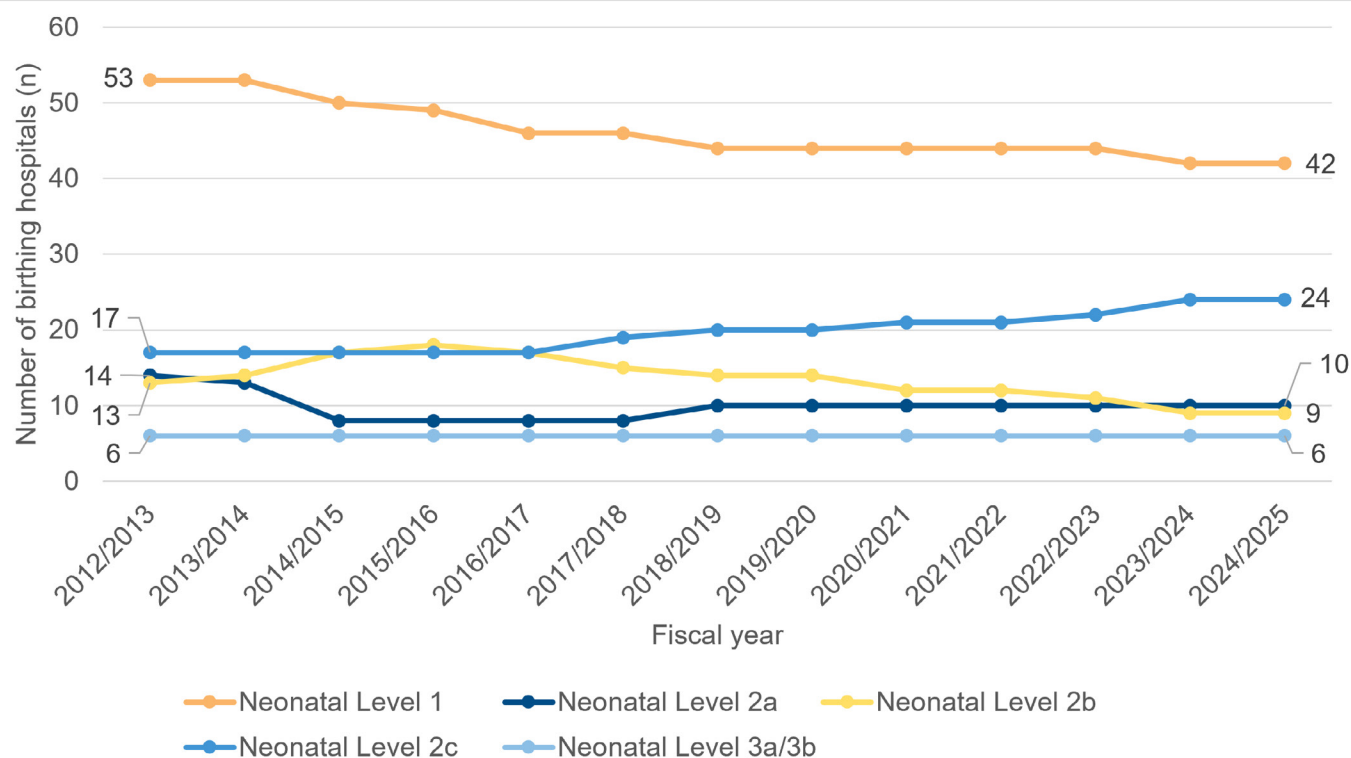


- Out-of-scope prevalence was reported bi-annually for OH North West due to small cell sizes. This prevalence reflects the combined fiscal years of 2023/2024 and 2024/2025.
- The time periods shown in the plot for OH North West are as follows:
 - 2012/2013: Combined fiscal years of 2013/2014 and 2014/2015
 - 2024/2025: Combined fiscal years of 2023/2024 and 2024/2025

4.3 HOSPITALS BY LEVEL OF CARE (LOC) AND OH REGION

- The number of level 2C centres has grown substantially over time, increasing from 17 hospitals in April 2012 to 24 by April 2024.
- The greatest concentration of level 2C centres is found in the OH Central and OH Toronto regions, which now include nine and seven hospitals, respectively.
- Among the seven centres added since April 2012:
 - Three were introduced in OH Toronto (Scarborough Health Network – Scarborough General Site; St. Joseph's Health Centre Toronto; Humber River Regional Hospital – Wilson Site).
 - Three were added in OH Central (Southlake Regional Health Centre; William Osler Health System – Etobicoke General Hospital; Trillium Health Partners – Mississauga Hospital).
 - One new centre was added in OH West (Niagara Health System – St. Catharines).
- This expansion of level 2C capacity may have played a role in reducing the prevalence of out-of-scope births, working in tandem with provincial efforts to improve transfer efficiency and standardize assessment using the implementation of the Obstetrical Triage & Acuity Scale (OTAS) (Gratton et al., 2016).
- [See Appendix A2 for the data tables](#)

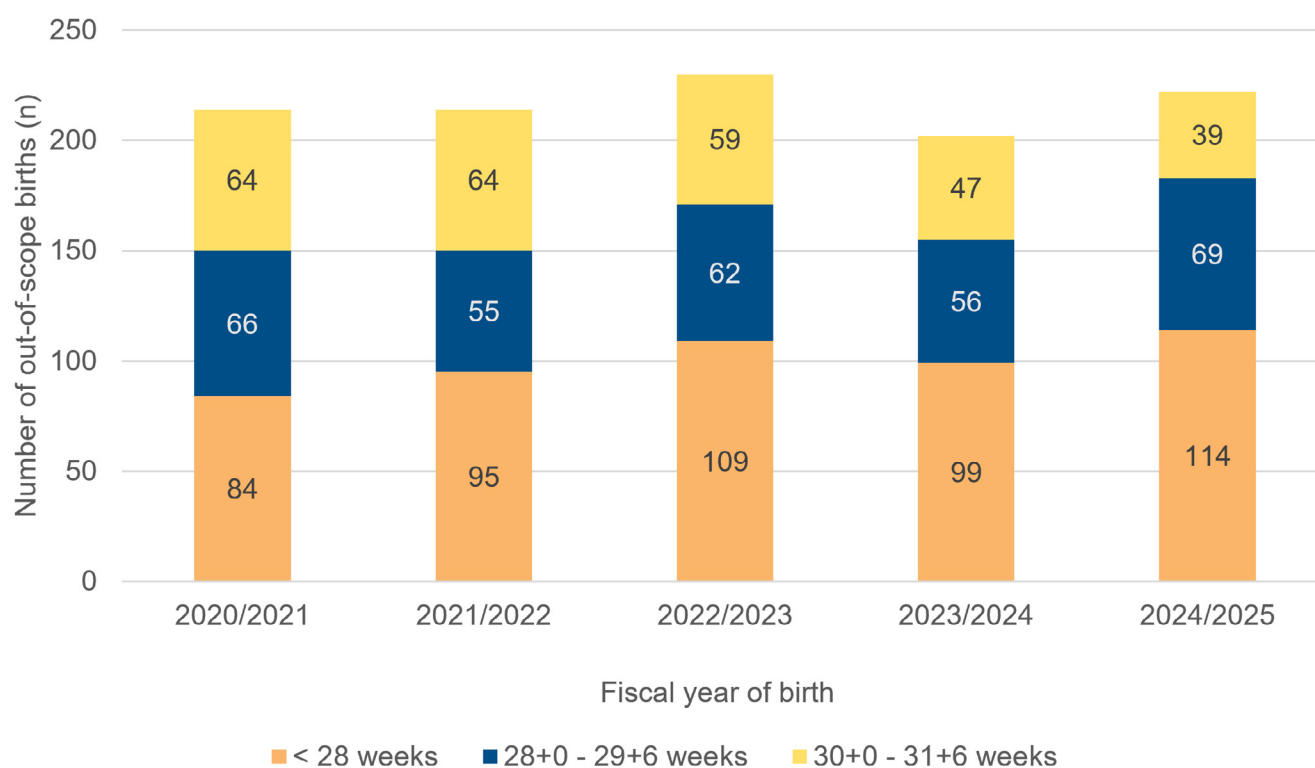
Figure 3: Number of birthing hospitals. by neonatal LOC. 2012/2013 - 2024/2025.



4.4 OUT-OF-SCOPE BIRTHS 2020/2021 - 2024/2025

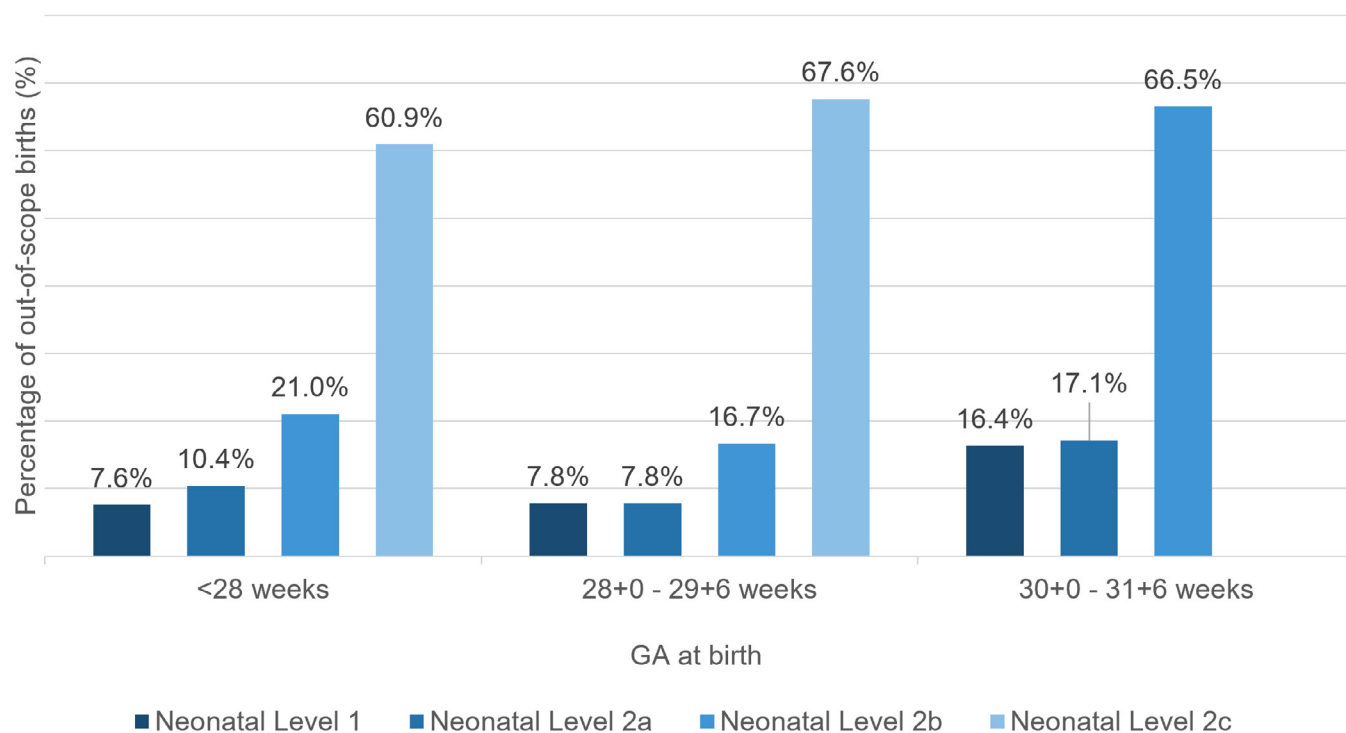
- The number of out-of-scope births among infants born before 32 weeks' GA remained relatively stable over time, ranging from 201 births in 2023/2024 to a peak of 230 births in 2022/2023
- Infants born at <28 weeks' GA consistently accounted for the largest proportion of out-of-scope births, increasing from 84 births in 2020/2021 to 114 births in 2024/2025.
- Out-of-scope births most commonly occurred in neonatal Level 2c hospitals for births before 30 weeks' gestation (60.9%-67.6%). The majority of out-of-scope births at 30+0 to 31+6 weeks' gestation occurred in Level 2b hospitals (66.5%). Few occurred in Level 1 and 2a hospitals (7.6%-17.1%).
- [See Appendix A3 for the data tables](#)

Figure 4a: Number of out-of-scope births by GA group, 2020/2021 - 2024/2025.



4.4 OUT-OF-SCOPE BIRTHS 2020/2021 - 2024/2025 (continued)

Figure 4b: Prevalence of out-of-scope births less than 32 weeks' gestation occurring in each neonatal LOC, by GA, Ontario, 2020/2021 - 2024/2025.³

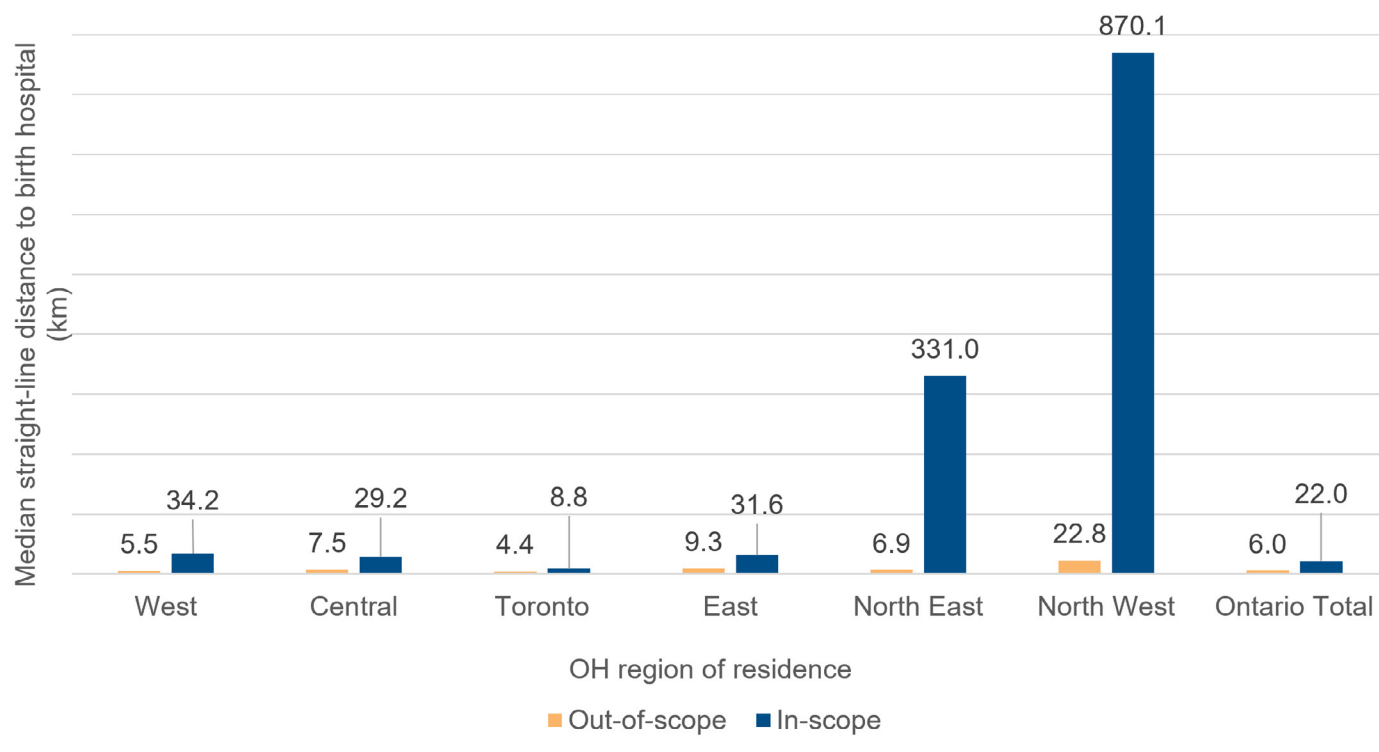


3. 8 out-of-scope births occurring at hospitals that do not offer birthing services were excluded from the percentages in this plot.

4.5 GEOGRAPHY, 2020/2021 - 2024/2025

- Median travel distance was longer for in-scope births (22.0km, IQR: 8.5-46.8) compared to out-of-scope births (6.0km, IQR: 3.1-15.2). Out-of-scope births generally occurred close to the place of residence regardless of region.
- Travel distances for in-scope births were substantially higher in northern Ontario than in southern regions. The median distance reached 331.0 km in the North East and 870.1 km in the North West, compared with less than 35 km in all southern OH regions.
- The distances reported here reflect straight-line calculations ('as the crow flies'). Actual travel routes are often longer, particularly in remote areas where road access is limited.

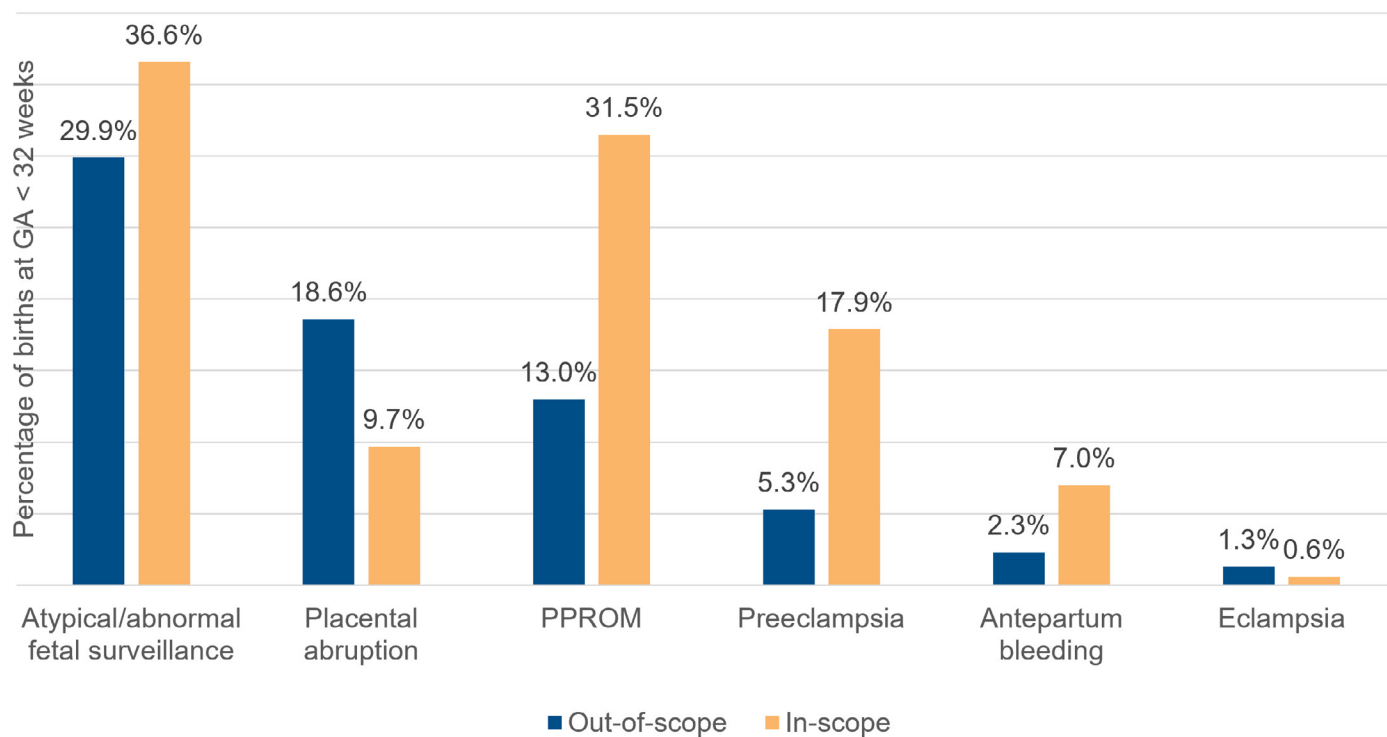
Figure 5: Median straight-line distance (in km) from residence to birth hospital among births less than 32 weeks' gestation, by out-of-scope status and OH region of residence, 2020/2021 - 2024/2025.



4.6 PREGNANCY COMPLICATIONS, 2020/2021 - 2024/2025

- Atypical/abnormal fetal surveillance was the most common indication among births <32 weeks' gestation in both groups, occurring in 29.9% of out-of-scope births and 36.6% of in-scope births.
- Several high-risk obstetric conditions were more common among in-scope births, including Preterm prelabour rupture of membranes (PPROM) (31.5% vs. 13.0%), preeclampsia (17.9% vs. 5.3%), and antepartum bleeding (7.0% vs. 2.3%), suggesting that individuals with these complications were more likely to deliver at an appropriate higher-level hospital.
- Placental abruption was more common among out-of-scope births than in-scope births (18.6% vs. 9.7%). This may reflect the acute and unpredictable nature of placental abruption, which can limit opportunities for maternal transfer prior to delivery.
- These findings suggest that out-of-scope births may disproportionately occur in rapidly evolving clinical situations requiring urgent delivery, where opportunities for maternal transfer may be limited.

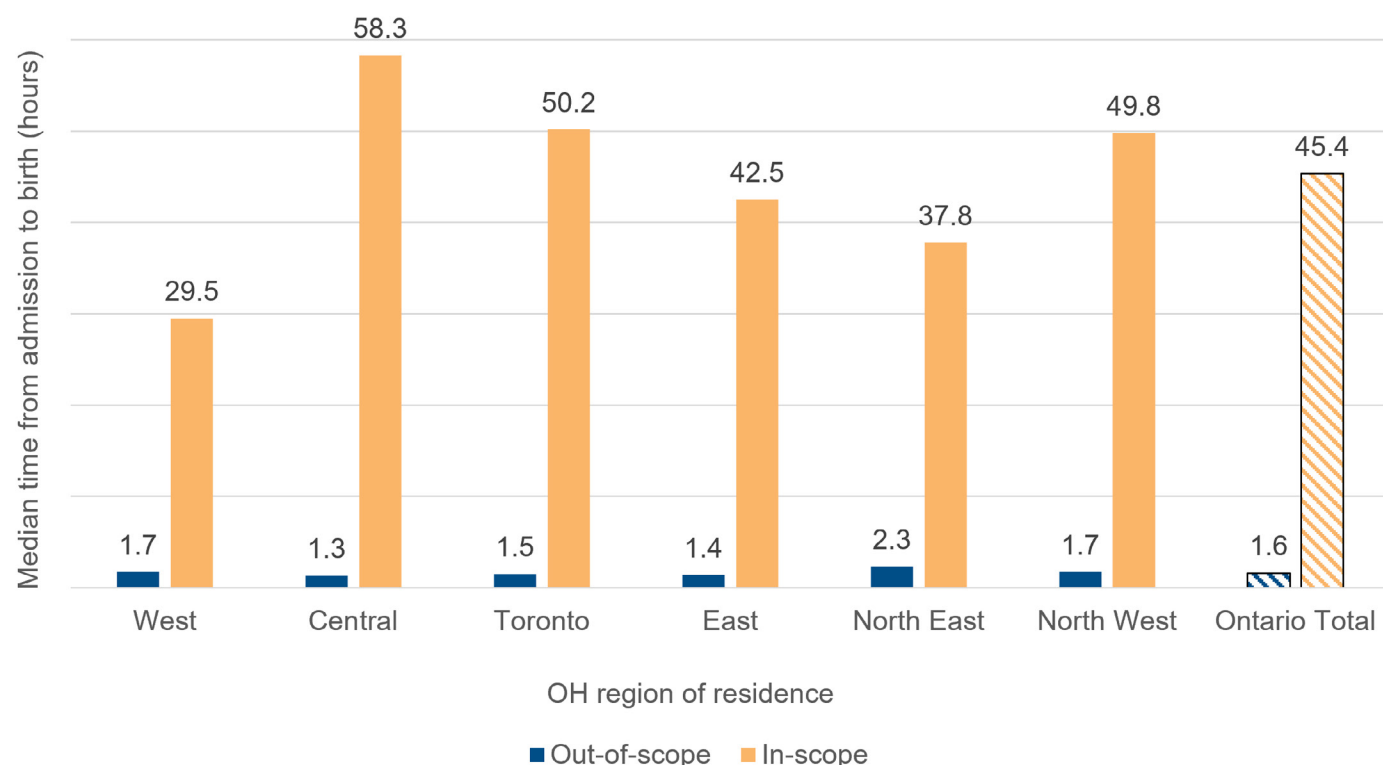
Figure 6: Prevalence of pregnancy complications for births less than 32 weeks' gestation, by out-of-scope status, Ontario, 2020/2021 - 2024/2025.



4.7 COMPARISON OF ADMISSION TO DELIVERY TIMES AND BARRIERS TO TRANSFER, 2020/2021 - 2024/2025

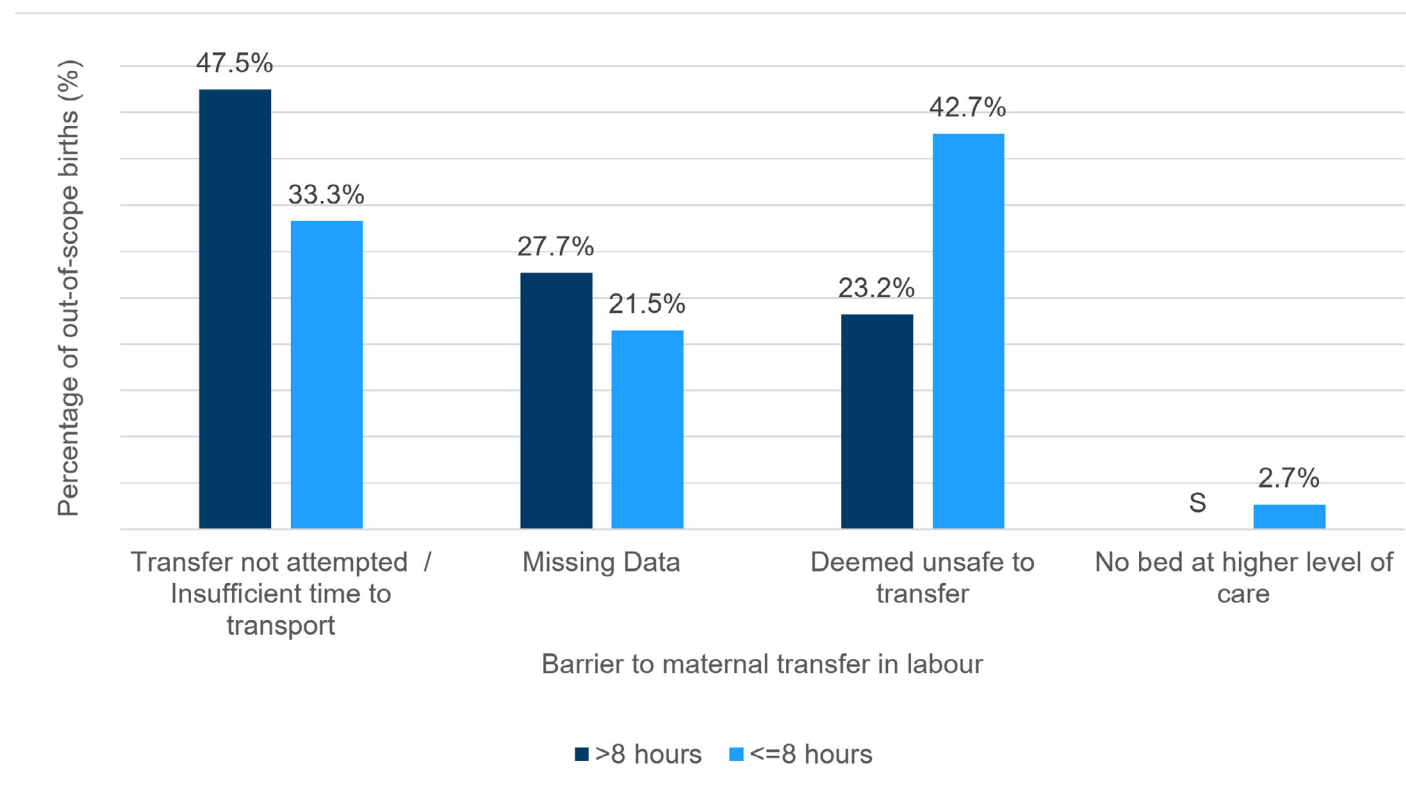
- Out-of-scope births were characterized by very short admission-to-birth intervals, with a provincial median of 1.6h compared with 45.4h for in-scope births.
- Among out-of-scope births, the most commonly reported barriers to maternal transfer in labour were transfer not attempted/insufficient time to transport and transfer deemed unsafe. For births with an admission-to-birth interval >8 hours, 47.5% were attributed to transfer not attempted or insufficient time, while among those with intervals ≤8 hours, 42.7% were considered unsafe to transfer.
- Barriers related to health system capacity were uncommon. Lack of an available bed at a higher LOC accounted for only 2.7% of out-of-scope births with admission-to-birth intervals ≤8 hours, suggesting that clinical circumstances were more often barriers to transfer than resource availability

Figure 7a: Median time from admission to birth (in hours) by out-of-scope status and OH region of residence, 2020/2021 - 2024/2025



4.7 COMPARISON OF ADMISSION TO DELIVERY TIMES AND BARRIERS TO TRANSFER, 2020/2021 - 2024/2025 (continued)

Figure 7b: Prevalence of barriers to maternal transfer for out-of-scope births, by time from admission to birth, Ontario, 2020/2021 - 2024/2025.⁴

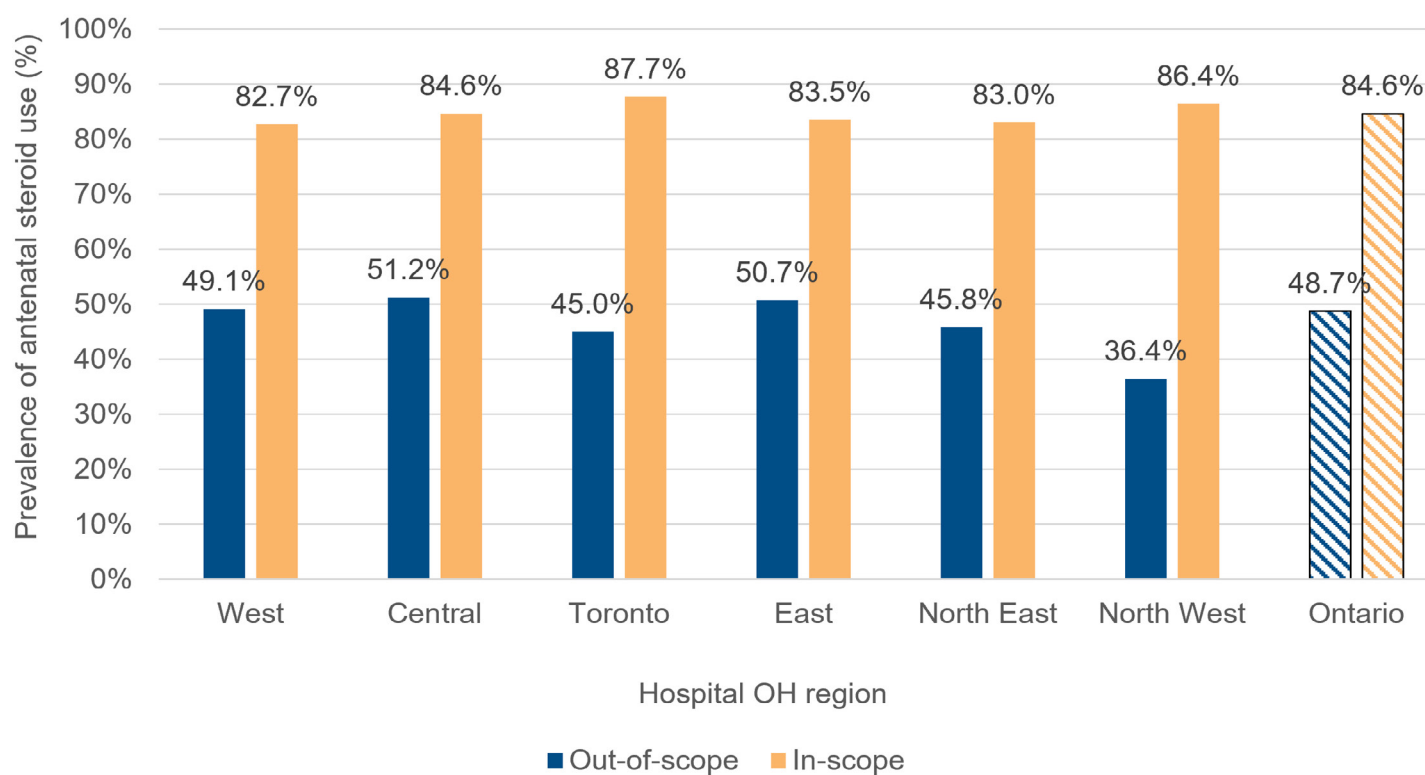


4. S = suppressed due to frequency less than 6. Other maternal barriers to transfer were not included in the figure due to counts less than six, namely: "Transport services not available", "Inclement weather or environmental barrier", and "Patient refuses transfer (for births occurring after May 2024)".

4.8 PREVALENCE OF STEROID ADMINISTRATION BY OH REGION, 2020/2021 - 2024/2025

- Antenatal steroid administration was substantially lower among out-of-scope births than in-scope births. Provincially, 48.7% of out-of-scope births received antenatal steroids compared with 84.6% of in-scope births, indicating fewer opportunities to provide this important intervention before delivery.
- The lower use of antenatal steroids among out-of-scope births was consistent across all hospital OH regions. In-scope births had steroid administration rates ranging from 82.7% to 87.7%, while rates among out-of-scope births ranged from 36.4% to 51.2%.
- Among out-of-scope births, antenatal steroid use varied by hospital OH region. The prevalence ranged from 36.4% in the North West to 51.2% in Central, although all regions remained well below the corresponding rates observed among in-scope births.

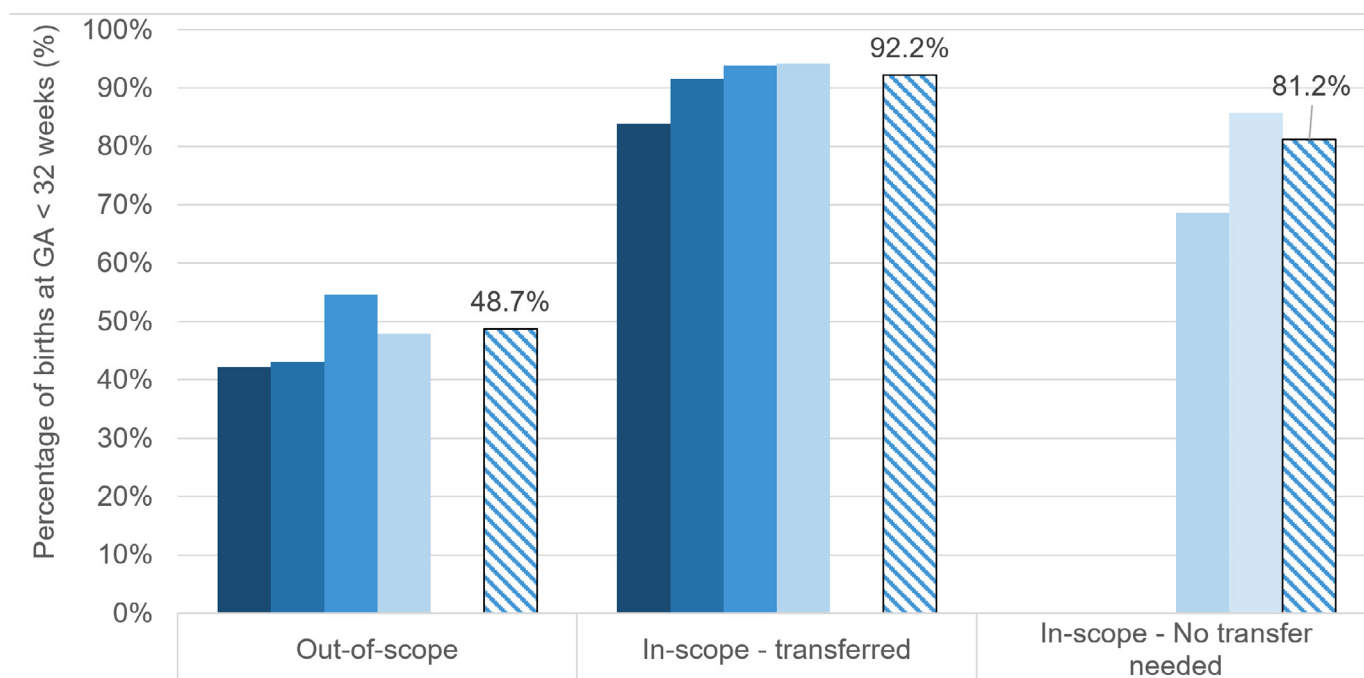
Figure 8: Prevalence of antenatal steroid use among births less than 32 weeks' gestation, by out-of-scope status and OH region, 2020/2021 - 2024/2025.



4.9 ANTENATAL STEROID ADMINISTRATION BY LOC, 2020/2021 - 2024/2025

- Antenatal steroid use was lower among out-of-scope births (48.7%) than in-scope births. Provincially, steroid administration was 92.2% among in-scope births involving maternal transfer and 81.2% among in-scope births not requiring transfer.
- Among out-of-scope births, antenatal steroid use was consistently low across neonatal care levels. Rates ranged from 42.2% in level 1 hospitals to 54.6% in level 2b hospitals.
- Among transferred in-scope births, antenatal steroid use was consistently high across neonatal care levels. More than 83% of transferred in-scope births received steroids in all LOCs, reaching 94.2% in level 2c hospitals.

Figure 9: Prevalence of antenatal steroid use among births less than 32 weeks' gestation, by out-of-scope status and neonatal LOC, Ontario, 2020/2021 - 2024/2025.

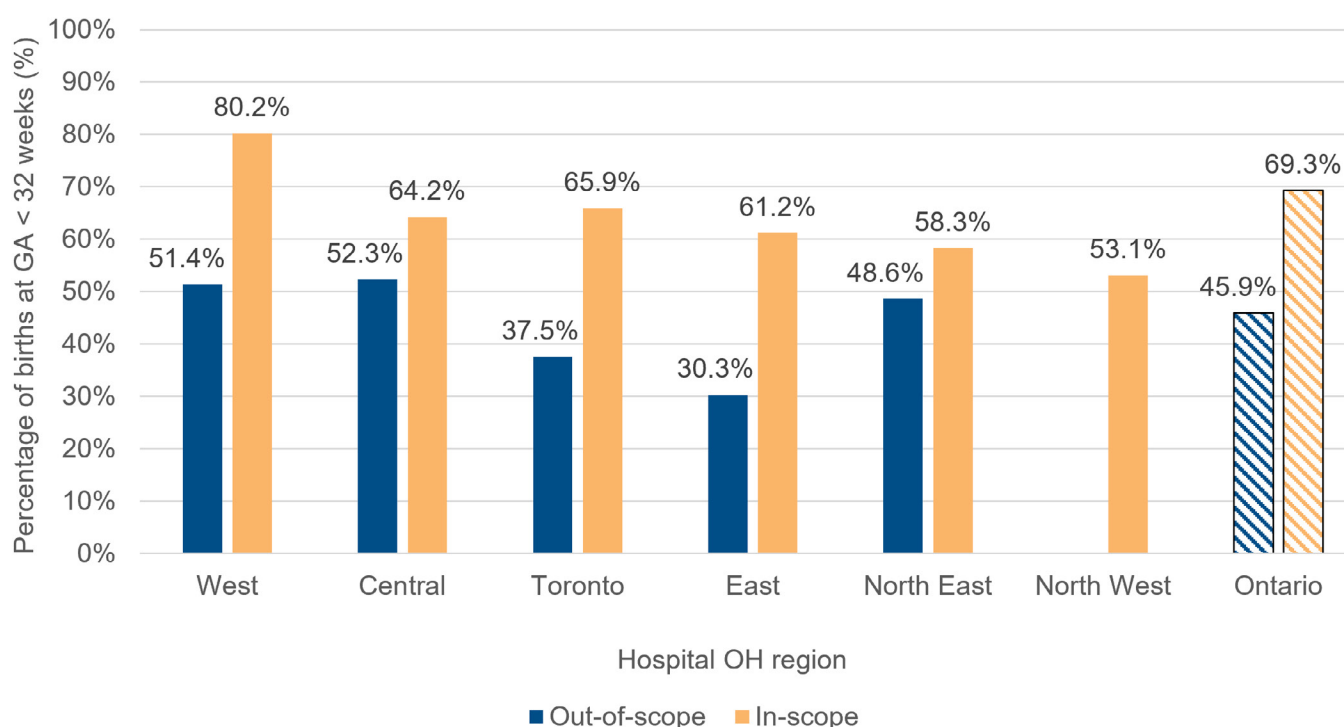


Level	Out-of-scope	In-scope - transferred	In-scope - No transfer needed
Level 1	42.2%	83.8%	-
Level 2a	43.0%	91.6%	-
Level 2b	54.6%	93.8%	-
Level 2c	47.9%	94.2%	68.6%
Level 3a/3b	-	-	85.8%
Ontario	48.7%	92.2%	81.2%

4.10 MAGNESIUM SULPHATE ADMINISTRATION BY OH REGION, 2021/2022 - 2024/2025

- Data on magnesium sulphate administration is available beginning in April 2021.
- The prevalence of magnesium sulphate was lower among out-of-scope births (45.9%) compared to in-scope births (69.3%). This pattern was consistent across all OH regions.
- Among out-of-scope births, magnesium sulphate administration varied by region, ranging from a low of 30.3% in OH East to a high of 52.3% in OH Central.

Figure 10: Prevalence of antenatal magnesium sulphate use among births less than 32 weeks' gestation, by out-of-scope status and OH region, 2021/2022 to 2024/2025.⁵

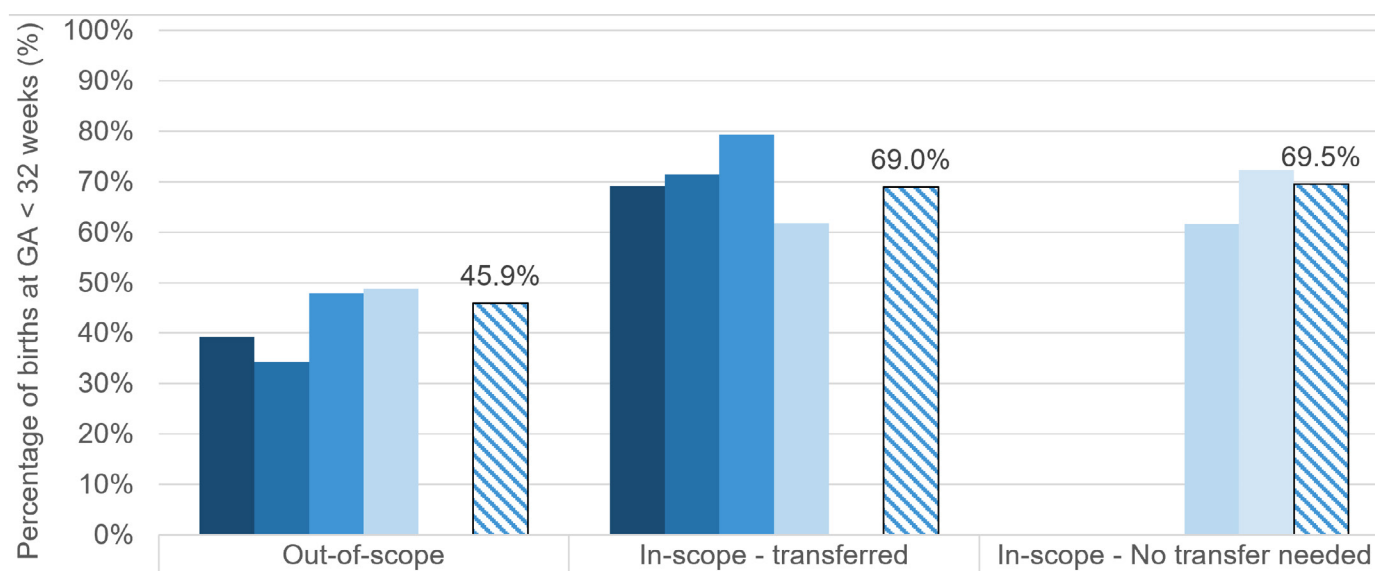


⁵. S = suppressed due to frequency less than 6.

4.11 MAGNESIUM SULPHATE ADMINISTRATION BY LOC, 2021/2022 - 2024/2025

- Among in-scope births, the prevalence of magnesium sulphate administration was similar regardless of whether a maternal transfer occurred (69.5% for in-scope without a transfer vs. 69.0% for in-scope births following a maternal transfer).
- The prevalence of magnesium sulphate administration varied by LOC. For out-of-scope births, the prevalence ranged from 34.3% at level 2a hospitals and the highest was 48.8% at level 2c hospitals.

Figure 11: Prevalence of antenatal magnesium sulphate use among births less than 32 weeks' gestation, by out-of-scope status and LOC, Ontario, 2021/2022 to 2024/2025.

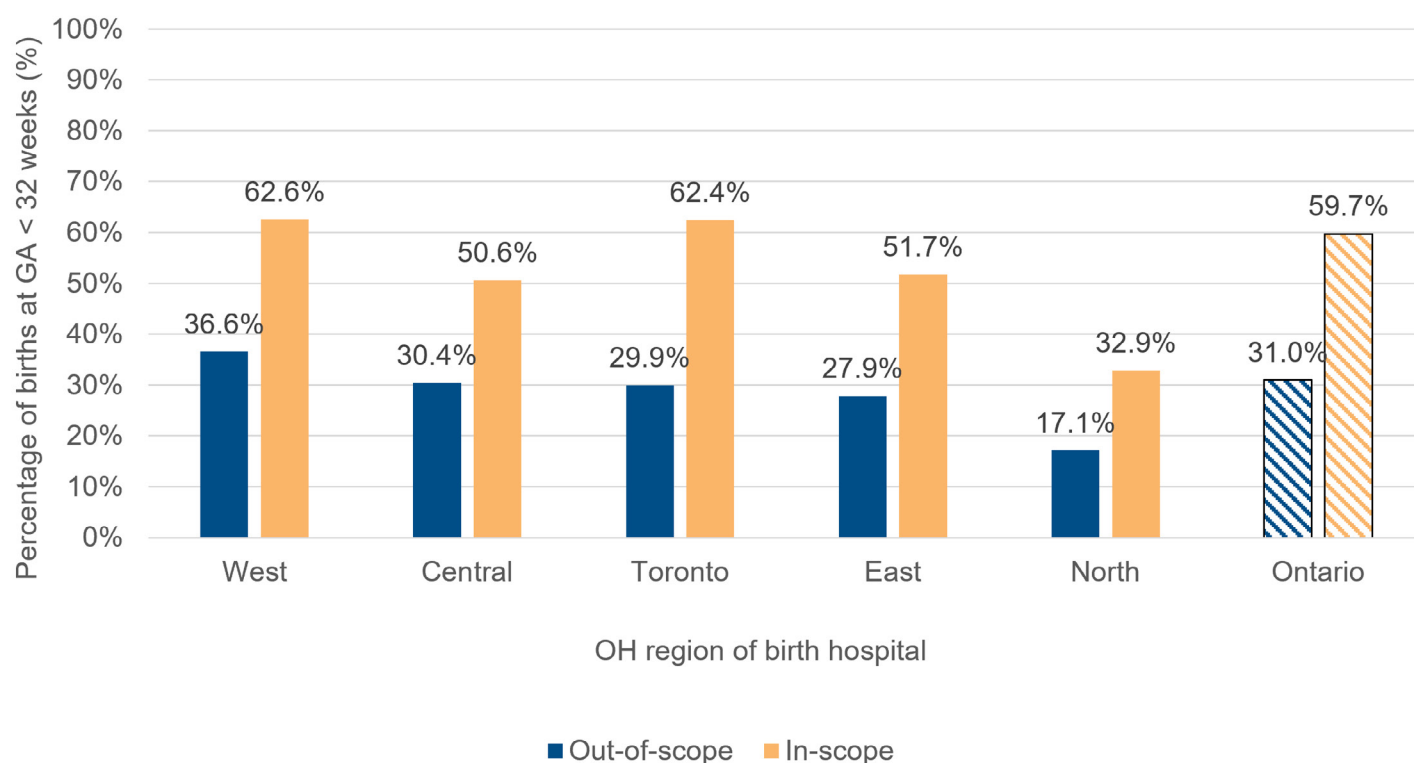


Level	Out-of-scope	In-scope - transferred	In-scope - No transfer needed
Level 1	39.2%	69.2%	-
Level 2a	34.3%	71.5%	-
Level 2b	47.9%	79.4%	-
Level 2c	48.8%	61.8%	61.6%
Level 3a/3b	-	-	72.4%
Ontario	45.9%	69.0%	69.5%

4.12 DEFERRED CORD CLAMPING (DCC) FOR AT LEAST 30 SECONDS BY OH REGION, 2020/2021 - 2024/2025⁶

- Due to the way deferred cord clamping was historically recorded in BORN, we are only able to assess whether delayed cord clamping occurred for at least 30 seconds. Data collection was enhanced in 2024, and future analyses will allow for more detailed assessment.
- OH North East and OH North West were combined to prevent suppression due to small group sizes.
- The prevalence of deferred cord clamping was lower for out-of-scope births (31.0%) compared to in-scope births (59.7%). This difference was observed across all hospital OH regions.
- Among out-of-scope births, deferred cord clamping varied by region, ranging from 17.1% in OH North (combined North East and North West) to 36.6% in OH West

Figure 12: Prevalence of DCC for at least 30 seconds among births less than 32 weeks' gestation, by out-of-scope status and OH region, 2020/2021 - 2024/2025.

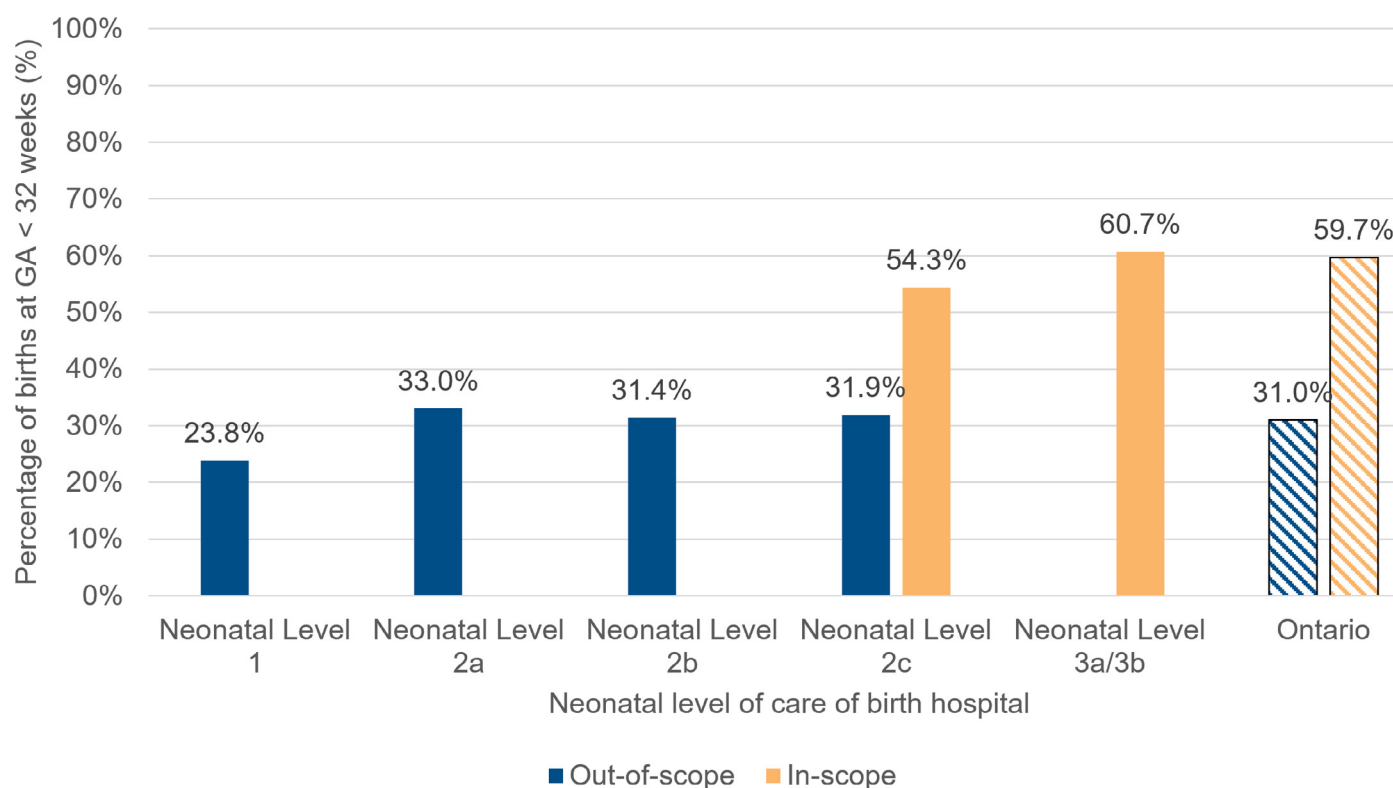


6. BORN enhanced the DCC data in May of 2024, which will allow for more granular analysis going forward that aligns closer with clinical practice guidelines. Data quality work is ongoing for the retrospective DCC data in the BIS. The discrepancy in the prevalence in DCC between out-of-scope and in-scope births is very unlikely to change as a result of these ongoing quality investigations.

4.13 DCC FOR AT LEAST 30 SECONDS BY LOC, 2020/2021 - 2024/2025⁶

- This analysis uses the birth hospital, to reflect the hospital where the infant could have received this intervention. Antenatal maternal transfer was not considered for this intervention as DCC occurs after birth.
- The lowest prevalence of deferred cord clamping was at Level 1 hospitals (23.8%). The highest prevalence of DCC was at level 3 hospitals (60.7%).

Figure 13: Prevalence of DCC for at least 30 seconds among births less than 32 weeks' gestation, by out-of-scope status and neonatal LOC, Ontario, 2020/2021 - 2024/2025.



6. BORN enhanced the DCC data in May of 2024, which will allow for more granular analysis going forward that aligns closer with clinical practice guidelines. Data quality work is ongoing for the retrospective DCC data in the BIS. The discrepancy in the prevalence in DCC between out-of-scope and in-scope births is very unlikely to change as a result of these ongoing quality investigations.

4.14 MORTALITY AND SEVERE NEUROLOGICAL INJURY, 2012/2013 - 2024/2025⁶

Consistent with findings from Amer et al. (2018), the prevalence of mortality and severe neurological injury was higher among out-of-scope births than in-scope births (mortality: 22.7% vs. 12.1%; severe neurological injury: 8.4% vs. 5.6%)

- Prevalences of both severe neurological injury and infant mortality up to one year varied by GA at birth, as did the differences between out-of-scope and in-scope births.
- Infant mortality
 - The largest differences were observed at the lowest gestational ages, specifically at 22 weeks (96.6% out-of-scope vs. 85.2% in-scope), 23 weeks (78.0% vs. 61.9%), and 24 weeks (45.3% vs. 34.4%).
 - These differences narrowed as GA increased. By 30-31 weeks, mortality was similar between groups (30 weeks: 2.0% out-of-scope vs. 2.6% in-scope; 31 weeks: 1.8% vs. 2.4%).
- Severe neurological injury
 - Prevalence was higher among out-of-scope births across nearly all GA groups. The largest differences were observed at 24 weeks (21.5% out-of-scope vs. 15.9% in-scope), 25 weeks (20.4% vs. 12.0%), and 26 weeks (13.7% vs. 8.4%).
 - As with mortality, the curves became similar at older gestational ages. At 30–31 weeks, prevalence was comparable between groups (GA = 30 weeks: 3.4% out-of-scope vs. 3.0% in-scope; GA = 31 weeks: 1.9% vs. 1.7%).
 - The spike in prevalence between 23 and 24 weeks is expected as the number of surviving infants is extremely small and many infants do not survive long enough for a neurological injury to be diagnosed.
- [See Appendix A4 and A5 for the data tables](#)

6. The data for infant mortality is for births between 2012/2013 and 2023/2024 due to the lag in the observation of outcomes.

Figure 14a: Prevalence of infant death (up to one year of age) by GA at birth and out-of-scope status, Ontario, 2012/2013 - 2023/2024.

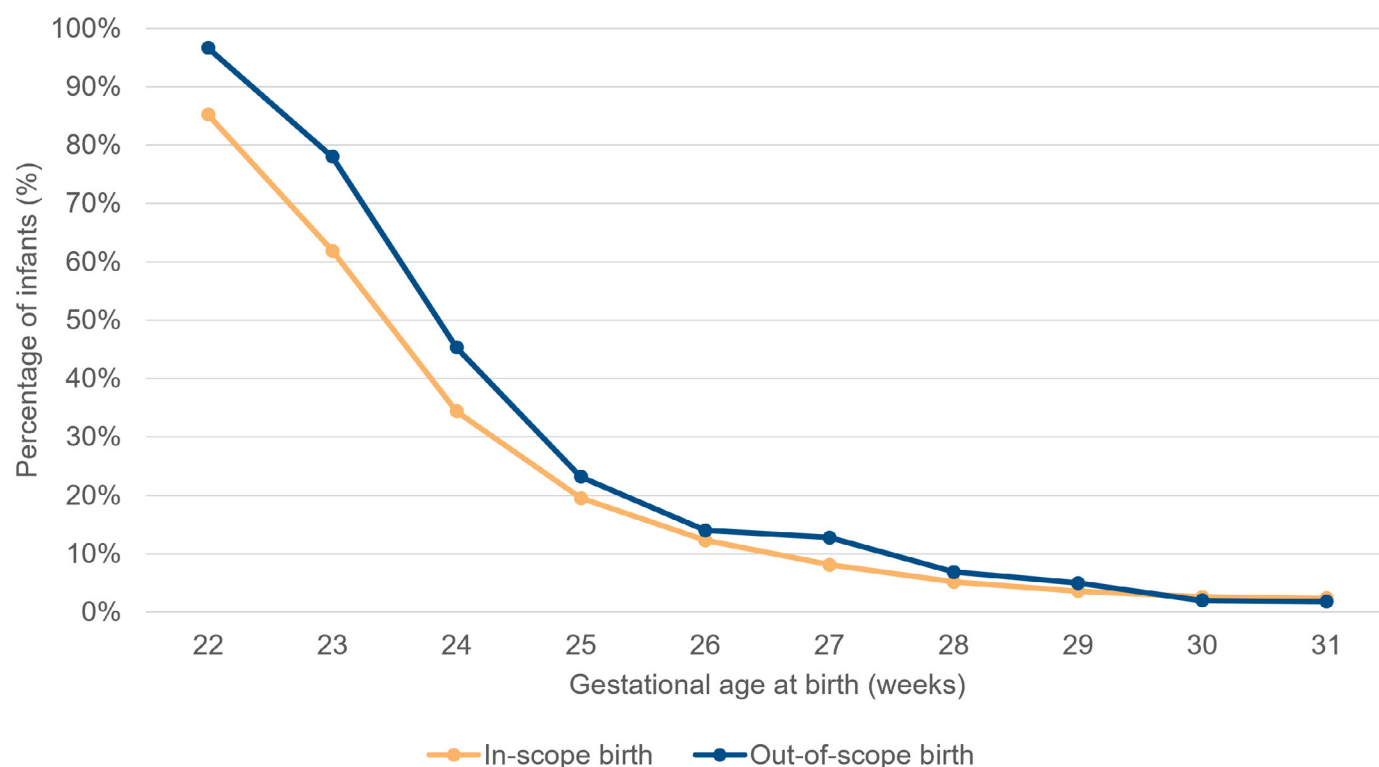
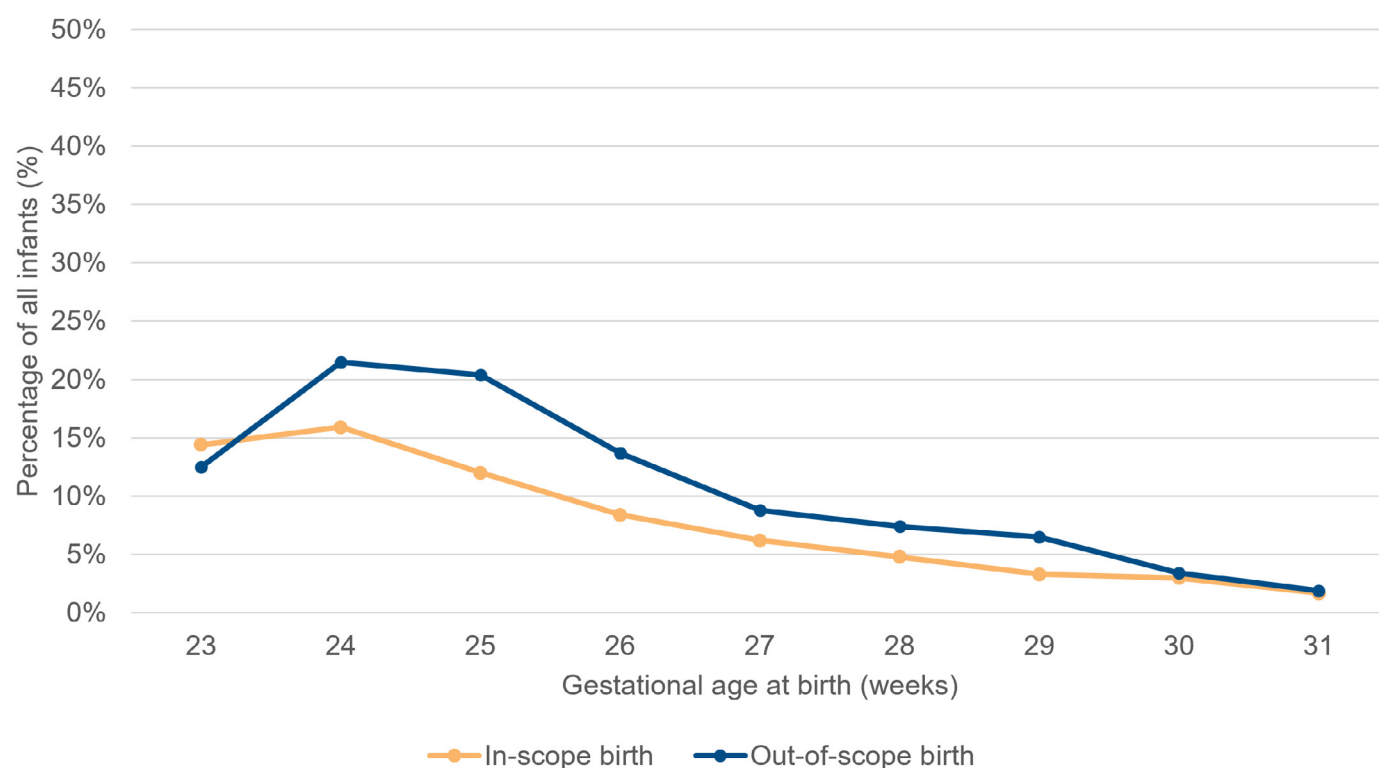


Figure 14b: Prevalence of severe neurological injury by GA at birth and out-of-scope status, Ontario, 2020/2021 - 2024/2025.



Summary of Key Findings

This provincial review shows that Ontario has made meaningful progress in reducing out-of-scope births over the past 13 years, with declines in both the <32 week and <28 week GA groups. Despite these improvements, prevalence remains variable across OH regions. In 2024/2025, out-of-scope births <32-weeks' GA ranged from 10.1% in OH Toronto to 32.0%⁷ in OH North West. The increase in the number of level 2C hospitals, especially in OH Toronto and OH Central, likely contributed to overall reductions and aligns with evidence highlighting the value of level 2C resources and efficient obstetrical triage and transfer processes (Gratton et al., 2016).

Over the past five years, the number of out-of-scope births has remained relatively stable, however, a growing proportion involve infants born at <28 weeks' GA. Although most of these extremely preterm out-of-scope births occurred in level 2C hospitals, a small proportion still occurred in level 1 centres. Additionally, geographic analyses highlight regional differences in distance to appropriate care, with the North regions facing the greatest transport challenges.

Out-of-scope births more frequently involved pregnancy complications requiring immediate intervention, including placental abruption and eclampsia. They were also less likely to receive evidence-based neonatal interventions, such as antenatal steroids, magnesium sulphate, and deferred cord clamping. These patterns contrast with what is observed for in-scope births. These differences were consistent across levels of care and across OH regions. Both mortality and severe neurological injury were more common among out-of-scope births, particularly at the lowest GAs.

Interpretation

Taken together, these findings show that although the province has made meaningful progress, timely access to the appropriate level of maternal and neonatal care remains uneven.

Regions with geographically dispersed populations and fewer high-acuity birth centres face persistent structural barriers that increase the likelihood of out-of-scope births. Interpretation of regional differences should also consider the unique realities of northern, remote, and many First Nations communities, where pregnant individuals may be required to travel or temporarily relocate before delivery to access the appropriate LOC. These strategies may reduce out-of-scope births but can place significant burdens on individuals, families, and communities.

Gaps in timely transfer, limited understanding of transfer barriers, and lower uptake of recommended interventions suggest opportunities to strengthen coordination between sending and receiving hospitals and to identify and address barriers that may prevent timely transfer when transfer is feasible. The findings also suggest that many out-of-scope births occur in the context of rapidly evolving clinical emergencies where maternal transfer may not be feasible or safe, highlighting the importance of both improving transfer pathways and ensuring readiness to provide high-quality stabilization and evidence-based care when out-of-scope births cannot be avoided.

These results highlight the need to ensure that all birthing hospitals, regardless of LOC, have the capacity, training, and protocols required to deliver essential stabilizing interventions when preterm birth occurs unexpectedly. Key training material could include the PROTECT Bundle created by Werlang et al. (2022).

7. This is the bi-annual out-of-scope prevalence for combined fiscal years 2023/2024 and 2024/2025.

Impact and Next Steps

Moving forward, several areas may merit system-level attention:



- Strengthen regional capacity and planning: Regions with persistently higher out-of-scope prevalence, particularly the North and West, may benefit from targeted strategies to enhance maternal transfer pathways, increase transport capacity, and review distribution of neonatal beds and levels of care.



- Improve documentation and understanding of transfer barriers in BORN data: Standardized, high-quality recording of maternal transfer decisions will improve the ability to identify avoidable delays.



- Strengthen preparedness for unavoidable out-of-scope births & support consistent delivery of evidence-based interventions: Variability in administration of antenatal steroids (Melamed et al., 2024), magnesium sulphate (Shepherd et al., 2024), and deferred cord clamping suggests the need for more standardized protocols, care bundles such as the PROTECT Bundle (Werlang et al., 2022) and audit-and-feedback tools across hospitals recognizing that some out-of-scope births will occur despite appropriate transfer planning and system capacity.



- Enhance early identification and triage: Creation and implementation of tools, similar to OTAS, to support timely recognition of preterm labour and to support decision-making to facilitate earlier mobilization of transport resources.



- Monitor outcomes and equity implications: Ongoing surveillance of mortality and neurological injury stratified by geography, LOC, and transfer status, will be essential to track progress and to ensure that improvements extend across all regions.

Overall, the declining provincial prevalence of out-of-scope births reflects meaningful system improvements. Continued action focused on regional disparities, timely maternal transport, and consistent care across all levels of hospitals will further strengthen perinatal outcomes for Ontario's most vulnerable infants.

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5. Provincial Council for Maternal and Child Health (2023). Perinatal, Birthing and Newborn Levels of Care. Retrieved April 17, 2026 from *Perinatal_Birthing_Newborn_Levels_of_Care_Guidance_Document.pdf*.
6. Shepherd ES, Goldsmith S, Doyle LW, Middleton P, Marret S, Rouse DJ, Pryde P, Wolf HT, Crowther CA. Magnesium sulphate for women at risk of preterm birth for neuroprotection of the fetus. *Cochrane Database Syst Rev*. 2024 May 10;5(5):CD004661. doi: 10.1002/14651858.CD004661.pub4. PMID: 38726883; PMCID: PMC11082932.
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Appendix A1: Data tables for Figure 1b. Prevalence of out-of-scope births less than 28 weeks' gestation, Ontario, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope births (%)	Out-of-scope births (n)	Total births (N)
2012/2013	30.4%	172	566
2013/2014	27.5%	148	539
2014/2015	23.4%	125	535
2015/2016	26.4%	136	515
2016/2017	21.0%	117	558
2017/2018	22.2%	118	531
2018/2019	21.8%	119	546
2019/2020	19.1%	96	502
2020/2021	17.5%	84	481
2021/2022	17.6%	95	541
2022/2023	21.9%	109	497
2023/2024	19.6%	99	505
2024/2025	19.8%	114	577

Appendix A2: Data tables for Figure 3. Number of birthing hospitals, by neonatal level of care, 2012/2013 - 2024/2025.

Fiscal Year	Neonatal Level 1 (n)	Neonatal Level 2a (n)	Neonatal Level 2b (n)	Neonatal Level 2c (n)	Neonatal Level 3a/3b (n)	Total (N)
2012/2013	53	14	13	17	6	103
2013/2014	53	13	14	17	6	103
2014/2015	50	8	17	17	6	98
2015/2016	49	8	18	17	6	98
2016/2017	46	8	17	17	6	94
2017/2018	46	8	15	19	6	94
2018/2019	44	10	14	20	6	94
2019/2020	44	10	14	20	6	94
2020/2021	44	10	12	21	6	93
2021/2022	44	10	12	21	6	93
2022/2023	44	10	11	22	6	93
2023/2024	42	10	9	24	6	91
2024/2025	42	10	9	24	6	91

Appendix A3: Data tables for Figure 4b. Prevalence of out-of-scope births less than 32 weeks' gestation occurring in each neonatal level of care, by gestational age, Ontario, 2020/2021 - 2024/2025.

Neonatal Level of Care	<28 weeks (n)	28+0 - 29+6 weeks (n)	30+0 - 31+6 weeks (n)	Total (N)
Non-birthing hospital	<6	<6	<6	8
Neonatal Level 1	38	24	44	106
Neonatal Level 2a	52	24	46	122
Neonatal Level 2b	105	51	179	335
Neonatal Level 2c	304	207	0	511
Total	501	308	273	1,082

Appendix A4: Data tables for Figure 14a. Prevalence of infant death (up to one year of age) by gestational age at birth and out-of-scope status, Ontario, 2012/2013 - 2024/2025.

GA weeks	Neonatal/infant death (up to 1 year)		Total		Neonatal/infant death (up to 1 year)	
	In-scope birth	Out-of- scope birth	In-scope birth	Out-of- scope birth	In-scope birth	Out-of- scope birth
-	n	n	n	n	% (row)	% (row)
22	333	256	391	265	85.2%	96.6%
23	424	198	685	254	61.9%	78.0%
24	337	91	979	201	34.4%	45.3%
25	206	59	1,055	254	19.5%	23.2%
26	138	37	1,119	264	12.3%	14.0%
27	108	39	1,336	305	8.1%	12.8%
28	81	27	1,561	394	5.2%	6.9%
29	67	26	1,885	516	3.6%	5.0%
30	71	7	2,687	342	2.6%	2.0%
31	87	9	3,669	510	2.4%	1.8%

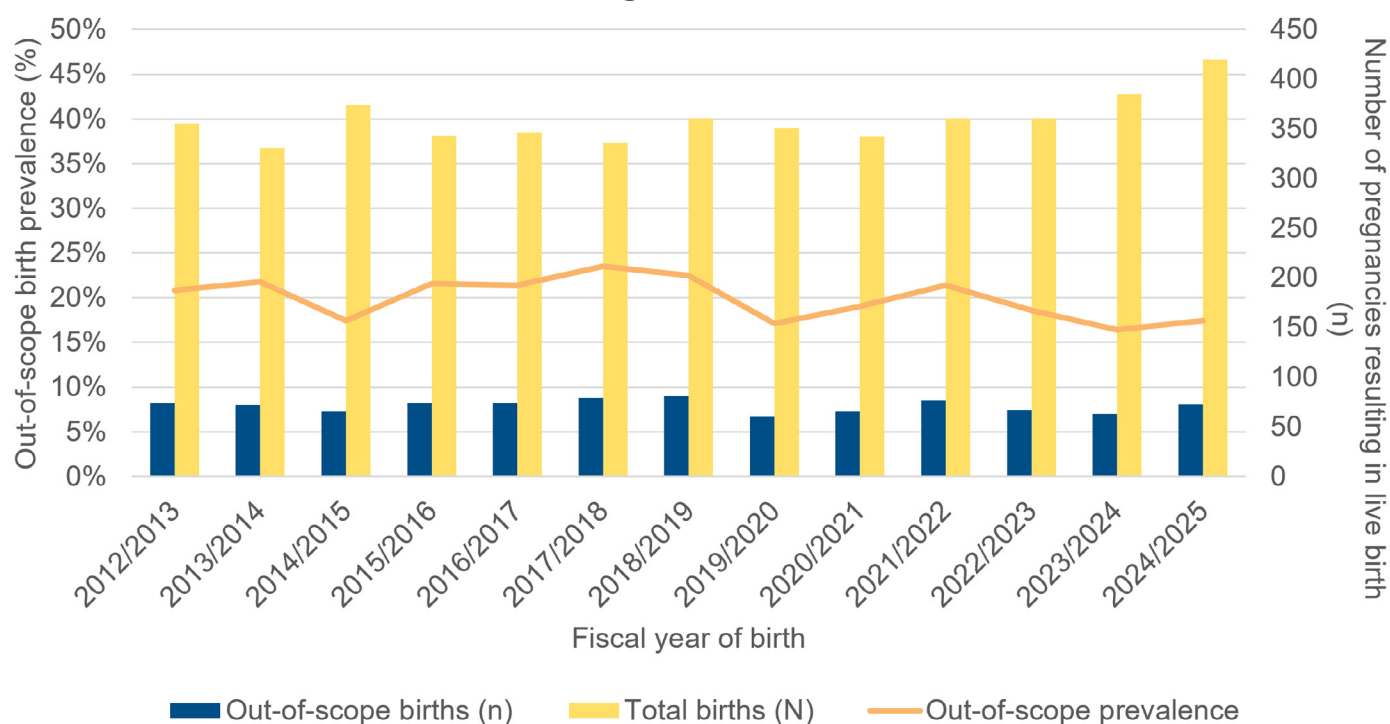
Appendix A5: Data tables for Figure 14b. Prevalence of severe neurological injury by gestational age at birth and out-of-scope status, Ontario, 2012/2013 - 2024/2025.

GA weeks	Severe Neurological Injury (n)		Total (N)		Severe Neurological Injury (%)	
	In-scope birth	Out-of- scope birth	In-scope birth	Out-of- scope birth	In-scope birth	Out-of- scope birth
-	n	n	n	n	% (row)	% (row)
22	34	<6	421	280	8.1%	S
23	103	33	714	265	14.4%	12.5%
24	162	46	1,020	214	15.9%	21.5%
25	130	56	1,083	274	12.0%	20.4%
26	97	39	1,161	284	8.4%	13.7%
27	88	29	1,411	330	6.2%	8.8%
28	79	31	1,631	419	4.8%	7.4%
29	66	36	1,984	555	3.3%	6.5%
30	85	12	2,833	355	3.0%	3.4%
31	65	10	3,850	527	1.7%	1.9%

Appendix B1: Prevalence of out-of-scope births less than 32 weeks' gestation, OH West, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	20.8%	74	355
2013/2014	21.8%	72	331
2014/2015	17.4%	65	374
2015/2016	21.6%	74	343
2016/2017	21.4%	74	346
2017/2018	23.5%	79	336
2018/2019	22.5%	81	360
2019/2020	17.1%	60	351
2020/2021	19.0%	65	342
2021/2022	21.4%	77	360
2022/2023	18.6%	67	360
2023/2024	16.4%	63	385
2024/2025	17.4%	73	420

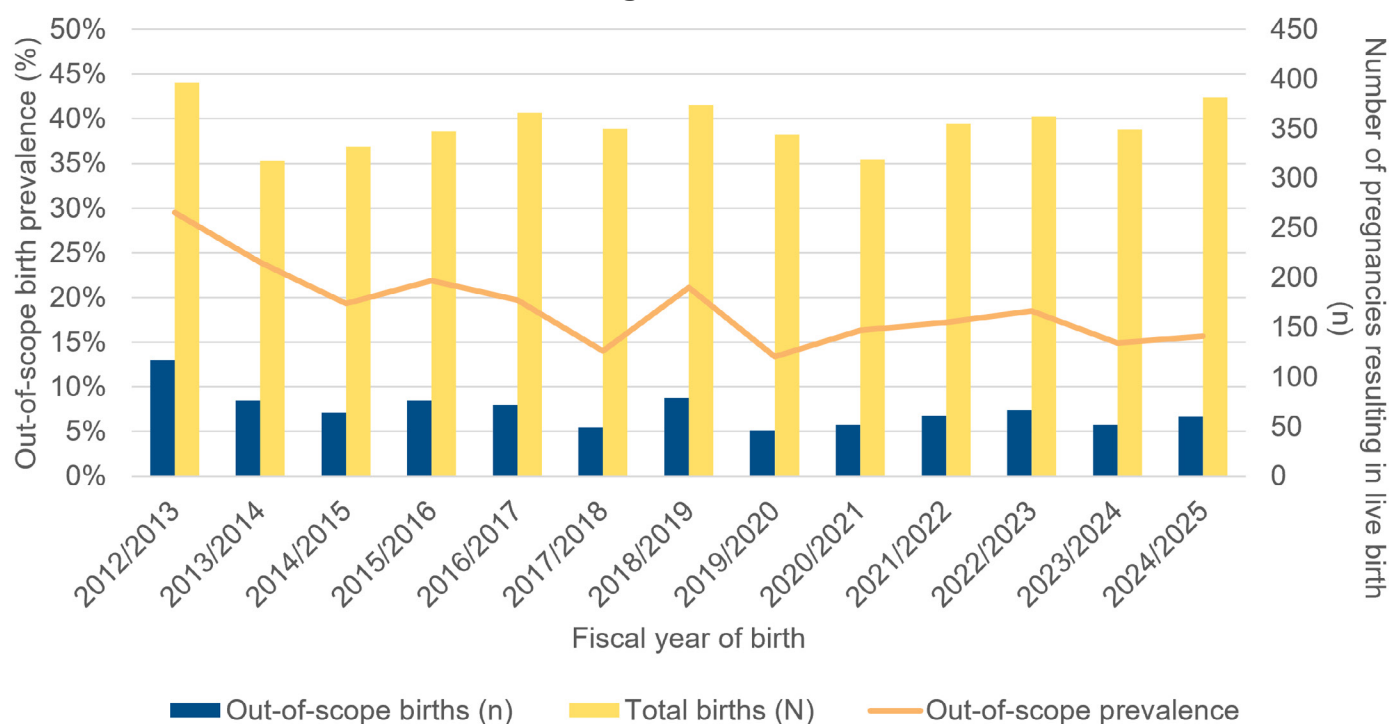
Figure B1



Appendix B2: Prevalence of out-of-scope births less than 32 weeks' gestation, OH Central, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	29.5%	117	396
2013/2014	23.9%	76	318
2014/2015	19.3%	64	332
2015/2016	21.9%	76	347
2016/2017	19.7%	72	366
2017/2018	14.0%	49	350
2018/2019	21.1%	79	374
2019/2020	13.4%	46	344
2020/2021	16.3%	52	319
2021/2022	17.2%	61	355
2022/2023	18.5%	67	362
2023/2024	14.9%	52	349
2024/2025	15.7%	60	381

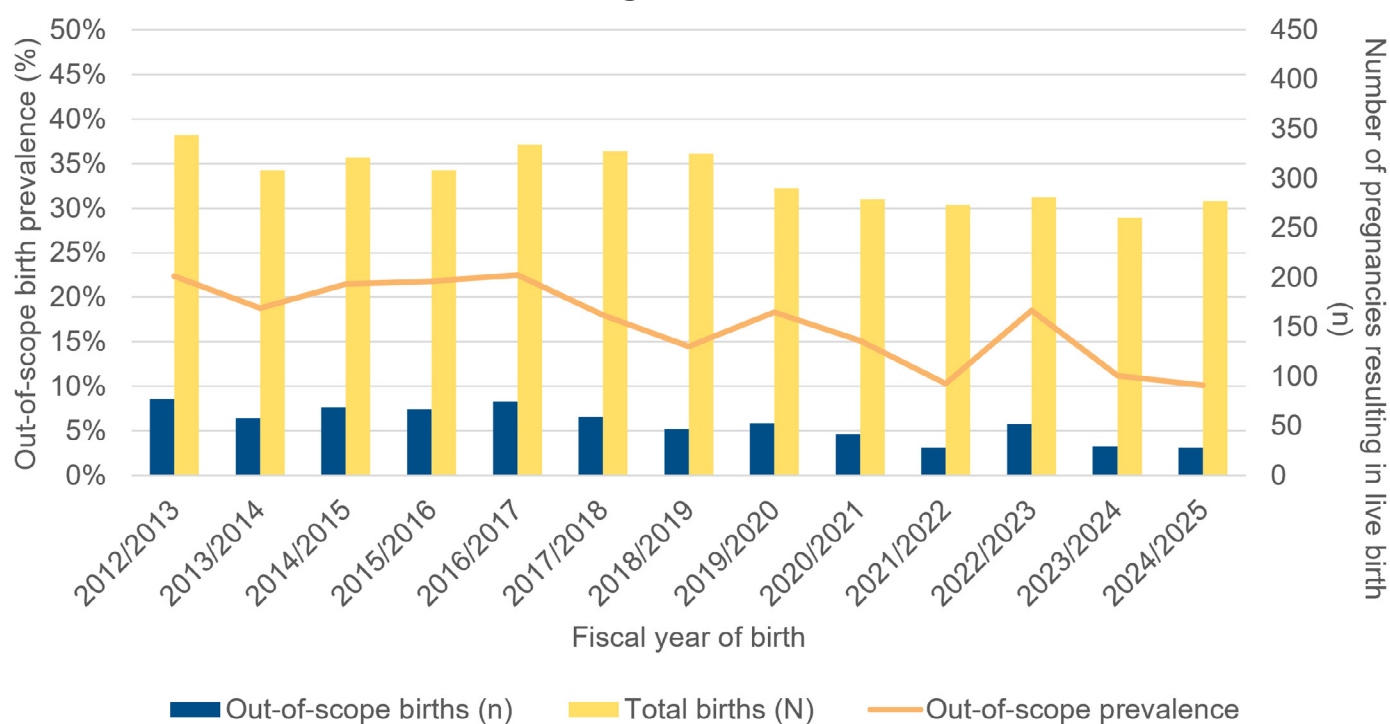
Figure B2



Appendix B3: Prevalence of out-of-scope births less than 32 weeks' gestation, OH Toronto, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	22.4%	77	344
2013/2014	18.8%	58	308
2014/2015	21.5%	69	321
2015/2016	21.8%	67	308
2016/2017	22.5%	75	334
2017/2018	18.0%	59	327
2018/2019	14.5%	47	325
2019/2020	18.3%	53	290
2020/2021	15.1%	42	279
2021/2022	10.3%	28	273
2022/2023	18.5%	52	281
2023/2024	11.2%	29	260
2024/2025	10.1%	28	277

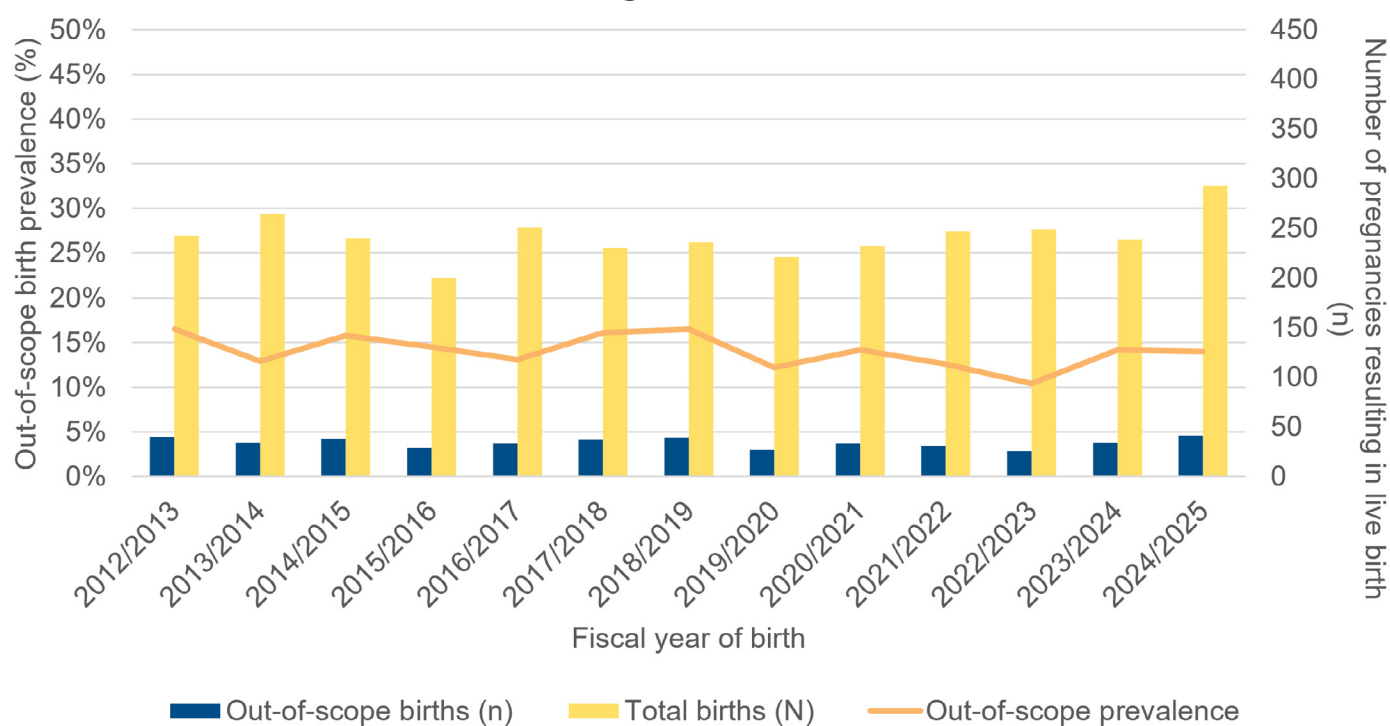
Figure B3



Appendix B4: Prevalence of out-of-scope births less than 32 weeks' gestation, OH East, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	16.5%	40	242
2013/2014	12.9%	34	264
2014/2015	15.8%	38	240
2015/2016	14.5%	29	200
2016/2017	13.1%	33	251
2017/2018	16.1%	37	230
2018/2019	16.5%	39	236
2019/2020	12.2%	27	221
2020/2021	14.2%	33	232
2021/2022	12.6%	31	247
2022/2023	10.4%	26	249
2023/2024	14.2%	34	239
2024/2025	14.0%	41	293

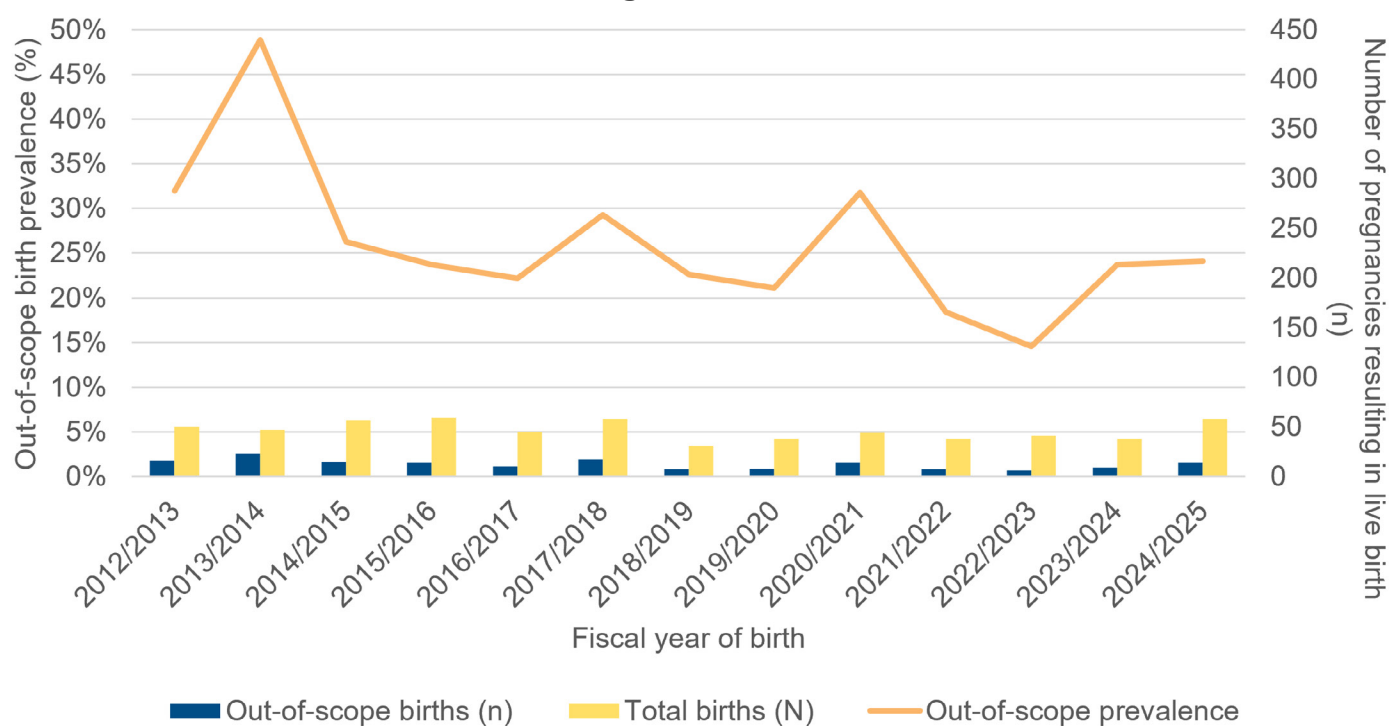
Figure B4



Appendix B5: Prevalence of out-of-scope births less than 32 weeks' gestation, OH North East, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	32.0%	16	50
2013/2014	48.9%	23	47
2014/2015	26.3%	15	57
2015/2016	23.7%	14	59
2016/2017	22.2%	10	45
2017/2018	29.3%	17	58
2018/2019	22.6%	7	31
2019/2020	21.1%	8	38
2020/2021	31.8%	14	44
2021/2022	18.4%	7	38
2022/2023	14.6%	6	41
2023/2024	23.7%	9	38
2024/2025	24.1%	14	58

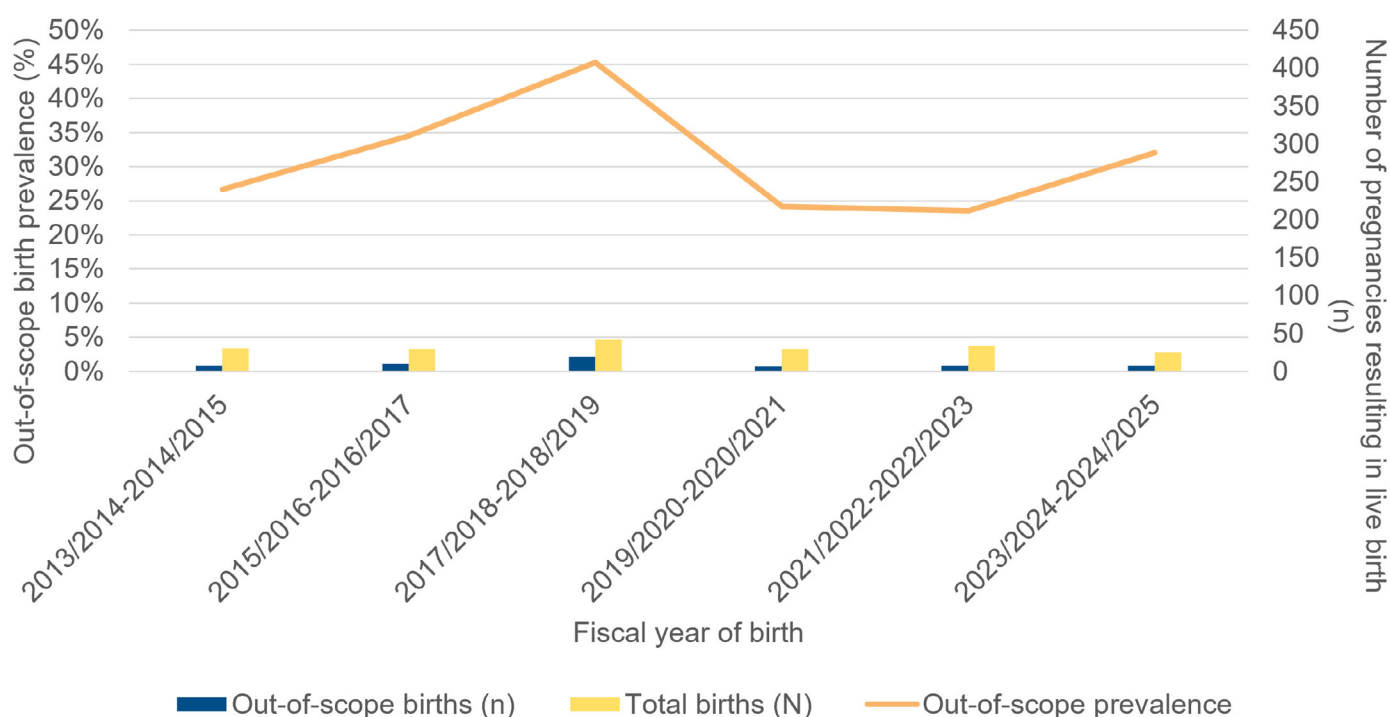
Figure B5



Appendix B6: Prevalence of out-of-scope births less than 32 weeks' gestation, OH North West, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2013/2014- 2014/2015	26.7%	8	30
2015/2016- 2016/2017	34.5%	10	29
2017/2018- 2018/2019	45.2%	19	42
2019/2020- 2020/2021	24.1%	7	29
2021/2022- 2022/2023	23.5%	8	34
2023/2024- 2024/2025	32.0%	8	25

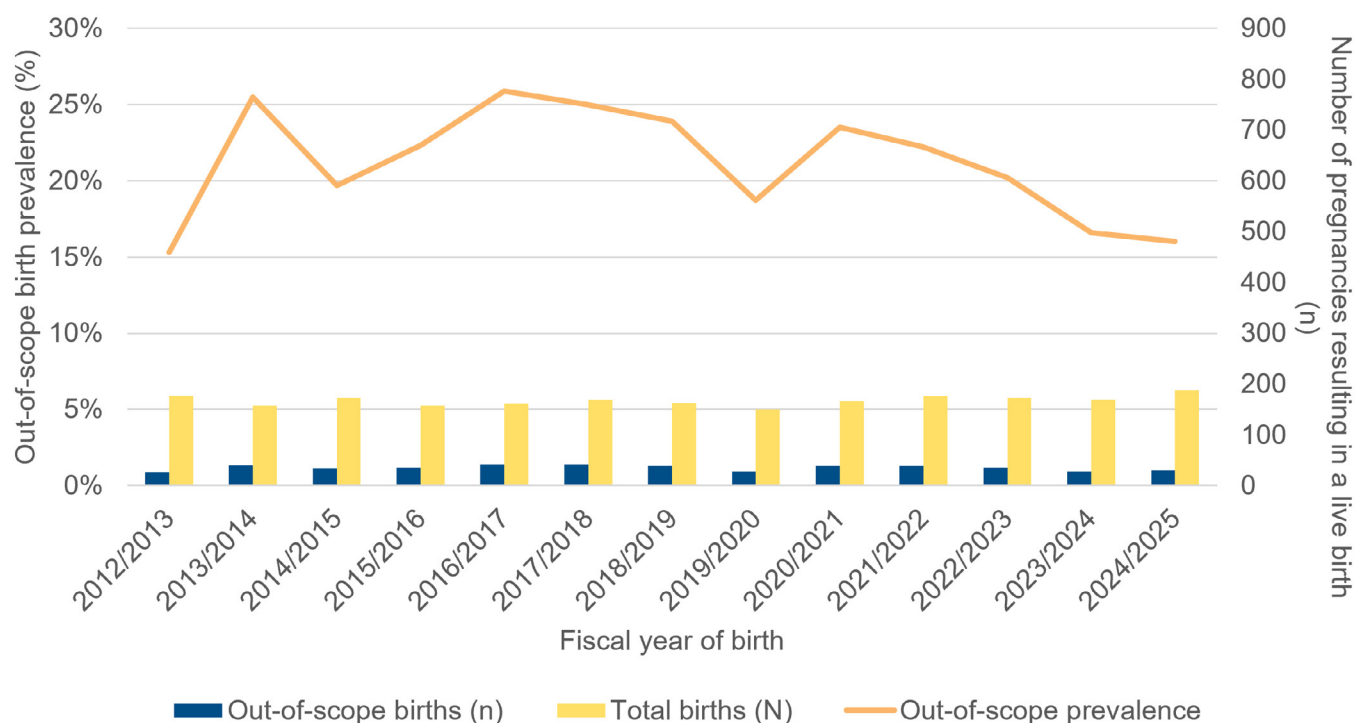
Figure B6



Appendix C1: Prevalence of out-of-scope births less than 32 weeks' gestation, London Transport Region, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	15.3%	27	177
2013/2014	25.5%	40	157
2014/2015	19.7%	34	173
2015/2016	22.3%	35	157
2016/2017	25.9%	42	162
2017/2018	25.0%	42	168
2018/2019	23.9%	39	163
2019/2020	18.7%	28	150
2020/2021	23.5%	39	166
2021/2022	22.2%	39	176
2022/2023	20.2%	35	173
2023/2024	16.6%	28	169
2024/2025	16.0%	30	188

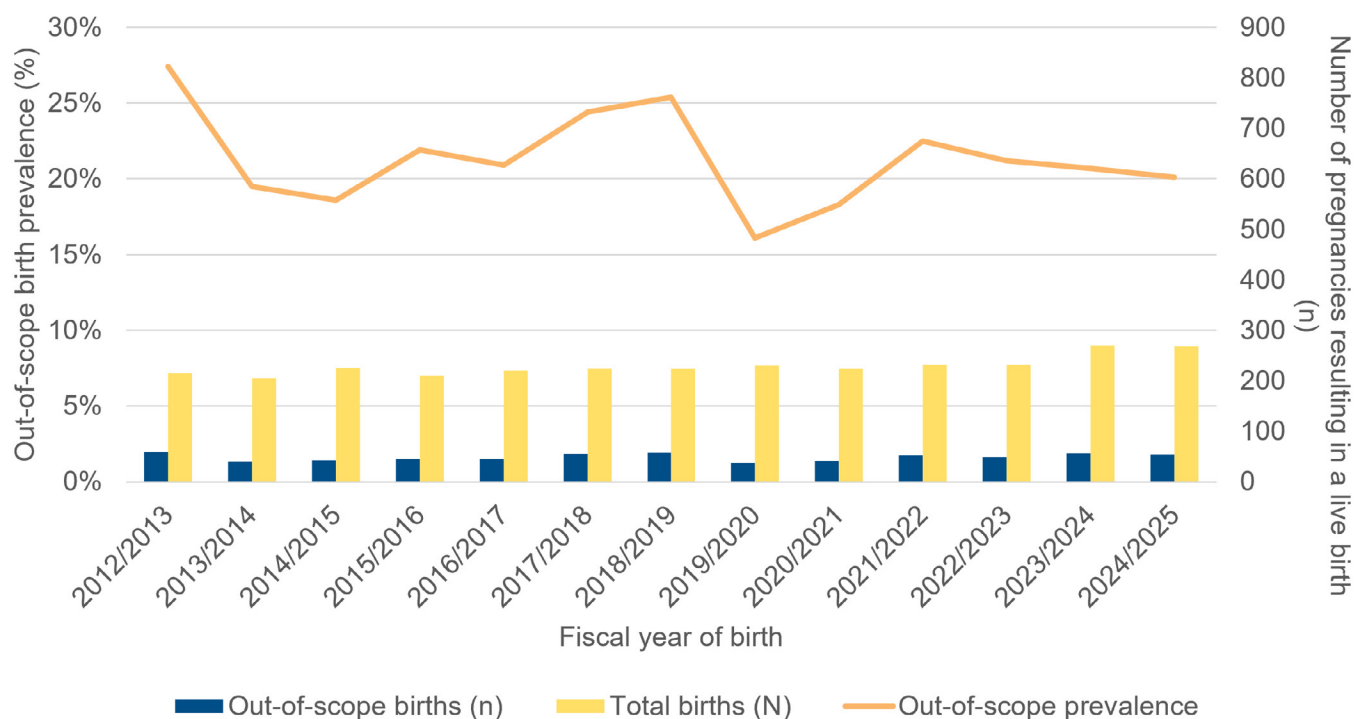
Figure C1



Appendix C2: Prevalence of out-of-scope births less than 32 weeks' gestation, Hamilton Transport Region, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	27.4%	59	215
2013/2014	19.5%	40	205
2014/2015	18.6%	42	226
2015/2016	21.9%	46	210
2016/2017	20.9%	46	220
2017/2018	24.4%	55	225
2018/2019	25.4%	57	224
2019/2020	16.1%	37	230
2020/2021	18.3%	41	224
2021/2022	22.5%	52	231
2022/2023	21.2%	49	231
2023/2024	20.7%	56	270
2024/2025	20.1%	54	268

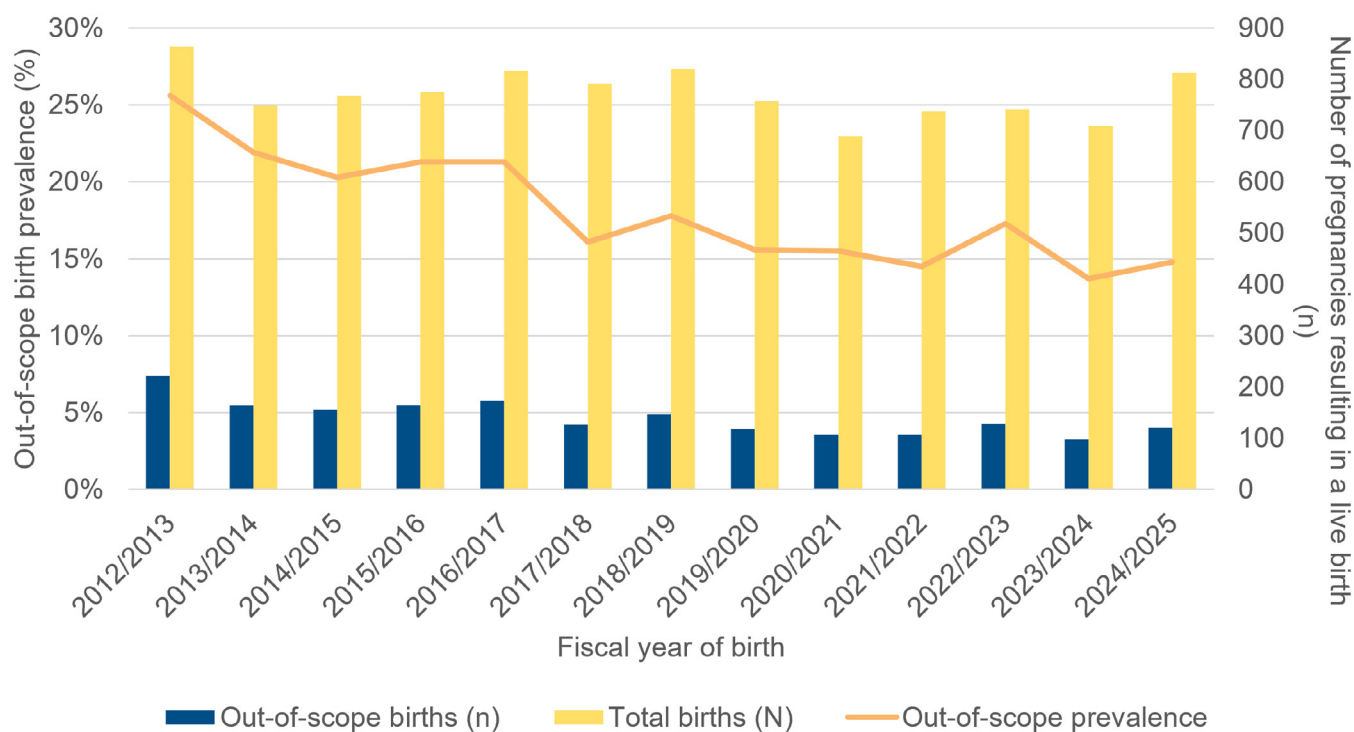
Figure C2



Appendix C3: Prevalence of out-of-scope births less than 32 weeks' gestation, Toronto Transport Region, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	25.6%	221	863
2013/2014	21.9%	164	749
2014/2015	20.3%	156	768
2015/2016	21.3%	165	776
2016/2017	21.3%	174	817
2017/2018	16.1%	127	791
2018/2019	17.8%	146	820
2019/2020	15.6%	118	757
2020/2021	15.5%	107	689
2021/2022	14.5%	107	738
2022/2023	17.3%	128	741
2023/2024	13.7%	97	710
2024/2025	14.8%	120	813

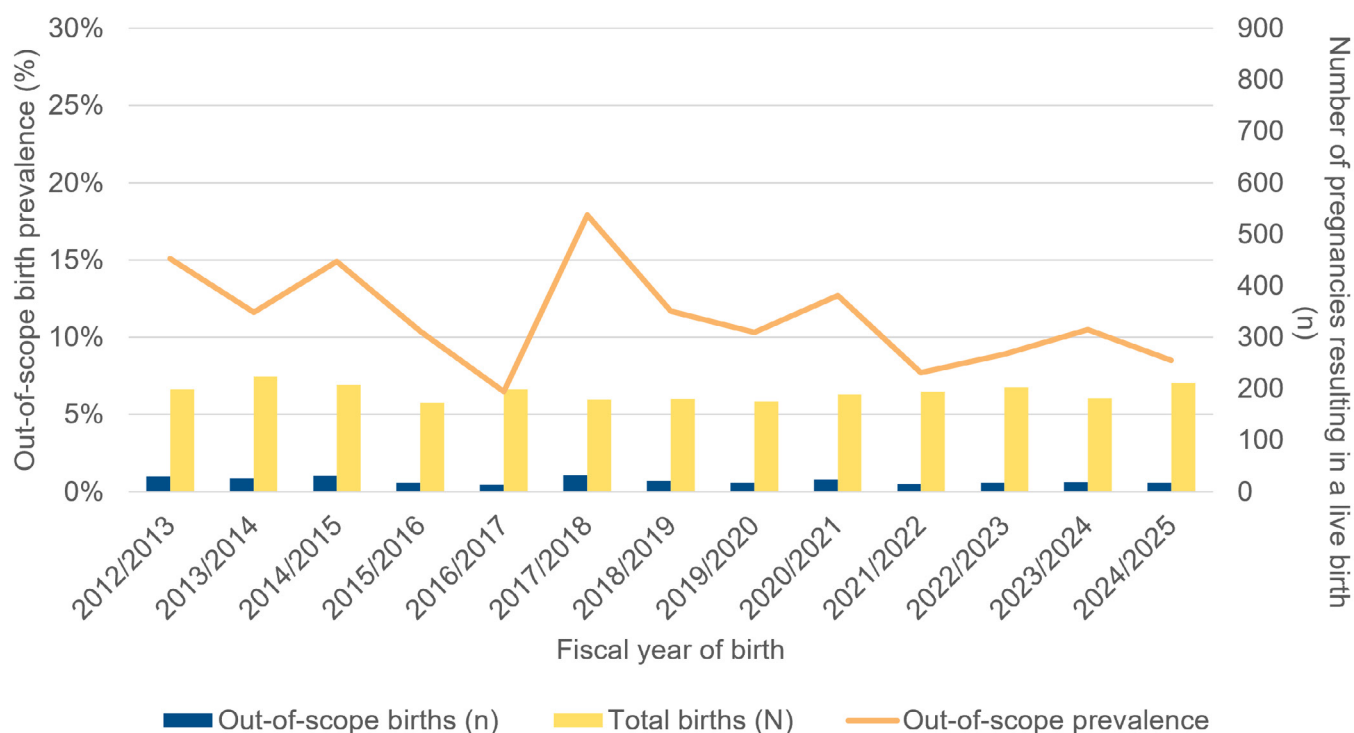
Figure C3



Appendix C4: Prevalence of out-of-scope births less than 32 weeks' gestation, Ottawa Transport Region, 2012/2013 - 2024/2025.

Fiscal Year	Out-of-scope prevalence	Out-of-scope births (n)	Total births (N)
2012/2013	15.1%	30	199
2013/2014	11.6%	26	224
2014/2015	14.9%	31	208
2015/2016	10.4%	18	173
2016/2017	6.5%	13	199
2017/2018	17.9%	32	179
2018/2019	11.7%	21	180
2019/2020	10.3%	18	175
2020/2021	12.7%	24	189
2021/2022	7.7%	15	194
2022/2023	8.9%	18	203
2023/2024	10.5%	19	181
2024/2025	8.5%	18	211

Figure C4



Organization Name	Ontario Health Region	Transport Region	Neonatal Level of Care	First Fiscal Year as level 2C Centre (if changed since April 2012)
Collingwood General and Marine Hospital	Central Region	Toronto	Neonatal Level 1	
Georgian Bay General Hospital - Midland Site	Central Region	Toronto	Neonatal Level 1	
Halton Healthcare Services - Georgetown Hospital	Central Region	Hamilton	Neonatal Level 1	
Halton Healthcare Services - Milton District Hospital	Central Region	Hamilton	Neonatal Level 2a	
Halton Healthcare Services - Oakville Trafalgar Memorial Hospital	Central Region	Hamilton	Neonatal Level 2b	
Headwaters Health Care Centre - Orangeville Site	Central Region	Toronto	Neonatal Level 1	
Mackenzie Health - Cortellucci Vaughan Hospital	Central Region	Toronto	Neonatal Level 2c	
Muskoka Algonquin Healthcare - Huntsville District Memorial Hospital Site	Central Region	Toronto	Neonatal Level 1	
Muskoka Algonquin Healthcare - South Muskoka Memorial Hospital Site	Central Region	Toronto	Neonatal Level 1	
Oak Valley Health - Markham Site	Central Region	Toronto	Neonatal Level 2c	
Orillia Soldiers' Memorial Hospital	Central Region	Toronto	Neonatal Level 2c	
Royal Victoria Regional Health Centre	Central Region	Toronto	Neonatal Level 2c	
Southlake Regional Health Centre	Central Region	Toronto	Neonatal Level 2c	2017/2018
Stevenson Memorial Hospital	Central Region	Toronto	Neonatal Level 1	
Trillium Health Partners - Credit Valley Hospital	Central Region	Toronto	Neonatal Level 2c	
Trillium Health Partners - Mississauga Hospital	Central Region	Toronto	Neonatal Level 2c	2023/2024
William Osler Health System - Brampton Civic	Central Region	Toronto	Neonatal Level 2c	

Organization Name	Ontario Health Region	Transport Region	Neonatal Level of Care	First Fiscal Year as level 2C Centre (if changed since April 2012)
William Osler Health System - Etobicoke General Hospital	Central Region	Toronto	Neonatal Level 2c	2022/2023
Almonte General Hospital	East Region	Ottawa	Neonatal Level 1	
Brockville General Hospital	East Region	Ottawa	Neonatal Level 1	
Cornwall Community Hospital - McConnell Avenue Site	East Region	Ottawa	Neonatal Level 1	
Hawkesbury and District General Hospital	East Region	Ottawa	Neonatal Level 1	
Hôpital Montfort	East Region	Ottawa	Neonatal Level 2a	
Kingston Health Sciences Centre	East Region	Ottawa	Neonatal Level 3a/3b	
Lakeridge Health - Ajax and Pickering Site	East Region	Toronto	Neonatal Level 2b	
Lakeridge Health - Oshawa	East Region	Toronto	Neonatal Level 2c	
Lakeridge Health - Port Perry	East Region	Toronto	Neonatal Level 1	
Northumberland Hills Hospital	East Region	Toronto	Neonatal Level 1	
Pembroke Regional Hospital	East Region	Ottawa	Neonatal Level 1	
Perth and Smiths Falls District Hospital - Smiths Falls	East Region	Ottawa	Neonatal Level 1	
Peterborough Regional Health Centre	East Region	Toronto	Neonatal Level 2b	
Queensway Carleton Hospital	East Region	Ottawa	Neonatal Level 2a	
Quinte Health - Belleville General	East Region	Ottawa	Neonatal Level 2a	
Ross Memorial Hospital	East Region	Toronto	Neonatal Level 1	
The Ottawa Hospital - Civic Campus	East Region	Ottawa	Neonatal Level 2c	
The Ottawa Hospital - General Campus	East Region	Ottawa	Neonatal Level 3a/3b	
Winchester District Memorial Hospital	East Region	Ottawa	Neonatal Level 1	
Health Sciences North - Sudbury	North East Region	Toronto	Neonatal Level 2c	
Lady Dunn Health Centre	North East Region	London	Neonatal Level 1	
Manitoulin Health Centre	North East Region	Toronto	Neonatal Level 1	

Organization Name	Ontario Health Region	Transport Region	Neonatal Level of Care	First Fiscal Year as level 2C Centre (if changed since April 2012)
North Bay Regional Health Centre	North East Region	Ottawa	Neonatal Level 2c	
Notre-Dame Hospital	North East Region	Ottawa	Neonatal Level 1	
Sault Area Hospital	North East Region	London	Neonatal Level 2c	
Sensenbrenner Hospital	North East Region	Ottawa	Neonatal Level 1	
St. Joseph's General Hospital Elliot Lake	North East Region	Toronto	Neonatal Level 1	
Temiskaming Hospital	North East Region	Ottawa	Neonatal Level 1	
Timmins and District Hospital	North East Region	Ottawa	Neonatal Level 2a	
Weeneebayko Area Health Authority - Weeneebayko General Hospital	North East Region	Ottawa	Neonatal Level 1	
West Parry Sound Health Centre	North East Region	Toronto	Neonatal Level 1	
Dryden Regional Health Centre	North West Region	Winnipeg	Neonatal Level 1	
Lake of the Woods District Hospital	North West Region	Winnipeg	Neonatal Level 1	
Red Lake Margaret Cochenour Memorial Hospital	North West Region	Winnipeg	Neonatal Level 1	
Riverside Health Care Facilities Inc. - La Verendrye Hospital	North West Region	Winnipeg	Neonatal Level 1	
Sioux Lookout Meno-Ya-Win Health Centre	North West Region	Winnipeg	Neonatal Level 1	
Thunder Bay Regional Health Sciences Centre	North West Region	London	Neonatal Level 2c	
Wilson Memorial General Hospital	North West Region	London	Neonatal Level 1	

Organization Name	Ontario Health Region	Transport Region	Neonatal Level of Care	First Fiscal Year as level 2C Centre (if changed since April 2012)
Humber River Regional Hospital - Wilson Site	Toronto Region	Toronto	Neonatal Level 2c	2023/2024
Michael Garron Hospital	Toronto Region	Toronto	Neonatal Level 2c	
Mount Sinai Hospital	Toronto Region	Toronto	Neonatal Level 3a/3b	
North York General Hospital	Toronto Region	Toronto	Neonatal Level 2c	
Scarborough Health Network - Centenary Site	Toronto Region	Toronto	Neonatal Level 2c	
Scarborough Health Network - Scarborough General Site	Toronto Region	Toronto	Neonatal Level 2c	2017/2018
St. Joseph's Health Centre Toronto	Toronto Region	Toronto	Neonatal Level 2c	2018/2019
St. Michael's Hospital	Toronto Region	Toronto	Neonatal Level 2c	
Sunnybrook Health Sciences Centre	Toronto Region	Toronto	Neonatal Level 3a/3b	
Alexandra Marine & General Hospital	West Region	London	Neonatal Level 1	
Bluewater Health - Sarnia Site	West Region	London	Neonatal Level 2a	
Brant Community Healthcare System - Brantford General Site	West Region	Hamilton	Neonatal Level 2b	
Brightshores Health System - Owen Sound	West Region	London	Neonatal Level 2b	
Cambridge Memorial Hospital	West Region	Hamilton	Neonatal Level 2a	
Chatham-Kent Health Alliance - Chatham	West Region	London	Neonatal Level 2b	
Erie Shores HealthCare	West Region	London	Neonatal Level 1	
Groves Memorial Community Hospital	West Region	Hamilton	Neonatal Level 1	
Guelph General Hospital	West Region	Hamilton	Neonatal Level 2a	
Hamilton Health Sciences - McMaster Site	West Region	Hamilton	Neonatal Level 3a/3b	
Hamilton Health Sciences - West Lincoln Memorial Site	West Region	Hamilton	Neonatal Level 1	

Organization Name	Ontario Health Region	Transport Region	Neonatal Level of Care	First Fiscal Year as level 2C Centre (if changed since April 2012)
Hanover and District Hospital	West Region	London	Neonatal Level 1	
Huron Perth Healthcare Alliance - Stratford	West Region	London	Neonatal Level 2a	
Joseph Brant Hospital	West Region	Hamilton	Neonatal Level 2b	
Listowel Memorial Hospital	West Region	London	Neonatal Level 1	
London Health Sciences Centre - Victoria Hospital	West Region	London	Neonatal Level 3a/3b	
Middlesex Health Alliance - Strathroy Middlesex General Hospital	West Region	London	Neonatal Level 1	
Niagara Health System - St. Catharines	West Region	Hamilton	Neonatal Level 2c	2020/2021
Norfolk General Hospital	West Region	Hamilton	Neonatal Level 1	
South Bruce Grey Health Centre - Walkerton	West Region	London	Neonatal Level 1	
St. Joseph's Healthcare Hamilton - Charlton Campus	West Region	Hamilton	Neonatal Level 2b	
St. Thomas Elgin General Hospital	West Region	London	Neonatal Level 2a	
Waterloo Regional Health Network - Midtown	West Region	Hamilton	Neonatal Level 2b	
Windsor Regional Hospital - Metropolitan Campus	West Region	London	Neonatal Level 2c	
Wingham and District Hospital	West Region	London	Neonatal Level 1	
Woodstock General Hospital	West Region	London	Neonatal Level 1	

