- The first ambulance response was dispatched at 2.12pm, however this was diverted to a higher priority case (Code 1B – unconscious patient) at 2.13pm.
- An ambulance crew was dispatched from the RBWH at 2.16pm and was requested to go via the Roma Street Ambulance Station, to pick up a student paramedic, slightly further delaying the QAS response, arriving on scene at 2.55pm.
- Upon QAS arrival at the residence at 2.55 pm, paramedics found the patient deceased, post hanging. Queensland Police Service (QPS) was asked to attend the scene.

Timeline

1st Key Stroke:	12.32pm
In waiting queue:	12.34pm
CDS phone back:	1.12pm (no answer)
Assigned:	2.14pm
Enroute:	2.17pm
At scene:	2.55pm

Review

- The QAS was experiencing a high demand for service throughout 15 February 2021.
- The QAS received 3,126 Triple Zero (000) calls for 15 February 2021, compared to an average of 2,589 calls per day in 2020/21YTD, with the Brisbane Operations Centre receiving 1,296 calls compared to an average of 1,022 calls in 2020/21YTD.
- The increase in Triple Zero (000) calls on 15 February 2021 occurred over each of the hours of the day when compared to the average number of Triple Zero calls received each hour of the day for the Brisbane Operations Centre in 2021/21YTD.
- At the time the call for service was received there were 21 ambulances located at Metro North HHS hospital ED ramps, with 28 pending acute (Code 2 – immediate dispatch without lights and/or siren) cases in the Brisbane Operations Centre dispatch queue: refer Figure 1.
- The Redcliffe District Hospital (7 ambulances on ramp, longest wait 2 hrs 5 mins) and Prince Charles Hospital (4 ambulances on ramp, longest wait 1hr) were on Level 3 escalation and RBWH (6 ambulances on ramp, longest wait 59 mins) and Caboolture Hospital (4 ambulances on ramp, longest wait 18mins) were on Level 2 escalation at the time of this incident.
- These hospitals remained on the same escalation levels at the time of QAS unit response at 2.12 pm: refer Figure 2.
- On 15 February 2021, the QAS lost approximately 186 hours of paramedic availability (where Patient Off-Stretcher Time (POST) performance >30mins) across these four hospitals. Across all SEQ HHS hospital EDs (Metro North, Metro South, West Moreton, Sunshine Coast and Gold Coast HHS'), QAS lost 573 hours and 24 minutes of paramedic availability (where POST performance >30mins) on this day.
- The QAS SEQ Local Ambulance Service Networks were escalated at the Extreme level at the time of the incident and across 15 February 2021, experiencing high demand with 57 pending cases (2 x Code 1 and 55 x Code 2) in the community, and was affected by extreme hospital ED pressures affecting paramedic availability (4 x hospitals on Level 3 escalation and 7 on Level 2 escalation), with 69 ambulances located on these HHS hospital ED ramps.

Outcomes

- ROLE form completed and patient left with the QPS.

Post review actions

- A QAS Senior Operations Supervisor was responded to the incident, providing support for staff.
- The QAS Staff Support Service, Priority One, has been offered to the attending paramedics and Operations Centre staff, with follow up staff welfare checks conducted by their supervisors.

Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- AVL tracking of unit positions at time of incident;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active; and
- State OpCen ProQA.

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Name	Position	Signature	Date
John Hammond	Assistant Commissioner	Irrelevant	02/03/2021
Warren Painting	Acting Director Operations		02/03/2021

Significant Incident Review Template Version 1.0 August 2020

West Moreton Local Ambulance Service Network

Authority:

By authority of Ms Lisa Dibley, A/Chief Superintendent, LASN Manager, West Moreton LASN

Executive Summary:

QAS responded to incident 13919939 at Irrelevant Mount Barney QLD 4287 t 15:53 rs on 19th February 2021, where it was reported that a Irrelevant male had rolled h ehicle a d was apped between his car and the road, the male patient was the sole occupant of the ve cle.

The patient was trapped for an unknown period of time bef e being un by a m mber of the public. On the arrival of the initial responding QAS unit the patient was f nd to h e sustain d massive head injuries that were incompatible with life and the patient was declared de ased a

Terms of Reference:

This review will investigate all aspec of am ulance ponse to ncident 13919939. The review will examine ambulance operations p or to, duri and foll ing th response.
This review will include all requ ements outl ed in the *Operational Incident Review Process*.

LASN Clinical Incident Summ ry Report:

- The man ement of this patient b he attending crews conformed to CPG and CPPs.
- Resuscitatio not commenced due to nil signs of life and injuries – rapid discontinuation CPG foll wed appro iately
- ocumentation w at standard with a ROLE form attached.

State OpC ProQA:

- Nil QA rev w conducted for this incident, as nil Triple Zero calls received for this incident by QAS.
- Incident Attendance Request (IAR) received via ICEMS from QPS.
- ICEMS IAR received and actioned by Southport OpCen EMD Darcy Staskiewicz.
- As per information provided by QPS the incident has be coded correctly: 29D06 RTC Rollover t) – 1A Response.
- EMD has correctly called back to the QPS informant and gathered further information, updating ProQA accordingly – with nil change to Coding or Response.

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Incident Review/Investigation:

Scope:

West Moreton reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:

- On 19 February 2021, the Queensland Ambulance Service (QAS) received a request or assistance for Irrelevant male who had rolled his vehicle and was trapped between his car an he ro
- A member of the public who was passing by on the rural road found the car and alerte emergency services.
- On arrival at scene the patient was found to have massive head injuries wh ch we incomp e with life. The patient was declared deceased at scene.

Timeline:

Received:	15:51hrs
Dispatched:	15:52hrs
On Case:	15:53hrs
On Scene	16:31hrs
Clear:	16:59hrs

Review:

- The incident was approp tely resou ed with clo st most appropriate units being assigned.1 x Bravo Unit, 1 x CSO C P and SOS ere dispatched.
- Response time of 40 ns for the t QAS unit to arrive on scene which was appropriate given the distance travelled from B onah mbulance S ion.
- No operational or clinical is s noted.
- Nil OpCen issues identified.

Outcomes

- Irrelevant male as declared deceased on scene.
  Ap ropriate resourcin arrived on scene.
- WM OS attended scene to ensure staff welfare and activate Priority One.

st OIRR actions

N

Review Recommendations:

Nil.

Appendix of relevant documents/files:

Incident Detail Report	INC 13919939 - IDR 08.03.2021.pdf
Ambulance Report Form	13919939 eARF.pdf
LASN Notification Email	WM Incident Notification - Fatalit
Clinical Review	FW_ WM Incident Notification - Fatalit
OpCen Brief	190221 DAY SOUTHPORT OPCEN
Triple Zero Call and Audio Files	19-02-2021 15.53.04 Call to informant IN
OpCen Review	FW_ WM Incident Notification - Fatalit

LASN Endorsement

Name	Position	Signature	Date
Lisa Dibley	A/LASN Manager	Irrelevant	11/03/2021
Ross Hodges	A/Executive Manager Operations	Ross Hodges	10/03/2021

Significant Incident Review Template Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:
By authority of Mr Gerard Lawler, Assistant Commissioner, LASN Manager, Metro South LASN.

Executive Summary:
QAS responded to incident 13929011 at Irrelevant Loganlea QLD 4131 at 23:26hrs on 21 February 2021 to a Irrelevant female complaining of difficulty in breathing with end stage renal failure. Case initially coded as a 1B, patient deteriorated and subsequently upgraded to a code 1A. Response time was 21 minutes. QAS treated patient for cardiac arrest with ROSC achieved. Patient transported to Logan Hospital; patient's husband advised that the patient died a few days later. Irrelevant Irrelevant QAS undertook a review of the incident including a SOS meeting with the husband.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13929011. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:
???

State OpCen ProQA:
???

Incident Review/Investigation:
Scope:
Metro South reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:
QAS called to a Irrelevant female in cardiac arrest, ? end stage renal failure.
Case initially coded 06D01 - DIB, 1B response.

23:26 - Delay in response due to workload, waiting in queue.
23:30 - Delay in dispatch due to workload, common call.
23:32 - 501234 dispatched from Newmarket Road, Newmarket, ETA 20 minutes
23:37 - Upgraded by the CDS to a 1A response after the patient was said to be unconscious.
23:39 - 506292, CCP attached, proceeding from Manly.
23:40 - Common Call.
23:42 - 601405 attached and proceeding from Logan Hospital.
23:43 - 601424 attached from Loganlea Road
23:46 - 601424 On Scene – approximately not recorded via MDT.
23:47 - 601405 On Scene.
23:58 - 507246, Operations Supervisor attached and proceeding.
00:04 - CCP 506292 On Scene.

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00:29 - Operations Supervisor On Scene
00:36 - 601445, Departed Scene for Logan Hospital with a CCP escort, the Unit proceeded lights and siren to hospital.
00:41 - 601445 arrived at hospital– approximately not recorded via MDT.

Comments from Operations Supervisor that attended the scene;
On arrival the QAS to the scene the patient's husband was said to be distraught, the crews stated that the Husband was annoyed and had commented that the QAS took too long to arrive. He also stated that there was nothing they could do for his wife.

The patient's husband was said to have been lying next to the patient and was reluctant to move The crew did manage to move the husband and gain access to the patient after a short discussion and rea ura This interaction is said to have caused a short delay in the administration of patient care.

The crews also stated to the OS that there was a discussion about the patients Perm ath rega ing its placement and the impact CPR would have. The crew attempted to call the consult ne for a ic ut were unsuccessful.

The initial crews to arrive at the scene stated that the situation was explain the husb nd and CPR was commenced.

The crew requested QPS Code 1 for assistance.

Timeline:
Received: 23:26hrs
Dispatched: 23:32hrs
On Case: 23:32hrs
On Scene: 23:47hrs
Cleared: 02:25hrs

Review:
On the 8th of March 2021 at proximate 19:15hrs nio perations Supervisor (SOS), Irrelevant contacted Irrelevant t discuss the ues raised in a request to the Irrelevant In a brief phone discussion, a m ting was ar ged at Irrelevant residence for the following day at 3.00pm.

The following issues were raise t t s meeting;

The Street Address.

The street addr of Irrelevant was correctly recorded by the call taker from the details provided by Irrelevant Irrelevan his was ut into the SOS GPS located in Unit 507316 to direct the SOS to the location for the meet g with Irreleva on the 8th of March. This has highlighted that for the current QAS mapping the street do not exist. The GP egistered Irrelevant Underwood and then Irrelevant Loganlea but not e r uired address.

The add s was input into the SOS phone and Google maps located the correct location.

Irrelevant s located only a short distance away and is said to be the street currently undergoing a name change to Irrel t

At some point prior to the arrival of the QAS on the night of the call Irrelevant had received a text message from QAS questioning the street address, he did not respond as he was on the phone discussing CPR and first aid instructions with the QAS call taker.

The SO reviewed two other calls to the same address and located the comments highlighted below from CN 13679004 on the 23.12.2020. The crew appears to have been directed by the GPS to Irrelevant Irrelevant

- CN 13679004 – 23.12.2020

- 0306 - 601412 GPS GOTTEN US LOST
- 0309 - 601412 ALPHA SEEMS TO HAVE SAME GPS ERROR

The length of the response time for the incident.
Received: 23:26hrs
On Scene: 23:47hrs

Response Time – 21 Minutes.

This was a busy time of the night with multiple cases pending and limited available resources, at 3:30hrs t OpCen Dispatcher made a common call broadcast. At 23:37hrs the CDS upgraded the response a and a second common call broadcast was made by the dispatcher at 23:40hrs. A unit from Logan Hospital (601405) was attached to the case at 23:42hrs and subsequently was the first QAS resource to at the address just under 5 minutes later at 23:47hrs.

In the conversation with the SOS, Irrelevant asked why a single officer or officers aiting n triag Logan Hospital were not considered to be dispatched to his residence soon after his request for n ambu nce.

The CPR instructions regarding the patients Permcath.
Irrelevant stated he would like clarification on the instruction for him perform CPR on his wife against his concerns regarding the Permcath.

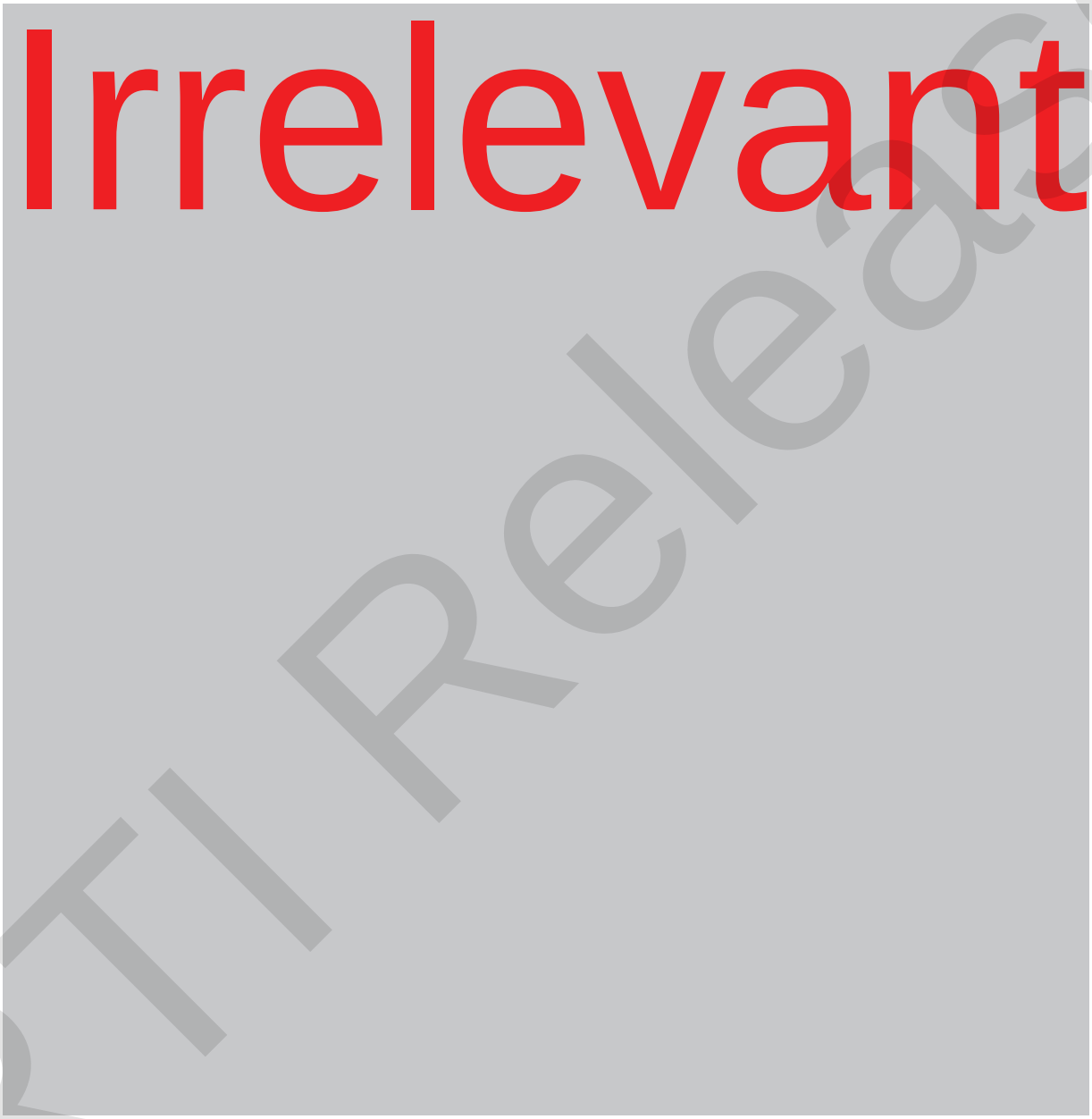
General Comment
Irrelevant praised the professionalism of the crews that attended addres did not highlight any issues with the treatment administered to his wife.

FSG Review of Case
InformCAD and the Logan City Coun line Map ng how that relevant has cross streets of Irrelevant Irrelevant in Loganlea and Irre vant as a cr street of I elevant This is where the incident was geolocated to in InformCAD an f the crew rrectly us R to Incident' on the MDT, they would have been routed to a latitude an ongitude on t s street.

InformCAD -

Logan City Council Mapping -

The maps in the Trapeze MDT show the streets in reverse – Irrelevant has cross streets of Irrelevant Irrelevant Loganlea and Irrelevant has a cross street of Irrelevant in the MDT). This map requires updating to match the Logan City Council Data, but despite this incorrect spatial data, if 'Route to Incident' was used, the crew should have been routed to what is believed to be the correct location off Irrelevant It is the understanding of FSG it would not be standard practice to manually input the address into the MDT GPS.

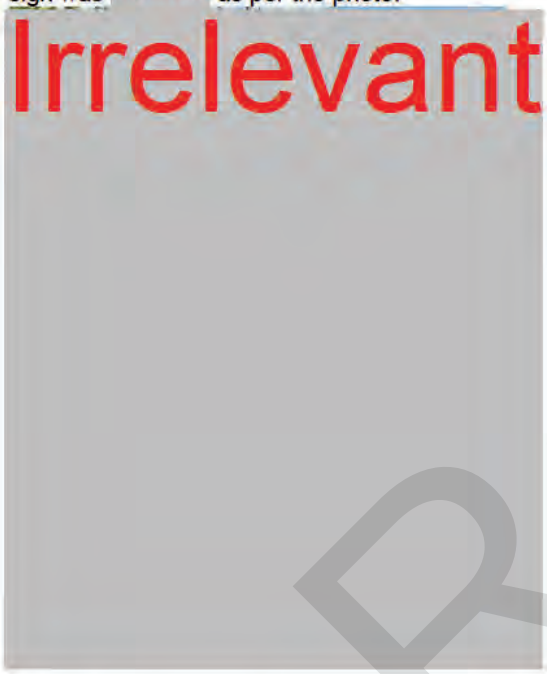


The iPad mapping (not to be used by paramedics) shows the street off Irrelevant is called both Irrelevant Irrelevant and Irrelevant

Issue raised regarding street name 10 September 2020
FSG received a report from an EMD that took a call for Loganlea where they had difficulty Geo-Verifying the address as the caller was stating on the corner of Irrelevant Loganlea". The difficulties came as the spatial data in CAD does not have these 2 roads intersecting, it does however have Irrelevant and Irrelevant intersecting. A CCP briefly arrived on scene and advised also that it was Irrelevant

We have since commenced investigating the correct name for this street to determine what, if any changes need to be made. All council mapping, CAD mapping, Google Maps show it as Irrelevant as well as Google StreetView shows the sign saying Irrelevant although the StreetView image is from 2014. This means that all systems have the street name incorrect or that the CCP was also mistaken just as the caller was.

OIC at Woodridge attended the location on the 19 September 2020 and confirmed the street name on the sign was Irrelevant as per the photo.



Outcomes:

- Cases coded as 2A unknown sick person – appropriate given the information provided.
- Protracted response due to workload.
- EMD attempted to speak with patient through alternative means such as mobile phone to no avail.
- Nil clinical concerns with case.

Review Recommendations:

- ???

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- LASN Notification
- State OpCen Review
- FSG Review

LASN Endorsement

Name	Position	Signature	Date
Gerard Lawler	Assistant Commissioner		
Anthony Hose	Director Operations		

s47(3)(b)

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s47(3)(b)

s47(3)(b)

Department of Health
Queensland Ambulance Service

Significant Incident Review Template Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:
By authority of Mr Gerard Lawler, Assistant Commissioner, LASN Manager, Metro South LASN.

Executive Summary:
QAS responded to incident 13948620 at Irrelevant Forest Lake QLD 4078 at 01:21hrs on 26 February 2021 to a Irrelevant female sick with flu and difficulty in breathing. Case coded as 1C, delayed response due to workload. Second call, patient now unconscious. Case upgraded to Code 1A. Response time 27mins. Bravo crew and CCP attended and resuscitation attempted. Patient deceased on scene. Patient handed over to QPS.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13948620. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:
- Nil clinical issues noted.

State OpCen ProQA:
- Nil issues noted.

Incident Review/Investigation:
Scope:
Metro South reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:
- Nil further to add.

Timeline:

Received:	01:21hrs
Dispatched:	01:33hrs
On Case:	01:33hrs
On Scene:	01:48hrs
Cleared:	03:21hrs

Review:
- ACP crew and CCP attached once case upgraded to 1A.
- Additional single ACP attended scene to assist with resuscitation.
- Response time for first unit on scene was 27mins.

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Outcomes:

- Case coded as 1C ?COVID19 ABN BRTH 2+SYM LVL0, caller was advised of high workload at time of call.
- Protracted response initially due to workload, however once case was upgraded to 1A, immediate response occurred.
- Nil clinical concerns with case.

Post OIRR actions:

- Nil.

Review Recommendations:

- Nil.

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- LASN Notification
- LASN Clinical Review

LASN Endorsement

Name	Position	Signature	Date
Gerard Lawler	Assistant Commissioner	Irrelevant	15/03/21
Anthony Hose	Director Operations		10/03/2021

s47(3)(b)

s47(3)(b)

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of A/Assistant Commissioner Chris Draper – General Manager Gold Coast LASN

Executive Summary:

At 9:24pm on Saturday 27 February 2021, Queensland Ambulance received a quest or se at Irrelevant Reedy Creek. The call was for a Irrelevant female, who reported had fa en from bed. The request for service was received at the Brisbane Operations Centre.

Case number 13957296 was created and coded as a 2C response as er MPDS determinants.

The Gold Coast Local Ambulance Service Network (GCL SN) had een xperien ng high demand with delays at both Gold Coast public hospitals. As result of those d ys this e was plac d in the pending queue until a paramedic acute unit became available.

The initial Triple Zero call was received in the Brisbane OpCen at 9.2 m with call taking complete within four minutes. The Southport OpCen CDS conducted a ca back a st one urs after the initial call and advised of delays. The caller rang back on triple zero at .02pm t update th OpCen with changes in patients condition. The EMD further advised of delays. Jus after m dnigh he Southport CDS upgraded the incident from a 2C to a code 2A response. At this time he risbane PCen received another call back from the caller and the EMd advised of d ys. Jus efore 1 3.5hour after the initial call, the Southport OpCen CDS conducted a call back an gained furth informati pgraded the incident to a 1C response.

The first unit assigned to t incident, wa at 12 39 am – being a single officer ACP, however this unit was diverted to a higher priority i dent at 2.51am upgraded toa code 1 response an acute paramedic crew was attached to the case d ponded. On scene, the crew advised they suspected the patient was suffering from a suspected stroke transported to GCUH code 1 for stroke referral.

The patient w s declared deceased Gold Coast University Hospital on the 5 March 2021.

Initially an IAR w completed – SIR initiated due to patient outcome.

Terms of Referen e:

T s view will investigat l aspects of ambulance response to incident 13957296.
The re w will examine amb ance operations prior to, during and following the response.
This revie will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clini l Incident Summary Report:

GC LASN Clinical Education completed a clinical review of this case.

Summary of Report: Nil clinical concerns identified.

State OpCen ProQA:

A detailed review of all calls as placed into State OpCen were reviewed. Details of the reports attached.

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Summary: There were moderate and minor deviations with the call taking process, however initial coding, based on the information obtained during the initial call was correct.

During the third call back, there was some change of condition provided that should have resulted in reactivation of ProQA and may have resulted in recoding at that time.

It was information gathered by the Second CDS call back, that prompted the CDS to upgrade the incident to a code 1 response.

Incident Review/Investigation:

Scope:

The review considered the QAS information provided to the OpCen to generate the response le or this incident as well as resource allocation and response. The first unit on scene was dispatch from Gold Coast University Hospital and arrived on scene 3 hours and 40minutes after the initial call.

Background:

The call was placed at 2.26pm by the patient's husband advising his Irrelevant wife has falle of the b d onto the floor and was unable to get up. This incident was coded as a 2C and was p ing due t workloa .

The Southport OpCen CDS rang to advise of delays and noted the h band ad sed the patient was stil on the floor, when asked if she was injured he stated "… no sh has hip p n…" a this w s recorded in the IDR.

Over the next couple of hours the caller rang back twice and ad ed that had start vomiting, she became dizzy and she was difficult to wake, and she was not making sen when aking

The first unit was dispatched at 3hours after the initial call howeve was diverted to a higher priority case. During the second CDS call back, the CDS identifi d infor tion th the patient had an altered level of consciousness and upgraded the incident to a code respon .

An ACP acute unit was dispatched a rrived on cen at 1.04a , 3 hours and 40 minutes after the initial call. This unit provided a sitrep vising he pati was susp cted of experiencing a stroke and were completing a referral process th ough the oke refe line T e patient was transferred to GCUH code 1 and the patient arrived at 1.3 m.

The QAS was advised this p ent never d passed away on the 5 March 2021.

Timeline:

21:24:08	hone pickup
21:24:0	1 Keystroke
21:2 24	EMD D 5JESCOO created an incident as MPDS Determinant of 17-A-04 (Falls) (PUBLI ASSISTANCE (no injuries and no priority symptoms) Suffix; G (On the ground or or) with problem description **"FALLEN FROM BED"** which is a QAS Code 2C (QAS Non-Lights and Sirens) response.
21:26:24	Incident entered the In-Waiting Queue (2min 16 sec)
21:27:19	MD ID 5JESCOO entered a comment, **"EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS"**
21:29:08	EMD ID 5JESCOO entered a comment, **"DIALYSIS PT"**
21:29:12	EMD ID 5JESCOO entered a comment, **"NIL INJS JUST STUCK ON FLOOR"**
22:2	CDS ID 6PHIGAD entered a comment; **"CDS CALLBACK - PT IS STILL ON THE FLOOR C/O HIP PAIN - CONSCIOUSAND ALERT - ADVISED OF DELAYS DUE TO WORKLOAD AND TOCALLBACK IF REQUIRED" [sic]**
23:02:47	EMD ID 6TANWAL appended a duplicate call to the incident

23:03:20	EMD ID 6TANWAL entered a comment; **"PT NOW VOMMITING DIZZY & HEADACHE"**
23:03:58	EMD ID 6TANWAL entered a comment; **"I APOLOGISED FOR DELAY DUE TO WORKLOAD"**
00:05:13	CDS ID 6AMAKUH changed the priority from Code 2C to a Code 2A
00:05:23	CDS ID 6AMAKUH entered a comment; **"CDS UG ELDERLY PT STILL ON FLOOR"**
00:07:02	EMD ID 5LACWEA appended a duplicate call to the incident
00:07:02	EMD ID 5LACWEA entered a comment; **"FURTHER CALL - ADV OF DELAYS"**
00:39:34	B601523 Assigned
00:39:39	B601523 EnRoute
00:51:15	B601523 Cancelled EnRoute (Diverted to Higher Priority)
00:54:40	CDS ID 6AMAKUH entered a comment; **"CDS CALLBAC - PT RY RETCHING, PT NOT MAKING ANY SENSE.LANGUAGE BARRIER. UG ?ALOC"**
00:54:44	CDS ID 6AMAKUH changed the priority from C de 2A to Code
00:54:56	CDS ID 6AMAKUH entered a comment; **"CDS G ?ALOC"**
00:56:10	B601508 Assigned
00:56:16	B601508 EnRoute
01:04:32	B601508 Arrived
01:19:43	CDS ID 6PHIGAD sent a pager mes to 6015 8 **"#: CDS instruction - Unless confirmed as clinically unsuitab e via R io, pro ed to GCHRB"**
01:23:49	EMD ID 6CHEDAV entered a tuation Repo t (SITREP); **"601508** Irrelevant **SUSPECTED STR KE - DO NG REFERRAL AND Tx SHORTLY" [sic]**
01:26:37	601508 departe cene f Gold C st Unive ity Hospital (Code 1)
01:34:37	601508 arriv at Gold C ast Univer ospital

Review:

A comprehensive review of the ca s currently under way.

The following re the findings of this re w thus far

- **OpCen view**
  - Du g the initial call, only 2 Moderate deviations and 1 Minor deviation was identified. The Codin and response was appropriate based on the information provided.
  - Through e Special review, there were no concerns noted in the first CDS call back
  - The review entified there were new details provided in the first call back, but these were deemed not gnificant enough to warrant recoding through ProQA, however the EMD did not advise the patient to call back on triple zero if conditions changed. It was during this call the information that the patient had been on the ground for some time was documented. e CDS would use this information to upgrade the incident from a 2C to a 2A - an hour late d to patient being on the floor.
  - The review showed that during the third call back, significant changes to the patient were presented by the caller and ProQA should have be reapplied. This may have resulted in a change in the incident coding at that time. The EMD also did not advise the caller to call back on triple zero if conditions changed.
  - The CDS call back the CDS and caller discussed the patients verbal ability and proceeding symptoms. Although the CDS does not advise the caller to call back if conditions changes, she did at this time upgrade the incident to code 1 response.

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- **Clinical – Clinical review of case to be completed.**
    - **Patient outcome** – on arrival, the patient presented GCS14, hypertensive, left sided weakness and slurred speech. The patient was referred through the stroke referral line and transported to GCUH code 1. NIHSS Score = 8. The patient passed away 5 March 2021
    - **Transport appropriateness** – the ACP unit on scene identified signs consistent with a stroke and consulted with Stroke Referral line and transported code 1 to GCUH.

- Outcomes: describe outcomes and impacts of the OIRR;
- Post OIRR actions: detail any actions taken at the LASN level since the OIRR occurred (including but not limited to Priority One access and post incident debrief).

Review Recommendations:

1. OPCEN review: follow up on moderate and minor deviations from initial call. And review opportunities from subsequent call interactions where a change in response may have occurred.
2. Clinical Education Unit to review clinical aspects of case - pending.
3. Nil operational concerns with the case

Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Briefing notes identifying operational issues;
- Consultation with State OpCen Assistant Commissioner (for "State .01.21 Special Review" if relevant);
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- Incident Detail Report (IDR) - not attached
- Electronic Ambulance Report Form (eARF) - not attached
- Local level clinical review (Eclipse) Completed
- State level clinical audits (should be requested from the Medical Directors Office for complex clinical incidents or incidents with deviations from clinical policy and procedure);
- Relevant audio (wav) files – not attached

Incident Details Report	210227_SR16786594 _13957296 ASHMOR
GCLASN Notifiable PSDU Notification	Re 27.02.2021 - IAR - CN 13957296 - ASHMORE - Pt POH.msg
dARF/dCRF	DARF 13957296 ASHMORE.pdf
Voice Logs	210227_SR16786594_13957296 ASHMOR 210227_SR16786594_13957296 ASHMOR 210227_SR16786594_13957296 ASHMOR 210227_SR16786594_13957296 ASHMOR 210227_SR16786594_13957296 ASHMOR

State OpCen Review	210227_SR16786594210127_SR16786594210127_SR16786594 _13957296 ASHMOR_13957296_ASHMOF_13957296_ASHMOF
Southport OpCen Brief	270221 NIGHT SOUTHPORT OPCEN
Clinical Review	Pending

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager		
A/Chief Superintendent	Rohan Foote	Director Operations		

Significant Incident Review

Metro North Local Ambulance Service Network

Authority:
By authority of Assistant Commissioner, Metro North Local Ambulance Service Network (LASN).

Executive Summary:
Metro North LASN responded to an incident (IDR 13965965) located at Morayfield Irrelevan at 7:12pm on Monday 1 March 2021 to Irrelevant female patient who had seen her General Practitioner P) du o recent chest tightness and dizzy episodes.

Whilst ramped at the Caboolture Hospital (CAH) the patient became hypotensive a d brad ardic.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13965965.
The review will examine ambulance operations prior to, during and foll wing th respo e
This review will include all requirements outlined in the *Operational I ident R view Process*.

LASN Clinical Incident Summary Report:
- A LASN clinical review (Eclipse) was undertaken on this ca which d all documentation, drug therapy and clinical practice were performed at the standard r uired.

State OpCen ProQA:
- N/A

Incident Review/Investiga ion:

Scope
- Metro North LASN reviewed th esponse, clinical performance and operational decision making to ensure the appropriate response d management of this case was achieved.
- Metro North ASN will identify any o rational or clinical performance issues with this case and ensure appropriate ac ns are taken to return erformance to the required standards.

Backgr und
- QAS ttended the Moray ld Irrelevant at Morayfield, to assess a Irrelevant female who had seen her GP ue to recent ches tightness and dizzy episodes.
- GP found e patient to be hypertensive at 220/100 and had treated with 300mg Aspirin and one Glyceryl trin te (GTN).
  QAS assessed d treated the patient and transported to the CAH.
- Whilst ramped at CAH, the patient complained of dizziness and nausea. Patient then became hypotensive and bradycardic.
  S alerted hospital staff of patient's deteriorating condition.
- Patient s heart rate dropped to 30bpm then became unresponsive.
- The patient had a hypoxic seizure and went into asystole.
- QAS did approximately 30 seconds of Cardiopulmonary Resuscitation and achieved return of spontaneous circulation, back to GCS 14.
  The patient was then handed over to resus.

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Timeline

1st Key Stroke:	7:12pm
In waiting queue:	7:13pm
Assigned:	7:14pm
Enroute:	7:14pm
At scene:	7:16pm
Departed scene:	7:37pm
At hospital:	7:46pm
Available:	9:08pm

Review

- Unit in question ramped from 19:46 to 21:08 approximately.
- When the unit arrived at Caboolture hospital there were 4 other ambulances ramped, the longest delay was 1hr 8mins.
- The unit in question called "ramped" for the last time at 20:31, at the time there were 6 ambulances ramped including the unit in question which had been on the ramp for 48 mins, the longest delay was 1hr 24 mins

Outcomes

- The patient was handed over to CAH resus unit.

Post review actions

- Metro North Hospital and Health Service are undertaking an internal review.

Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- AVL tracking of unit positions at time of incident;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active.

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Name	Position	Signature	Date
John Hammond	Assistant Commissioner	Electronically endorsed	03/03/2021
Warren Painting	Acting Director Operations	Electronically endorsed	03/03/2021

s47(3)(b)

s47(3)(b)

s47(3)(b)

s47(3)(b)

Department of Health
Queensland Ambulance Service

Significant Incident Review Template Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:
By authority of Mr Gerard Lawler, Assistant Commissioner, LASN Manager, Metro South LASN.

Executive Summary:
QAS responded to incident 13979330, at AVEO Durack – Nursing Home, 276 Blunder Road, Durack QLD 4285 at 20:20hrs on 4 March 2021 PTS transported a Irrelevant female back to her nursing post dialysis When transferring the patient from QAS stretcher to her bed, it is alleged when the stretcher was raised it caused the patient to fall forward striking her arm on a lifting hoist. The patient states she heard a click, patient was left in care of a registered nurse at the Nursing Home.

At 22:04hrs QAS responded to incident 13980606 at AVEO Durack – Nursing Home, 276 Blunder Road, Durack QLD 4285 for the patient with query a fractured arm. Bravo crew attended and treated patient and transported to Princess Alexandra Hospital.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13979330 & 13980606. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:
- Review of incident 13980606 identified nil issues.

State OpCen ProQA:
- N/A

Incident Review/Investigation:
Scope:
Metro South reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:
- Nil further to add.

Timeline:

	13979330	13980606
1st Key Stroke:	1141	2204
In waiting queue:	1558	2207
Assigned:	1936	2323
Enroute:	1943	2324
At scene:	2007	2342
Departed scene:	2020	0034
At hospital:		0059
Partially available:	2124	0412

Review:

- Operations Supervisor met crew and patient at PAH. Patient appeared comfortable and in good spirits. Patients pain was well managed by crew 501169 with morphine administration.
- Patient interviewed and believes that when the stretcher was raised, it made her fall forward and hit the hoist, causing her pain and discomfort. The patient stated that she did not wish to make a formal complaint and was happy with the treatment has received from crew 501169.

Outcomes:

- Adequately resourced.
- Appropriate notification from OpCen to SOS.
- Crew 501169 managed the patient well.
- OS met crew and patient at hospital to review incident.
- Patient did not wish to make complaint and happy with QAS's care.

Post OIRR actions:

- Nil.

Review Recommendations:

- Nil.

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- LASN Notification
- Clinical Review

LASN Endorsement

Name	Position	Signature	Date
Gerard Lawler	Assistant Commissioner	Irrelevant	15/03/21
Anthony Hose	Director Operations		10/03/2021

Department of Health
Queensland Ambulance Service

Significant Incident Review Template Version 1.0 August 2010

Metro South Local Ambulance Service Network

Authority:
By authority of Mr Gerard Lawler, Assistant Commissioner, LASN Manager, Metro South LASN.

Executive Summary:
QAS responded to incident 13981134 at Irrelevant Spring Hill QLD 4000 at 0227hrs on 5 March 2021. The call was for a Irrelevant male that had a nosebleed, reportedly severe. The patient was located within a COVID-19 quarantine hotel, after arriving into Australia from Irrelevant on the 26 February 2021. The patient had undergone testing for COVID-19 2 days prior but had not yet received a result of the test. A Bravo crew responded and found patient to be hypertensive and tachycardic, as well as epistaxis. Patient transported to Princess Alexandra Hospital emergency department (PAHED). A nurse from PAHED contacted the operations group the following morning to advise that they considered the ACP involved in the handover had a major PPE breach.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13981134. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the Operational Incident Review Process.

LASN Clinical Incident Summary Report:
- Desktop review of eARF showed at standard.

State OpCen ProQA:
- N/A

Incident Review/Investigation:

Scope:
Metro South reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:

- Nil further background to incident.

Timeline:

Received:	0213
Dispatched:	0227
On Case:	0228
On Scene:	0237
Depart:	0322
Hospital:	0336
Cleared:	0430

Review:

- 1 x Bravo Crew attended scene.
- Response time was 24 mins. First assigned unit was diverted to higher priority (1A) case.
- Crew applied personal protective equipment to QAS standards prior to entering the patients' room
- Treatment was as per QAS clinical guidelines
- On arrival at PAHED, ACP Irrelevant entered the triage area and enquired as to the best entrance to use to reduce the risk of virus transmission.
- An alternative entrance was utilised, and the patient taken to resus bay 5.
- There was some discussion in the bay regarding where the handover was to take place. ACP Irrelevant was advised that the handover would take place in the airlock and there were hospital staff waiting in that area.
- A doctor in the resus bay asked for a quick hand over.
- The nurse in resus bay 5 instructed ACP Irrelevant to remove her PPE and dispose of it in a clinical waste bin near the exit, specifying mask to be taken off last. ACP Mills asked the nurse to repeat the instructions as she was expecting to remove her PPE once out of the area.
- ACP Irrelevant thought the request to remove PPE was to prevent contaminating the staff waiting in the airlock.
- ACP Irrelevant complied with the direction of the nurse and removed PPE while in the resus cubicle and exited the area. ACP Irrelevant state that she was more than 1.5 metres away from the patient and was exposed with no PPE for less than 2 minutes.
- Handover and clean up were unremarkable.

Outcomes:

- SIMIR medical cell was present at interview via teleconference. Low risk exposure due to low time without PPE and distance away from patient.
- SOS provided copy of current QAS PPE Don and Doff procedure as well as current clinical matrix to ACP Irrelevant
- SOS reminded ACP Irrelevant of priority one and Peer support available if required and offered time OOS post interview if required
- Nil further action required

Post OIRR actions:

- SOS followed up with Officer as documented in this review.

Review Recommendations:

- Nil

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- LASN Notification

LASN Endorsement

Name	Position	Signature	Date
Gerard Lawler	Assistant Commissioner	Irrelevant	15/03/21
Anthony Hose	Director Operations		10/03/2021

s47(3)(b)

s47(3)(b)

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of A/Assistant Commissioner Chris Draper – General Manager Gold Coast LASN

Executive Summary:

At 12.17 am on Monday 15 March 2021, Queensland Ambulance received a req est for er e for to attend a Irrelevant patient experiencing "RUNNY NOSE – COUGHING – SWEATING" ncide t num 14025007, initially coded a 36A03S -? COVID19 FLU SYMPTOMS ONLY 2C. The initial ca was r ceived in the Townsville OpCen, the patient was the caller.

A second call was received around 25minutes later from the patient's on and t e caller was advised of delays. Within the Incident Detail Report (IDR) it was recorded tha he patie will cuss ernate transport with the patient and would call back to advise. This call was received the Br ne OpCe

Almost 1 hour later, at 1.39am, the EMD from the Southport Op n cond a call back, and was advised the patient has travelled by private means and the case was subs uently cancelled. It was later identified the patient initially presented to the Renal area of GCUH as t y are f miliar with this location. When spotted by security, they were placed back into their private vehicle nd directed to the Emergency Department. The patient was entered as an unknown patient at 1 1am n car c arrest. The patient received 15min of resuscitation with ROSC and is now ntil d in IC

CNC at GCUH advised the GC LASN Opera ns Superv f the incident shortly after 6am.

Terms of Reference:

This review will investigate all aspe of ambulance response to incident 14025007. The review will examine ambulance operations prior during and following the response.
This review will in lude all requirements tlined in the *Operational Incident Review Process*.

LASN Clinical In dent Summary Report:

QAS Re urces were not ispatched to incident – nil clinical interaction with patient.

St te Op en ProQA:

The Queenslan mbulance Service Medical Director requested a State OpCen Review for this incident.

T summary of find gs are:

"…Moderate Deviations: - Key Question not asked…Overall compliance:Compliant…"

I coding of 36-A-3…. Which is QAS Code 2C (QAS Non-Lights and Sirens) response, which is correct based on patient presentation."

During the second Triple Zero Call …" The EMD had an opportunity to have reconfigured key questions… and potentially upgraded the incident priority.":

Incident Review/Investigation:

Scope:

The review considered the QAS resource allocation and response.

Due to reported workload, QAS resources were not dispatched to this incident. The attached iROAM snapshot indicates multiple code 1 response through this period.

Background:

The Gold Coast LASN (GCLASN) had been experiencing high workload with the South East Q enslan LASN escalated to extreme pressure since 9.45pm the proceeding day.

There were no resources dispatched to the incident, with the case held pending. The caller lled S ba k and at this point, was advised of high workload. The caller advised the EMD that they would dis uss alterna e means of transport and would advise the OpCen of their decision.

The caller conveyed the patient to GCUH, but arrived at the renal unit, as they are fam ia with this area. Security intercepted the group and returned them to their vehicle to proceed aroun to t Emergency Department. On arrival the patient presented in cardiac arrest and was immediately moved to resus bay, where staff performed resuscitative measures. The patient was triaged a NKNOW PATIENT" at 1.21 am. ROSC was achieved after around 15 minutes.

At 1.39am the Southport OpCen performed a call back and were advi d th the pa ent has been transported via private means to GCUH, with no other information provid d and t ase was osed.

After 6am, the day shift Operations Supervisor was advised the atient h esented to the ED in cardiac arrest and had passed away. The Family had raised concern that ey were directed to transport by private means. Subsequent follow up by the Senior Operatio s Supe isor ide ified the patient was currently in ICU, ventilated with ROSC.

Timeline:

12.17 am – Request for servi received th ugh Townsville OpCen

12.43 am – second call received th Brisbane OpCen and the caller advised of delays – discussion held with the caller who said they would cuss with the patient the option of transport via private means.

1.21 am – "UNKNOWN PATIENT" in diac arrest entered in to GCUH ED Triage – around 15min of resuscitative meas s provided with patie in ROSC and transferred to ICU.

1.39 am Southport O Cen conducted a call back and were informed the patient had been conveyed by private eans to GCUH.

6 a (app ximately) – GC L SN day OS advised of incident by GCUH CNC. Callers family had advised hospital supp t workers that the ambulance service had directed the family to transport via private means.

R iew:

T e Office of the Medical Director has requested a State QA be conducted as part of this review

The review dentified that despite one identified moderate deviation, the coding of 36A3 – Code 2C was appropriate given the information provided.

The Review identified a second call was placed by the patient's son 25 minutes after the original call. The EMD opened ProQA but did not reconfigure any key questions. The State review identified an opportunity to reconfigure key questions to address "laboured breathing" information provided by the caller and potentially upgrade the incident priority.

Review Recommendations:

1. The review summary from State OpCen identified 1x Moderate deviation, and an opportunity to review key questions at the second call. EMD was provided feedback regarding reopening ProQA and updating key question when new information is provided. The State OpCen conducted a Record of Event and followed up with the EMD and follow up actions in regard to education feedback in call management as per the QA evaluation that was undertaken; and EMD is up to date with all mandatory skillsets.
2. Clinical Education Unit review non applicable – no patient interaction with clinicians.

Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Briefing notes identifying operational issues;
- Consultation with State OpCen Assistant Commissioner (for "State .01.21 Special Review" if relevant);
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR; - atta d
- Incident Detail Report (IDR) - attached
- Electronic Ambulance Report Form (eARF) - not applicable – no units on scen
- Local level clinical review (Eclipse) – not applicable.
- State level clinical audits (should be requested from the Medic l Direct Offic complex clinical incidents or incidents with deviations from clinical policy and rocedu); N/A
- Relevant audio (wav) files – attached.

Incident Details Report	IDR 14025007 - cx prior to arrival - pt a
GCLASN Notifiable PSDU Notification	5_03_202 otifiable Inci nt -
dARF/dCRF	N/A
Voice Logs	14025 7 mp4 ; 14025007 - Duplicate call.mp3 ; 14025007 - Call back 01.38am.mp3
State O cen Re ew	210315_SR16859569_14025007_WORON ; 210315_SR16859569_14025007_WORON ; 210315_SR16859569_14025007_WORON ; 210315_SR16859569_14025007_WORON
Southport pCen Brief	140321 NIGHT SOUTHPORT OPCEN I
Clinical Review	N/A
iROAM	iROAM 14025007.pdf

Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Tony Armstrong	General Manager	Irrelevant	03/08/21
A/Director	Justin Payne	Director Operations		

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of A/Assistant Commissioner Chris Draper – General Manager Gold Coast LASN

Executive Summary:

At 12.04pm Monday 15 March 2021, Queensland Ambulance received a reque t for se ic via triple zero (000) from the Southport Watchhouse to attend a Irrelevant male who was foun n his ell un scious with his shirt around his neck, cyanosed and apnoeic.

On QAS arrival, the officers located a male patient, alert and orientate , under e car f t e WH registered nurse. Officers were advised that the nurse identified the male patien as unc scious and not breathing, with his shirt wrapped around his neck. Ventilation support was rovided b the n rse, th ugh Intermittent Positive Pressure Ventilation (IPPV) and the patient regained conscio ness a d elf-venti tion.

QAS responded ACP, CCP HARU and the LASN SOS to attend incide h the HARU stood down prior to arrival. GC LASN SOS identified Courthouse media taking an in est in the arriving units and were filmed as they entered and exited the Watch house carpark QAS dia wa notified and requests for information were referred to the Queensland Police Service.

The Patient was transported under po ard to G ld oast Un ersity Hospital in a stable condition.

Terms of Reference:

This review will investigate all pects of a b l e response to incident 14027157. The review will examine ambulance operations p or to uring and fo wing the response.
This review will include all requirem s outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summa Report:

GC LASN Clinical E cation completed a clinical review of this case.

Summar of Report:

> *se managed to st dard with minor variation due to omittance of 12-Lead ECG in a patient that was id to have had a period of ALOC before QAS arrival. CSO has requested feedback through eclipse view and will follow up with crew"*

S te OpCen ProQA:

N Required as this case was an ICEM initiated case**.**

Incident Review/Investigation:

Scope:

he review considered the QAS resource allocation and response. The first unit on scene was dispatched from Gold Coast University Hospital and arrived on scene within 11 minutes of the initial call. The GCLASN SOS arrived on scene at the same time.

The Gold Coast Local Ambulance Service Network (GCLASN) at the time of the request for service was experiencing increased demand for service with delays at GCUH resulting in level 2 escalation. Robina Hospital was experiencing minor delays leading up to and during the case, Robina Hospital had minimal delays at the time of the incident.

Background:

The patient was a located in a cell in the Southport Watchhouse. At midday, watchhouse staff noticed he patient was laying lateral with his shirt around his neck and unresponsive. A review of the security foo ge from his cell noted the patient was recorded wrapping his shirt around his neck at 11.19am and he stop ed moving shortly after. The Watchhouse nurse immediately attended to the patient and the QAS was call within 4 minutes. The RN advised the patient was found unresponsive, apnoeic and cyanos d, but with a pulse. After ventilation support through IPPV the patient's condition improved. On QAS ar val, the p ient was alert and well perfused. Obvious ligature marks were noted about his neck, as documen ed in e Acu units Patient Care Record.

On arriving at the watchhouse car park, the GC LASN SOS identified media intere t from e court ters and notified QAS media team of the incident and interest.

Timeline:

12:04 pm – Request for service received.

12.07 pm – B 601307 (Acute ACP Unit) dispatched

12.08 pm – A 606853 (HARU) and B936323 (Acute ACP Un dispatc

12.09 pm – update from on scene "RN IS GIVING PT O2 – PT IS N CUST

12.09 pm – GC LASN SOS notified of incident

12.10 pm – A 606692 (CCP POD Unit) and O6065 (SOS disp ched

12.14 pm B601307 on scene

12.14 pm – A 606851 (CCP PO Unit) dispa hed – A 60 2 Stood down

12.15 pm – S 606515 on scen

12.17 pm – A 606851 on scene

12.19 pm – sitrep from S 606515 – MA E PT CASE AS GIVEN – APPROX 10MIN WITH SHIRT AROUND NEC KEEP CCP & HARU OMING – GETTING VITALS NOW FROM NURSE

12.23 pm – trep from S 606515 – STAND DOWN HARU

12.23 p – A 606853 mar d on scene – discussed case with SOS and CCP from outside and stood down

12 4 pm itrep from S 6065 – WILL BE DELAYS ORGANISING QPS ESCORT

12.36 pm – sitr from S 606515 – POD & 515 AVAIL

58 pm – B 6013 transporting to GCUH with QPS escort

1 pm – B601307 advised ramped at GCUH

B601307 marked off stretcher via GWN

1.56 pm – B601307 marked clear and incident closed.

Review:

A comprehensive review of the case is currently under way.

The following are the findings of this review thus far

- **OpCen Review**
  - Pending

- **Clinical – Clinical review of case to be completed.**

  - **Patient outcome** – Patient transported alert and orientated, well perfused with Vital Signs within normal limits. Obvious marks about his neck from his attempted strangulation noted y ACP crew.

  - **Transport appropriateness** – patient was identified to be in a stable condition, and transp was delayed whilst waiting for appropriate QPS resources to transport, and the atient was t remain in QPS custody. Pt was transported with ACP unit and QPS. No CCP uring transport.

- **Outcomes**: incident not captured in OpCen Brief
- **Post OIRR actions**: Incident notification and OpCen brief did not capture ficer s port pr d. recommending Officer welfare to be followed up post event.

Review Recommendations:

1. Clinical Education Unit to review clinical aspects of case – min r varia due tting 12lead ECG – CEU team to follow up with officers.
2. Nil operational concerns with the case, resource a cation, r spon e all w in appropriate expectations.

Appendix of relevant documents/files:

- Briefing notes identifying response informati ;
- Briefing notes identifying operational issues
- Consultation with State OpCen Assistant C mmi ioner r “State .01.21 Special Review” if relevant);
- A clear timeline of events om recei of Triple ro (0 0) call for the OIRR;
- Incident Detail Report DR) - not att ched
- Electronic Ambulance eport Form eARF) not attached
- Local level clinical revie Eclip e) Completed
- State level clinical audits (s ld be requested from the Medical Directors Office for complex clinical incidents or incidents with de tions from clinical policy and procedure);
- Relevant udio (wav) files – not ached

Incide t Deta s Rep rt	IDR 14027157 - Southport WH Self I
GCLASN Notifiable PSDU Not cation	15_03_2021 - Notifiable Incident (
dARF/dCRF	DARF 503237094 - 14027157 - 601307 -
Voice Logs	Nil

Southport OpCen Brief	150321 DAY SOUTHPORT OPCEN
Clinical Review	QAS GOL CEU Clinical Review Temp

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager	Irrelevant	24/06/2021
A/Chief Superintendent	Rachel Latimer	Director Operations		25/06/2021

Significant Incident Review

Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of A/Assistant Commissioner Chris Draper – General Manager Gold Coast LASN

Executive Summary:

At 8.36am on Wednesday 17 March 2021, Queensland Ambulance received a reques fo ervice at Irrelevant Irrelevant Miami to attend to an off-duty paramedic in cardiac arres witn sed b wo other off duty paramedics and an off-duty consultant from GCUH ED. Officers were able to loc e a def brillator from a nearby medical centre and were able to administer one shock, which ed in a eturn f spontaneous circulation (ROSC).

QAS responded an acute ACP unit, a nearby LARU, CC POD, HA U, O and OS. The LASN Assistant Commissioner was immediately notified of the incident. The t unit o ene was ispatched from Bermuda Street and arrived on scene around 5 minutes after the first ph e pick

The patient was transported code 1 to GCUH. (CATH LAB ACTIVA ION by HARU) and arrived at GCUH at 9.38 am. GC LASN A/DO, and SOS attended the GCUH ramp supp staff, Priority one has been activated for staff welfare who also attended GCUH and rem ned pre ent during debrief.

Terms of Reference:

This review will investigate all as ects of am lance resp to incident 14035070.
The review will examine ambu ance operati s prior to, during and following the response.
This review will include all requ ments o *Operational Incident Review Process*.

LASN Clinical Incident Sum ary Report:

GC LASN Clinical Education completed clinical review of this case.

Summary of Report

"*Great sponse from a concerned. Good communication, teamwork and CRM with all perf m g their designat role competently and efficiently with a great outcome for this patient*"

State OpCe ProQA:

t required

In ident Review/Investigation:

p

The review considered the QAS information provided to the OpCen to generate the response level for this incident as well as resource allocation and response.

ckground:

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The call was placed via triple zero (000) by an off-duty paramedic, to attend to another off-duty paramedic (known to her) who was in cardiac arrest at Irrelevant A third off duty paramedic was also in attendance. The patient was lightheaded and collapsed while Irrelevant and became unresponsive. CPR was immediately commenced by the off-duty officers and the call was placed. The QAS responded an ACP crew who arrived on scene first as well identified a nearby LARU who arrived shortly after to assist. The CCP, POD, HARU OS and SOS were also attached.

The Senior Operations Supervisor immediately notified the LASN General Manager of the incident.

Following interventions on scene, the Patient was conveyed in unit 601537 to GCUH with CCP and HAR

The units who did not assist in the transport had a hot debrief on site with the OS, this include m mbers o the public who were also present and assisted.

The LASN Director Operations, SOS and CSO's attended GCUH to provide support to staff, h ority o being activated.

Timeline:

08:54:56	Phone pickup and1st Keystroke – 1A MATA1 – CALL from OFF DUTY PARAMEDIC – PT NOT BREATHING Irrelevant
08:56:05	B 601537 – ACP Acute unit and A606692 – CCP PO unit ass gned
08:56:13	EMD – PT [redacted] PARAMEDIC
08:56:39	EMD – CPR in progress
08:56:53	CDS – ATTACH CCP AND HARU CODE 1
08:57:04	A 606853 – HARU assigned
08:57:07	EMD – PT WAS Irrelevant – GOT LIGHT HEA ED & COLLAPSED
08:57:35	EMD – [redacted] OFF DUT PA MEDIC
08:58:25	EMD – SOMEONE LOOKING FOR A DEFIB NOW
08:58:36	L 608569 – LARU Bravo unit assig ed
08:58:36	S 607843 – LASN OS ned
08:59:21	CDS2 – SOS ADV ED
08:59:55	B 601537 on sc ne
09:00:25	B 601537 sitr p – IN Irrele ant
09:00:52	S 606851 – LA N SOS a g
09:03:44	L 608569 on sce
09:04:28	OCS – PDSU advis
09:04:40	A 606692 on scene
09:04:58	B 606692 sitrep – CONF MIG IT IS Irrelevant
09:06:08	L 6 569 sitrep – CONFIRMING PT OUTPUT AFTER 1X SHOCK HR 123 – VENTILATING – SU RS FINE – HAVE ACCESS – CONTINUE HARU AND CCP – OFF DUTY PARAM IC ONSCENE AS WELL
09:10	A606692 s p – GCS12 GETTIN [sic] READY TO EXTRICATE CONT HARU
09: :35	S 606851 on ene
09 14:52	S 607843 on scene
09:24:52	606853 on scene
09:25:28	B 01537 depart HOT to GCUH (HARU and CCP on board)
0 27:38	S 6 851 sitrep - OS AND LARU REMAINING ON SCENE DEBRIEF WITH OTHER STAFF - POD CAR LEFT ON SCENE - 606851 FOLLOWING BEHIND HOT
0 38:55	(as marked by SOS unit) pt. arrived at GCUH – transport unit did not press at hospital.

Review:

A comprehensive review of the case is currently under way.

T e following are the findings of this review thus far

- **OpCen Review**

- requested

- **Clinical – Clinical review**

  - **Patient outcome** – patient achieved ROSC on scene after 1x DCCS from an AED obtained from a nearby medical centre. The patient improved to GCS 12 and subsequent GCS 14 at transport. Good resourcing and CRM on scene which contributed to a positive outcome or this patient.

  - The patient had a LAD occlusion which was removed, and stent placed in the CATH lab, patient responded well to the surgery and is in recovery supported by his OIC wh l remai until the arrival of family.

  - **Transport appropriateness** – the patient was transported code 1 to GCUH, ATH LA was activated by the HARU, the patient was transported directly to th CATH lab via a b ef assessment in RESUS at GCUH.

- Outcomes:
  - The review indicated that resourcing was adequate given tient w s a QAS staff member, with other off duty staff members on scene. Staff welfa e played signif role in resourcing of this event.
  - The Clinical review identified the response was well ana ed, wit good CRM, including the utilisation of off duty QAS officers.
  - OpCen Review not required

- Post OIRR actions:
  - Crew followed up by Peer Support
  - Off duty officer supported during th r reco ery.

Review Recommendations:

1. Clinical Education Unit o review clin al aspects of case –recommended the case be identified as a commendable case.
2. Nil operational concerns ith th case – with g od resourcing and CRM.

Appendix of relevant docum ts/files:

Incident D ails Report	IDR 14035070 - Off duty paramedic Carc
GCLA N Notifiable PSDU N tification	Nil
dARF/d RF	eARF 14035070 - Off duty paramedic; eARF 14035070 - Off duty paramedic; eARF 14035070 - Off duty paramedic; eARF 14035070 - Off duty paramedic
Voice Logs	Nil
State OpCen Review	Nil required
Southport OpCen Brief	170321 DAY SOUTHPORT OPCEN

Clinical Review	QAS GOL CEU Clinical Review CIM CIM Checklist CSOs CIM 14035070 Burle
Other Documents	Nil

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager	Irrelevant	24/06/2021
A/Chief Superintendent	Rachel Latimer	Director Operations		25/06/2021

Department of Health

Queensland Ambulance Service

Significant Incident Review

Wide Bay Local Ambulance Service Network

IR030-2021 (14046434)

Authority:

By authority of Russell Cooke, Director Wide Bay LASN, SOS Martin Kelly undertook this review into incident 14046434.

Executive Summary:

On 19 March 2021, the QAS received a call indicating that there had been a single vehicle RTC on the Irrelevant Eureka. There was said to be three occupants in the vehicle at the time of the RTC. It was stated by the caller that the passenger was trapped and not in a good condition and the Irrelevant was having difficulty in breathing.

- The Irrelevant M passenger was deceased on arrival of QAS.
- The Irrelevant F driver, self-extricated from the vehicle and suffered minor injuries and was transported to BBH.
- The Irrelevant F suffered a significant head injury with a large developing skull haematoma and was transported by 8511 to QCH.

Three road units responded from Childers to the scene some 20 kms from Childers, one full crew and two solo from EA. Two helicopters were utilised on the incident, the Bundaberg 8522 to provide initial CCP support and would have transported to QCH if 8511 from Sunshine Coast was unable to attend due to weather or diversion. R8511 was requested by the FCCP from 8522 due to the infant's condition.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14046434.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

A review by the Wide Bay CEU found no issues with the clinical management of this case.

Incident Review/Investigation:

Scope:

This review will consider all aspects of the QAS response to case 14046434, including resource allocation and clinical treatment.

Background:

- QAS called to a single vehicle RTC at Eureka on the Irrelevant 20 kms west of Childers.
- Single vehicle into tree with three occupants.
- Irrelevant M, trapped, deceased.
- Irrelevant F with head injuries coded as red, GCS 8 developing haematoma, flown by 8511 to QCH.
- Irrelevant F minor injuries listed as green, transported to BBH by road.

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Timeline:

Call Received:	17:19
In waiting Queue:	17:22
First unit assigned:	17:23
First Unit on Case:	17:23
First Unit on Scene:	17:40

Review:

On review it was found that the response intervals were within expectation and the transport options chosen were appropriate to the situation.

Outcome:

The male passenger was deceased on arrival of QAS, the female driver had self-extricated from the vehicle and suffered minor injuries. They were the parents of the Irrelevant F who suffered a significant head injury with a large developing skull haematoma. The female was transported by road to BBH. There were two helicopters allocated to the incident. The first from Bundaberg, who stabilised the infant. They then requested the helicopter from Sunshine Coast attend to assist with the Irrelevant as according to the FCCP on scene, her airway required securing via intubation, and she would be best served by direct transfer to the QCH. The 25 Irrelevant F was transported by road without delay as the initial response by the Bundaberg 8522 had a FCCP and an intern CCP on board, who had been cleared to fly. The lengthy on scene time with the Irrelevant F was due to the difficulty in securing her airway. The outlook for the Irrelevant has been reported as not being too good, with significant brain trauma evident on the MRIs taken at QCH, as advised by the FCCP when he followed up this week.

Review Recommendations:

This review finds no recommendations.

Appendix of all documents and files used in compilation of the review:

- Incident Detail Report (IDR)
- Electronic Ambulance Report Forms (eARF) (for the three patients) and
- Local level clinical review (Eclipse).
- Notification email.
- IRoam capture.

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to QASStateLASNOps@ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Director	Russell Cooke	General Manager	Irrelevant	

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of Acting Director of Operations, Gold Coast Local Network service network

Executive Summary:

IDR 14049589 – At 12.26pm on Saturday, 20 February 2021, the Queensland Ambula c Service (QAS) received a request for service from Queensland Health for a patient located at t Irrele ant Irrelevant Surfers Paradise. This request was for a Irrelevant F presenting with a non pecific ynaecological complaint.

This patient was accommodated in a mandatory quarantine hotel r a pe d of fourteen days. She had reportedly completed one of fourteen days.

QAS LARU Officer Irrelevant was assigned to case along th Ope tional Su ervisor Irrelevant who was deployed to oversee the donning of PPE process. The trans throug ospital was without incident.

Upon arrival at GCUH the patient was ramped by QH alth d direc d to the COVID holding area. After an extended period, Officer Irrelevant allegedly removed h s PPE w ilst the pa ent remained in his care for a further hour.

Officer Irrelevant reported to QAS SIMR Med l Cell t he had moved his PPE without a supervisor being present.

Subsequently Officer Irrelevant as been pl ed in mandatory isolation at the direction of the QAS Medical Director.

Terms of Reference:

This review will in stigate all aspects of bulance response to incident 14049589. The review will examine ambulanc perations prior to, dur ng and following the response.
This review ill includ ll requirements outlined in the *Operational Incident Review Process*.

LASN linical Inciden Summary Report:

N Require

State OpCen roQA:

O ine of report (the ASN Manager must request this from the Assistant Commissioner State Operations C tre (OpCens) as early as possible following the incident).

Incident Review/Investigation:

Scope:

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The process of this SIR is to determine if any clinical or operational failures of this incident has been identified to ensure that best practice in prehospital care is provided to stakeholders whilst ensuring the safety of QAS staff is upheld.

Through the analysis of the data provided both positive and negative indicators are identified, this analysis should be used to determine actions that create opportunities for improvement.

Background:

- Irrelevant F Day 01/14 in quarantine hotel
- C/C Nonspecific gynaecological issue
- Case assigned to LARU officer Colin Irrelevant and Operations Supervisor Irrelevant
- Nil issue reported with donning of PPE process.
- Patient transported to GCUH without incident.
- Upon arrival at GCUH A/SOS Irrelevant on scene assigned to oversee doffing pro ss.
- Patient ramped and directed to COVID holding area.
- After an unknown period, Officer Irrelevant allegedly removed his PPE however r main d in th inity whilst his patient remained in his care.
- Officer Irrelevant reports there was no supervisor on scene supervising e ffing p cess

- **Timeline:**
  - 1st key stroke: 12:25:35
  - In waiting queue: 12:29:41
  - Assigned 1st unit: 15:34:58
  - Enroute 1st unit: 15:35:05
  - At scene 1st Unit: 15:35:07
  - Departed scene: 15:37:42
  - At hospital: 16:14:28
  - Clear from hospital 1 1:51 (O stretcher me not documented)

- **Review:**
- A/SOS Irrelevant (06:00 18:00) wa are of the said case along with others that were coming to GCUH
- A/OS Irrelevant was at the CO D Hotel to oversee the donning process.
- A/SOS Irrelevant was at GCUH t meet ACP Irrelevant which he arrived in PPE gear along with the patent wi a mask on.
- Patent walk d from the LARU Amb lance with ACP Irrelevant into the COVID Triage area and then wa moved in e COVID Holding area (Patent was sitting on a QHealth chair). At 17:30 A/SOS Irr ant spoke to CP Irrelevant who was still in the COVID holding area. There was no QAS monitoring eing conducted w the patent and ACP Irrelevant was at least 4 meters from the patent. A/SOS I vant explained to A P Irrelevant the requirement for cleaning and clean up. A/SOS Irrelevant had alre y watched ACP I elevant re another patent from a COVID hotel this morning and there was no issue.
- A/SOS Ir ant spoke to the CNC for a off load plan which would allow ACP Irrelevant to be released.
- The plan wa for an Enrolled Nurse (EN) to come and watch the patent - this would happen in about 15 mins. A/SOS Irrelevant explained the plan to ACP Irrelevant and asked if the QAS unit would need to be cleaned as per the requirement. It was noticed that Officer Irrelevant PPE - gown and mask - had en removed, without supervision due to supervisor attending to other issues at GCUH (Level 3) at the time.
- A/SOS Irrelevant left GCUH at 17:30 for a shift termination at 18:00. Two attempts were made to contact QAS Medical services at 17:30 to provide an update, said phone line was busy. Hence GC PACH contacted and a requested a CAD entry be entered.
- [Private] SOS ADVISES THAT PLAN IN 10MINS IS TO RELEASE OFFICER AND REPLACE CARES WITH AIN

WHO WILL REMAIN WITH PATIENT ON RAMP. NIL QAS CARES PROVIDED, QAS STAYING WITH PT AS DEEMED TO BE A FLIGHT RISK

- Contact was made with QAS Medical Services and the plan was made aware to them.
- **Other Supervisors** – 2 x CSO's finished at 17:00
- No OIC's rostered on
- Day Operational Supervisor terminating at 18:00
- Night Operational Supervisor attending to COVID plane arrival at Coolangatta Airport
- Afternoon Senior Operational Supervisor attending to a COVID hotel transfer in Surfers Paradise

- **Outcomes:**
- A/SOS Irrelevant should have stayed past his finish time to make sure appropriate proced es was enforced at the time or have another Supervisor attend GCUH to which there was no e.
- ACP Irrelevant should have kept his mask / PPE on, he was greater than 4 metres from the p nt a had no patent contact.
- QAS is unaware if the patient was a positive or negative for COVID-19.

- **Post OIRR actions**:

- Outcome patient COVID-19 negative and officer remain asympt

Review Recommendations:

- Peer support to be provided to attending crews.

Appendix of relevant documents/files:

Incident Details Report	n t port_140 589.pc
GCLASN Notifiable PSDU Notification	N fiab Incident_ Sat y March 20 2
dARF/dCRF	Earf_14049589.pdf
oice Logs	Nil
S ate O Cen Review	il
Southport pCen Brief	200221 DAY SOUTHPORT OPCEN
Clinical Review	Nil Required
Documents	Nil

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager	Irrelevant	24/06/2021
A/Chief Superintendent	Rachel Latimer	Director Operations		25/06/2021

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of Acting Assistant Commissioner, Gold Coast Local Network Service Network

Executive Summary:

Gold Coast LASN responded to an incident (IDR 14053294) to Irrelevant allebud er at 11.04am on the 21 March 2021, where a Irrelevant emale had collapsed at her home.

Severe Weather in the area played a major part which cause a major respo se time d e to po r vision, flooded roads as well trees across the road which blocked access.

The crew eventually accessed the patent 1hr and 26 mins from the 0 0 call With u izing a civilian 4WD to get from the roadside to the patient in a flooding house. The also us d th same 4WD to move the patent from the house back up to the roadside where the Ambulance as.

A CCP LARU was dispatched from Southport Station to support th atient in a DMUX 4WD unit.

Crew and CCP teamed up and transported the pate to GCU (Hot).

Terms of Reference:

This review will investigate all asp ts of am lance r onse t incident 14053353. The review will examine ambulance operations rior to, duri g and following the response.
This review will include all re rements ou ned in the *Operational Incident Review Process*.

LASN Clinical Incident Summ y Report:

If required a state level clinical review uld be requested from Medical Directors Office.

State OpCen Pr QA:

Nil requir d

Inci en Review/Invest ation:

- **Scop**
  - ld Coast reviewed the response, Clinical performance and operational decision making to en e the appropriate and management of this case was achieved. Gold Coast will identify any operational or clinical performance issues with this case and ensure appropriate actions are taken to return to the required standards.

ound:

- At 11:01 QAS received a request to attend to a Irrelevant F at Irrelevant Tallebudgera. Patent has collapsed with agonal breathing.
- It was advised by the caller that the patient was in ankle deep water as the house was flooding.
- EMD noted in CAD that CPR had commenced.
- QFES contacted for support re access.

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- QAS Unit 601516 responded but due to flooding was unable to response by the most direct route. Multi detours as well blockages over the road delayed the response to the patent.

- **Timeline:**
  - 1st key stroke: 11:01
  - In waiting queue: 11:03
  - Assigned 1st unit: 11:04
  - Enroute 1st unit: 11:04
  - CCP LARU dispatched: 12:14 CCP changed into 606851 DMux 4WD
  - At scene 1st Unit: 12:30
  - Departed to GCUH: 12:49
  - CCP LARU at scene: 12:50
  - Arrived GCUH: 13:24
  - Complete: 14:15
- **Review:**
  - Multi roads flooded, they used some local knowledge as well speakin people that wer stopped at flooded roads for best access to the address.
  - Issues with gaining a QAS 4WD to support the crew on scene w delay d.
  - A very difficult job with challenges to the crew.
- **Outcomes:**
  - On arrival the crew had to use a public 4WD to get to th p nt with QAS cr w on board.
  - Crew confirmed Patent not in cardiac arrest, SITREP VA GC 5
  - Property had ankle deep water in the area as well g ng thro gh th house.
  - Same public 4WD retrieved the patient wit QAS cre on oard.
  - Crew meet up with the CCP en-route to GCU
  - Transported HOT to GCUH Patent condition no large C A GC 3
  - Patent current condition – suffered a basal tip ane ysm rupture
  - The patient is for End of Life now.
- **Post OIRR actions**:
  - OIC to follow up with the crew for welfar check
  - 601516 unable to r he trac data for t s unit in IROAM.

Review Recommendati ns:

- Crew went above and be nd i using public 4WD to access and retrieve the patent back to the ambulance on the road whi n difficult weather conditions.
- Locations of the LASN 4WD d e units, if moved from their normal station locations to other stations need to b done via an email so eryone is aware.
- EARF Prim y Complaint is listed a Childbirth – Ruptured Membranes" which will need to be cha ged

Appe ix of relevan documents/files:

Incide t Details Report	Incident Report_14053294_Tr
GCLASN Notifiable PSDU Notification	Notifiable Incident_ o_CN 14053294 – AI
dARF/dCRF	Earf_14053294.pdf

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Voice Logs	Nil
State OpCen Review	Nil
Southport OpCen Brief	210321 DAY SOUTHPORT OPCEN
Clinical Review	Nil
Other Documents	Nil

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager	Irrelevant	24/06/2021
A/Director Operations	Rachel Latimer	Chief Superintendent		25/06/2021

Incident Assurance Review

Sunshine Coast Local Ambulance Service Network

Authority:
By authority of Sunshine Coast Assistant Commissioner (AC) Mr Paul Shaw, this review was completed by Senior Operations Supervisor (SOS) Kristy McAlister.

Executive Summary:
Officer Irrelevant has reported being verbally and physically assaulted while assessing patient Irrelevant at his home residence in Currimundi on the 27th March 2021. The offender is believed to be the patients' son. The assault was unwitnessed and not reported to a QAS supervisor until after arrival at Sunshine Coast University Hospital (SCUH). The assault has resulted in a Lost Time Injury (LTI). At the time of writing this report it is unknown if officer Irrelevant intends on pursuing the matter further through Queensland Police Service (QPS).

Terms of Reference:

- The review will review the circumstances of an injury sustained to an officer during his shift.
- This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:
SOS has performed a primary review of case documentation. Evaluating Clinical Improvement and Patient Safety (ECLIPSE) has not been requested for this incident

Chronology:
Below is a chronological sequence of events

19:18 Request for QAS attendance

19:21 Incident "In Waiting Queue"

19:22 B401853 dispatched and responding to incident at same time from Birtinya area

19:35 B401853 arrived on scene

19:51 B401853 departed scene with patient onboard for SCUH

19:56 B401853 arrived at SCUH

21:39 B401853 cleared from incident

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Incident Review/Investigation:

- Incident Detailed Report (IDR) 14082684; 17B01G; Irrelevant Minyama; Irrelevant male (YOM) fall, hit head
- B401853 crewed by Irrelevant
- Nil response issues
- Situation Report (SR) provided by B401853 at 19:42 states QPS are not required
- Officer Irrelevant advised PACH Operations Supervisor (OS) of the assault in the hos tal hallway while OS was attending to delayed POST at SCUH
- Officer Irrelevant stated to PACH OS that she was verbally abused by an ntoxicated male. The male person (name unknown) also grabbed her utility belt a d pulled her backwards
- The assault has not been witnessed
- The assault has not been reported to Maroochydore Ope ation Centr an Operational Supervisor at time of occurrence
- Officer Irrelevant initially refused medical treatment for any injuries ut complained of back pain to PACH OS
- Officer Irrelevant partner was unaware the assault ha occur d un ked about the incident by PACH OS
- PACH OS notified OS and Operations Cen e Supe vi or (OC) of the assault
- The OCS has reported the assault in IDR 140 2684 20:53
- Officer Irrelevant continued duty and was dispatched to IDR 14083330 at 22:06. After completion of this case officer Irrelevant was anspo ed to Buderim Private Hospital (BPH) by officer Irrelevant
- Additional information regarding the ass ult ha been entered into IDR 1408330 by the OCS at 23:03, 23:0 and 3:18
- SOS was notified of he assau by OS a 18
- Officer Irrelevant was ssessed a BPH and administered Ibuprofen and Diazepam
- Officer Irrelevant was p ovide a Medic Certificate from 28/03/2021 to 31/03/2021 inclusive
- SHE Report requested; (known if submitted)
- Priority activation requeste by SOS and actioned by OCS
- Bud rim O icer in Charge (OIC) and Workplace Health and Safety Adviser (WHSA) n tified
- atient Safety D tribution Unit (PSDU) updated
  D point provided Executive Manager Operations (EMO)

Review Recom endations:

- Buderim O C has contacted Duty SOS on 28th March and is performing further welfare checks with officer Irrelevant
  Education is required regarding officer responsibilities surrounding occupational violence – 'an injured officer is responsible for notifying the Operations Centre of an incident via duress or phone call as soon as practicable'

This review be noted and filed.

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Appendix of all documents and files used in compilation of the review:

- IDR 14082684
- SHE Report requested, unknown if submitted
- Dot point to EMO
- Email notification to OIC and WHSA
- Senior Operations Supervisor End of Shift (EOS) Report (1800-0600) 27/03/2021

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Assistant Commissioner	Paul Shaw	General Manager	Irrelevant	27/03/2021

Department of Health

Queensland Ambulance Service

Significant Incident Review

Wide Bay Local Ambulance Service Network

IR035-2021 (14109485)

By authority of Russell Cooke, Director Wide Bay LASN, SOS Martin Kelly undertook this review into incident 14109485.

Executive Summary:

On 3 April 2021, the QAS were called to a domestic incident in which three persons had suffered injuries involving knives, QPS advise that one person was deceased on their arrival. On arrival of the first QAS crew that status was confirmed and two other persons, a male and a female were advised to have suffered injuries. An Operations Supervisor and another crew were dispatched to the scene. The Irrelevant male and Irrelevant female were both transported to Hervey Bay Hospital (HBH) in separate ambulances at the request of the QPS to ensure separation of evidence.

This review found no recommendations and ascertained that there were no operational abnormalities with this incident. A review by the Clinical Education Unit found some minor documentation abnormalities, further discussed below.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14109485.
This review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

The Wide Bay CEU clinical report found that documentation on the Irrelevant female was lacking in detail. This was rectified following a discussion between the crew and Manager Clinical Education, who deemed the clinical management sound, however more detail needed to be added to the eARF to clarify the rationale for incomplete VSS and documented treatment of a laceration. These deficiencies have been resolved with addendum to eARF.

Incident Review/Investigation:

Scope:

This review will consider all aspects of the QAS response to case 14109485, including resource allocation and clinical treatment.

Background:

- QAS called to an address in Pacific Haven near Howard.
- The caller advised that a domestic incident with knives involved and someone was bleeding.
- When QPS arrived on scene they discovered one male deceased, and two persons injured.
- A4542 Howard unit arrived on scene and confirmed:
    - 1 male deceased,
    - 1 male with serious injuries to head and face,
    - 1 female patient requiring treatment for non-life-threatening injuries.

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Timeline:

Call Received:	12:10
In waiting queue:	12:13
First unit assigned:	12:14
First Unit on Case:	12:16
First Unit on Scene:	12:20

Review:

On review it was found that the incident was resourced appropriately and the officers on scene managed their patients, the circumstances and the conditions well. No operational concerns were noted with the case.

Outcome:

- One person, a Irrelevant M, significant trauma, deceased on arrival of QAS.
- One person, a Irrelevant M, severe head lacerations, transported with QPS escort to HBH by A4542.
- One person, a Irrelevant F, Leg lacerations and significant bruising post assault, transported to HBH with QPS escort by B4541.
- HOT debrief held at HBH post event and Priority One advised.
- QPS requested the provision of the attending crew's footwear for crime scene evidence analysis.

Review Recommendations:

This review finds no recommendations.

Appendix of all documents and files used in compilation of the review:

- Incident Detail Report (IDR)
- Electronic Ambulance Report Forms (eARF) and
- Local level clinical review (Eclipse).

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Director	Russell Cooke	General Manager	Irrelevant	7-4-21

Wide Bay Local Ambulance Service Network

14127727

Authority:

By authority of Russell Cooke LASN Director, completed by Officer in Charge Matthew Steer.

Executive Summary:

On Thursday 8 April 2021 at 04:05, the Maroochydore Operations Centre (MOC) received a call from Queensland Police Service (QPS) that had been miss-directed requesting assistance to a Irrelevant female who had fallen and injured her elbow, ribs and hip.

The incident was located at Irrelevant Burrum Heads.

MPDS assigned was 17A02G with a 2C response level and Bravo (B) 4528 were responded at 04:19 from Hervey Bay Hospital and arrived on scene at 04:49.

Intelligence from the scene via QPS was that the caller had been verbally aggressive when speaking to QPS communications staff. Crew found on arrival two (2) females under the influence of alcohol. During assessment and stretcher loading, a female patient and bystander became aggressive towards crew. Crew requested QPS lights and sirens via portable radio, attempts of duress activation failed and were not received by MOC.

From the time of the QAS MOC request to QPS for a lights and sirens response to QPS notifying they were enroute, a thirteen (13) minute delay occurred. Adding to the travel time for QPS of eighteen (18) minutes this accounted to a QPS response period of 31 minutes. Review of the IDR displays numerous communications from QPS to QAS MOC that seem to point to the QPS seeking justification for the response before undertaking tasking of QPS resource.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14127727.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

Documentation

- DARF 503300108 was documented to required standards.

Clinical Practice Guidelines

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- CPG aligned to expected outcomes

Clinical Procedures

- All clinical procedures aligned with QAS CPP

State OpCen ProQA:

To be added to report once supplied

Incident Review/Investigation:

Scope:

This review will consider all aspects of QAS response to case 14127727, including:

- MOR management
- resource allocation
- events leading up to the assault of Officer Hardy
- failure of Duress activation
- delay in QPS response

Background:

On Thursday 8 April 2021 at 04:05 MOC received a call from QPS to provide details of a misdirected 000 call in relation to Irrelevant female who had suffered a fall and was complaining of elbow, rib and hip injuries.

At 04:28 QPS provided details to MOC that the female caller had been verbally aggressive toward QPS Communications staff during the misdirected 000 call. At 04:30 QAS MOC undertook a call back to provide information that a QAS resource was enroute but were unable to provide an ETA. Nil information recorded on the Incident Detail Report (IDR) that provided any intelligence of the caller's level of aggression.

The information of the caller's aggressive stance was not provided to the crew by MOC and no QPS response was initiated on this information.

At 04:21 B5428 with crew Advanced Care Paramedic (ACP) Irrelevant and ACP Irrelevant responded to the address Irrelevant Burrum Heads. They responded to a MPDS Code 17A02G as a 2C response category.

At 04:49 B4528 arrived on scene and the patient Irrelevant was found outside sitting on the ground with her friend Irrelevant There was also a male who identified as the Irrelevant Both females appeared to be intoxicated and mildly aggressive in nature. The male person appeared to be sober and was helpful but did not remain on scene after arrival of the QAS crew.

Both ACPs started to undertake an assessment of the female patient and the patient was non-compliant and repeatedly stated 'last time I had to go in an ambulance I had to be handcuffed'. Shortly after commencing assessment, the patients friend became upset and her agitation elevated as she made statements alluding that she did not feel the crew where assisting the patient. This person then ran inside of Irrelevant and could be heard screaming and gagging. ACP Irrelevant followed this person to provide assistance.

The female patient was at this time being attended by ACP Irrelevant The patient's aggressive nature escalated and when asked to move to the stretcher, she refused and pushed ACP Irrelevant in the chest and entered the unit. On entering the unit, the patient became aggressive toward ACP Irrelevant and grabbed ACP Irrelevant arms. The patient and friend then became aggressive towards each other. Both ACP Irrelevant and Irrelevant used this opportunity to tactically withdraw from the scene.

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At 05:04 crew from unit 4528 requested QPS lights and sirens. QAS MOC acted on this request at 05:04 and QPS resources where tasked at 05:17. Information drawn for the IDR indicates ongoing communications between QAS MOC and QPS to justify the QPS response leading to a 13-minute delay in QPS response. QPS arrived on scene with the crew at 05:35.

When ACP Irrelevant attempted to enter the driver side of the ambulance unit, the patient approached ACP Irrelevant in an aggressive manner and attempted to block ACP Irrelevant. ACP Irrelevant was able to convince the patient to assist her friend and both paramedics withdrew from the scene in Unit 4528.

Both paramedics retreated from the scene and met up with scene A/Officer in Charge (A/OIC) Irrelevant Irrelevant and responding QPS officer. They retuned to the scene with QPS assistance. The patient at this time refused treatment and transport and the crew carried out an appropriate VIRCA. Both officers provided information to QPS that they were happy to support assault charges to be laid against the patient.

During the escalation, ACP Irrelevant and Irrelevant utilised the QAS Portable Radio Duress system five (5) times and received nil response or confirmation to duress received by QAS MOC. Review by on scene A/OIC Irrelevant found the crew utilised the correct technique to activate the duress system and both radios were on the correct channel (UHF 94) for the area.

Testing conducted by OIC Irrelevant at Burrum Heads and Hervey Bay, and Operations Supervisor (OS) Irrelevant in Bundaberg utilising multiple portable radios and UHF respective channels found that the duress system failed to activate and alert QAS MOC staff on their panels.

Timeline

- 04:05 Phone pick up
- 04:19 1st Unit assigned (4528)
- 04:21 1st Unit enroute (4528)
- 04:28 IDR – Note CALL FROM QPS WHO GOT A MISDIRECTED 000 CALL FROM PT - PT WAS VERBALLY AGGRESSIVE WITH QPS COMMS BUT PROBABLY CONCERNED FOR FALLEN FRIEND - QPS WANTED TO ENSURE QAS HAD A CASE - SEARCH FOR PHONE NUMBER DONE AND DETAILS MATCHED QPS INFORMATION - END WILL CALL BACK TO CHECK PT CONDITION - CALLER MENTIONED A BROKEN HIP TO QPS (User 6JACCHA)
- 04:30 IDR – Note CALLER BACK TO PT - AND ADV QAS ENROUTE UNABLE TO GIVE ETA. (User 6JACCHA)
- 04:49 1st Unit (4528) on scene
- 05:04 IDR – Note >POL-Q> (Urgent) QAS ON SCENE REQUESTING QPS L&S PLS - WILL PROVIDE FURTHER DETAILS SHORTLY - ORIGINAL CALL FOR Irrelevant F POST FALL (User 6)
- 05:11 IDR – Note HOWARD ARE TERMINATE (User: ICEMS QPS)
- 05:14 2nd Unit assigned (4503) – OIC/Supervisor response
- 05:17 QPS enroute
- 05:19 Unit 4528 have retreated from scene in nearby park and are safe.
- 05:35 QPS on scene
- 05:39 2nd Unit on scene
- 06:22 IDR – Note Crew will do Duress Test
- 06:23 IDR – Note Nil Duress come through to comms.
- 06:34 4528 Clear
- 06:34 4503 Clear

Review

Review of this incident found several precursors that potentially led to the assault on ACP Irrelevant and impacted on the support for the primary crew.

QAS MOC

- Noted on the IDR logged is record that the caller had been aggressive to QPS staff on the initial 000 call. The crew allege this information was not relayed to alert them of the potential of an aggressive person on scene. This impacted on the crew to make appropriate assessment and approach to the

scene. **Note: Audio has not been reviewed at time of publishing this preliminary report to confirm this statement.**

- QAS MOC responded in a timely manner and provided a Supervisor response once crew alerted for need of urgent QPS assistance.

QPS

- Delay in QPS response. Review of IDR notes indicate numerous communications seeking clarification and justification for a QPS urgent response. Mention of overtime impact and removal of QPS Howard from the response was noted in one of the communications.
- QPS response delay was 13 minutes, but when responded the time period of 18 minutes urgent response would be the expected travel time for a QPS Hervey Bay Unit to respond to Burrum Heads.

B4528

- Unit 4528 crew allege they were not alerted to the potential of an aggressive person on scene by QAS MOC and as a result their 'guard' was lowered, and this led them to approach the scene.
- Both officers allowed themselves to become separated when both the patient and friend escalated and placed themselves in a small unit with agitated and aggressive people.
- Both officers achieved a tactical retreat and proceeded to a safe area to await further assistance appropriately when they realised, they were in an unsafe environment.

Duress System

- Both officers on scene attempted to utilise the duress system via portable radio five (5) times. Review found that their technique was correct, and they had both radios on the correct channel 94 UHF.
- Follow up testing by OiC Irrelevant and OS Irrelevant in Burrum Heads, Hervey Bay and Bundaberg on multiple radios and UHF channels led to consistent failure of the duress system to notify on QAS MOC panels.
- On review, it was found that there is no regular duress system test procedure to ensure system operation and familiarity with activation within the Wide Bay LASN/QAS MOC operational area.

Outcomes

- The crew was able to return to scene with QPS assistance and the patient subsequently refused all QAS assessment, treatment and transport. The patient undertook a VIRCA and the crew left the scene.
- ACP Irrelevant and Irrelevant report no physical injuries.
- Supervisor activated by QAS MOC.
- ACP Irrelevant and Irrelevant welfare follow up undertaken by their OIC Irrelevant and Priority One notified.

Review Recommendations:

1. Review of the current QAS Duress System to determine efficiency and potential workarounds.
2. Review be conducted by the MOC into the non-notification to the responding crew with a known aggressive person on scene to assist the responding crew with situation awareness.
3. ACP Irrelevant and ACP Irrelevant meet with OIC Irrelevant to review the incident to look for 'do differently' options to assist them to identify potential unsafe and challenging situations.
4. Consider development and implementation of a Duress System testing procedure within the Wide Bay LASN/MOC Operations area.
5. Wide Bay LASN liaise with QPS to identify root cause of QPS dispatch delay.

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Appendix of relevant documents/files:

- Appendix 1 – IDR 14127727
- Appendix 2 – DARF 503300108
- Appendix 3 – Dot Point A/OIC Irrelevant
- Appendix 4 – Dot Point A/SOS Irrelevant
- Appendix 5 – Dot Point OIC Irrelevant
- Appendix 6 – Dot Point Irrelevant

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Chief Superintendent	Russell Cooke	General Manager	Irrelevant	09/04/2021

Significant Incident Review Template Version 1.0 July 2020

Sunshine Coast Local Ambulance Service Network

Authority:

By authority of Sunshine Coast Assistant Commissioner (AC), Mr Paul Shaw, in ompliance with LASN directive 08-15, this review was completed by Senior Operations Supe isor (OS) Da ll Williams.

Executive Summary:

At 12:00 on the 10th April 2021 Queensland Ambulance Service QAS) r ceived a request to attend a male patient who had fallen on Mt Ngungun.

The incident was categorised through the Medical Priority spatch stem (MPDS) as a 17D03P; extreme fall; code 1B; Incident Detailed Report (IDR) 141387

QAS responded with Queensland Fire and Re ue (QFES), Quee land Police Service (QPS) and the State Emergency Services (SES) to an I elev nt male who had fallen forty (40) metres on Mt Ngungun.

Maroochydore Operations C ntre (MOC dispatche ollowing resources:

- One (1) Critical C e Paramedi (CCP)
- One (1) single offic Advan medic (ACP)
- One (1) ACP crew
- One (1) Senior Operatio Supervisor (SOS) for scene coordination
- The Clinical Deployment S ervisor (CDS) consulted with Retrieval Services Queensland (RSQ nd R500 was dispatc d

QFES SES and Q S ascended the mountain and located the patient approximately 300 metres up Mt Ngungun off the m in walking track.

atien rrelevant ars of age was declared deceased at scene.

Terms of R ference:

This review will investigate all aspects of the ambulance response to incident 14138772.
This review will include all requirements outlined in the Operational Incident Review Process.

LASN Clinical Incident Summary Report:

A Digital Ambulance Report Form was completed by attending officers. Nil deviation from normal clinical practices was identified.

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Due to the nature of the incident a clinical review Evaluating Clinical Improvement and Patient Safety (ECLIPSE) audit has been requested.

ECLIPSE audit completed, minor documentation errors identified, no further clinical follow-up required.

Incident Review/Investigation:

The Senior Operations Supervisor conducted a review of all available documentation and re ords post incident.

Unit activity for the Sunshine Coast LASN has been reviewed. The initial units dispatch d w in accordance with State Operations Centre (OpCen) Standard Operating Procedure (SOP) SOP02, Dispatching of Ambulance Resources

- The closest available units were dispatched from Beerwah 461882, 50 375 fro Caboolture, and SOS 407707 from Birtinya QAS
- A406808 solo CCP was dispatched and responding from Birtinya QAS
- CDS consulted with RSQ, R500 assigned

Background

Queensland Ambulance Service received a reques to att an Irrelev m who had fallen approximately 40 metres while allegedly free climbing on M Ngung

The incident was witnessed by several bystande an apture n drone footage; which was later handed over to QPS.

QAS resources dispatched to this dent:

B501375	Irrelev nt Caboolture
B461882	Irrel vant – responded solo, later teamed at scene with off r Irrelevant
A406808	
S407707	
8500	

Irrelevant

Chronology

Below a chrono ical sequence of events:

12 0 Incident WiQ t ttend male fallen 40 metres on Mt Ngungun

12:11 461882 solo offic arrived at scene

12:45 solo fficer ‘at patient’

12:45 R500 o head, attempting winch down of flight crew

12:46 B461882 CPR in progress

6 B461882 nil output for 10 minutes

13:05 Declared life extinct

CSO File Note Contacting Family	FILE NOTE - Failed contact attempt - IN
OpCen Review	

LASN Endorsement

Name	Position	Signature	Date
Andrew Hebbron	LASN Manager		
Ross Hodges	A/Executive Manager Operations	Irrelevant	19/04/2021

Incident Outcomes:

One (1) Irrelevant male patient declared deceased at scene at 13:05

Patient retrieved with the assistance of QFES and QPS

Events since Incident

PSDU completed a dot point and forwarded to Executive Manager Operations Irrelevant

An ECLIPSE audit has been requested

Priority One has been notified

Review Recommendations:

That this Significant incident review be noted and filed.

Appendix of relevant documents/files:

- Incident Detail Report 14138772
- DARF 503306754
- Senior Operations Supervisor end of shift report 10/04/2021 (0600-1800)
- ELICPSE audit

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Assistant Commissioner	Paul Shaw	General Manager	Irrelevant	18/04/2021

Incident Detail Report 14138772.do

DARF_503306754 - 401881.pdf

Eclipse review CN14138772 fall fata

Significant Incident Review Template Version 1.0 August 2020

West Moreton Local Ambulance Service Network

Authority:

By authority of Mr Andrew Hebbron, Chief Superintendent, LASN Manager, West Moreton LASN.

Executive Summary:

Queensland Ambulance Service (QAS) received a request for service for (14163993) Irrelevant Springfield Lakes at 09:29 on the 16th of April 2021. QAS was requested for a Irrelevant female who had collapsed and was not responsive. The total response time to this incident was 34 minutes. During this period of time South East Queensland (SEQ) was experiencing moderate pressure with Ipswich Hospital (IH) on a Level 2 Escalation resulting in limited resource availability. Two common calls were made by the Southport Opcen and at 09:36 a Bravo Unit was assigned from St Andrews Hospital, Ipswich with an ETA to scene of 16 minutes. At 09:53 the incident was reconfigured to a 1A response with CPR in progress and the Logan West OIC was attached as the nearest available CCP resource with an ETA of 14 minutes. On arrival at scene at 10:04 Advanced Life Support (ALS) was commenced for a period of 21 minutes however the patient remained in asystole for the duration and therefore CPR ceased at 10:26 and Recognition of Life Extinct (ROLE) was completed.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14163993.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

- **Waiting on Report**

State OpCen ProQA:

- **Waiting on Report**

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Incident Review/Investigation:

Scope:

West Moreton reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved. It is intended that any operational or clinical performance issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:

- On the 16th of April 2021 at 09:29, the Queensland Ambulance Service (QAS) receiv d a request for assistance for a Irrelevant female who had collapsed and was not responsive in Sp ngfiel ak the incident was initially assigned a 1C response.
- At the time the call was received there were no available units in the Ipswich to respond resulting in two common calls being carried out by the EMD. The nearest r comm dable 09:29 in CAD was 601442 at Logan West Station but this unit was not as gned.
- At 09:36 a Bravo Unit became available at St Andrews Hospital, Ipswich nd w assi d to the incident with an ETA to scene of 16 minutes.
- At 09:53 the incident was reconfigured to a 1A response and CP comm nced n scene and the Logan West OIC was attached as the nearest available C P resou e with ETA of 14 minutes.
- The primary crew arrived at scene at 10:04 and Ad nced Li Su port wa commenced for a period of 21 minutes however the patient remained in asysto for the ration an therefore CPR ceased at 10:26.
- Recognition of Life Extinct (ROLE) was completed at 10:26 nd Queensland Police Service (QPS) were requested to attend scene, arriving at 1 52.

Timeline:

Received:	09:29hrs
Dispatched:	09:35h s
On Case:	09:3 s
On Scene:	10:04hr
Clear:	11:59hrs

Review:

- 1 x Bravo U (601613) dispatched at 09:35 following 2 x Common Calls from the EMD. Unit did not be n moving f m St Andrews Hospital, Ipswich until 09:43. Delay noted in Incident Detail Report DR) as the crew ere making the vehicle operationally ready.
- CCP OIC (6014 was dispatched at 09:56 following the reconfiguration to a 1A response with an TA of 14 minutes. his resource was available at the time of the initial call at 09:29 but not dispa ed.
- Both un responded using the fasted most appropriate routes available for the time of day.
- The total r onse time to the incident was 34 minutes.
- West Moreton LASN was adequately resourced at the time of the incident.
- At the time of the call SEQ was on a moderate escalation due to hospital delays and Ipswich Hospital was on a Level 2 escalation with two units at destination with the longest at 1 hr and 3 mins.
- Moreton LASN had 2 pending Code 2's at the time of call. (1 x 2B at 1 hr 28 mins and 1 x 2A at 25 mins).

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Outcomes:

- A Irrelevant female was declared deceased at scene.
- Appropriate resourcing arrived on scene.
- QPS notified and attended scene.
- West Moreton CSO attempted to contact family the following day but was unable to make contact.

Post OIRR actions:

- Pending OPCEN + Clinical Review

Review Recommendations:

- Pending OPCEN + Clinical Review

Appendix of all documents and files used in compilation of the review:

Incident Detail Report	IDR 14163993.pdf
Ambulance Report Form	DARF 14163993.pdf
LASN Notification Email	Incident 144163993 - Springfield Lakes.r Incident 144163993 - Springfield Lakes -
Clinical Review	
OpCen Brief	160421 DAY SOUTHPORT OPCEN
Workforce Planning	WTM Supervisors Report - Friday 16th WTM Resource Report - Friday 16th Shift Replacement.pdf DAY SICK REPORT FOR 16.04.21.xlsm
State OpCen Review Request	RE_ Incident 144163993 - Springf
FSG Activity Log	14163993 - Activity log.xlsx Map - 20210417T103409.ht DOC170421-170420 21112307.pdf
Preliminary	
iROAM Snapshots	

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Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **14163993**
ProQA number: **17006514**
Console name: **PA205**
Incident Date: **16/04/2021 09:27:57**
Last Updated:

Incident Information

Incident Type:	ACUTE AND CCP IF AVAILABLE	**Alarm Level:**	
Priority:	1A	**Problem:**	NIL BREATHING
Determinant:	09E01	**Agency:**	QAS
Base Response#:	069396	**Jurisdiction:**	6 Southport West
Confirmation#:	00411242	**Division:**	6 Springfield
Taken By:	Irrelevant	**Battalion:**	6 Springfield
Response Area:	6 Springfield	**Response Plan:**	1A
Disposition:	A Case Completed	**Command Ch:**	
Cancel Reason:		**Primary TAC:**	TLK GRP 115/UHF h 116
Incident Status:	Closed	**Secondary TAC:**	
Certification:	ACUTE	**Delay Reason (if any):**	
Longitude:	27083067	**Latitude:**	62305680
Patient Name:	Irrelevant	**Patient DOB:**	Irrelevant

Incident Location

Location Name:		**County:**	IP WICH
Address:	Irrelevant	**Location Type:**	
Apartment:	HOUSE	**Cross Street:**	CARNARV N A GRAND CANYON R
Building:		**Map Reference:**	B257C
City, State, Zip:	SPRINGFIELD LAKES QLD 4300		

Call Receipt

Caller Name:	Irrelevant	**Original CLI Phone**	Irrele
Method Received:		**Call Back Phone:**	
Caller Type:		**Call ocation:**	l levant

Time Stamps

Description	Date	Time	User
Phone Pickup	16/04/2021	09:27:57	
1st Key Stroke	16/04/2021	09:27:57	
In Waiting Queue	16/04/2021	09:29:39	
Call Taking Complete	16/04/2021	09:32:21	Irrelevant
1st Unit Assigned	16/04/2021	09:35:56	
1st Unit Enroute	16/04/2021	09:36:09	
1st Unit Arrived	16/04/2021	10:04:34	
Closed	16/04/2021	11:59:04	Irrelevant

Elapse mes

Descrip	Time
Received to Queue	00:01:42
Call Taking	00:04:24
e to 1st A ign	00:06:17
Call R ved to 1s sign	00:07:59
Assi d to 1st Enro e	00:00:13
En te to 1 Arrived	00:28:25
I dent Du on	02:31:07

Resources Assigned

Unit	Assigned	Disposition	Enrout	Staged	Ar ed	At Patie	Avail	Complete	Odm. Enroute	Odm. Arrived	Cancel Reason
B601613	09:35:56	A Case Completed	09:36		10 :34		11:58:45	11 59:04			
A601442	09:55:03	A Case Completed	09 56				10:37:55	10:39:24			
B601610	10:30:36	Cancel En Route						10:31:29			.Diverted To Higher Priority

Personnel Assigned

Unit	Name
601442	Irrelevant
601610	
601613	

Pre-Schedu nformation

No Pre-S uled Information

Tran ts

No ansports

Comments

Date	Time	User	Type	Comments
04/2021	09:29:38	RFAU	Response	[ProQA Dispatch] Dispatch Level: 31C01 (Alert with abnormal brea hing) Response Text: 1C Irrelevant , Female, Conscious, Breathing. Problem Description: FAINTED CLAMMY
16/ 2021	09:29:39	2LORFAU	Response	[ProQA: Key Questions] 1. Her breathing is not completely normal. 2. She is completely alert (responding appropriately). 3. She is changing colour. 4. Her colour change is pale. 5. She has no history of heart problems.
	31:02	2LORFAU	Response	EIDS Tool U ilised CALLER ANSWERED NO TO ALL QUESTIONS
16/04/2021	34	6JOEMCE	Response	[Private] CDS NOTIFIED SOS OF L MITED LASN COVER AND PENDING WORKLOAD INCLUDING CODE 1S - AWAITING OFFLOAD PLAN
16/04/2021	09:32:53	5REBCOU	Response	Duplicate call appended to incident at 09:32:53
16/04/2021	09:33:29	5REBCOU	Response	[Private] CALL FROM TELSTRA - ADV CALL DROPPED OUT- CONFIRMED SAME NUMBER AND REGISTERED NAME DETAILS
6/04/2021	09:34:12	6NIKSWE	Response	[Private] COMMON CALL X2
4/2021	09:35:43	6FRAGUE	Response	Duplicate call appended to incident at 09:35:43
16 04/2021	09:35:56	PS	Response	[Page] Dispatch page sent to Unit:601613, Sent From: KEDCADQASPIS01
16/04/2021	09:35:57	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:36:08	PS	Response	[Page] Dispatch page to Unit:601613 complete to PIN 0432377472: 41072247 Message sent successfully.
16/04/2021	09:36:08	PS	Response	[Page] Dispatch page to Unit:601613 complete to PIN 0409145636: 40535580 Message sent successfully.
16/04/2021	09:36:21	6NIKSWE	Response	[Private] SLIGHT DELAY PUTTING VEH BACK TOGETHER
16/04/2021	09:38:23	6FRAGUE	Response	2ND CALL - HAVING DIB, AWAKE AND ALERT. ADVISED OF DELAYS
16/04/2021	09:38:24	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.

16/04/2021	09:53:06	6GREKRA	Response	Duplicate call appended to incident at 09:53:06
16/04/2021	09:53:07	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:53:40	6GREKRA	Response	[ProQA Reconfigure] Reconfigure Level: 09E01 (Not brea hing at all) Response Text: 1A Irrelevant Female, Not Conscious, Not Breathing.
16/04/2021	09:53:44	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:53:44	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:53:45	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:53:56	6GREKRA	Response	[ProQA: Key Questions] 6. The cardiac arrest was not witnessed (time unknown). 7. A defibrillator (AED) is not available.
16/04/2021	09:55:03	PS	Response	[Page] Dispatch page sent to Unit:601442, Sent From: KEDCADQASPIS01
16/04/2021	09:55:04	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:55:11	6GREKRA	Response	[Notifica ion] [QAS]-CPR IN PROGRESS
16/04/2021	09:55:13	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:55:16	PS	Response	[Page] Dispatch page to Unit:601442 complete to Irrelevant Message sent successfully.
16/04/2021	09:55:29	6NIKSWE	Response	[Page] Units: 601442, Sent From: PA607, Please change to talk group 115
16/04/2021	09:56:34	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:56:34	6GREKRA	Response	LOCATED AT THE TOP OF THE HILL
16/04/2021	09:56:35	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	09:56:36	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED B DT.
16/04/2021	09:56:43	6GREKRA	Response	CPR IN PROGRESS
16/04/2021	09:56:44	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIV D BY MDT.
16/04/2021	09:56:45	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECE ED BY MDT
16/04/2021	09:58:25	6NIKSWE	Response	601442 ETA 15-20MINS
16/04/2021	09:58:26	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEI DT.
16/04/2021	09:58:26	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	10:00:29	6GREKRA	Response	WHITE LANDROVER OUT THE FRONT
16/04/2021	10:00:30	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF INC ENT R EIVED BY MDT
16/04/2021	10:00:31	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF IN IDENT RE VED BY M
16/04/2021	10:03:19	6GREKRA	Response	NEIGHBOURS ON SCENE NOW HELP G
16/04/2021	10:03:20	601613	Response	[PRIVATE] ACKNOWLEDGEMENT OF CIDENT ECEIV BY MDT.
16/04/2021	10:03:21	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF CIDEN RECEIV MDT.
16/04/2021	10:04:29	6NIKSWE	Response	601613 CPR IN PROGRESS
16/04/2021	10:04:31	601442	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCID T RECEIV D BY MDT.
16/04/2021	10:04:31	601613	Response	[PRIVATE] ACKNOWLED F INCID T RECE ED BY MDT.
16/04/2021	10:04:58	601613	Response	[PRIVATE] ACKNOWL GEMENT NCIDEN IVED BY MDT.
16/04/2021	10:04:58	601442	Response	[PRIVATE] ACKNOW DGEMENT INCIDENT RECEIVED BY MDT.
16/04/2021	10:05:21	601613	Response	[PRIV TE] ACKNOW DGEME OF IN DENT RECEIVED BY MDT.
16/04/2021	10:05:21	601442	Response	[PRIV E] ACKNOW DGEM NT OF IN ENT RECEIVED BY MDT.
16/04/2021	10:05:33	601613	Response	[PRIVAT CKNOWL G ENT OF IN ENT RECEIVED BY MDT.
16/04/2021	10:05:33	601442	Response	[PRIVATE] KNOWLE MENT OF IN DENT RECEIVED BY MDT.
16/04/2021	10:30:05	6NIKSWE	Response	601442 CEA CPR - Q REQ
16/04/2021	10:30:36	PS	Response	[Page] Dispatch e sent to 10, Sent From: KEDCADQASPIS01
16/04/2021	10:30:37	601610	Response	[PRIVATE] ACKN EDGEMENT OF INCIDENT RECEIVED BY MDT.
16/04/2021	10:30:48	PS	Response	[atch page Unit:601610 complete to Irrelevant Message successf
16/04/2021	10:30:50	PS	Response	[Page] Di tch page to U 601610 complete to Irrelevant Messa ent su essfully.
16/04/2021	10:33:33	6GREKRA	Response	>POL > 2 QAS REWS ON SCENE PT DECEASED FAMILY AND KIDS ON SC NE.
16/04/2021	10:33:33	ICEMS	Respon	L-Q Reques Attendance sent for Incident Q21-A017876
16/04/2021	10:35:22	ICEMS	Resp e	L-Q> POL has been attached to the incident
16/04/2021	10:38:29	6NIKSWE	Re nse	60 R OF SCENE CREW AWAITING QPS
16/04/2021	11:27:46	ICEMS	R ponse	POL-Q EnRoute
16/04/2021	11:28:22	ICEMS	esponse	<POL-Q< QPS 30MINS AWAY. DO YOU KNOW IF THERE WILL BE A CAUSE OF DEATH CERT?
16/04/2021	11:29:59	6NIKSWE	R nse	ge] Units: 601613, Sent From: PA607, HEY, QPS ARE ASKING IF THERE WILL BE A CAUSE OF DEATH CERTIFICATE? QPS ETA 1158hrs
16/04/2021	11:31:03	6NIKSWE	Respon	601613 STILL WAITING FOR QPS (EMD ADV HAVE JUST PAGED THEM)
16/04/2021	11:32:26	6NIKSWE	Response	601613 IN RESPONSE TO QPS - NO
16/04/2021	11:33:01	6NIKSWE	Response	>POL-Q> THATS A NEGATIVE QPS NIL CAUSE OF DEATH CERT
16/04/2021	11:38:01	CEMS	Response	The 'Incident Update' has not been ac ioned by POL-Q. Please contact agency.
16/04/2021	11:39:06	EMS	Response	[AMB-Q] Sent error 55 - Message received after Operational Acceptance time
16/04/2021	11:52:42	I MS	Response	POL-Q OnScene

Priority Chang

Date	me	Chang	om Priority	Reason	User
16/04/2021	09:53:40	1C		Patient Condition	Irrelevant

Ca ctivities

Dat	Time	Radio	Activity	Location	Comments	User
16/04/2021	09:27:5		AML Data Received		Center of caller area HELI: -27 41.652000, 152 55 022400 ESCAD: #-27.6942/152.91704	SDSIAML
/04/2021	09:29:39		Incident in Wai ing Queue			
/2021	09:29:39		ANI/ALI Statistics		INT Insert:Apr 16 2021 09:27:54 / INT SendNP:Apr 16 2021 09:27:53 / WS RecvNP:Apr 16 2021 09:27 53 / WS Process:Apr 16 2021 09:29:39	2LORFAU
1 4/2021	09:29:39		Waiting Pending Incident Time Warning		Waiting Pending Incident Time Warning timer expired	
16/04/2021	0		Read Comment		Comment for Incident 514 was Marked as Read.	2LORFAU
16/04/2021	09:29:40		ProQA	Irrelevant	ProQA determinant sent	2LORFAU
16/04/2021	09:29:43		Read Incident		Incident 514 was Marked as Read.	6NIKSWE
16/04/2021	09:29:47		UserAction		User clicked Initial Assign	6NIKSWE
6/04/2021	09:29:49		Remove Waiting Pending Incident Warning		Removing Wai ing Pending Incident Time Warning timer expired	
16 4/2021	09:29:49		Incident in Wai ing Queue Timer Clear			
16/04/2021	09:29:51		Initial Assignment		The following unit(s) is (are) recommended for assignment: 601442 (00:14:47)	6NIKSWE
16/04/2021	09:29:57		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	09:29:59		Initial Assignment		The following unit(s) is (are) cleared from assignment: 601442	6NIKSWE
16/04/2021	09:30:05		VisiCAD Recommendation		601442: 00:14:47, 690488: 00:17:29, 503226: 00:22:47, 503443: 00:22 55, 502544: 00:23:15,	6NIKSWE

16/04/2021	09:30:33		VisiCAD Recommendation		601442: 00:14:47, 606693: 00:17:15, 607691: 00:17:19, 690488: 00:17:29, 506047: 00:18:36,	6NIKSWE
16/04/2021	09:31:02		UserAction		User Accepted 690488	
16/04/2021	09:31:02		Initial Assignment		The following unit(s) is (are) recommended for assignment: 606693 (00:17:15)	6NIKSWE
16/04/2021	09:31:04		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	09:31:09		Pending Incident Time Warning		Pending Incident Time Warning timer expired	
16/04/2021	09:31:09		Incident Late			
16/04/2021	09:31:36		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	09:32:18		Read Comment		Comment for Incident 514 was Marked as Read.	2LORFAU
16/04/2021	09:32:21		UserAction		User clicked Exit/Save	2LORFAU
16/04/2021	09:32:39		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	09:32:53		Duplicate Call Warning		Duplicate Call Warning - New call appended to incident	5REBCO
16/04/2021	09:32:54		Read Comment		Comment for Incident 514 was Marked as Read.	5REBC
16/04/2021	09:32:56		Notification		Out of Region message displayed for: Irrelevant Irrelevant	5REBCO
16/04/2021	09:32:57		Notification		Out of Region message acknowledged fo Irrelevant	5REBCOU
16/04/2021	09:33:32		UserAction		User clicked Exit/Save	5RE
16/04/2021	09:33:35		Read Comment		Comment for Incident 514 was Marke s Read.	MC
16/04/2021	09:35:11		UserAction		User clicked Initial Assign	6NIKSWE
16/04/2021	09:35:13		Initial Assignment		The following unit(s) is (ar mended for assignment: 601442 (00 :47)	6NIKSW
16/04/2021	09:35:16		AML Data Received	Irrelevant	AML data appended m duplicat (Incident #14164025 Center of ler a HELI: -27 41.65740 52 55.0 400 E D: #-27.69429/152.917	S AML
16/04/2021	09:35:43		Duplicate Call Warning		Duplicate Call Warning - N call appen ed to incident	6FRAGUE
16/04/2021	09:35:44		Read Comment		Comm nt 514 Marke as Re	6FRAGUE
16/04/2021	09:35:56	601613	Dispatched	Irrelevant	R onse Num (069396)	6NIKSWE
16/04/2021	09:35:56		Incident Timer Clear		In ent Tim leared	
16/04/2021	09:36:09	601613	Resp	Irrelevant	R ondin rom = R ERICK ST & PRING ST T DREWS IPS CH PRIVATE HOS AL]	VisiNET
16/04/2021	09:36:37	601613	Calculate Vehicle ETA	RODERICK ST & PRING [ST ANDREWS IPSWICH PRIVATE HOSPITAL]	ETA to e Add Irrelevant , SPRINGF KES is 00:16:17	6FRAGUE
16/04/2021	09:36:39		UserAction		U clicked Exit/Save	6NIKSWE
16/04/2021	09:37:58		UserAction		Use ked Exit/Save	6JOEMCE
16/04/2021	09:38:24		UserAction		User c ked Exit/Save	6FRAGUE
16/04/2021	09:50:51		AML Data Received	Irrelevan	AML data appended from duplicate call (Incident #14164086): Center of caller area HELI: -27 41.653200, 152 55.027800 ESCAD: #-27.69422/152.91713	SDSIAML
16/04/2021	09:53:06		Duplicate Ca arning		Duplicate Call Warning - New call appended to incident	6GREKRA
16/04/2021	09:53:07		Read C ment		Comment for Incident 514 was Marked as Read.	6GREKRA
16/04/2021	09:53:37	601613	Calcul Vehicle ETA	RY HWY NB\CEN HWY SB	ETA to Scene Address Irrelevant SPRINGFIELD LAKES is 00:09:58	6TANLIN
16/04/2021	09:53:39	601613	Priority Cha		The priority of incident 514 has been changed from 1C to 1A. Unit 6613 is responding HOT1A	VisiNET
16/04/2021	09:53:40		Incident Priority ge		Incident priority changed from 1C to 1A due to Patient Condition	6GREKRA
16/04/2021	09:53:40		ProQA	Irrelevant	ProQA determinant sent	6GREKRA
16/04/2021	09:53:57		Read Comment		Comment for Incident 514 was Marked as Read.	6JOEMCE
16/04/2021	09:5 8		UserAction		User clicked Exit/Save	6TANLIN
16/04/2021	0 :40		UserAction		User clicked Exit/Save	6FRAGUE
16/04/2021	54:43		erAction		User clicked Add Resource	6NIKSWE
16/04/2021	09:54:49		AD Recommendation		601442: 00:14:47, 506047: 00:18:36, 606535: 00:19:15, 601414: 00:19:35, 506111: 00:21:19,	6NIKSWE
16/04 1	4:59		UserA		User Accepted 506047	
16 021	09 59		Add Res rces		The following unit(s) is (are) recommended for assignment: 601442 (00:14:47)	6NIKSWE
16/04/2021	09:55:0	601442	Dispatched	Irrelevant	Response Number (069477)	6NIKSWE
16/04/2021	09:55:11		Read Comment		Comment for Incident 514 was Marked as Read.	6TANLIN
/2021	09:55:19		Read Comment		Comment for Incident 514 was Marked as Read.	6JOEMCE
16/ 2021	09:55:41		Read Comment		Comment for Incident 514 was Marked as Read.	6GREKRA
1 4/2021	09:55:42	601613	Calculate Vehicle ETA	CENTENARY HWY\CENTENARY HWY SB	ETA to Scene Address 34 Park Edge Dr, SPRINGFIELD LAKES is 00:07:27	6NIKSWE
16/04/2021	2	601442	Calculate Vehicle ETA	ORR CT\UNNAMED HILLCREST RD	ETA to Scene Address 34 Park Edge Dr, SPRINGFIELD LAKES is 00:14:47	6NIKSWE
16/04/2021	09:56:03		Incident Late		Active incident marked as late	
16/04/2021	09:56:33	601442	Resp	Irrelevant	Responding From = ORR CT\UNNAMED HILLCREST RD	VisiNET
6/04/2021	09:56:45		Read Comment		Comment for Incident 514 was Marked as Read.	6GREKRA
16 4/2021	09:57:54	601613	Calculate Vehicle ETA	CENTENARY HWY\CENTENARY HWY SB	ETA to Scene Address 34 Park Edge Dr, SPRINGFIELD LAKES is 00:04:46	6NIKSWE
16/04/2021	09:57:54	601442	Calculate Vehicle ETA	ORR CT\UNNAMED HILLCREST RD	ETA to Scene Address 34 Park Edge Dr, SPRINGFIELD LAKES is 00:13:48	6NIKSWE
16/04/2021	09:58:30		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	09:58:41		Read Comment		Comment for Incident 514 was Marked as Read.	6JOEMCE
16/04/2021	10:02:55		Read Comment		Comment for Incident 514 was Marked as Read.	6GREKRA

16/04/2021	10:03:22		Read Comment		Comment for Incident 514 was Marked as Read.	6GREKRA
16/04/2021	10:04:34	601613	At Scene	Irrelevant		6NIKSWE
16/04/2021	10:04:57		Read Comment		Comment for Incident 514 was Marked as Read.	6JOEMCE
16/04/2021	10:04:57		UserAction		User clicked Exit/Save	6TANLIN
16/04/2021	10:05:20		Read Comment		Comment for Incident 514 was Marked as Read.	6GREKRA
16/04/2021	10:05:45		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	10:05:53		Read Comment		Comment for Incident 514 was Marked as Read.	6JOEMCE
16/04/2021	10:07:32		UserAction		User clicked Exit/Save	6GREKRA
16/04/2021	10:14:09	601442	At Scene	Irrelevant		VisiNET
16/04/2021	10:15:22		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	10:19:59		UserAction		User clicked Exit/Save	6GREKR
16/04/2021	10:20:43		Premise History Access		Premise History Viewed	6GREK A
16/04/2021	10:27:07		UserAction		User clicked Exit/Save	6GREK
16/04/2021	10:30:07		Read Comment		Comment for Incident 514 was Marked as Read.	6NIKSW
16/04/2021	10:30:36	601610	Dispatched	Irrelevant	Response Number (069650)	NIKSWE
16/04/2021	10:31:00		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	10:31:03		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	10:31:29	601610	ReAssign Vehicle	Irrelevant	ReAssign Reason: .Diverted To Highe riority	6NIK
16/04/2021	10:31:29		ReAssign Response	Irrelevant	Clearing Primary Vehicle Flag	SWE
16/04/2021	10:31:40		Remove Waiting Pending Incident Warning		Removing Wai ing Pending Incident Ti Warning timer expired	
16/04/2021	10:31:41		Read Comment		Comment for Incident 514 rked as Read.	6NIKSW
16/04/2021	10:32:27		UserAction		User clicked Exit/Sav	6 SWE
16/04/2021	10:33:33		[ICEMS]		[ICEMS] Sent Incide Attendanc o Q : Incident Q21-A0178	ICEMS
16/04/2021	10:34:21		UserAction		User clicked Exit/Sa	6GREKRA
16/04/2021	10:35:22		[ICEMS]		[ICEMS] Received Incident quest Acknowled ent from PO : Inciden Q21-A0178	ICEMS
16/04/2021	10:35:29		[ICEMS]		[ICE S] Receive esource Query from P Q for Incid Q21-A017876	ICEMS
16/04/2021	10:35:35		[ICEMS]		[I MS] Rec ed Re rce Status Update fr POL or Inciden 21-A017876, Re r Status: WillA nd	ICEMS
16/04/2021	10:37:55	601442	Partially Av	Irrelevant		VisiNET
16/04/2021	10:39:24	601442	Available	Irrelevant		6NIKSWE
16/04/2021	10:39:24	601442	Disposition	Irrelevant	A Case C	6NIKSWE
16/04/2021	10:39:25		[ICEMS]		EMS] Sent Resource Status Update to POL-Q Incident Q21-A017876, Status: OnScene	ICEMS
16/04/2021	10:39:41		Read Comment		Com nt for Incident 514 was Marked as Read.	12BENTOD
16/04/2021	10:44:44		Premise History Access		Premise History Viewed	6NIKSWE
16/04/2021	10:44:51		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	11:02:27		UserAction		User clicked Exit/Save	12BENTOD
16/04/2021	11:02:59		UserAction		User clicked Exit/Save	6JOEMCE
16/04/2021	11:27:46		[ICEMS]		[ICEMS] Received Resource Status Update from POL-Q for Incident Q21-A017876, Resource Status: EnRoute	ICEMS
16/04/2021	11:28:22		[ICEM		[ICEMS] Received Incident Update from POL-Q for Incident Q21-A017876	ICEMS
16/04/2021	11:28:44		[ICEMS]		[ICEMS] Sent Incident Update Ack Message to POL-Q : Incident Q21-A017876	ICEMS
16/04/2021	11:28:46		Read Comme		Comment for Incident 514 was Marked as Read.	6NIKSWE
16/04/2021	11:30:16		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	11:32:39		Read Comment		Comment for Incident 514 was Marked as Read.	6NIKSWE
16/04/2021	11:33:01		[ICEMS]		[ICEMS] Sent Incident Update Message to POL-Q : Incident Q21-A017876	ICEMS
16/04/2021	1 :05		UserAction		User clicked Exit/Save	6NIKSWE
16/04/2021	38:01		EMS]		The 'Incident Update' has not been actioned by POL-Q. Please contact agency.	ICEMS
16/04/20	:39:06		[IC]		[ICEMS] Sent Error to AMB-Q: 55-Message received after Operational Acceptance time	ICEMS
16 021	11 57		[ICEMS]		[ICEMS] Error message 'The 'Incident Update' has not been actioned by POL-Q. Please contact agency.' has been marked as read	DS
16/04/2021	11:52:42		[ICEMS]		[ICEMS] Received Resource Status Update from POL-Q for Incident Q21-A017876, Resource Status: OnScene	ICEMS
16 2021	11:58:45	601 3	Partially Av	Irrelevant		VisiNET
16/ 2021	11:59:04	601613	Available	Irrelevant		6NIKSWE
16 2021	11:59:04	601613	Disposition	Irrelevant	A Case Completed	6NIKSWE
1 4/2021	11:59:04	601613	Response Closed	Irrelevant	Response Disposition: A Case Completed	6NIKSWE
	1 59:05		[ICEMS]		[ICEMS] Sent Incident Status Update to POL-Q for Incident Q21-A017876, Status: Closed	ICEMS
17/04/2021	07:48:46		Read Comment		Comment for Incident 514 was Marked as Read.	9NICFIS
17/04/2021	12:26:56		UserAction		User clicked Exit/Save	9NICFIS

dit Log

D	Time	Field	Changed From	Changed To	Reason	Table	Workstation	User
16/04/2021	09:27:57	Call_Back_Phone		Irrelevant	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/2021	09:28:01	City		SPRINGFIELD LAKES	Updated City	Response_Master_Incident	PA205	2LORFAU
16/04/2021	09:28:01	City		SPRINGFIELD LAKES	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/2021	09:28:05	Address	(Blank)	Irrelevant	New Entry	Response_Master_Incident	PA205	2LORFAU

16/04/202109:28:23Jurisdiction		6 Southport West	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23Division		6 Springfield	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23Battalion		6 Springfield	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23Response_Area		6 Springfield	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23ResponsePlanType	0	0	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23Primary_TAC_Channel		TLK GRP 115/UHF Ch 116	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:28:23Address	Irrelevant Irrelevant	Irrelevant Irrelevant	Entry Selected/Returned from GeoLocator	Response_Master_Incident	PA205	2LORF
16/04/202109:28:23Latitude	0	62305680	Entry Selected/Returned from GeoLocator	Response_Master_Incident	PA205	2LO AU
16/04/202109:28:23Longitude	0	27083067	Entry Selected/Returned from GeoLocator	Response_Master_Incident	PA205	2LORFA
16/04/202109:28:36Apartment		HOUSE	(Response Viewer)	Response_Master_Incident	PA205	2 U
16/04/202109:28:38ProQaCaseNumber		17006514	(Response Viewer)	Incident	PA205	2LORFA
16/04/202109:29:39Problem		UNCON/FAINT ALERT ABNORM BRTH	(Response Viewer)	Response_Master_Inciden	05	2LORF U
16/04/202109:29:39Response_Plan		Acute	(Response Viewer)	Response_Master_I dent	P 05	2LORFAU
16/04/202109:29:39DispatchLevel		Normal	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:29:39ResponsePlanType	0	1	(Response Viewer)	Respo _ Incident	PA205	2LORFAU
16/04/202109:29:39Incident_Type		ACUTE	(Response View)	Re onse_Mast _Incident	PA205	2LORFAU
16/04/202109:29:39Pickup_Map_Info	(Blank)	B257C11		Re onse ansports	POLCADQASCXA122	LORFAU
16/04/202109:29:39Map_Info		B257C11		Re Master_Inci t	POLCADQASCXA122	LORFAU
16/04/202109:29:40Read Comment	False	True	(Response Viewer)	Resp Master_Inc nt	PA205	2LORFAU
16/04/202109:29:40Priority_Number	0	3	Updated by ProQA	Response_ _ ncident	PA205	2LORFAU
16/04/202109:29:40Determinant		31C01	Viewer)	R nse_Master_Incident	PA205	2LORFAU
16/04/202109:29:40EMD_Used	0	1	(Respons Viewer	Respo _Master_Incident	PA205	2LORFAU
16/04/202109:29:40CIS_Used	0	null	(Res nse Vi er)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:29:43Read Call	Fal e		esponse wer)	Response_Master_Incident	PA607	6NIKSWE
16/04/202109:30:30Field_Data		Ir vant l evant elevant	P	Response_User_Data_Fields	PA205	2LORFAU
16/04/202109:30:48Field_Data			Patient DOB:	Response_User_Data_Fields	PA205	2LORFAU
16/04/202109:32:15CIS_Used	0		(Response wer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:32:15ProQATerminationStateCode		C	(Response Viewer)	Incident	PA205	2LORFAU
16/04/202109:32:18Read Comment	Fals	True	(Response Viewer)	Response_Master_Incident	PA205	2LORFAU
16/04/202109:32:54Read mment	False	True	(Response Viewer)	Response_Master_Incident	QA523	5REBCOU
16/04/202109:33:35Read Co nt	False	rue	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202109:3 Read Comme	False	True	(Response Viewer)	Response_Master_Incident	PA615	6FRAGUE
16/04/2021 36:06Current_UnitRespP yDesc	601613: 1C	HOT1C	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
16/04/20 3:07Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16 02109:53 urrent_UnitRespPriorityD	c601613: HOT1C	HOT1A	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
16/04/202109:53:40P Description	1C	1A	Patient Condition	Response_Master_Incident	PA608	6GREKRA
16/04/202109:53:40Prio Number	3	1	Patient Condition	Response_Master_Incident	PA608	6GREKRA
/04/202109:53:40Respo Plan	Acute	1A	Updated by ProQA	Response_Master_Incident	PA608	6GREKRA
16 202109:53:40Incident_Typ	ACUTE	ACUTE AND CCP IF AVAILABLE	Updated by ProQA	Response_Master_Incident	PA608	6GREKRA
1 4/202109:53:40Problem	UNCON/FAINT ALERT ABNORM BRTH	NIL BREATHING	Updated by ProQA	Response_Master_Incident	PA608	6GREKRA
16/04/202109:53:40Determinant	31C01	09E01	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16/04/202109:53:40CIS_Used	0	null	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
4/202109:53:40ProQATerminationStateCode	C		(Response Viewer)	Incident	PA608	6GREKRA
16/04/202109:53:57Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202109:55:11Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA602	6TANLIN
16/04/202109:55:19Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202109:55:41Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA

16/04/202109:56:33Current_UnitRespPriorityDesc	601442: 1A	HOT1A	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
16/04/202109:56:45Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16/04/202109:58:41Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202110:02:55Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16/04/202110:03:22Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16/04/202110:03:49CIS_Used	0	null	(Response Viewer)	Response_Master_Incident	PA608	6GREKRA
16/04/202110:04:57Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202110:04:57City	SPRINGFIELD LAKES	ST AUBYN	(Response Viewer)	Response_Master_Incident	PA602	6TANLI
16/04/202110:05:19City	SPRINGFIELD LAKES	ST AUBYN	(Response Viewer)	Response_Master_Incident	PA608	6GR RA
16/04/202110:05:20Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA608	6GR RA
16/04/202110:05:31City	ST AUBYN	SPRINGFIELD LAKES	(Response Viewer)	Response_Master_Incident	PA601	6JOEM
16/04/202110:05:53Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA601	6JOEMCE
16/04/202110:30:07Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA607	IKS
16/04/202110:31:41Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PA607	6NIKSW
16/04/202110:39:41Read Comment	False	True	(Response Viewer)	Response_Master_Incid	MA	12B TOD
16/04/202111:28:46Read Comment	False	True	(Response Viewer)	Response_Master_I dent	PA 7	6NIKSWE
16/04/202111:32:39Read Comment	False	True	(Response Viewer)	Response_Master_In dent	A607	6NIKSWE
17/04/202107:48:46Read Comment	False	True	(Response Viewer)	Response M ster_Inciden	SA912	9NICFIS

Significant Incident Review Template Version 1.0 July 2020

Sunshine Coast Local Ambulance Service Network

Authority:

By authority of Sunshine Coast Assistant Commissioner (AC), Mr Stephen Gou h in compliance with LASN directive 08-15, this review was completed by Senior Operatio s Sup visor (SOS Danielle Williams.

Executive Summary:

At 13:28 on the 17th April 2021, a '000' call was received at t e Brisb ne Operations Centre for Queensland Ambulance Service (QAS) to attend a ma patient volv d in a s gle vehicle accident.

The incident was categorised through the Medical Priority Dispatc Syste (MPDS) as a 29B01; Road Traffic Crash (RTC), with injuries; code 1C; Incident De iled Report (IDR) 14169113.

QAS responded with Queensland Fire and Re cue (QF S) and Q eensland Police Service (QPS) to a Irrelevant male who had fallen from a m orcyc and ay have fractured his arm.

Based on the information p vided t Maro hydore Operations Centre dispatched one (1) Advance Care Paramedic (CP) crew.

At 13:45 a second '000' l was re M roochydore Operations Centre (MOC), the caller advised that the patient is no ler grunting and not speaking at all.

A Irrelevantm patient was transported the Maroochydore Airport, intubated by the Flight Critical Care Paramedic (CCP) and Doctor and wn to the Royal Brisbane Hospital for ongoing treatment.

Term of Refere e:

T eview will investig e all aspects of the ambulance response to incident 14169113.
This r ew will include all quirements outlined in the Operational Incident Review Process.

LASN Clini l Incident Summary Report:

At the time of the report an eARF was not available.

Due to the nature of the incident a clinical review Evaluating Clinical Improvement and Patient Safety (E) audit has been requested.

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Incident Review/Investigation:

The Senior Operations Supervisor conducted a review of all available documentation and records post incident.

Unit activity for the Sunshine Coast LASN has been reviewed. The initial unit dispatched was in accordance with State Operations Centre (OpCen) Standard Operating Procedure (SOP) SOP02, Dispatching of Ambulance Resources:

- The closest available unit B401772 was dispatched from the Bruce Highway on ra p

Issues identified:

- 13:45 second '000' call received advising change in patient condition, it is to be determined if the Clinical Deployment Supervisor (CDS) or the Operations Centre Su ervi r (OCS) were notified
- '000' calls to be interrogated to determine if the Emergency Medic Dispa her MD) re-triaged the second '000' through ProQA as per SOP01.18
- Audio files requested to verify chronology and Situation Report (SitReps

WAV file verification is required for all communication in relation o this in dent.

Background

Queensland Ambulance Service received a request to atten a Irrelevant m who had fallen from a motorcycle.

QAS resources dispatched to this incident:

B401772	Irrelevan)
A406786	Irrele nt
A406801	Irre vant

Chronology

Below is a chronological sequen of events:

13:32 Incide WiQ single motorcy e accident, Irrelevant m (later verified as Irrelevant m), conscious breathin possible fractured arm

13:3 B401772 dis tched and responding (CAD ETA 15:15)

:4 Call back from s e 'patient now not alert, grunting, not speaking at all'

13:48 B 01772 arrived at scene

14:00 SR 4 772 – high speed off motorbike, tachy 150-100

13:52 A406786 dispatched

14:08 A406786 at scene

14:13 406786 SR > Irrelevant m agitated, clammy, unequal pupils, high mechanism, request medical crew from airport

14:14 CDS contacted RSQ to advise of road tasking

14:13 A406801 dispatched

14:30 A406801 met up with crew

14:48 B401772 departed for airport with flight crew on board

14:49 B401772 arrived at airport. Flight crew will intubate patient prior to departure

15:41 R511 departed for RBH

16:28 R511 arrived at RBH

Incident Outcomes:

One (1) Irrelevant male with multi-system trauma flown to RBH

Events since Incident

Dot point to Executive Manager Operations (EMO)

An ECLIPSE audit has been requested

Audio files requested from Maroochydore Operations Centre

Review Recommendations:

To be determined on receipt of WAV files and clinical audit.

Appendix of relevant documents/files:

- Incident Detail Report 14169113
- Senior Operations Supervisor end of shift report 17/04/2021 (0600-1800)
- Dot point to EMO

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Assistant Commissioner	Stephen Gough	General Manager	Irrelevant	19/04/2021

21_04_17 (0600-1800) SCT LASI Report

Incident Detail 14169113.doc

RTC - motorcycle accident Yandina Cr

s47(3)(b)

s47(3)(b)

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s47(3)(b)

s47(3)(b)

s47(3)(b)

Significant Incident Review Template Version 1.0 July 2020

Sunshine Coast Local Ambulance Service Network

Authority:

By authority of Sunshine Coast Assistant Commissioner (AC), Mr Paul Shaw, in ompliance with LASN directive 08-15, this review was completed by Acting/Senior Operation Supe sor (A/SOS Nick Haug.

Executive Summary:

At 15:21 on the 25th April 2021 Queensland Ambulance Service QAS) r ceived a request to attend 4 people in the water off beach access 201, Point Car wright.

The incident was categorised through the Medical Priority Dispatc Syste (MPDS) as a 14E02; Drown Underwater Non-Specialised; code 1A; Incident Detail d Report (IDR) 14202991.

QAS responded with Surf Lifesaving Queensla d (SLSQ and Que nsland Police Service (QPS) to 4 patients that had been caught struggling in w er off each ccess 201 Point Cartwright . 1 Irrelevant was situated on beach whilst 3 Ir t were re cu d by SL Q via surf ski and jetski. One 28 Y/O Irrelevant was in Cardiac Arrest an treated

Maroochydore Operation Centre (MO) dispatched the following resources:

- One (1) Critical Ca Parame (d)
- One (1) Critical Care ra edic crew (CCP)
- One (1) Advanced Care aramedic crew (ACP)
- One (1) Operations Super or (OS) for scene coordination

SLSQ, QAS an QPS rescued, assessed and treated patients located at Beach access 201.

Pati nt Irrelevant was successfully resuscitated on scene and transported to S ine Coast Univer y Hospital (SCUH) Hot.
Two Ir levant were tra ported as a precaution to SCUH Cold

Terms of R ference:

This review will investigate all aspects of the ambulance response to incident 14202991.
This review will include all requirements outlined in the Operational Incident Review Process.

LASN Clinical Incident Summary Report:

A Digital Ambulance Report Form was completed by attending officers. Nil deviation from normal clinical practices was identified.

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Due to the nature of the incident a clinical review Evaluating Clinical Improvement and Patient Safety (ECLIPSE) audit has been requested.

ECLIPSE audit completed, minor documentation errors identified, no further clinical follow-up required.

Incident Review/Investigation:

The Senior Operations Supervisor conducted a review of all available documentation and re ords post incident.

Unit activity for the Sunshine Coast LASN has been reviewed. The initial units dispatch d w in accordance with State Operations Centre (OpCen) Standard Operating Procedure (SOP) SOP02, Dispatching of Ambulance Resources

- The closest available units were dispatched from Sippy Downs B4 1827, 6786 from Maroochydore, and OS A406891 from Birtinya (SCUH)
- A401775 second CCP was dispatched and responding from Birtinya (SCUH)

Background

Queensland Ambulance Service received a request to ttend 4 p ople n the w er off Beach Access 201 while allegedly caught in rip off Point Cartwright.

QAS resources dispatched to this incident:

B401827	Irrelevant	– Maroochydore
A406786	Irrelevant	Maro hydore
A401775	Irrelevant	– Caloundra
A406891	Irrelevant	

Chronology

Below is a chronological s uence event

15:20 Incident WiQ to attend ultiple patients struggling in water off Beach access 201 Point Cartwright.

15:24 CDS Irr evant called SL Q Comms who responded as unpatrolled beach.

15:30 401827 d A406786 crews arrived at scene

15 401827 Sitrep Pt in water / 2 on beach

15:31 PR Commenced n Irrelevant reported on 4786 EARF

15:36 A4 891 Sitrep, Resus on Irrelevant Pt, 2 more Pt from water

15:52 A40689 Sitrep ROSC achieved

16:09 B401827 with A406786 (CCP) departed code 1 SCUH

12 A401775 departed Code 2 SCUH with 2 Patients

16:23 B401827 arrived at SCUH

16:29 A401775 arrived at SCUH

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Incident Outcomes:

One (1) Irrelevant patient resuscitated and transported to SCUH arriving 16:23

Two Irrelevant patients transported as a precaution to SCUH arriving 16:29

Events since Incident

OS Irrelevant completed Dot Point and sent to A/SOS Irrelevant and A/EMO Irrelevant

PSDU completed a dot point and forwarded to Executive Manager Operations Irrelevant

An ECLIPSE audit has been requested

Audio Files requested

Review Recommendations:

That this Significant incident review be noted and filed.

Appendix of relevant documents/files:

- Incident Detail Report 14202991
- DARF 503345608 (4786)
- DARF unknown (4827)
- Senior Operations Supervisor end of shift report 25/04/2021 (0600-1800)
- OS Irrelevant Dot Point Email
- ECLIPSE audit

LASN Endorsement

(Document must be signed by LASN Manager, converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Role	Name	Position	Signature	Date
Assistant Commissioner	Paul Shaw	General Manager	Stephen Gough	4/05/2021

IDR 14202991 Point Cartwright.pdf
4786 EARF 14202991 Point Cart
4827 EARF 14202991 Point Cart
SCT LASN DAILY PERFORMANCE REP
Dot Point Brief - Immersion Buddina.

Significant Incident Review

Metro South Local Ambulance Service Network

Authority:

By authority of Mr Peter Warrener, Assistant Commissioner, State Operations Centres and Mr Anthony Hose, Acting Assistant Commissioner, Local Ambulance Service Network (LASN) Manager, Metro South LASN.

Executive Summary:

On 29 April 2021 at 23:04hrs, the Queensland Ambulance Service (QAS) received sec d party Triple Zero (000) call in the Brisbane Operations Centre (OpCen), for a Irrelevant patient o had shortness of breath and was described as being fatigued and not alert.

The case was initially prioritised in the Advanced Medical Priority Dispatch System (A PDS) as MPDS Determinant 06D01 – Breathing problems – Not Alert, requiring a Cod 1B im ediate sp nse with lights and/or siren.

At 23:07hrs, the Emergency Medical Dispatcher (EMD), app priately n cted the form Computer Aided Dispatch (InformCAD) Recommend Function to identify availab units respond o the incident. Several units appeared in a recommendable status but were not available xcept fo e Critical Care Paramedic (CCP) unit number A506083, which was located in Fortit d Valley, ree minutes from the patient's location. The EMD did not accept the recommendation to res nd the CP unit owever this unit was later dispatched to the incident at 23:41hrs, then located t Kedr n Park.

At 23:07hrs the Emergency Medical spa er (EM otified th Clinical Deployment Supervisor (CDS) that there were no "recommende units and made two omm Calls at 23:07hrs and 23:21hrs to identify any available paramedics to m e themselv available to respond to a Code 1 incident, however no resources were identified to r pond.

A second Triple Zero (000) call wa eived at 23:21hrs, requesting an estimated time of arrival (ETA) of the ambulance. The caller, waiting ou ide for the ambulance, was unable to provide an update of the patient's condition however, was able t rovide the contact number for the carer on scene with the patient. The EMD attempt to make contact and l a voice message for the carer to contact QAS if the patient's condition wo ened.

A third T ple Zero (000) c was received at 23:29hrs, advising the patient was struggling to breathe, with the c s sequently discon cting. The EMD notified the Clinical Deployment Supervisor (CDS) of the ch ging p ent condition befo another (fourth) Triple Zero (000) call was received at 23:31hrs, when the caller advised e patient was sweating profusely, sometimes stopped breathing and the caller was concerned for th atient.

A 3:37hrs, the EMD noted they could hear extreme shortness of breath on the telephone and caller ad sed patient is going cold and requested permission from the CDS to dispatch the CCP unit to the scene.

At 23: aller advised patient is extremely exhausted and a single officer Critical Care Paramedic (CCP) unit was dispatched to attend the patient from the Kedron Park Emergency Services Complex, Kedron arriving on scene at 23:54hrs.

23:42hrs, the CDS contacted the Operations Supervisor (OS) at the Princess Alexandra Hospital (PAH) to release a crew to respond to the incident and if unable to, the OS was asked to proceed. At 23:42hrs, an Advanced Care Paramedic (ACP) unit was dispatched from a "partially available" status at Cannon Hill,