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 13715033 at Irrelevant Woolloongabba, QLD 4102 at 02:17hrs on 1 January 2021, where a Irrelevant was suffering and anxiety attack. Patient treated with Droperidol and transport to Princess Alexandra Hospital initiated. Upon arrival at hospital patient became further agitated and physically assaulted both QAS Officers and spat on Officers and University Student. Patient subsequently absconded. OS attended and provided necessary support. Both Officers treated at Greenslopes Hospital and University Student seen at Princess Alexandra Hospital. Patient later found by QPS and treated with a further dose of Droperidol and transported to hospital with QPS. Peer Support activated, LASN Management and OIC providing ongoing support to Officers. University notified.

### Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13715033. 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:
- N/A – Notification of Occupational Violence.

### 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: | 02:17hrs |
| Dispatched: | 02:17hrs |
| On Case: | 02:17hrs |
| On Scene: | 02:25hrs |
| Depart: | 02:37hrs |
| Hospital: | 03:07hrs |
| Cleared: | 04:28hrs |



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**Review:**

- 1 x Bravo Crew attended scene and transported patient.
- Response time was 7mins.
- Upon the incident occurring, crew confirmed LR with QPS attached to case.
- Second bravo crew and OS also attended.

**Outcomes:**

- Both QAS Officers sustained punches resulting in minor injuries and cleared to continue to work.
- Bloods taken regarding the biological contamination.
- Both Officers gave statements to QPS regarding the events with view for patient to be charged.
- University appropriately notified and also providing support to student.
- Supervisors completed follow up with Officers.
- Peer Support activated through the Operations Centre.
- CAD Caution Note completed for patient.

**Post OIRR actions:**
Nil.

## Review Recommendations:
Nil.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- LASN Notification
- File Note from OIC

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Gerard Lawler | Assistant Commissioner | Irrelevant | 08.01.21 |
| Anthony Hose | Director Operations | | 08/01/2021 |

# 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:

Gold Coast LASN responded to an incident (IDR 13719510) Irrelevant Hele svale a 06:01am on the 2 January 2021, where Irrelevant was reported to be blue, not breathing tient wa a Irrelevant with CPR being performed prior to QAS arrival. QAS continued treatm nt on sc ne an sported to Gold Coast University Hospital.

### Terms of Reference:

This review will investigate all aspects of ambulance spons o incid t 13719510. The review will examine ambulance operations prior to, during and ollowing he response.
This review will include all requirements outlined in e *O eration Incident Review Process*.

### LASN Clinical Incident ummary Report:

Difficult and emotive scene. Nil c cal ncerns identified, all treatment and transport options appropriate.

### State OpCen ProQA:

- 06:00:42 - ial Triple Zero call wa received from Telstra and actioned by a Brisbane EMD, an inc ent has b n created INC 13719511, and when it populated the WIQ is was appended to INC 719510
  01:52 - Southpor MD Irrelevant received a 2nd Triple Zero call, she created the inci nt INC 13719510 The incident was coded correctly as a 09E01 with a priority 1A respon Unfortunately, as she commenced providing CPR instructions, the call has dropped out, and she w unable to make further contact with the caller
- 06:07:14 - A d Triple Zero call was received and actioned by a Brisbane EMD, and appended to INC 13719510

I have att d both IDRs and the audio file of the call received by the Southport EMD, I'm unable to complete a QA review, however based on the audio prior to the call dropping out, nil issues have been identified, and the EMD was following the correct pathway, and processing the call appropriately.

## Incident Review/Investigation:

**Scope:**

- Gold Coast reviewed the response, Clinical performance and operational decision making to ensure 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 action are taken to return to the required standards.

- **Background:**
  - Irrelevant found unresponsive blue and not breathing at residence.
  - CPR commenced prior to QAS arrival
  - QAS continued with clinical care
  - QAS transported patient to Gold Coast University Hospital
  - Due to emotional environment at scene the patient's Irrelevant was transp rte ith patient to GCUH
  - The patient's Irrelevant were transported by QAS in a second unit
  - GCUH notified as to patient condition and ETA
- **Timeline:**
  - 1st key stroke: 06:01:52
  - In waiting queue: 06:02:59
  - Assigned 1st unit: 06:03:27
  - Enroute 1st unit: 06:03:40
  - At scene 1st Unit: 06:12:06
  - Arrival GCUH 06:43:56

- **Review:**
  - Bravo unit on scene 11 minutes aft call
  - Second Bravo unit, HARU, CCP a OS d patch d
  - Senior Operations Su or awar of cident
  - Priority On activate and of ed all o cers

- **Outcomes:**
  - The patient wa declare g h spital.

- **Post OIRR actions**:
  - Peer Support to cont QAS officers

## Review Recomme dations:

- IC's to follow up w QAS officers involved
  F wing the OpCen iew, nil issues identified.
- Follo ng the Clinical review, nil issues identified.
- Nil oper onal issues identified at the time of this incident review.

## A pendix of rel ant documents/files:

| | |
|---|---|
| **Incident Details eport** | IDR 13719510.pdf |



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| | |
|---|---|
| **GCLASN Notifiable PSDU Notification** | RE_ Notification Ni breathing 1A.msg; RE_ Notification Ni breathing 1A (1).msg; Notification Ni breathing 1A.msg; FW_ Notification Ni breathing 1A.msg |
| **dARF/dCRF** | EARF CN13719510.pdf; EARF CN 13719510 second.pdf; DACRF.pdf |
| **Voice Logs** | 02-01-2021 06.01.49 000 Audio INC 1371; DACRF.pdf |
| **Southport OpCen Brief** | 020121 DAY SOUTHPORT OPCEN |
| **LASN Resource Report** | 6. GOL LASN Resource Report - S |
| **iRoam Cases** | iROAM.docx |
| **Supporting Documents** | Nil |
| **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 | 14/01/21 |

| | | | | |
|---|---|---|---|---|
| A/Director Operations | Rachel Latimer | Director Operations | Irrelevant | 14/01/2021 |

# Incident Detail Report

Data Source: QACIR
Incident Status: Closed
Incident number: 13719510
ProQA number: 16527126
Console name: PA606
Incident Date: 02/01/2021 06:01:52
Last Updated:

## Incident Information

| | | | |
|---|---|---|---|
| **Incident Type:** | ACUTE AND CCP IF AVAILABLE | **Alarm Level:** | |
| **Priority:** | 1A | **Problem:** | NIL BREATHING |
| **Determinant:** | 09E01 | **Agency:** | QAS |
| **Base Response#:** | 005686 | **Jurisdiction:** | 6 Southport Gold Coast |
| **Confirmation#:** | 00004335 | **Division:** | 6 Runaway Bay |
| **Taken By:** | Irrelevant | **Battalion:** | 6 Runaway Bay |
| **Response Area:** | Irrelevant | **Response Plan:** | 1A |
| **Disposition:** | A Case Completed | **Command Ch:** | |
| **Cancel Reason:** | | **Primary TAC:** | TLK GRP 111/UHF Ch 103 |
| **Incident Status:** | Closed | **Secondary TAC:** | |
| **Certification:** | ACUTE | **Delay Reason (if any):** | |
| **Longitude:** | 26640831 | **Latitude:** | 62117210 |
| **Patient Name:** | UNK | **Patient DOB:** | UNK |

## Incident Location

| | | | |
|---|---|---|---|
| **Location Name:** | | **County:** | GOLD COAST |
| **Address:** | Irrelevant | **Location Type:** | |
| **Apartment:** | | **Cross Street:** | Irrelevant Not less 1km |
| **Building:** | | **Map Reference:** | G8B14 |
| **City, State, Zip:** | HELENSVALE QLD 4212 | | |

## Call Receipt

| | | | |
|---|---|---|---|
| **Caller Name:** | Irrelevant | **Original CLI Phone** | Irrelevant |
| **Method Received:** | | **Call Back Phone:** | |
| **Caller Type:** | | **Caller Location:** | Irrelevant |

## Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| **Phone Pickup** | 02/01/2021 | 06:01:52 | |
| **1st Key Stroke** | 02/01/2021 | 06:01:52 | |
| **In Waiting Queue** | 02/01/2021 | 06:02:59 | |
| **Call Taking Complete** | 02/01/2021 | 06:06:38 | Irrelevant |
| **1st Unit Assigned** | 02/01/2021 | 06:03:27 | |
| **1st Unit Enroute** | 02/01/2021 | 06:03:40 | |
| **1st Unit Arrived** | 02/01/2021 | 06:12:06 | |
| **Closed** | 02/01/2021 | 08:25:38 | Irrelevant |

## Elapsed Times

| Description | Time |
|---|---|
| **Received to In Queue** | 00:01:07 |
| **Call Taking** | 00:04:46 |
| **In Queue to 1st Assign** | 00:00:28 |
| **Call Received to 1st Assign** | 00:01:35 |
| **Assigned to 1st Enroute** | 00:00:13 |
| **Enroute to 1st Arrived** | 00:08:26 |
| **Incident Duration** | 02:23:46 |

## Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| B601525 | 06:03:27 | A Case Completed | 06:03:40 | | 06:12:06 | | | 07:14:27 | | | |
| A606692 | 06:03:27 | A Case Completed | 06:04:09 | | 06:25:49 | | | 08:25:38 | | | |
| B601505 | 06:06:57 | A Case Completed | 06:07:02 | | 06:21:11 | | | 07:36:22 | | | |
| B607843 | 06:15:58 | A Case Completed | 06:16:02 | | 06:30:21 | | 06:31:39 | 06:34:52 | | | |

## Personnel Assigned

| Unit | Name |
|---|---|
| 601505 | Irrelevant |
| 601525 | |
| 606692 | |
| 607843 | |

## Pre-Scheduled Information

**No Pre-Scheduled Information**

## Transports

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 601525 | QH GOLD COAST UNIVERSITY HOSPITAL 1 HOSPITAL BVD | | Hot | Pre Hosp - patient condition | 0.0// | 06:28:37 | 06:43:56 | 07:14:27 |

## Comments

| Date | Time | User | Type | Comments |
|---|---|---|---|---|
| 02/01/2021 | 06:01:01 | 5NARMIL1 | Response | [Appended, 06:04:09] TELSTRA - HEARD CPR IN PROGRESS |
| 02/01/2021 | 06:02:48 | 5NARMIL1 | Response | [Appended, 06:04:09] TESLTRA UNABLE TO GAIN ADDRESS - TL TO CALL BACK WITH INFO - TELSTRA COULD NOT HEAR CALLER |
| 02/01/2021 | 06:02:59 | 6ALIHOR | Response | [ProQA Dispatch] Dispatch Level: 09E01 (Not breathing at all) Response Text: Irrelevant Not Conscious, Not Breathing. Problem Description: ? DECEASED |
| 02/01/2021 | 06:03:04 | 6ALIHOR | Response | [Notification] [QAS]-CPR in progress |
| 02/01/2021 | 06:03:11 | 5NARMIL1 | Response | [Appended, 06:04:09] [ProQA: Key Questions] 1. The cardiac arrest was witnessed or just occurred. |
| 02/01/2021 | 06:03:11 | 5NARMIL1 | Response | [Appended, 06:04:09] [ProQA Dispatch] Dispatch Level: 09E01 (Not breathing at all) Response Text: 1A Age unknown, Gender unknown, Not Conscious, Not Breathing. Problem Description: Obviously NOT BREATHING & Unconscious (non-traum) |
| 02/01/2021 | 06:03:28 | PS | Response | [Page] Dispatch page sent to Unit:601525, Sent From: KEDCADQASPIS01 |
| 02/01/2021 | 06:03:28 | PS | Response | [Page] Dispatch page sent to Unit:606692, Sent From: KEDCADQASPIS01 |

| | | | | |
|---|---|---|---|---|
| 02/01/2021 | 06:03:29 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:03:29 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:03:31 | 6ALIHOR | Response | [ProQA: Key Questions] 1. The cardiac arrest was witnessed or just occurred. |
| 02/01/2021 | 06:03:41 | PS | Response | [Page] Dispatch page to Unit:601525 complete to PIN 0428394791: 39473000 Message sent successfully. |
| 02/01/2021 | 06:03:42 | PS | Response | [Page] Dispatch page to Unit:601525 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:03:43 | PS | Response | [Page] Dispatch page to Unit:606692 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:03:44 | PS | Response | [Page] Dispatch page to Unit:606692 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:03:55 | 6JULKIL | Response | [Appended, 06:04:09] [Private] DUP OF 126 |
| 02/01/2021 | 06:04:09 | 5NARMIL1 | Response | Duplicate call appended to incident at 06:04:09 |
| 02/01/2021 | 06:04:10 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:04:10 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:04:11 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:04:28 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:04:28 | 6ALIHOR | Response | PHONE DROPPED OUT |
| 02/01/2021 | 06:04:29 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:05:07 | 5NARMIL1 | Response | [Private] - OCS ADV |
| 02/01/2021 | 06:05:53 | 6ALIHOR | Response | UNABLE TO RE-ESTABLISH CONTACT |
| 02/01/2021 | 06:05:54 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:05:54 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:06:57 | PS | Response | [Page] Dispatch page sent to Unit:601505, Sent From: KEDCADQASPIS01 |
| 02/01/2021 | 06:06:59 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:07:10 | PS | Response | [Page] Dispatch page to Unit:601505 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:07:11 | PS | Response | [Page] Dispatch page to Unit:601505 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:07:14 | 5FALHAR | Response | Duplicate call appended to incident at 06:07:14 |
| 02/01/2021 | 06:07:15 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:07:16 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:07:16 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:08:41 | 6TRECRO | Response | CDS PHONED CCP ON SCENE AT CASE # 13719444 BUT UNAVAILABLE TO HELP WITH THIS CASE |
| 02/01/2021 | 06:08:42 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:08:42 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:15 | 5FALHAR | Response | BABY IS BLUE |
| 02/01/2021 | 06:09:16 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:16 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:27 | 5FALHAR | Response | [Notification] [QAS]-CPR in progress |
| 02/01/2021 | 06:09:29 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:32 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:43 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:44 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:09:45 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:10:57 | 5FALHAR | Response | UNABLE TO HEAR DUE TO POOR RECEPTION |
| 02/01/2021 | 06:10:59 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:10:59 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:11:00 | 601525 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:12:17 | 5FALHAR | Response | 3 MONTH OLD MALE PT - CPR STILL IN PROGRESS |
| 02/01/2021 | 06:12:19 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:12:19 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:13:12 | 6JULKIL | Response | 601525 CPR in progress |
| 02/01/2021 | 06:13:13 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:13:13 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:15:58 | PS | Response | [Page] Dispatch page sent to Unit:607843, Sent From: KEDCADQASPIS01 |
| 02/01/2021 | 06:15:58 | 607843 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:16:10 | PS | Response | [Page] Dispatch page to Unit:607843 complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:20:18 | 6JULKIL | Response | 601525 ? CCP BACK UP LOCATION CPR in progress |
| 02/01/2021 | 06:20:19 | 606692 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:20:20 | 607843 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:20:20 | 601505 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:29:02 | 6JULKIL | Response | 601525 DEP CODE 1 WITH CCP ON BOARD |
| 02/01/2021 | 06:29:04 | 607843 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:29:37 | 6JULKIL | Response | Unit 606692 has been placed in Unit Unattended. |
| 02/01/2021 | 06:29:38 | 607843 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:30:22 | 6JULKIL | Response | 601505 HEADING UP WITH THE IrrelevantON BOARD - CCP CAR LEFT ON SCENE |
| 02/01/2021 | 06:30:24 | 607843 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 02/01/2021 | 06:31:28 | 6JULKIL | Response | 607843 LIASED WITH CREW - WILL FOLLOW TO GCUH |
| 02/01/2021 | 06:34:38 | 6JULKIL | Response | 606692 CDS TO CALLK OFFICER ARNOLD |
| 02/01/2021 | 06:38:26 | 6JULKIL | Response | Unit 601505 has been placed in Unit Unable to Respond. |
| 02/01/2021 | 06:44:09 | PS | Response | [Page] Page processing complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 06:44:10 | PS | Response | [Page] Page processing complete to Irrelevant Message sent successfully. |
| 02/01/2021 | 07:35:10 | 6ALIHOR | Response | [Page] Units: 601505, Sent From: PA606, PLS CONFIRM AVAIL TO RESPOND |
| 02/01/2021 | 07:36:23 | 6JULKIL | Response | Unit 601505 has been removed from Unit Unable to Respond. |
| 02/01/2021 | 08:25:41 | 6ALIHOR | Response | Unit 606692 has been removed from Unit Unattended. |

Priority Changes
**No Priority Changes**

Call Activities

| Date | Time | Radio | Activity | Location | Comments | User |
|---|---|---|---|---|---|---|
| 02/01/2021 | 06:01:52 | | No AML Data Received | | No AML data received with this call | SDSIAML |
| 02/01/2021 | 06:02:59 | | Incident in Waiting Queue | | | |
| 02/01/2021 | 06:02:59 | | ANI/ALI Statistics | | INT Insert:Jan 02 2021 06:01:50 / INT<br>SendNP:Jan 02 2021 06:01:49 / WS<br>RecvNP:Jan 02 2021 06:01:50 / WS<br>Process:Jan 02 2021 06:02:59 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 02/01/2021 | 06:03:00 | | Read Comment | | Comment for Incident 126 was Marked as Read. | 6ALIHOR |

| | | | | | |
|---|---|---|---|---|---|
| 02/01/2021 | 06:03:00 | | ProQA | | ProQA determinant sent 6ALIHOR |
| 02/01/2021 | 06:03:02 | | Read Incident | | Incident 126 was Marked as Read. (Response Viewer) 6JULKIL |
| 02/01/2021 | 06:03:04 | | Notify Comment | | |
| 02/01/2021 | 06:03:05 | | UserAction | | User clicked Initial Assign 6JULKIL |
| 02/01/2021 | 06:03:07 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 661742 (00:09:15),601525 (00:09:21),606692 (00:23:25) 6JULKIL |
| 02/01/2021 | 06:03:09 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired |
| 02/01/2021 | 06:03:09 | | Incident In Waiting Queue Timer Clear | | |
| 02/01/2021 | 06:03:18 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6TRECRO |
| 02/01/2021 | 06:03:19 | | Initial Assignment | | The following unit(s) is (are) cleared from assignment: 661742 6JULKIL |
| 02/01/2021 | 06:03:27 | 601525 | Dispatched | | Response Number (005686) 6JULKIL |
| 02/01/2021 | 06:03:27 | 606692 | Dispatched | | Response Number (005687) 6JULKIL |
| 02/01/2021 | 06:03:32 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6KRIHOL |
| 02/01/2021 | 06:03:39 | | UserAction | | User clicked Exit/Save 6JULKIL |
| 02/01/2021 | 06:03:40 | 601525 | Resp | | Responding From = 6(02) RUNAWAY BAY VisiNET |
| 02/01/2021 | 06:04:09 | | Duplicate Call Warning | | Duplicate Call Warning - New call appended to incident 5NARMIL1 |
| 02/01/2021 | 06:04:09 | 606692 | Resp | | Responding From = 6(08) BURLEIGH HEADS CCP VisiNET |
| 02/01/2021 | 06:04:12 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5NARMIL1 |
| 02/01/2021 | 06:04:15 | | Notification | | Out of Region message displayed for: [redacted] 5NARMIL1 |
| 02/01/2021 | 06:04:16 | | Notification | | Out of Region message acknowledged for: [redacted] 5NARMIL1 |
| 02/01/2021 | 06:04:55 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6JULKIL |
| 02/01/2021 | 06:05:31 | | UserAction | | User clicked Exit/Save 5NARMIL1 |
| 02/01/2021 | 06:06:38 | | UserAction | | User clicked Exit/Save 6ALIHOR |
| 02/01/2021 | 06:06:57 | 601505 | Dispatched | | Response Number (005702) 6JULKIL |
| 02/01/2021 | 06:07:02 | 601505 | Resp | | Responding From = 6(03) SOUTHPORT VisiNET |
| 02/01/2021 | 06:07:14 | | Duplicate Call Warning | | Duplicate Call Warning - New call appended to incident 5FALHAR |
| 02/01/2021 | 06:07:16 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5FALHAR |
| 02/01/2021 | 06:07:17 | | Notification | | Out of Region message displayed for: 27 Champagne Bvd 5FALHAR |
| 02/01/2021 | 06:07:18 | | UserAction | | User clicked Exit/Save 6JULKIL |
| 02/01/2021 | 06:07:19 | | Notification | | Out of Region message acknowledged for: 27 Champagne Bvd 5FALHAR |
| 02/01/2021 | 06:08:52 | | UserAction | | User clicked Exit/Save 6TRECRO |
| 02/01/2021 | 06:09:31 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6JULKIL |
| 02/01/2021 | 06:09:47 | | UserAction | | User clicked Exit/Save 6JULKIL |
| 02/01/2021 | 06:11:32 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5SANTHO |
| 02/01/2021 | 06:12:02 | | UserAction | | User clicked Exit/Save 5SANTHO |
| 02/01/2021 | 06:12:06 | 601525 | At Scene | | VisiNET |
| 02/01/2021 | 06:13:29 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6KRIHOL |
| 02/01/2021 | 06:15:58 | 607843 | Dispatched | | Response Number (005713) 6JULKIL |
| 02/01/2021 | 06:16:02 | 607843 | Resp | | Responding From = HOSPITAL BVD\CROSSOVER VisiNET |
| 02/01/2021 | 06:16:11 | | Read Comment | | Comment for Incident 126 was Marked as Read. 12MITRID |
| 02/01/2021 | 06:18:13 | | UserAction | | User clicked Exit/Save 5SANTHO |
| 02/01/2021 | 06:19:30 | | UserAction | | User clicked Exit/Save 5FALHAR |
| 02/01/2021 | 06:21:11 | 601505 | At Scene | | VisiNET |
| 02/01/2021 | 06:25:49 | 606692 | At Scene | | VisiNET |
| 02/01/2021 | 06:26:17 | | UserAction | | User clicked Exit/Save 6TRECRO |
| 02/01/2021 | 06:28:37 | 601525 | Dep | QH GOLD COAST UNIVERSITY HOSPITAL | VisiNET |
| 02/01/2021 | 06:29:16 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5FALHAR |
| 02/01/2021 | 06:29:37 | 606692 | Out Of Service | | Unit Unattended 6JULKIL |
| 02/01/2021 | 06:29:46 | | UserAction | | User clicked Exit/Save 5FALHAR |
| 02/01/2021 | 06:30:21 | 607843 | At Scene | | VisiNET |
| 02/01/2021 | 06:31:39 | 607843 | Partially Av | | VisiNET |
| 02/01/2021 | 06:32:11 | | UserAction | | User clicked Exit/Save 6KRIHOL |
| 02/01/2021 | 06:33:32 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5SANTHO |
| 02/01/2021 | 06:33:46 | | UserAction | | User clicked Exit/Save 5SANTHO |
| 02/01/2021 | 06:34:52 | 607843 | Available | | 6JULKIL |
| 02/01/2021 | 06:34:52 | 607843 | Disposition | | A Case Completed 6JULKIL |
| 02/01/2021 | 06:38:26 | 601505 | Out Of Service | | Unit Unable to Respond 6JULKIL |
| 02/01/2021 | 06:43:56 | 601525 | Dest | 1 HOSPITAL BVD [QH GOLD COAST UNIVERSITY HOSPITAL] | VisiNET |
| 02/01/2021 | 06:43:56 | 601525 | Transport Time | | Depart Scene Time: 06:28:37, Arrive Destination Time: 06:43:56 VisiNET |
| 02/01/2021 | 06:44:09 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5SANTHO |
| 02/01/2021 | 06:44:10 | | Read Comment | | Comment for Incident 126 was Marked as Read. 5SANTHO |
| 02/01/2021 | 06:44:41 | | UserAction | | User clicked Exit/Save 5SANTHO |
| 02/01/2021 | 06:46:10 | | UserAction | | User clicked Exit/Save 12MITRID |
| 02/01/2021 | 06:46:35 | | UserAction | | User clicked Exit/Save 12MITRID |
| 02/01/2021 | 07:01:03 | | UserAction | | User clicked Exit/Save 6GLEDEK |
| 02/01/2021 | 07:03:30 | | UserAction | | User clicked Exit/Save 6TRECRO |
| 02/01/2021 | 07:13:56 | | Incident Late | | Active incident marked as late |
| 02/01/2021 | 07:14:25 | | UserAction | | User clicked Exit/Save 6ALIHOR |
| 02/01/2021 | 07:14:27 | 601525 | Available | 1 HOSPITAL BVD [QH GOLD COAST UNIVERSITY HOSPITAL] | 6ALIHOR |
| 02/01/2021 | 07:14:27 | 601525 | Disposition | | A Case Completed 6ALIHOR |
| 02/01/2021 | 07:17:12 | | UserAction | | User clicked Exit/Save 6KRIHOL |
| 02/01/2021 | 07:36:22 | 601505 | Available | | 6JULKIL |
| 02/01/2021 | 07:36:22 | 601505 | Disposition | | A Case Completed 6JULKIL |
| 02/01/2021 | 07:40:37 | | Read Comment | | Comment for Incident 126 was Marked as Read. 6TRECRO |
| 02/01/2021 | 07:40:43 | | Premise History Access | | Premise History Viewed 6TRECRO |
| 02/01/2021 | 07:41:12 | | UserAction | | User clicked Exit/Save 6TRECRO |
| 02/01/2021 | 07:54:12 | | UserAction | | User clicked Exit/Save 6KRIHOL |
| 02/01/2021 | 08:25:38 | 606692 | Available | | 6ALIHOR |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 02/01/2021 | 08:25:38 | 606692 | Disposition | Irrelevant | A Case Completed | | 6ALIHOR |
| 02/01/2021 | 08:25:38 | 606692 | Response Closed | | Response Disposition: A Case Completed | | 6ALIHOR |

Edit Log

| Date | Time | Field | Changed From | Changed To | Reason | Table | Workstation | User |
|---|---|---|---|---|---|---|---|---|
| 02/01/2021 | 06:01:52 | Call_Back_Phone | | 0422251132 | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:00 | City | | HELENSVALE | Updated City | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:00 | City | | HELENSVALE | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:00 | Address | (Blank) | Irrelevant | New Entry | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Jurisdiction | | Irrelevant | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Division | | | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Battalion | | | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Response_Area | | | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | ResponsePlanType | 0 | | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Primary_TAC_Channel | | TLK GRP 111/UHF Ch 103 | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Address | | Irrelevant | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Latitude | 0 | 62117210 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:02 | Longitude | 0 | 26640631 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:27 | ProQaCaseNumber | | 16527126 | (Response Viewer) | Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | Problem | | NIL BREATHING | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | Response_Plan | | 1A | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | DispatchLevel | | Normal | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | ResponsePlanType | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:02:59 | Incident_Type | | ACUTE AND CCP IF AVAILABLE | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | Priority_Number | 0 | 1 | Updated by ProQA | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | Determinant | | 09E01 | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | EMD_Used | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | Pickup_Map_Info | (Blank) | G8B14 | | Response_Transports | KEDCADQASCXA076 | 6ALIHOR |
| 02/01/2021 | 06:03:00 | Map_Info | | G8B14 | | Response_Master_Incident | KEDCADQASCXA076 | 6ALIHOR |
| 02/01/2021 | 06:03:02 | Read Call | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JULKIL |
| 02/01/2021 | 06:03:18 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6TREGRO |
| 02/01/2021 | 06:03:32 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6KRIHOL |
| 02/01/2021 | 06:03:40 | Current_UnitRespPriorityDesc | 601525: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 02/01/2021 | 06:04:10 | Current_UnitRespPriorityDesc | 606692: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 02/01/2021 | 06:04:12 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA525 | 5NARMIL1 |
| 02/01/2021 | 06:04:55 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JULKIL |
| 02/01/2021 | 06:05:09 | Field_Data | | UNK | Patient Name: | Response_User_Data_Fields | PA606 | 6ALIHOR |
| 02/01/2021 | 06:05:13 | Field_Data | | UNK | Patient DOB: | Response_User_Data_Fields | PA606 | 6ALIHOR |
| 02/01/2021 | 06:06:30 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:06:30 | ProQATerminationStateCode | | C | (Response Viewer) | Incident | PA606 | 6ALIHOR |
| 02/01/2021 | 06:07:02 | Current_UnitRespPriorityDesc | 601505: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 02/01/2021 | 06:07:16 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA528 | 5FALHAR |
| 02/01/2021 | 06:09:31 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JULKIL |
| 02/01/2021 | 06:11:32 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA511 | 5SANTHO |
| 02/01/2021 | 06:12:37 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | QA528 | 5FALHAR |
| 02/01/2021 | 06:13:29 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6KRIHOL |
| 02/01/2021 | 06:16:03 | Current_UnitRespPriorityDesc | 607843: 1A | COLD1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 02/01/2021 | 06:16:11 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | MA502 | 12MITRID |
| 02/01/2021 | 06:28:36 | Map_Info | (Blank) | G28K8 | | Response_Transports | KEDCADQASMDI01 | VisiNET |
| 02/01/2021 | 06:29:16 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA528 | 5FALHAR |

| | | | | | | |
|---|---|---|---|---|---|---|
| 02/01/202106:33:32Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA511 | 5SANTHO |
| 02/01/202106:44:09Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA511 | 5SANTHO |
| 02/01/202106:44:10Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA511 | 5SANTHO |
| 02/01/202107:40:37Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6TRECRO |

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 13721217 at Irrelevant Carindale, QLD 4152 at 15:46hrs on 02 January 2021, where it was reported a person was no longer on fire. On QAS arrival patient found lying in backyard deceased. Evidence of fire with fuel found nearby. Patient had Irrelevant and had not been scene for previous 90 minutes or so. QPS and QFES also attended. SOS attended scene and provided necessary support and debrief for Officers involved. Peer Support activated by OpCen.

**Terms of Reference:**
This review will investigate all aspects of ambulance response to incident 13721217. 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:**
- N/A – Patient found deceased on arrival with nil interventions.

**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: | 15:46hrs |
| Dispatched: | 15:47hrs |
| On Case: | 15:48hrs |
| On Scene: | 16:01hrs |
| Cleared: | 16:53hrs |

**Review:**
- 1 x Bravo Crew / 1 x CCP / SOS attended scene.
- Response time was 14mins.
- Nil clinical concerns with case.
- Nil operational concerns with case.



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**Outcomes:**

- Irrelevant deceased on QAS arrival.
- Supervisor completed debrief with Officers.
- Peer Support activated through the Operations Centre.

**Post OIRR actions:**

Nil.

## 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 | 08/01/21 |
| Anthony Hose | Director Operations | | 06/01/2021 |

# Significant Incident Review Template Version 1.0 July 2020

## Gold Coast Local Ambulance Service Network

### Authority:

By authority of (LASN Manager).

### Executive Summary:

At 06.30 am on Tuesday 5 January 2021, Queensland Ambulance received a requ t for s vice for three Irrelevant one with a cut to Irrelevant foot post swimming in the surf.

A single 000 call was received in relation to the incident (CN 13731086 A CCP rew (601529) was dispatched as the closest response to the incident.

QPS on scene with three Irrelevant and advised all are conscious nd bre ing.

On arrival QPS advised that there is another Irrelevant missing in the wa and QPS and Surf lifesaving are looking for the missing person.

QPS advised Irrelevant went swimming in the early ho s and as been missing since.

Crew assessed all Irrelevant on scene a tra port no quired. No clinical sitrep given.

CDS spoke with QPS and advi d that QAS crew woul due to workload and that QPS to call QAS if required or a body located.

ICEMS advised at 08:56 that a b dy ha been locate and is deceased. Location given as Hooker Sunshine Boulevard. QPS request that QAS nd.

Second Bravo unit 601593 attached to case at 08:57 travelling code 2.

QPS advised that d eased Irrelevant is approx relevant

09:26 QA on scene.

09:40 B6 593 advised pati signal 4.

### Terms of Refe nce:

Th review will investigate all aspects of ambulance response to incident 13731086. The review will e mine ambulance operations prior to, during and following the response.
will include all requirements outlined in the *Operational Incident Review Process*.

### LASN Clinical Incident Summary Report:

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


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Summary of Report:

*Case managed to standard. Nil Further action required.*

## State OpCen ProQA:

Not completed.

## Incident Review/Investigation:

**Scope:**

The review considered the QAS resource allocation and response. It was found the response as appropriate considering the location of the incident, proximity to the closest most appropriate resource A 01529 rm d Waters) located at Mermaid Waters station with a response time of 10 mins code 2A.

The response was within appropriate timeframes and expectations of service deli ry c sidering the me, location of the incident and location of available responding crews.

The Gold Coast Local Ambulance Service Network (GCLASN) at the time of he re uest f r ervice was experiencing moderate demand with delays at GCUH resulting in level 2 escalatio Robin Hospital was experiencing minor delays leading up to and during the case, Robina H spita ad mi mal lays at the time of the incident.

Nine (9) active cases in the GCLASN during the time of r uest for ervi and c se duration with three (1) units at Robina Hospital, nine (2) units at Gold Coast Univers Hospi

**Background:**

The Gold Coast LASN (GCLASN) had been expe encing oderat workload thought the evening. This resulted infrequent surges into hospitals and bu ding de ays which was appropriately managed by the GCLASN overnight OS.

Immediately prior to the request r servic for this ase, th Gold Coast LASN had been experiencing moderate demand for service. T e GCLASN ACH had managing hospital flow and assisting with case supervision at the time of the tial call and uring the case.

Initial enquiries indicate that the pon e from QAS for service delivery was timely with no obvious delays to a 2A response.

Good communication between both QA nd QPS allowed QAS to attend other cases in the community whilst a search was con cted for the missing rson. After QPS requested QAS to attend. B601593 crew was dispatched a Road ed within a reasonable time frame.

**Tim ine**

06:30 am – R est for service received.

6:34 am – A 6015 dispatched

06 5 am – A 601529 responded

40 am – A 601529 – on scene

07. 01 am – A 601529 – request to clear

07.08 am – ***QPS advise they are happy for QAS to clear and will locate if body located.***

36 am – QAS contacted QPS via ICEMS asking if body located yet?

**07.36 am – QPS advise via ICEMS that body not located yet.**

08.36 am – QAS contacted QPS via ICEMS asking for any updates.

08.56 am - QPS advise via ICEMS that a body had been located and request QAS to attend Irrelevant Irrelevant

08.57 am – B 601593 attached to the case code 2A

09:26 am – B601593 on scene

09.40 am – B601563 advised patient signal 4

**Review:**

A comprehensive review of the case is currently under way.

The following are the findings of this review thus far

- **Case accuracy**
  - The Incident Detail Report (IDR) lacks clinical detail he sitre from the initial attending CCP crew and the backup response crew.
- **Clinical – Clinical review of case to be completed.**
  - **Patient outcome** – At this stage of the tigation is not known what caused the drowning of the patient. No obvious concern from a nical a ect for this case. Nil sitrep given by primary unit.
  - **Transport appropr tene** – Uns if non - t ansportation of the patient with a lacerated foot was approp ate as no c nical sitrep ven.
- Outcomes: describe outc e nd impacts of the OIRR;
- Post OIRR ctions: detail any acti taken at the LASN level since the OIRR occurred (including but t limite o Priority One access and post incident debrief).

## Review Rec mmendations:

1. OPCEN to iew any missing clinical sitrep information in IDR.
2. Clinical Education Unit to review clinical aspects of case.
3. Nil operational concerns with the case, resource allocation, response all within appropriate xpectations.

## Appendix of relevant documents/files:



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- 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** | IDR 13731086.pdf |
| **GCLASN Notifiable PSDU Notification** | Incident Notification - Gold ( |
| **dARF/dCRF** | eARF 13731086.pdf |
| **Voice Logs** | |
| **Southport OpCen Brief** | |
| **Clinical Review** | QAS GOL CEU Clinical Review CIM |

## 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/AC | Chris Draper | General Manager | Irrelevant | 04/03/2021 |
| | | | | |

s47(3)(b)

s47(3)(b)

# Wide Bay Local Ambulance Service Network

# IR005-2021

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

## Executive Summary:

On Sunday 10 January 2021, QAS responded to Incident number 13752434. The incident was located at Lowmead under the railway bridge on Lowmead Road, Lowmead. The call was to a car on fire with one occupant trapped in that vehicle. On arrival of QFES rural fire it was confirmed that the person was trapped, and the vehicle was well engulfed in flames. After all services arrived on scene it was confirmed there was only one occupant who was deceased. The scene was said by the QAS crew to be distressing to those first on scene who attempted to put the fire out.

## Terms of Reference:

This review will investigate all aspects of ambulance response to incident 13752434.
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 Clinical Education Unit found that the documentation had been completed to standard with no concerns noted.

**Scope:**

This review will consider all aspects of the QAS response to case 13752434, including resource allocation and clinical treatment.

**Background:**

- QAS called to a single vehicle RTC at Lowmead, said to be Irrelevant
- Caller stated vehicle to be on fire with one deceased occupant.
- Single QFES rural fire officer first on scene.
- QFES confirmed incident located under rail bridge, on fire with one occupant, who was deceased and entrapped.
- Significant impact with extensive damage to vehicle.
- QAS crew provided support to single rural fire fighter and young people on scene who assisted in firefighting.
- QAS crew advised that:
  - Single firefighter and bystanders on scene distressed by incident.
  - Fire damage evident to railway bridge.
  - Witnesses advised that the vehicle was seen parked next to the bridge and driving up and down the roadway in the 30 minutes prior the incident.
  - The vehicle was then seen to approach the railway bridge at considerable speed prior the impact.



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- SOS contacted OCS Rockhampton to ensure Queensland Rail had been advised and that additional QFES resources were being dispatched to support the rural firefighter on scene.

**Timeline:**

| | |
|---|---|
| Call Received: | 17:27 |
| In waiting Queue: | 17:29 |
| First unit assigned: | 17:29 |
| First Unit on Case: | 17:30 |
| First Unit on Scene: | 18:03 |

## Review:

The review did not identify any issues with the response by QAS to the incident. The estimated travel timeframe was 37 minutes and the responding unit took 33 minutes to respond to the scene.

## Outcomes:

The patient was left in the care of QPS. Priority One provided post event support to the crew involved.

## Review Recommendations:

This review finds no recommendations.

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

- Notification Brief Email incident
- Incident Detail Report (IDR) 13752434
- Electronic Ambulance Report Form (eARF) 503062647; and
- Local level clinical review (Eclipse).

## LASN Endorsement

| Role | Name | Position | Signature | Date |
|---|---|---|---|---|
| LASN Director | Russell Cooke | General Manager | Irrelevant | 18-01-21 |



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s47(3)(b)

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 (LASN Manager).

### Executive Summary:

At 7:22pm on Monday 11 January 2021, the Queensland Ambulance Service (QAS) received a request for service from Irrelevant This request was for the Irrelevant nursing home located at Irrelevant Irrelevant Burleigh Heads.

The request for service related to a Irrelevant patient who was diagnosed with chest pain and lung issues extending for a period of 3 days. The patient was seen by a doctor and the request was made to transport the patient to John Flynn Hospital. The case was coded a MATA3 – 2A response CN 13756908.

The case was placed into the pending queue as a 2A response, due to demand there was no available resources available to respond to the case. The Southport Clinical Dispatch Supervisor (CDS) reviewed the case and a number of call backs were made to the RN at the nursing home following up on patient's condition.

During Southport OPCEN call backs to the nursing home registered nurse, the patient passed away at approximately 9:23pm.

An ambulance was dispatched to the case at 9:38pm, 2hrs and 16minutes from the initial request for service.

The Southport OPCEN spoke to the nursing home RN at 9:42pm, the RN stated the patient treating doctor was willing to issue a death certificate and QAS services were not required. QAS never arrived on scene.

The Gold Coast Local Ambulance Service Network (GCLASN) had been experiencing extreme pressure from community demand, this resulted in a pending workload at the time of this case and extensive hospital delays at both GCHHS hospitals.

- 15 Pending Code 2 cases.
- 2-hour delays at Gold Coast University Hospital.
- 2-hour delays at Robina Hospital.
- 20 Off load Immediately (OLI) completed between both GCUH and GCHRB.
- Metro South LASN supported GCLASN by providing 3 x Acute resources to assist with demand.

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident CN 13756908.
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:

eARF has not been completed by the responding crew.

GCLASN SOS has requested the crew complete an eARF or send email to GCLASN SOS as there were several conversations and consults with HARU Adams and Dr Rashford which need to be documented and considered as part of this review.

## State OpCen ProQA:

Outline of report (the LASN Manager must request this from the Assistant Commissioner State Operations Centre (OpCens) as early as possible following the incident).

There are several phone calls and radio transmissions between the OPCEN, responding crew, nursing home and Dr Rashford which need to be considered as part of this review.

## Incident Review/Investigation:

**Scope:**

The review considered the QAS resource and response.

The response was coded as a MATA 3 (Code 2A) based on available nformat n supplied by the registered nurse at the nursing home. Numerous call backs were com leted by CD and ca aker due to GCLASN demand, some of these call backs were unanswered by the N mess e left with rsing home to contact if anything changes.

***Resource allocation:***

- B 601318 was dispatched from Bigga Wa

***Other available resources***

- A 606692 was avai d not re on ed, close resource according to CAD recommend. Unit was located Burleig Heads S on (two b cks from scene); consideration could have been given fo nitial asses ent consid ngth of time in pending queue.

***Workload***

The Gold Coast Local Amb n Service Network (GCLASN) at the time of the incident was experiencing both and increased mand for service as well as delays at both Gold Coast Hospitals, both facilities were on level 3 escalations bed blocking of a mixture of COVID and medical patients. There was active assess ent of OLI suitable patie at both facilities during this time.

There w re 15 P ding Code 2 cases, 2-hour delays at Gold Coast University Hospital (Level 3 escalation), 2-hour elays at Ro a Hospital (Level 3 escalation), 20 Off load Immediately (OLI) completed between both GCU and GCHRB. M ro South LASN supported GCLASN by providing 3 x Acute resources to assist with in sing demand.

***OPCEN itiated Call back***

A review of Incident Detail Report (IDR) revealed a total of 4 call backs, initial call to first call back 38mins, first call back t econd call back 1hr 3mins. Call from RN at nursing home patient deceased at 09:23pm. A further 2 call bac were one by CDS to obtain further information from RN regarding patient history.

***Background:***

ld Coast LASN has been experiencing extreme workload throughout the day and into the evening, infrequent surges into hospitals resulted in building delays which load share was managed appropriately by the GCLASN PACH.

The Metro South LASN had been assisting the GCLASN throughout the day and evening with resources to assist to meet increasing community demand.

The GCLASN OS and SOS were located at both hospitals initiating OLI to reduce delays at hospital and attempt to returning vehicles to service in a timely manner.

- Timeline: a clear timeline of events of the OIRR from receipt of the Triple Zero (000) call;

  07:22pm – ***request for service*** received Brisbane OPCEN.
  07:23pm – ***CASE NOTE*** – *Dx chest pain and lung issue – Destination John Flynn Hospital.*
  07:24pm – ***CASE NOTE –*** *Patient* Irrelevant *female.*
  07:25pm – **CASE NOTE** – *Patient located in F Wing.*
  08:00pm – **CASE NOTE** – *CDS Call back – Caller attempts to transfer call to RN on multiple ccasions – caller will pass message t RN regarding delays and to call b ck with an changes to patient condition.*
  09:03hrs – **CASE NOTE** – *EMD call back to nursing home, nil changes with patient condit advised further delays and may still be some time be we get there and to call back 000 if anything at all changes with atient ndition require EMD to conduct call back)*
  09:23pm – ***2nd request for service*** received by nursing home advised pati t dece sed, S services not required.
  09:24pm – ***CASE NOTE*** – *As per JU RN on scene 55070800.*
  09:34pm – ***CASE NOTE*** – *CDS call back to RN – Patient has d ong g che pai and SOB on excretion for 3/7 on a background IHD an ther cardiac concerns, GP assessed patient this a ernoon an hen r ueste RN to contact QAS for referral to cardiologist a categor 3 w s the req ested coding – patient* Irrelevant *passed away peacefully – nil resuscitation s attem d b anyone on scene – QAS required for ROLE form and RN I speak to Dr about issuing Dr Certificate – SOS notified.*
  09:38pm – **B 601318 Dispatched**.
  09:42pm – ***CASE NOTE*** - *CDS spoke to R - Dr ha been ontacted will issue death certificate – QAS advi ed Rn will tend o issue OLE form and will leave patient in care of ursin ome an mily to ar nge undertaker.*
  09:44pm – **B 601318 re ponding.**
  10:13pm – **B 601318 ase comple d.**
  10:13pm – ***CASE N TE*** - *CDS in ally requested crew to attend due to patient being in care, to assist fam n s to leave role form with nursing home as per CPG – c w contacted consult line regarding case and medical director advised DS ROLE form not required – CDS call to RN to confirm they are happy t manage process with family and death certificate and that QAS not req d.*

- view: a mprehensive investigation of the OIRR, including findings as to why the incident had occurred, ou mes of the OIRR, and what actions are recommended to ensure that the incident does not reocc

- utcomes: describe tcomes and impacts of the OIRR;

- Post O R actions: detail any actions taken at the LASN level since the OIRR occurred (including but not lim d to Priority One access and post incident debrief).

## Review Recommendations:



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1. Based on content contained in both radio transmissions and phone recordings between OPCEN and responding crew B 601318, further review is required to determine if there is a breach of the code of conduct.
2. Discussion by OIC required with responding crew. The crew need to follow the appropriate process with the use of the consult line, the contact with the HARU on personal mobile was not appropriate. (LASN Directive 06-12).

## Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Briefing notes identifying operational issues;
- Consultation with State OpCen Assistant Commissioner (for "State ProQA Special Review" if relevant);
- Briefing notes identifying pertinent incident information;
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- 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;
- 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;
- Workforce planning reports; and
- Any reports or documents received from the Queensland Police Service (QPrime Number).

## 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 |
|---|---|---|---|---|
| | | General Manager | | |
| | | | | |

# 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 13757905 at Irrelevant LARAVALE, QLD 4285 at 04:46hrs on 12 January 2021, where it was reported that a motorcycle rider is reported deceased. Persons finding patient not related to the incident and not willing to commence CPR. On QAS arrival patient declared deceased, with significant down time to be noted. Details handed over to QPS. OS followed up with crew remotely.

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13757905. 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:
- N/A – Patient deceased on QAS arrival.

## State OpCen ProQA:
- N/A – Call received and coded as 1A with appropriate dispatch of resources.

## 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: | 04:46hrs |
| Dispatched: | 04:47hrs |
| On Case: | 04:47hrs |
| On Scene: | 04:58hrs |
| Cleared: | 05:51hrs |

**Review:**
- 1 x Bravo Crew / 1 x CCP attached to incident with Bravo Crew attending scene.
- Response time was 11mins.
- Nil clinical concerns with patient declared deceased on arrival.
- Nil operational concerns with case noted.

**Outcomes:**

- 1 x patient deceased on QAS arrival.
- Peer Support activated through the Operations Centre.

**Post OIRR actions:**

Nil.

## Review Recommendations:

Nil.

## Appendix of relevant documents/files:

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

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Gerard Lawler | Assistant Commissioner | Irrelevant | 15.01.21 |
| Anthony Hose | Director Operations | | 12/01/2021 |

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# 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 13792060) on 20 January 2021, at Irrelevant Everton Park for a Irrelevant female patient complaining of abdominal pain, with vomiting and dizziness.

Brisbane Operations Centre, Deployment Supervisor advised the Metro North Senior Operations Supervisor (SOS) that the case was in the pending queue for approximately 60 minutes.

On arrival, the Queensland Ambulance Service (QAS) crew found the patient deceased.

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13792060.
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:
Not required

## State OpCen ProQA:

Four Critical deviations were detected.

1. 2 x Case Entry questions not asked (Conscious and Breathing questions incorrectly assumed)
2. 1 x Final Coding incorrect.
3. 1 x Did not follow appropriate DLS Links (Delivered without evidence of using the ProQA links)

No Major deviations were detected.

Four Moderate deviations were detected.

1. 3 x Case Entry Question recorded incorrectly
2. 1 x Level 2 diagnostic not utilised

The reviewers were unable to find any outgoing calls from a CDS, nor any notes indicating CDS or Clinical HUB contact.

Call cycle times:

Timings;

| | |
|---|---|
| Call received to IWIQ | 3min 37sec |
| IWIQ to Unit Assigned | 43min 48sec |
| Call received to On Scene | 59min 37sec |

## Incident Review/Investigation:



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## Scope

- Metro North LASN reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved.
- Metro North LASN will identify any operational or clinical performance issues with this case and ensure appropriate actions are taken to return performance to the required standards.

## Background

- Patient called for QAS assistance at 12:11pm for abdominal pain and feeling dizzy.
- At 12:18pm the Emergency Medical Dispatcher had unsuccessfully tried to call the patient back as the line was engaged. This was due to the patient's sister calling the patient.
- At 12:38pm a duplicate call was made by the patient's sister and she was advised of delays by the call taker.
- A dispatch plan was entered at 12:43pm and again at 12:45pm before a QAS unit was dispatched to the case at 12:59pm.
- Another duplicate call was made at 12:59pm by the patient's sister who was unable to contact the patient. The patient's sister stated she was talking to her sister when she "groaned in pain" and dropped the phone.
- The QAS crew advised they were in partial status at the Royal Brisbane Hospital for around 10-15minutes prior to being attached to this case.
- Metro North SOS attended the scene and spoke directly with the patient's sister and asked her if she had any concerns and questions about how the QAS handled her sisters' case to which she replied she was very thankful and commended the crew on doing a fantastic job.

## Timeline

| | |
|---|---|
| **1st Key Stroke:** | 12:11pm |
| **In waiting queue:** | 12:15pm |
| **Assigned:** | 12:59pm |
| **EnRoute:** | 12:59pm |
| **At scene:** | 1:11pm |

## Review

- First Bravo unit on scene 60 minutes after call.
- The review found the initial coding of 2BL was incorrect the review indicated that a 1C response was required.

## Outcomes

- The patient was declared deceased at the scene and left with the Queensland Police Service.

## Post review actions

- Metro North SOS had a debrief with the crew and offered peer support and priority one services.

## Review Recommendations:

- OIC to do a welfare follow up with QAS officers involved.

## 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

- Any reports or documents received from the Queensland Police Service (QPrime Number).

## 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 | 27/01/2021 |
| Mel Bernas | A/Director Operations | | 27/01/2021 |

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 13793571 at Irrelevant Crestmead QLD 4132 at 19:09hrs on 20 January 2021, where it was reported a motorcyclist collided with a semi-trailer. The motorcycle rider was treated at the scene by QAS, however despite these efforts died at the scene. The truck driver was uninjured but was transported to Logan Hospital for ongoing emotional care.

**Terms of Reference:**
This review will investigate all aspects of ambulance response to incident 13793571. 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:**
- Reviewed by MS CEU with nil concerns identified.

**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: | 19:09hrs |
| Dispatched: | 19:10hrs |
| On Case: | 19:10hrs |
| On Scene: | 19:15hrs |
| Cleared: | 19:56hrs |

**Review:**
- 2 x Bravo Crews / CCP / HARU / SOS attended scene.
- Response time was 6mins.
- Nil clinical concerns with case.
- Nil operational concerns with case.
- Priority One was activated by SOC as per usual practice.
- Adequate welfare cares provided to all QAS Officers involved.

- On-going welfare managed by the OIC of the Officers involved.

**Outcomes:**

- Motorcycle rider deceased at scene.
- Truck driver taken to hospital for emotional support.

**Post OIRR actions:**

Nil.

## 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 | 04.02.21 |
| Anthony Hose | Director Operations | | 01/02/2021 |

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# Significant Incident Review Template Version 1.0 July 2020

## State Operations Centres Local Ambulance Service Network

### Authority:

By authority of the Assistant Commissioner, State Operations Centres Matthew Green (LASN Manager).

### Executive Summary:

Rockhampton Operations Centre presented with a Triple Zero call on the afternoon of Saturday 23rd January 2021 at 16:09:42hrs (#1384825). The informant at this private residence Irrelevant Oxenford Qld) reporting a Irrelevantmale, lying on the couch – not responding. The incident presented for dispatch 1min40secs, with an ambulance from Taroom station dispatched 16secs later. It was identified 6mins13sec following dispatch the incident address was incorrectly geo-verified by the EMD Call Taker. Incident then correctly geo-verified resulting in Southport units dispatched to scene, **resulting in a 9 minute delay** with the arriving at the correct address 15mins after incident first presenting for dispatch. Following extensive treatment at the scene the patient was declared life extinct at 17:10:53hrs. EMD Call Taker remained on call with informant providing CPR instructions until QAS unit arrived on scene.

### Terms of Reference:

This review will investigate Operations Centre aspects of ambulance response to incident 13804825. 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 LASN Clinical review of eARF 503094877 was undertaken by Senior Clinical Educator (SCE) Janeese Kenyon. Noting comments patient found in VF on QAS arrival. Resuscitation continued for approximately 40mins with consultation with QAS consult line occurring.

The clinical summation provided:

*"Nil clinical concerns identified, all resuscitative measures adhered to as per QAS practice and policy and documentation reflects same"*

### State OpCen ProQA:

State Quality Assurance Outline unit requested for incident to be reviewed by State Executive Manager Operations David Sell.



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## Incident Review/Investigation:

- **Scope:**

To investigate and collate information surrounding a Geo-verification error following a Triple Zero (000) emergency call request for QAS service. The review considered the call taking component of the ambulance response to this incident.

- **Background:** a comprehensive background to the OIRR;
  - On Saturday 23 January 2021 at 16:09:42hrs Rockhampton Operations Centre rec ed a Triple Zero call requesting assistance. Irrelevant male, lying on the couch – no responding or breathing
  - Incident 13804825 - 1A, 09E01
  - Correct address:
    - Irrelevant Oxenford QLD
  - Incident incorrectly geoverified to address:
    - Irrelevant
  - OpCen Staff
    - Call Taker - Irrelevant
    - OpCen Supervisor - OCS Ed Moorhouse

- **Timeline:**
  - 16:09:42 Triple Zero call received a ockhamp n O erations entre
  - 16:11:22 Incident presented in queue dispatc
  - 16:11:38 Taroom unit B3186 assigned in dent
  - 16:13:20 1st unit enroute to scene – Irrelevan
  - 16:15:27 1st unit advises "having i ith GPS nal"; EMD call taker reviews address
  - 16:17:58 1st unit arrived on s ne
  - 16:18:26 1st unit advises "larg dog at g , occupant informed officer not to enter gate"
  - 16:18:36 EMD Call Taker cor ts th cident dress
  - 16:18:50 EMD ker advi d patcher in orrect address – in Oxenford not Taroom
  - 16:20:33 S uthport it's B60 01 & A60 515 dispatched to incident
  - 16:20:47 Unit B60130 enroute
  - 16:22:48 Unit A6065 enroute
  - 16:26:22 Unit B601 1 o scene
  - 16:29:20 Sitrep ided fr 01 "CPR in progress, 1 shock delivered"
  - 16:34:06 nit 06515 on scene
  - 17:10:53 S p provided from B601593 "signal 4 QPS required"

- **Review:**
  - MD Call Taker error on l Geo-verification processes

- **Outcomes:**
  - Call w eviewed by the Duty OCS and identified issues with the call taking Geo-verification processin f the Triple Zero call.
  - Informant w the patient's wife, language barrier.
  - Informant left scene to seek assistance from neighbours; upon returning to scene commencing CPR
  - The OCS has discussed the incident with EMD Irrelevant who was apologetic and upset with actions. EMD identified that when geo-verification occurred with the incident, she misread the locality of Irrelevant Taroona CCT.
  - EMD Irrelevant expressed her intention to ensure all further calls are geo-verified correctly and upset her actions have caused this delayed response – see review recommendations below.
  - The Gold Coast LASN Senior Operations Supervisor was notified and attended the scene. Apology provided to the family on the delayed response. Family was very grateful of efforts made by QAS.



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- Post OIRR actions:
  - Peer Support notification for EMD follow up
  - EMD Irrelevant meeting with OCM Lea Kettle (27th January 2021), welfare check and verbal debrief of incident.

## Review Recommendations:

- EMD Irrelevant to complete refresher training on geo-verification processes with PDO Narelle Smith
- EMD Irrelevant to be placed on a Supportive Learning Plan (SLP)

## Appendix of relevant documents/files:

- Dot-Point-Brief from Duty OCS
- Email from Duty OpCen SOS to executive managers, including timeline
- Email from OpCen EMO requesting Review be undertaken on incident
- Special Review by State QA Unit of Initial Call with geo-error
- Local level clinical review (Eclipse) by Gold Coast LASN
- Relevant audio (wav) files attached

## 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 |
|---|---|---|---|---|
| | | General Manager | | |
| | | | | |


Dot Point Bec Busby - Geo Error.d


Geo-verification error Rockhampton


FW_ Geo-verification erro


FW_ Special review OXENFORD.msg


QAS GOL CEU Clinical Review 13801A


RE_ GEO Error on a case 13804825.ms


210123_SR16620263_13804825_OXENFO

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 13806734 at Irrelevant Inala QLD 4077 at 03:02hrs on 24 nuary 202 to a Irrelevantfemale not responding with a history of cerebral palsy. CPR in progr ior to QAS arriv l. On QAS assessment, pt in arrest with signs of rigor mortis. Patient declared decea ed afte nitial resuscitation attempt. QPS attended scene.

### Terms of Reference:
This review will investigate all aspects of ambulance response to incid nt 1380 734. re ew will examine ambulance operations prior to, during and following the resp nse.
This review will include all requirements outlined in the *Op rational I iden Review Process*.

### LASN Clinical Incident Summary Report:
- Case reviewed by MS CEU.
- Nil clinical issues noted.

### State OpCen ProQA:
- N/A

### Incident Review/Investig tion:
**Scope:**
Metro South reviewed the respo e, clin al perfo and operational decision making to ensure the appropriate response and manage e of this case was achieved. It is intended that any operational or clinical performance issues identified ith this case are addressed to ensure lessons are learnt to improve future responses

**Background:**
- Nil urther to a

**Time n**

| | |
|---|---|
| Re eived: | 03:02hrs |
| Dispatched: | 03:03hrs |
| On Case: | :03hrs |
| n Scene: | 03 4hrs |
| C ared: | 04:3 hrs |

**Revi**
- 2 X ACP units, 1 X CCP, OS attended scene.
- Response time for first unit on scene was 12mins.

**utcomes:**
- Nil operational concerns with case.
- Nil clinical concerns with case.

- Peer Support activated through OpCen.
- Debrief occurred on scene with OS.

**Post OIRR actions:**

- Nil.

## Review Recommendations:

- Nil.

## Appendix of relevant documents/files:

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

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Gerard Lawler | Assistant Commissioner | | |
| Anthony Hose | Director Operations | Irrelevant | 01/02/2021 |

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 Acting Director of Operations, Gold Coast Local Network service network

### Executive Summary:

**IDR 13817112** - Gold Coast LASN responded to an incident, address given as Irrelevant Irrelevant Southport. The call was received 26th January 2021 at 18:56hrs via ICEMS for a Irrelevant female threatening suicide.

Subsequent to the initial incident, duplicate calls for service were received from members of the public reporting Irrelevant ady had fallen from an apartment balcony. The two incidents were confirmed to be relating to the same patient, a Irrelevant who resided on the Irrelevant floor. This case was initially coded 2A 25B03 however was upgraded to a 1A Determinant 25D06 in response to the duplicate calls and additional information.

An ambulance was dispatched to the address at 19:04hrs including a Critical care paramedic, the High Acuity Response Unit and the Operational Supervisor. The patient was confirmed to be in traumatic arrest and after resuscitation attempts was declared signal 4.

There was no delay in responding to this case with a time of call to time on scene being 15 mins and 7 minutes from time of CDS review and upgrade of incident to 1A.

It was later identified QAS had previously attended this patient on the 21st January 2021 (IDR 13796521) and she was assessed by the QAS Mental Health co-responder.

**IDR 13796521–** At 13:54hrs on the 21st January 2021 Gold Coast LASN received a request to conduct a welfare check on a Irrelevant who had failed to attend work and was unable to be contacted. QAS responded to the incident address given as Irrelevant Southport. The first responding QAS crew reported the patient was stable, denied suicidal ideation but was showing signs of depression. The QAS Mental Health co-responder subsequently attended scene and remained on site between arrival at 15:11hrs to delayed available at 16:37hrs being 1hr 26mins during which time a patient action plan was developed.

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident 13796521 and 13817112. 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.*



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## LASN Clinical Incident Summary Report:

### Brief Case overview:

Irrelevant attended by ACP crew – requested LARU / MH Co Responder for MH issues.

Pt attended by Officer Stewart and MH CR – Pt left in own care with MH referral and discharge advice provided.

Thorough medical and MH assessment by QAS and MH CR provider.

Complete documentation provided by both.

Subsequently patient committed suicide a few days later Incident 13817112

### Case review:

This case was noted because of the suicide by the patient post initial ntact. O e note LARU officer and MH CR escalated through channels. Documentation was appr priate a d relevant to the discharge decision. Appropriate referral provided and expertise in thi rea delive d by he MH R. QAS delivered care appears within standard scope of practice and within guidelin / SOP xpected re delivery.

### Outcome Summary and Recommendations:

For review by Director MH QAS – this has occurred hrough andard escalation to QAS MD.

Support for providers to provide feedb on skills d a ions pro ded should be actioned.

## State OpCen ProQA:

Outline of report (the LASN Man e ust request this from the Assistant Commissioner State Operations Centre (OpCens) as early as poss following the incident).

The t separate inc nts need to be considered during the audit process, the first being IDR 13796521 a me al health assessm on the 21st January 2021 which all the patient notes will be logged with Gold a ospital mental hea Co-responder.

The sec being IDR 13817112 on the 26th January 2021 whereby after threatening suicide the patient fell from the ba ny of her Irrelevant floor apartment resulting in the patient suffering a traumatic cardiac arrest and subsequently ng declared signal 4 on scene.

## Incident Review/Investigation:

**Scope:**

- Gold Coast reviewed the response, case 13817112 was initially coded 2A – 25B03 as per available data for attempting /threatening suicide before CDS review and upgrade to 1A 25D06 as per available data for suicide jumped now. This was correctly coded.

- Gold Coast reviewed the response, case 13796521 was correctly coded as a 2A determinant 32B03 / UNK STAT UNKN PROB. A Mental Health Co-responder was attached and carri out an assessment on site and put in place an action plan, this action plan will need to be revi wed via Dr Rashford's office.

**Case 13817112 – 2A – 26th January 2021**

**Background:**

- ICEMS incident 70-year-old female threatening suicide.
- **Case upgraded to 1A** Patient witnessed to fall from balcony
- Patient located ground level on pathway.
- Patient assessed by QAS to be in traumatic cardiac ar st.
- Resuscitation attempts on scene.
- Patient declared deceased on scene.

- **Timeline:**
  - 1st key stroke: 18:56
  - In waiting queue: 18:58
  - Upgraded to 1A: 19:04
  - Assigned 1st unit: 19:04
  - Enroute 1st unit: 05
  - At scene 1st Un 19
  - Deceased: 19

- 18:56:15 Patie calls QPS states she wants to go Irrelevantfloors below (Not happy with her life)
- 18:58:15 Incid priority change from ICEMS to 2A due to patient's condition. (Threatening suicide)
- 18 8:15 Incident in pending queue
- 18:58: Nil answer on QAS call back to patient.
- 19:01:08 From QPS Irrelevant QAS attended 21/1/21
- 19:02:52 Duplicate call appended to incident
- 9:02:53 17B02 Irrelevantfallen from building
- 19:03:06 CDS review of incident priority
- 19:03:22 Dispatch page sent to 601586
- 19:03:35 QPS enroute
- 19:04:06 Incident priority change from 2A to 1A due to patient's condition.
- 19:04:42 Dispatch page sent to 601558



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- 19:05:16 Dispatch page sent to 606853
- 19:05:29 Dispatch page sent to 607843
- 19:08:23 ICEMS response > POL-Q on scene
- 19:10:18 Sit rep from 601558 patient is in traumatic arrest keep HARU coming.
- 19:28:40 Sit rep from 607843 Patient signal 4 QPS on scene.

- **Review:**
  - Alpha unit on scene 7 minutes after case upgraded to 1A
  - HARU, Bravo unit and OS dispatched
  - Acting SOS aware of incident

- **Outcomes:**
  - The patient was declared deceased at the scene and left with police for ensic investigation

- **Post OIRR actions**:
  - Peer Support to contact QAS officers

**Case 13796521 – 2A – 21st January 2021**

- **Background:**
  - QAS called for servi Irrele nt male we re check. Patient had not presented for work and was un le to be ontacte History of Mental health and ETOH abuse.
  - QAS response ACP crew; H Co-resp d
  - Co-respond attended the atient completing an extensive on-site assessment and an action plan as put in pl

- **Timeline:**
  - 1st key stroke: 13:54:26
  - In waiting queue: 13:57:02
  - Assigned 1st unit: :58:11
  - route 1st unit: 13:58:19
  - At ne 1st Unit: 14:19:28
  - Delay available: 15:38:21

  - Assigned M Co-responder 14:48:43
  - Enroute MH o-responder 14:48:47
  - At scene MH Co-responder 15:11:45
  - Delayed Available 16:37:54

  - 13:54:26 Call from work colleague requesting welfare check for Irrelevant Irrelevant Patient not presented to work, unable to be contacted. Caller spoke to patient's son who reported patient is very depressed.
  - 14:45:20 Sit rep from 601306 patient stable, denies suicidal ideation but is showing signs of depression.
  - 16:26:33 From 608568 (MH Co-responder) Pt left at home with referral to GP for Mental Health Plan.

- **Review:**
  - LARU Co-responder model attached to this case
- **Outcomes:**
  - The patient was left at the address with an appointment made for GP on 22/2/21 with plan for psychologist appointment.

## Review Recommendations:

- Gold Coast Mental Health Co-responder will be conducting their own review of the incident.
- Peer support for Co-responder and LARU officer involved

## Appendix of relevant documents/files:

- Incident detail report (IDR)
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- 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);

## 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 |
|---|---|---|---|---|
| | | General Manager | | |
| | | | | |

# Significant Incident Review Template Version 1.0 July 2020

## Gold Coast Local Ambulance Service Network

### Authority:

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

### Executive Summary:

At 17:09 on Friday 28 January 2021, The Queensland Ambulance Service (QAS) eceive a quest for attendance Case #13825748 at Irrelevant Jpper Coomera QLD 4209. The reque was elate a Irrelevant old male complaining of chest pain. The case was coded as a 10D04 – Code 1C resp nse.

An ambulance was dispatched at 17:12:01 but was cancelled at 17:12 6 with e can l ti n reason of "App Changed". Another ambulance with a single paramedic was dis atched 17:13:30 and an ambulance with two paramedics was dispatched at 17:14:32. The am lance wa a si gle par medic was cancelled off case with the cancelation reason of "Vehicle Change".

The Southport Operations Centre received a duplicate call from t addre 7:32:03 stating that the patient was now unconscious, not breathing and CPR wa in progr No call backs had been conducted prior to this duplicate call.

The case was upgraded to a 09D01 – 1A response A Lo l-are Assessment and Referral Unit (LARU) and Critical Care Paramedic (CCP) w patche o ase to a st. The Acting Senior Operations Supervisor (A/SOS) was made aw e of cas and wa urther at ached to case.

On QAS arrival, cardiac arrest as confirme by crew and return of spontaneous circulation (ROSC) was achieved shortly after. A High uity Resp it (HARU) was also requested by CCP on scene to assist. They were delayed on scene wh an RSI was compl ted before departing code 1 to GCUH with CCP and HARU on board.

A/SOS spoke to the family on scene du g the case and reassured family about QAS response and treatment patient s getting. Family wer appy and appreciative towards QAS throughout.

The Gold C ast Local mbulance Service Network (GCLASN) had been experiencing extreme pressure from community demand is resulted in a pending workload at the time of this case and extensive hospital delay both GCHHS hosp als.

- 8 P ding Cases.
- 2-hour lays at Gold Coast University Hospital with 96 QAS presentations until time of case.
- Minimal d ys at Robina Hospital with 43 QAS presentation until time of case.
- 4 Off load Im ediately (OLI) completed at GCUH prior to incident.

### T ms of Reference:

This rev ll investigate all aspects of ambulance response to incident 13825748. 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:


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The Clinical Review noted a well-managed and documented case, no further action required.

## OpCen Review:

Between 1700 – 1740, the Gold Coast Dispatcher received 10 code one incidents plus 2A incidents. The dispatcher was common calling for units for several incidents. There were radio transmission every 3-4 seconds cuffing this period.

17:09 Call received for Irrelevant male with chest pain. The caller was a first party caller stating he h d serious chest pains and is having problems. The call-taker appropriately coded the incident.
17:10 Case in queue.
17:11 The dispatcher 'common called' over the radio for any units for the code one in Labra or
17:11 The call-taker disconnect the call
17:12 Unit 601536 dispatched then removed – the officer advised their partner was still com g paperwork, the dispatcher stated to the crew that they had not responded to previous gers (re their statu at hospital)
17:13 The dispatcher 'common called' over the radio for any units for the code ne in U p Coomera
17:13 Unit 601562 single officer dispatched. The dispatcher advised they were he on reso e and she was searching for back up.
17:14 Unit 601588 advised they were available and dispatched, from Pi d ra Hosp al
17:15 Unit 601588 En route.
17:15 Unit 601562 was diverted to a code 1C in Labrador as the c sest un .
17:31 Second Call
17:32 Priority change from a 1C to a 1A.
17:32 Notify "CPR IN PROGRESS"
17:32 Recommend used 606515 closest Alpha dispatched.
17:33 Unit 606515 responding from Southport statio
17:34 Unit 601588 On Scene.
17:36 Unit 601588 SITREP- CPR in progress.
17:40 Unit 605563 On Scene
17:41 607852 (SOS) Dispatched nd En te.
17:43 605563 SITREP- HAVE OSC
17:46 Alpha unit 606515 on cene- reque HARU code 1
17:47 HARU 606853 Dispa ed
17:47 606853 En Route
17:47 Laru UNIT 606853 dispatc
17:47 Unit 606853 en route from Pa fic HWY and Kip Mcgrath drive
17:53 Unit 607 52 On Scene.
18:02 607852 S REP GCS 3 Ventilated oading.
18:08 Uni 06853 n Scene.
18:17 6 7852 Delay h RSI
18:40 nit 601588 Transp ting Hot with CCP and HARU on board.
18:5 it 601588 arrived stination GCUH.

## Incident Rev w/Investigation:

S pe:

G d Coast LASN reviewed the response and resourcing of QAS to this case to ensure appropriate service l

Background:

- Irrelevant male with primary complaint of severe chest pain.

- Initial crew dispatched 3min after call being received, however cancelled off case 30 seconds after. Crew had not hit responding and no reasons were noted on IDR
- Single Officer Paramedic dispatched from Olsen Ave, Southport 1 minute later
- 1 minute later, 2 officer ambulance dispatched from Pindara Hospital, Benowa. Single Officer paramedic cancelled off case
- Duplicate call received 23 minutes after initial call – CPR in progress
- CCP and LARU unit attached to assist. A/SOS advised of case and attached to respond.
- First unit arrived 25 minutes after initial call, 2 minutes after duplicate call.
- ROSC obtained with CCP on scene requesting HARU code 1.
- Delays on scene with extrication and difficult RSI completed by HARU
- Departed Code 1 to Gold Coast University Hospital with CCP and HARU on board ambulance. CCP vehicle driven up behind by QAS officer with wife escort. HARU vehicle driv n up behi by University Student. LARU unit clear from scene
- Follow Up: Patient taken to Cath Lab with LAD stent placed. Patient since aspirated and currently in ICU at GCUH

Timeline:

- Phone Pickup 28/01/2021 17:09:01
- 1st Key Stroke 28/01/2021 17:09:01
- In Waiting Queue 28/01/2021 17:10:09
- Call Taking Complete 28/01/2021 17:11:58
- 1st Unit Assigned 28/01/2021 17:12:01
- 1st Unit Enroute 28/01/2021 17:14:50
- 1st Unit Arrived 28/01/2021 17:34:14
- Closed 28/01/2021 21:18:15

Elapsed times:

- Received to In Queue 00:0 08
- Call Taking 00:02:57
- In Queue to 1st Assig 00:01:52
- Call Received to 1st A ign 00:03
- Assigned to 1st Enroute 02 9
- Enroute to 1st Arrived 00:19
- Incident Duration 04:09:14

| Date | Time | ser | Type | Comments |
|---|---|---|---|---|
| 28/01/ 21 | 17:10:09 | 6L KHAR | Response | [ProQA Dispatch] Dispatch Level: 10D04 (Clammy or cold sweats) Response Text: 1C Irrelevant Irrelevant Male, Conscious, Breathing. Problem Description: SERIOUS CHEST PAIN Irrelevant |
| 28/01/2021 | 17:12 2 | PS | Response | [Page] Dispatch page sent to Unit:601536, Sent From: KEDCADQASPIS01 |
| 2 01/2021 | 17:12:03 | 601536 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2 | 7:13:30 | PS | Response | [Page] Dispatch page sent to Unit:601562, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:13:31 | 601562 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |



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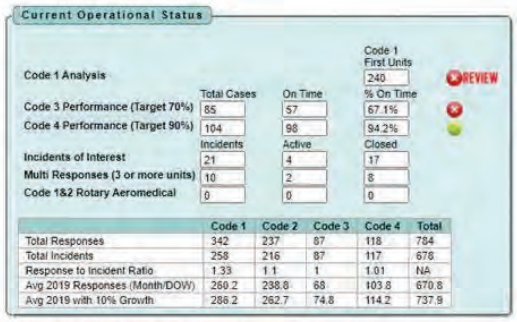
| | | | | |
|---|---|---|---|---|
| 28/01/2021 | 17:13:43 | PS | Response | [Page] Dispatch page to Unit:601562 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:14:33 | PS | Response | [Page] Dispatch page sent to Unit:601588, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:14:34 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:03 | 6RACDEV | Response | Duplicate call appended to incident at 17:32:0 |
| 28/01/2021 | 17:32:20 | 6RACDEV | Response | [ProQA Reconfigure] Reconfigure Level: 09D0 (INEFFECTIVE BREATHING) Resp nse Text: Irrelevant Male, Not Consci us, Not Breathing. |
| 28/01/2021 | 17:32:20 | 6RACDEV | Response | [ProQA: Key Questions] 13. Arrested during interrogation – reconfigu Protocol 9 14 defibrillator (AED) is n availa |
| 28/01/2021 | 17:32:35 | 6RACDEV | Response | [Notification] [QAS]-C R in p gre |
| 28/01/2021 | 17:32:56 | PS | Response | [Page] Dispatch page sent o Unit:606515, Sent From: KEDCADQASPIS0 |
| 28/01/2021 | 17:34:42 | PS | Response | [Page] Dis atch pa to Uni 5563 complete to Irrelevant Message sent uccessfu y. |
| 28/01/2021 | 17:36:03 | 6NICBIZ | Response | 60 88 CP N PROGRESS |
| 28/01/2021 | 17:36:05 | 6RACDEV | Response | [Priva SOC DI CONNECTED - QAS ON SCENE |
| 28/01/2021 | 17:41:04 | PS | Response | [P ge] Disp h page sent to Unit:607852, Sent rom: KEDCADQASPIS01 |
| 28/01/2021 | 17:43:07 | 6NICBIZ | nse | 60556 HAVE ROSC |
| 28/01/2021 | 17:47:35 | PS | Respo e | [Pa ] Dispatch page sent to Unit:606853, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:48:05 | 6NICB Z | Res | 606515 HARU CODE 1 |
| 28/01/2021 | 18:02:23 | 6JASJON | R sponse | 607852 PT GCS3 VENTILLATED AND LOADING TO STR AND NOW TO VEH |
| 28/01/2021 | 18:17:51 | 6JASJON | R ponse | 607852 DELAY ON SCENE WITH RSI |
| 28/01/2021 | 18:4 7 | 6JASJON | Resp nse | 601588 DEPT CODE 1 GCUH AND BOTH CCP AND HARU ON BOARD AND BOTH CARS FOLLOWING BEHIND |
| 28/01/2 1 | 18:42:38 | 6C AMUN | Response | 607852 CREW TX HOT - CCP & HARU ON BOARD - 853 DRIVIEN BY STUDENT - 515 DRIVEN BY OTHER OFFICER - NIL QAS VEH LEFT ON SCENE |
| 28/01/2021 | 20:3 35 | 6JASJON | Response | 601588 RESTOCK AND CCP STILL DOING PAPERWORK |

R ew:

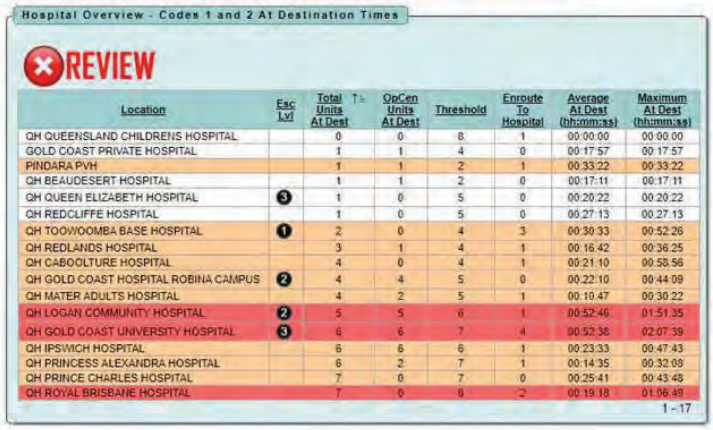
The community demand in the GCLASN was high, the GCLASN was on extreme escalation with ex sive delays at Gold Coast University Hospital. South East Queensland was escalated to moderate pressure.

- **Dispatching of resources**: - Initial crew was dispatched to job and has received case on MDT as evident in IDR. No notes were recorded in IDR about why crew were taken off case. A Single Officer was dispatched to incident as closest next available unit however was taken off case when a fully staffed ambulance became available despite being closer to incident. Patient deteriorated into

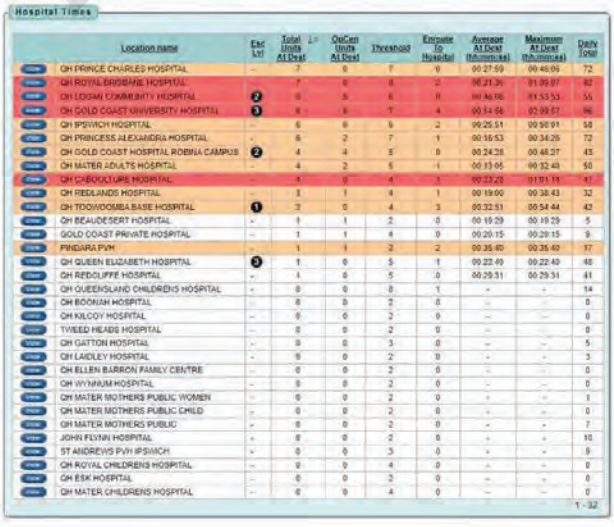
cardiac arrest just prior to QAS arrival and having a Single officer on scene earlier may have prevented this



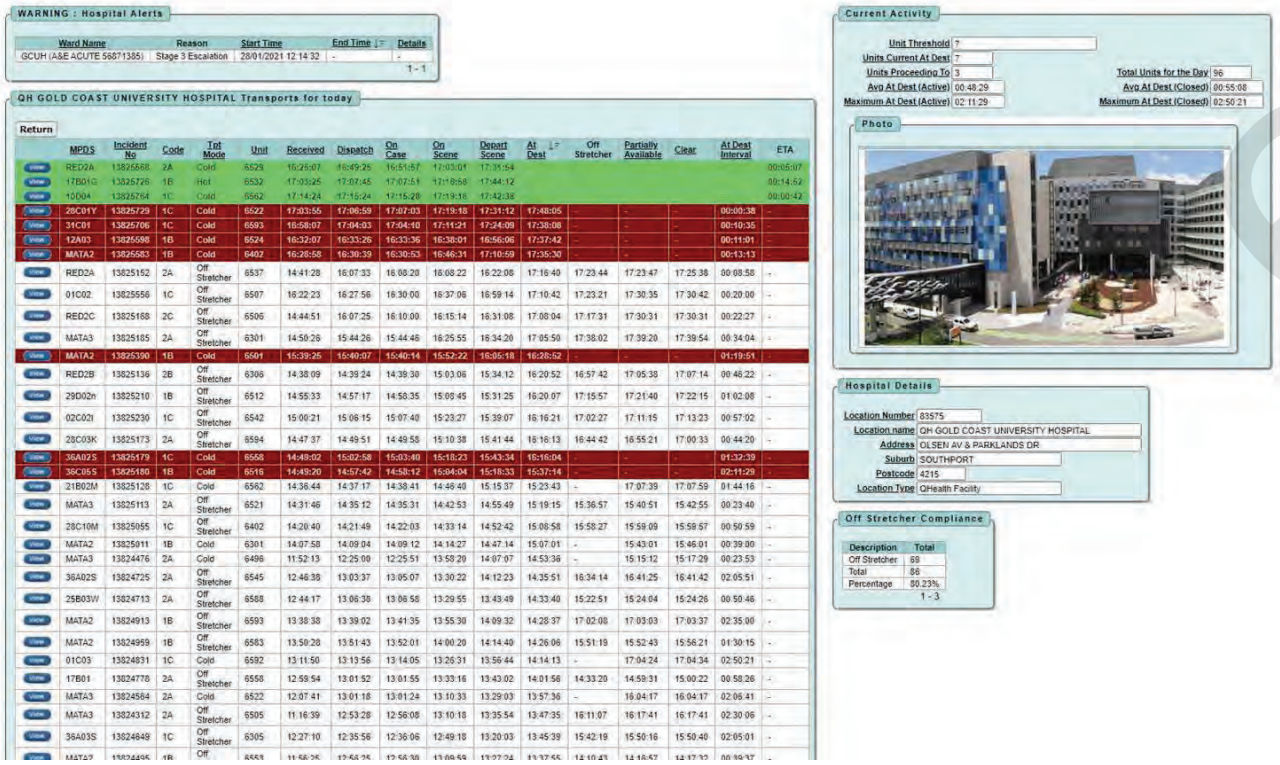


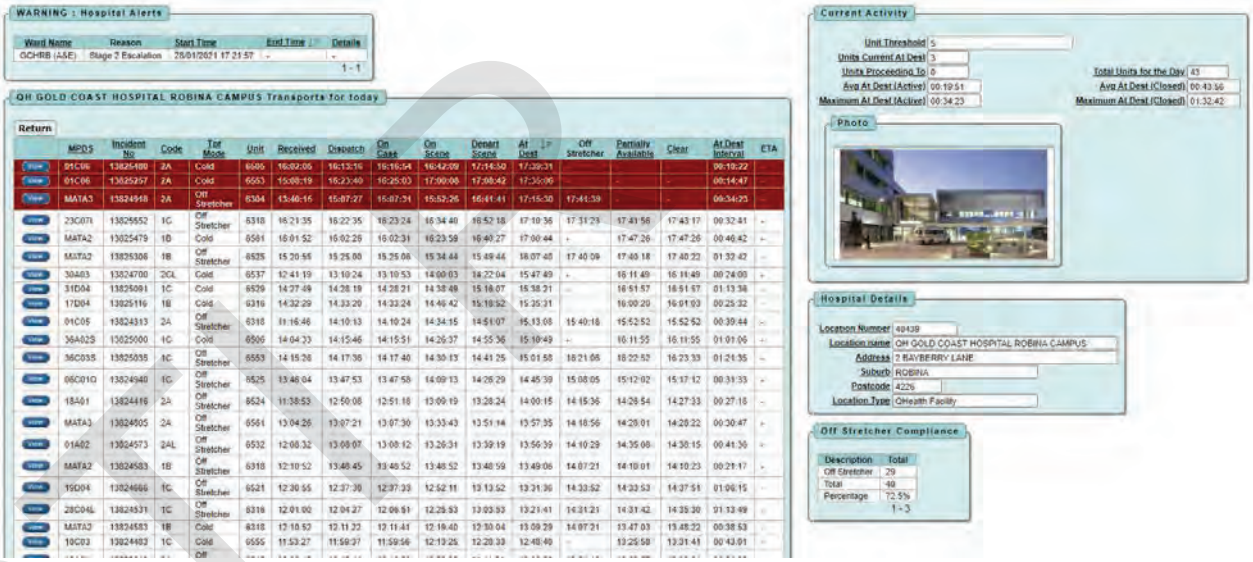





## Queensland Ambulance Service: Operational Incident Reporting



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Outcomes:

- de ribe outco s and impacts of the OIRR;

Post O R actions:

- deta any actions taken at the LASN level since the OIRR occurred (including but not limited to Priority One access and post incident debrief).

## eview Recom endations:

- Operations Centre Review in regards dispatching of case

## Appendix of relevant documents/files:

| | |
|---|---|
| **Incident Details Report** | IDR 13825748.pdf |
| **GCLASN Notifiable PSDU Notification** | FW_ 28_01_2021 - Notifiable Incident - C<br>RE_ 28_01_2021 - CNotifiable Incident - C |
| **dARF/dCRF** | EARF CN 13825748.pdf |
| **Voice Logs** | 170858 000 call Labrador.wav |
| **OpCen Review** | FW_ 28_01_2021 - Notifiable Incident - C |
| **Southport OpCen Brief** | 280121 DAY SOUTHPORT OPCEN<br>280121 NIGHT SOUTHPORT OPCEN |
| **Clinical Review** | QAS GOL CEU Clinical Review CIM 1: |
| **Other Documents** | FW_ 28_01_2021 - Notifiable Incident - C |

## 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 | 23/06/2021 |
| A/Director Operations | Rachel Latimer | Superintendent | | 23/06/2021 |

# Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **13825748**
ProQA number: **16643227**
Console name: **PA608**
Incident Date: **28/01/2021 17:09:01**
Last Updated:

## Incident Information

| | | | |
|---|---|---|---|
| **Incident Type:** | ACUTE AND CCP IF AVAILABLE | **Alarm Level:** | |
| **Priority:** | 1A | **Problem:** | INEFFECTIVE BREATHING 09D01 |
| **Determinant:** | 09D01 | **Agency:** | QAS |
| **Base Response#:** | 126040 | **Jurisdiction:** | 6 Southport Gold Coast |
| **Confirmation#:** | 00104697 | **Division:** | 6 Coomera |
| **Taken By:** | Irrelevant | **Battalion:** | 6 Coomera |
| **Response Area:** | 6 Coomera | **Response Plan:** | 1A |
| **Disposition:** | A Case Completed | **Command Ch:** | |
| **Cancel Reason:** | | **Primary TAC:** | TLK GRP 111/UHF Ch 103 |
| **Incident Status:** | Closed | **Secondary TAC:** | |
| **Certification:** | ACUTE | **Delay Reason (if any):** | |
| **Longitude:** | 26689751 | **Latitude:** | 62134036 |
| **Patient Name:** | Irrelevant | **Patient DOB:** | Irrelevant |

## Incident Location

| | | | |
|---|---|---|---|
| **Location Name:** | | **County:** | GOLD COAST |
| **Address:** | Irrelevant | **Location Type:** | |
| **Apartment:** | | **Cross Street:** | Irrelevant |
| **Building:** | | **Map Reference:** | G6P7 |
| **City, State, Zip:** | UPPER COOMERA QLD 4209 | | |

## Call Receipt

| | | | |
|---|---|---|---|
| **Caller Name:** | Irrelevant | **Original CLI Phone** | Irrelevant |
| **Method Received:** | | **Call Back Phone:** | |
| **Caller Type:** | | **Caller Location:** | |

## Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| **Phone Pickup** | 28/01/2021 | 17:09:01 | |
| **1st Key Stroke** | 28/01/2021 | 17:09:01 | |
| **In Waiting Queue** | 28/01/2021 | 17:10:09 | |
| **Call Taking Complete** | 28/01/2021 | 17:11:58 | Harvey, Luke |
| **1st Unit Assigned** | 28/01/2021 | 17:12:01 | |
| **1st Unit Enroute** | 28/01/2021 | 17:14:50 | |
| **1st Unit Arrived** | 28/01/2021 | 17:34:14 | |
| **Closed** | 28/01/2021 | 21:18:15 | o, Chantal |

## Elapsed Times

| Description | Time |
|---|---|
| **Received to In Queue** | 00:01:08 |
| **Call Taking** | 00:02:57 |
| **In Queue to 1st Assign** | 00:01:52 |
| **Call Received to 1st Assign** | 00:03:00 |
| **Assigned to 1st Enroute** | 00:02:49 |
| **Enroute to 1st Arrived** | 00:19:24 |
| **Incident Duration** | 04:09:14 |

## Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Ar ed | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| B601536 | 17:12:01 | Cancel En Route | | | | | | 17:12:36 | | | App Changed |
| B601562 | 17:13:30 | Cancel Prior To En Route,Vehic | 17:14:50 | | | | | 17:15:18 | | | Vehicle Change |
| B601588 | 17:14:32 | A Case Completed | 17:15:32 | | 17:34:14 | | | 20:37:47 | | | |
| A606515 | 17:32:55 | A Case Comple | 17:33:46 | | 7:46:05 | | | 21:18:15 | | | |
| B605563 | 17:34:17 | Treated Ot t Transpo | 17:34:25 | | 17:40:36 | | 18:42:41 | 18:44:02 | | | |
| B607852 | 17:41:03 | reated Other Unit Transport | 41:13 | | 17:53:30 | | 18:43:24 | 18:45:34 | | | |
| A606853 | 17:47 | A Case Completed | 17:4 | | 18:08:08 | | | 19:15:57 | | | |

## Personne Assigned

| Unit | Name |
|---|---|
| 601536 6 | Irrelevant |
| 01588 | |
| 605563 | |
| 606515 | |
| 606853 | |
| 607852 | |

## P cheduled Information

**Pre-Scheduled Information**

## Tra orts

| Unit | ocation/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 601588 | QH GOLD COAST UNIVERSITY HOSPITAL 1 HOSPITAL BVD | | Hot | Pre Hosp - patient condition | 0.0// | 18:40:56 | 18:57:20 | 20:37:47 |

## Comments

| Date | Time | User | Type | Comments |
|---|---|---|---|---|
| 28/01/2021 | 17:10:09 | 6LUKHAR | Response | [ProQA Dispatch] Dispatch Level: 10D04 (Clammy or cold sweats) Response Text: 1C Irrelevant Male. Conscious, Breathing. Problem Description: SERIOUS CHEST PAIN Irrelevant |
| 28/01/2021 | 17:10:09 | 6LUKHAR | Response | [ProQA: Key Questions] 1. This is a coronavirus (COVID-19) outbreak. 2. The locally designated Triage Level is 0 (surveillance only). 3. The most prominent |

| | | | | |
|---|---|---|---|---|
| | | | | complaint is having pain or discomfort in the chest. 4. He has not had a heart attack or angina (heart pains) before. 5. He is completely alert (responding appropriately). 6. He has sweats. 7. He is completely alert (responding appropriately). 8. He is not breathing normally. 9. He does not have any difficulty speaking between breaths. 10. He is clammy. 11. He has not had a heart attack or angina (heart pains) before. |
| 28/01/2021 | 17:10:20 | 6LUKHAR | Response | [ProQA: Key Questions] 12. He did not take any drugs (medications) in the past 12hrs. |
| 28/01/2021 | 17:11:29 | 6LUKHAR | Response | [ProQA: COVID-19] Has the patient travelled interstate or overseas in the past month? Yes: SOUTH AUS, |
| 28/01/2021 | 17:11:56 | 6LUKHAR | Response | RECENT TRAVEL TO SOUTH AUS - Irrelevant HASNT BEEN TO ANY HOT SPOTS |
| 28/01/2021 | 17:12:02 | PS | Response | [Page] Dispatch page sent to Unit:601536, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:12:03 | 601536 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:12:17 | PS | Response | [Page] Dispatch page to Unit:601536 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:12:20 | PS | Response | [Page] Dispatch page to Unit:601536 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:13:30 | PS | Response | [Page] Dispatch page sent to Unit:601562, Sent From: KEDCADQ PIS01 |
| 28/01/2021 | 17:13:31 | 601562 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY T |
| 28/01/2021 | 17:13:43 | PS | Response | [Page] Dispatch page to Unit:601562 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:13:44 | PS | Response | [Page] Dispatch page to Unit:601562 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:14:33 | PS | Response | [Page] Dispatch page sent to Unit:601588, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:14:34 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT |
| 28/01/2021 | 17:15:00 | PS | Response | [Page] Dispatch page to Unit:601588 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:15:01 | PS | Response | [Page] Dispatch page to Unit:601588 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:32:03 | 6RACDEV | Response | Duplicate call appended to incident at 17:32:03 |
| 28/01/2021 | 17:32:04 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:20 | 6RACDEV | Response | [ProQA Reconfigure] Reconfigure Level: 09D01 (INEFFECTIVE BREATHING) Response Text: 1A Irrelevant Male, Not Conscious, Not Breathing. |
| 28/01/2021 | 17:32:20 | 6RACDEV | Response | [ProQA: Key Questions] 13. Arrested during interrogation – reconfigured to Protocol 9 14. A defibrillator (AED) is not available. |
| 28/01/2021 | 17:32:22 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:22 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:23 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:35 | 6RACDEV | Response | [Notification] [QAS]-CPR in progress |
| 28/01/2021 | 17:32:36 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:32:56 | PS | Response | [Page] Dispatch page sent to Unit:606515, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:32:57 | 606515 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT |
| 28/01/2021 | 17:33:08 | PS | Response | [Page] Dispatch page to Unit:606515 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:33:10 | PS | Response | [Page] Dispatch page to Unit:606515 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:33:17 | 6RACDEV | Response | [Notification] [QAS]-CALLER STATES NO HEART BEAT OR PULSE |
| 28/01/2021 | 17:33:18 | 601588 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:33:46 | 606515 | Respons | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:34:18 | PS | Respo e | [Page] Dispatch page sent to Unit:605563, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:34:20 | 605563 | Re nse | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:34:42 | PS | R ponse | [Page] Dispatch page to Unit:605563 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:36:03 | 6NICBIZ | Resp e | 1588 CPR IN PROGRESS |
| 28/01/2021 | 17:36:04 | 606515 | Respon | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:36:04 | 605563 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 17:36:05 | 6RACDEV | Response | [Private] SOC DISCONNECTED - QAS ON SCENE |
| 28/01/2021 | 17:41:04 | PS | Response | [Page] Dispatch page sent to Unit:607852, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:41:07 | 60 2 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT |
| 28/01/2021 | 17:41:19 | PS | Response | [Page] Dispatch page to Unit:607852 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17:41:2 | PS | Response | [Page] Dispatch page to Unit:607852 complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 17 07 | 606515 | esponse | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/2021 | 7 | 6NICBIZ | ponse | 605563 HAVE ROSC |
| 28/01/2021 | 7:43: | 607852 | Re nse | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/202 | 17:47:35 | PS | Response | [Page] Dispatch page sent to Unit:606853, Sent From: KEDCADQASPIS01 |
| 28/01/2021 | 17:47:36 | 06853 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT |
| 28/01/2021 | 17:47:49 | P | Response | [Page] Dispatch page to Unit:606853 complete to Irrelevant Message sent successfully. |
| 01/2 | 17:47:52 | PS | Response | [Page] Dispatch page to Unit:606853 complete to Irrelevant Message sent successfully. |
| 28/01/202 | 17:48:05 | 6NICBIZ | Response | 606515 HARU CODE 1 |
| 28/01/202 | 17:48:06 | 607852 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01/20 | 17:48:07 | 606853 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 28/01 | | 6JASJON | Response | 607852 PT GCS3 VENTILLATED AND LOADING TO STR AND NOW TO VEH |
| 28/ 2021 | 18:02:24 | 606853 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 1/2021 | 18:17:51 | 6JASJON | Response | 607852 DELAY ON SCENE WITH RSI |
| 01/2021 | 18:41:27 | 6JASJON | Response | 601588 DEPT CODE 1 GCUH AND BOTH CCP AND HARU ON BOARD AND BOTH CARS FOLLOWING BEHIND |
| 28/0 21 | 18:41:45 | 6JASJON | Response | Unit 606853 has been placed in Reduced Response Capability. |
| 28/01/2 | 18:41:53 | 6JASJON | Response | Unit 606515 has been placed in Reduced Response Capability. |
| 28/01/202 | 18:42:38 | 6CHAMUN | Response | 607852 CREW TX HOT - CCP & HARU ON BOARD - 853 DRIVIEN BY STUDENT - 515 DRIVEN BY OTHER OFFICER - NIL QAS VEH LEFT ON SCENE |
| 28/01/2021 | 18:57:48 | PS | Response | [Page] Page processing complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 18:57:50 | PS | Response | [Page] Page processing complete to Irrelevant Message sent successfully. |
| 28/01/2021 | 19:16:00 | 6JASJON | Response | Unit 606853 has been removed from Reduced Response Capability. |
| 28/01/2021 | 19:59:26 | 6CHAMUN | Response | [Page] Units: 601588, Sent From: PA606, HI TEAM - HOW ARE YOU GOING WITH PAPERWORK ETC? |
| 28/01/2021 | 20:01:15 | 6TANLIN | Response | 601588 NOT AVAILABLE |
| 28/01/2021 | 20:33:20 | 6JASJON | Response | [Page] Units: 601588, Sent From: PA605, Please update your current status via |

| | | | | |
|---|---|---|---|---|
| 28/01/2021 | 20:35:24 | 6JASJON | Response | [Page] Units: 601588, Sent From: PA605, ANY ETA TO AVAILABILITY? |
| 28/01/2021 | 20:37:35 | 6JASJON | Response | 601588 RESTOCK AND CCP STILL DOING PAPERWORK |
| 28/01/2021 | 21:17:58 | 6CHAMUN | Response | Unit 606515 has been removed from Reduced Response Capability. |

Priority Changes

| Date | Time | Changed from Priority | Reason | User |
|---|---|---|---|---|
| 28/01/2021 | 17:32:20 | 1C | Patient Condition | de Vere, Rachael |

Call Activities

| Date | Time | Radio | Activity | Location | Comments | User |
|---|---|---|---|---|---|---|
| 28/01/2021 | 17:09:01 | | No AML Data Received | | No AML data received with this call | SDSIAML |
| 28/01/2021 | 17:10:09 | | Incident in Waiting Queue | | | |
| 28/01/2021 | 17:10:09 | | Incident in Waiting Queue | | | |
| 28/01/2021 | 17:10:09 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:10:10 | | ANI/ALI Statistics | | INT Insert:Jan 28 2021 17:08:58 / INT SendNP:Jan 28 2021 17:08:58 / WS RecvNP:Jan 28 2021 17:08:59 / WS Process:Jan 28 2021 17:10:10 | 6 KHAR |
| 28/01/2021 | 17:10:10 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUK R |
| 28/01/2021 | 17:10:10 | | ProQA | Irrelevant | ProQA determinant sent | 6LUKHAR |
| 28/01/2021 | 17:10:16 | | Read Incident | | Incident 227 was Marked as Read. | 6NICBIZ |
| 28/01/2021 | 17:10:19 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:10:20 | | Incident in Waiting Queue Timer Clear | | | |
| 28/01/2021 | 17:11:20 | | UserAction | | User clicked Exit/Save | 6NICBIZ |
| 28/01/2021 | 17:11:32 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6JASJON |
| 28/01/2021 | 17:11:39 | | Pending Incident Time Warning | | Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:11:39 | | Incident Late | | | |
| 28/01/2021 | 17:11:40 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 17:11:58 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:12:01 | 601536 | Dispatched | Irrelevant | Response Number (126040) | 6NICBIZ |
| 28/01/2021 | 17:12:02 | | Incident Timer Clear | | Incident Timer Cleared | |
| 28/01/2021 | 17:12:36 | 601536 | ReAssign Vehicle | | ReAssign Reason: App Changed | 6NICBIZ |
| 28/01/2021 | 17:12:36 | | ReAssign Response | | Clearing Primary Vehicle Flag | 6NICBIZ |
| 28/01/2021 | 17:12:36 | | ReAssign Response | | ReAssign Reason: App Changed | 6NICBIZ |
| 28/01/2021 | 17:12:36 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:12:36 | | Incident Late | | | |
| 28/01/2021 | 17:12:47 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:13:30 | 601562 | Dispatched | Irrelevant | Response Number (126046) | 6NICBIZ |
| 28/01/2021 | 17:13:30 | | Read Incident | | Incident 227 was Marked as Read. | 6NICBIZ |
| 28/01/2021 | 17:13:30 | | Incident Timer C ar | | Incident Timer Cleared | |
| 28/01/2021 | 17:14:30 | | Incident Late | | Active incident marked as late | |
| 28/01/2021 | 17:14:32 | 601588 | Dispatched | elevant | Response Number (126057) | 6NICBIZ |
| 28/01/2021 | 17:14:47 | | Read Co ment | | Comment for Incident 227 was Marked as Read. | 6JASJON |
| 28/01/2021 | 17:14:50 | 601562 | Resp | Irreleva | Responding From = OLSEN AVE\MELIA CT | VisiNET |
| 28/01/2021 | 17:14:54 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 17:15:18 | 601562 | ReAssign Vehicle | | ReAssign Reason: Vehicle Change | 6JASJON |
| 28/01/2021 | 17:15:18 | | ReAssign Respons | | Clearing Primary Vehicle Flag | 6JASJON |
| 28/01/2021 | 17:15:28 | | Remove Waiting Pend Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 28/01/2021 | 17:15:32 | 6015 | Resp | relevant | Responding From = ALLCHURCH AVE [PINDARA PRIVATE HOSPITAL] | VisiNET |
| 28/01/2021 | 17:19:2 | | d Comment | | Comment for Incident 227 was Marked as Read. | 6NICBIZ |
| 28/01/2021 | 17 43 | | User on | | User clicked Exit/Save | 6NICBIZ |
| 28/01/2021 | 3 | | AML D Received | Irrelevant | AML data appended from duplicate call (Incident #13825824): Center of caller area HELI: -27 51.966000, 153 18.614400 ESCAD: #-27.8661/153.31024 | SDSIAML |
| 28/01/2021 | 17:32:03 | | Duplicate Call Warning | | Duplicate Call Warning - New call appended to incident | 6RACDEV |
| 01/2 | 17:32:04 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6RACDEV |
| 28/01/202 | 17:32:04 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6RACDEV |
| 28/01/20 | 17:32:20 | | Incident Priority Change | | Incident priority changed from 1C to 1A due to Patient Condition | 6RACDEV |
| 28/ 2021 | 17:32:20 | 601588 | Priority Change | | The priority of incident 227 has been changed from 1C to 1A. Unit 6588 is responding HOT1A | VisiNET |
| 01/2021 | 17:32:20 | | ProQA | Irrelevant | ProQA determinant sent | 6RACDEV |
| 28 /2021 | 17:32:45 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6NICBIZ |
| 28/01/2 | 17:32:50 | | UserAction | | User clicked Add Resource | 6NICBIZ |
| 28/01/202 | 17:32:55 | | VisiCAD Recommendation | | 606515: 00:13:08, 506084: 00:32:09, 506035: 00:32:50, 506292: 00:32:59, 501251: 00:34:53, | 6NICBIZ |
| 28/01/2021 | 17:32:55 | 606515 | Dispatched | Irrelevant | Response Number (126142) | 6JASJON |
| 28/01/2021 | 17:33:04 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6PETCAF |
| 28/01/2021 | 17:33:04 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 17:33:08 | 601588 | Calculate Vehicle ETA | ABRAHAM RD\SERVICE CENTRE ACCS | ETA to Scene Address Irrelevant UPPER COOMERA is 00:01:26 | 6JASJON |
| 28/01/2021 | 17:33:08 | 606515 | Calculate Vehicle ETA | BINSTEAD DR\BINSTEAD DRIVE EXIT | ETA to Scene Address Irrelevant UPPER COOMERA is 00:13:08 | 6JASJON |
| 28/01/2021 | 17:33:23 | | UserAction | | User clicked Exit/Save | 6NICBIZ |
| 28/01/2021 | 17:33:46 | 606515 | Resp | Irrelevant | Responding From = BINSTEAD DR\BINSTEAD | VisiNET |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | DRIVE EXIT | |
| 28/01/2021 | 17:34:12 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LINWAN |
| 28/01/2021 | 17:34:14 | 601588 | At Scene | Irrelevant | | VisiNET |
| 28/01/2021 | 17:34:17 | 605563 | Dispatched | | Response Number (126147) | 6NICBIZ |
| 28/01/2021 | 17:34:25 | 605563 | Resp | | Responding From = PACIFIC MWY NB\PACIFIC MOTORWAY ON RAMP | VisiNET |
| 28/01/2021 | 17:34:30 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 17:34:39 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:34:45 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 17:35:06 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 17:35:31 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:35:39 | | UserAction | | User clicked Exit/Save | 6GREK |
| 28/01/2021 | 17:35:50 | | UserAction | | User clicked Exit/Save | 6LU HAR |
| 28/01/2021 | 17:36:25 | | UserAction | | User clicked Exit/Save | 6R CDEV |
| 28/01/2021 | 17:37:07 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6 ETCAF |
| 28/01/2021 | 17:37:44 | | UserAction | | User clicked Exit/Save | 6 TC |
| 28/01/2021 | 17:37:44 | | UserAction | | User clicked Exit/Save | 6JA AC |
| 28/01/2021 | 17:40:10 | | UserAction | | User clicked Exit/Save | 6LIN |
| 28/01/2021 | 17:40:36 | 605563 | At Scene | Irrelevant | | VisiNET |
| 28/01/2021 | 17:41:03 | 607852 | Dispatched | | Response Number (126171) | 6NICBIZ |
| 28/01/2021 | 17:41:13 | 607852 | Resp | | Responding From = HOLLOWS WAY\CAR PARK ACCS | VisiNET |
| 28/01/2021 | 17:41:43 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 17:42:51 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:42:55 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 17:43:22 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 17:43:32 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:46:05 | 606515 | At Scene | Irrelevant | | VisiNET |
| 28/01/2021 | 17:47:22 | | UserAction | | User clicked Exit/Save | 6JAYHAC |
| 28/01/2021 | 17:47:35 | 606853 | Dispatched | | Response Number (126189) | 6NICBIZ |
| 28/01/2021 | 17:47:39 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 17:47:42 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 17:47:51 | 606853 | Resp | Irrelevant | Responding From = PACIFIC HWY NB\K P MCGRATH DRIVE OFF RAMP | VisiNET |
| 28/01/2021 | 17:49:47 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 215STUCUT |
| 28/01/2021 | 17:50:11 | | UserAction | | User clicked Exit/Save | 215STUCUT |
| 28/01/2021 | 17:53:30 | 607852 | At Scene | Irrelevant | | VisiNET |
| 28/01/2021 | 18:07:04 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6LUKHAR |
| 28/01/2021 | 18:07:13 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 18:08:08 | 606853 | At Scene | Irrelevant | | VisiNET |
| 28/01/2021 | 18:11:51 | | UserAction | | User clicked Exit/Save | 6CHAMUN |
| 28/01/2021 | 18:12:58 | | UserAction | | User clicked Exit/Save | 6CHAMUN |
| 28/01/2021 | 18:17:23 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 18:22:25 | | Read C ment | | Comment for Incident 227 was Marked as Read. | 6JOEMCE |
| 28/01/2021 | 18:23:02 | | UserAction | | User clicked Exit/Save | 6JOEMCE |
| 28/01/2021 | 18:24:55 | | UserAction | | User clicked Exit/Save | 6LUKHAR |
| 28/01/2021 | 18:40:56 | 601588 | Dep | QH GOLD COAST UNIVERSITY HOSPITAL | | VisiNET |
| 28/01/2021 | 18:41:45 | 606853 | Out Of Service | Irrelevant | Reduced Response Capability | 6JASJON |
| 28/01/2021 | 18:41:53 | 60 5 | Out Of Service | | Reduced Response Capability | 6JASJON |
| 28/01/2021 | 18:42:41 | 6055 | Partially Av | | | VisiNET |
| 28/01/2021 | 18:43:06 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6JASJON |
| 28/01/2021 | 18:43 | | U ction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 18 24 | 607852 | Parti Av | Irrelevant | | VisiNET |
| 28/01/2021 | 4 2 | 605563 | Availab | | | 6JASJON |
| 28/01/2021 | 8:44:0 | 605563 | Dispositio | | Treated Other Unit Transport | 6JASJON |
| 28/01/202 | 18:45:34 | 607852 | Available | | | 6JASJON |
| 28/01/2021 | 18:45:34 | 7852 | Disposition | | Treated Other Unit Transport | 6JASJON |
| 28/01/2021 | 18:57:20 | 6 88 | Dest | 1 HOSPITAL BVD [QH GOLD COAST UNIVERSITY HOSPITAL] | | VisiNET |
| 28/01/202 | 18:57:20 | 601588 | Transport Time | | Depart Scene Time: 18:40:56, Arrive Destination Time: 18:57:20 | VisiNET |
| 28/01/202 | 19:00:26 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6TRECRO |
| 28/01 | | | UserAction | | User clicked Exit/Save | 6TRECRO |
| 28/ 2021 | 19:15:57 | 606853 | Available | Irrelevant | | 6JASJON |
| 1/2021 | 19:15:57 | 606853 | Disposition | | A Case Completed | 6JASJON |
| 01/2021 | 19:27:20 | | Incident Late | | Active incident marked as late | |
| 28 /2021 | 19:27:35 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6CHAMUN |
| 28/01/2 | 19:27:37 | | UserAction | | User clicked Exit/Save | 6CHAMUN |
| 28/01/202 | 19:27:46 | 601588 | Reset System Timer | | Days Warn before expiration Passwords | 6CHAMUN |
| 28/01/2021 | 19:57:47 | | Incident Late | | Active incident marked as late | |
| 28/01/2021 | 19:58:57 | | UserAction | | User clicked Exit/Save | 6CHAMUN |
| 28/01/2021 | 20:01:31 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6TANLIN |
| 28/01/2021 | 20:01:38 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 20:03:29 | | UserAction | | User clicked Exit/Save | 6TANLIN |
| 28/01/2021 | 20:04:59 | 601588 | Reset System Timer | | Days Warn before expiration Passwords | 6JASJON |
| 28/01/2021 | 20:05:01 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 20:29:59 | | Incident Late | | Active incident marked as late | |
| 28/01/2021 | 20:33:21 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 20:33:25 | | UserAction | | User clicked Exit/Save | 6TANLIN |

| | | | | | | |
|---|---|---|---|---|---|---|
| 28/01/2021 | 20:34:37 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 215STUCUT |
| 28/01/2021 | 20:35:26 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 20:35:28 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6JASJON |
| 28/01/2021 | 20:35:35 | | UserAction | | User clicked Exit/Save | 6JASJON |
| 28/01/2021 | 20:36:26 | | UserAction | | User clicked Exit/Save | 215STUCUT |
| 28/01/2021 | 20:37:47 | 601588 | Available | 1 HOSPITAL BVD [QH GOLD COAST UNIVERSITY HOSPITAL] | | 6JASJON |
| 28/01/2021 | 20:37:47 | 601588 | Disposition | Irrelevant | A Case Completed | 6JASJON |
| 28/01/2021 | 20:41:00 | | UserAction | | User clicked Exit/Save | 6TRECRO |
| 28/01/2021 | 21:02:52 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6TANLIN |
| 28/01/2021 | 21:17:41 | | UserAction | | User clicked Exit/Save | 6TANLI |
| 28/01/2021 | 21:17:58 | 606515 | At Scene | BINSTEAD DR\BINSTEAD DRIVE EXIT | | 6CH MUN |
| 28/01/2021 | 21:18:08 | | Read Comment | | Comment for Incident 227 was Marked as Read. | 6 NLIN |
| 28/01/2021 | 21:18:15 | 606515 | Available | Irrelevant | | 6 AM N |
| 28/01/2021 | 21:18:15 | 606515 | Disposition | | A Case Completed | 6C UN |
| 28/01/2021 | 21:18:15 | 606515 | Response Closed | | Response Disposition: A Case Completed | 6CHA N |
| 28/01/2021 | 21:23:47 | | UserAction | | User clicked Exit/Save | 6TANLIN |

Edit Log

| Date | Time | Field | Changed From | Changed To | Reason | Table | Workstation | User |
|---|---|---|---|---|---|---|---|---|
| 28/01/2021 | 17:09:01 | Call_Back_Phone | | Irrelevant | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:05 | City | | UPPER COOMERA | Updated City | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:05 | City | | UPPER COOMERA | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:07 | Address | (Blank) | Irrelevant | New Entry | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Jurisdiction | | 6 Southport Gold Coast | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Division | | 6 Coomera | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Battalion | | 6 Coomera | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Response_Area | | 6 Coomera | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | ResponsePlanType | 0 | 0 | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Primary_TAC_Channel | | TLK GRP 111/UHF Ch 103 | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Address | Irrelevant | Irrelevant | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Latitude | 0 | 621 36 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:10 | Longitude | 0 | | E try cted/Returned from GeoLocator | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:09:15 | ProQaCaseNumber | | 16643227 | (Response Viewer) | Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:10:09 | Problem | | HEST PAIN MMY | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:10:09 | Response_P | | Ac e | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:10:09 | D atchLevel | | Normal | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:10 | ResponsePlanType | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 10:09 | I ent_Type | | ACUTE | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:10:10 | Read mment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/ 21 | 17:10:10 | Priority_N er | 0 | 3 | Updated by ProQA | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/202 | 7:10:10 | Determinant | | 10D04 | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/202 | 7:10:10 | EMD_Used | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01 | | Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 1/2021 | 17:10:10 | Pickup_Map_Info | (Blank) | G6P7 | | Response_Transports | KEDCADQASCXA186 | LUKHAR |
| 01/2021 | 17:10:10 | Map_Info | | G6P7 | | Response_Master_Incident | KEDCADQASCXA186 | LUKHAR |
| 28 /2021 | 17:10:16 | Read Call | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6NICBIZ |
| 28/01/2 | 17:11:06 | Field_Data | | Irrelevant | Patient Name: | Response_User_Data_Fields | PA608 | 6LUKHAR |
| 28/01/202 | 17:11:10 | Field_Data | | | Patient DOB: | Response_User_Data_Fields | PA608 | 6LUKHAR |
| 28/01/2021 | 17:11:32 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JASJON |
| 28/01/2021 | 17:11:34 | Field_Data | Irrelevant | | Patient Name: | Response_User_Data_Fields | PA608 | 6LUKHAR |
| 28/01/2021 | 17:11:58 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:11:58 | ProQATerminationStateCode | | C | (Response Viewer) | Incident | PA608 | 6LUKHAR |
| 28/01/2021 | 17:12:36 | TimeCallViewed | 28/01/2021 17:10:16 | NULL | Reset Timestamp | Response_Master_Incident | PA606 | 6NICBIZ |
| 28/01/2021 | 17:13:30 | Read Call | False | True | (Drag Drop Unit Alert) | Response_Master_Incident | PA606 | 6NICBIZ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 28/01/2021 17:14:47 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JASJON |
| 28/01/2021 17:14:50 | Current_UnitRespPriorityDesc | 601562: 1C | HOT1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:15:32 | Current_UnitRespPriorityDesc | 601588: 1C | HOT1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:19:28 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6NICBIZ |
| 28/01/2021 17:32:04 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:04 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:20 | Priority_Description | 1C | 1A | Patient Condition | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:20 | Priority_Number | 3 | 1 | Patient Condition | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:20 | Response_Plan | Acute | 1A | Updated by ProQA | Response_Master_Incident | PA614 | 6RA V |
| 28/01/2021 17:32:20 | Incident_Type | ACUTE | ACUTE AND CCP IF AVAILABLE | Updated by ProQA | Response_Master_Incident | PA614 | RACDEV |
| 28/01/2021 17:32:20 | Problem | CHEST PAIN CLAMMY | INEFFECTIVE BREATHING 09D01 | Updated by ProQA | Response_Master_Incident | PA614 | RA DEV |
| 28/01/2021 17:32:20 | Determinant | 10D04 | 09D01 | (Response Viewer) | Response_Master_Incident | PA614 | 6RACD |
| 28/01/2021 17:32:20 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:20 | Current_UnitRespPriorityDesc | 601588: HOT1C | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:32:20 | ProQATerminationStateCode | C | | (Response Viewer) | Incident | PA614 | 6RACDEV |
| 28/01/2021 17:32:45 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6NICBIZ |
| 28/01/2021 17:33:04 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA617 | 6PETCAF |
| 28/01/2021 17:33:45 | Current_UnitRespPriorityDesc | 606515: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:33:49 | Caller_Name | Irrelevant | | (Response Viewer) | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:34:12 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6LINWAN |
| 28/01/2021 17:34:23 | Current_UnitRespPriorityDesc | 605563: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:34:30 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 17:34:45 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 17:36:10 | CIS_Used | 0 | ull | (Response Viewer) | Response_Master_Incident | PA614 | 6RACDEV |
| 28/01/2021 17:37:07 | Read Comment | Fal | Tru | (Response Viewer) | Response_Master_Incident | PA617 | 6PETCAF |
| 28/01/2021 17:41:14 | Current_UnitRespPriorityDe | 07852: 1A | HOT A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:41:43 | Read Comment | False | T | Response er) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 17:43:22 | Read Comment | F | True | (Response Viewer) | Response_Master_Incident | PA608 | 6LUKHAR |
| 28/01/2021 17:47:39 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA616 | 6LUKHAR |
| 28/01/2021 17:47:52 | Current_U RespPriorityDesc | 606853: 1A | T1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 28/01/2021 17:49:47 | Rea Commen | False | True | (Response Viewer) | Response_Master_Incident | PC919032 | 215STUCUT |
| 28/01/2021 18:07:0 | ad Comment | False | True | (Response Viewer) | Response_Master_Incident | PA616 | 6LUKHAR |
| 28/01/2021 18 2 | ad Comment | False | True | (Response Viewer) | Response_Master_Incident | PA617 | 6JOEMCE |
| 28/01/202 8:40:56 | Ma fo | (Blank) | G28K8 | | Response_Transports | KEDCADQASMDI01 | VisiNET |
| 28/01/2021 18:43:06 | Read mment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JASJON |
| 28/ 21 19:00:26 | Read Com t | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6TRECRO |
| 28/01/202 9:27:35 | Read Commen | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6CHAMUN |
| 28/01/202 0:01:31 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6TANLIN |
| 28/01 d | Comment | False | True | (Response Viewer) | Response_Master_Incident | PC919032 | 215STUCUT |
| 1/2021 20:35:28 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6JASJON |
| 28 /2021 21:02:52 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6TANLIN |
| 28/01/2 21:18:08 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA602 | 6TANLIN |

# 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 13832628 - Gold Coast LASN responded to an incident address given as number Irrelevant Elanora 4221. Call received 30 January 2021 at 11:26hrs for a Irrelevant Female Hanging coded 1A Determinant 09E03.

The request for service was via the patient's carer from Nursing Agency Australia. The caller was not located with the patient and could not gain access to the pt.

An Ambulance was dispatched to the address at 11:27hrs including a Critical care paramedic, the High Acuity Response Unit and the Operational Supervisor.

There was no delay in responding to this case with a time of call to time on scene being 14 mins

IDR 13832555 – 30 January 2021 was a request for information from the pts daughter. Call received at 11:02hrs asking if the patient had been transported to hospital yesterday – IDR notes Advised caller that pt. had not been transported.

IDR 13830008 – 29 January 2021 Gold Co st LASN responded to an incident address given as number Irrelevant Irrelevant Elanora 4221 Call receive at 17:04hrs. QAS remained on site with the Mental Health Co-n arrival at :07hrs to d ayed available at 19:53hrs being 1hr 46mins during which the mental Health co-responder de oped patient ac lan.

### Terms of Reference:

This review will in stigate all aspects of bulance response to incident 13832628, 1382555 and 13830008. The rev w will examine ambula ce operations prior to, during and following the response. This review ill includ ll requirements outlined in the *Operational Incident Review Process*.

### LASN linical Inciden Summary Report:

### S ate OpC n ProQA:

The calls have be deemed Partial Compliance and Non-Compliant however the correct response code w s applied to both idents and there was nil detriment to the patient.

### O erview

The thr arate incidents need to be considered during the audit process, the first being IDR 1383008 a mental health assessment on the 29 January 2021 which all the patient notes will be logged with Gold Coast hospital mental health Co-responder.

The second being IDR 13832555 on the 30 January 2021 from the patient's daughter requesting patient tr atment/transport information from a person stating they are the patient's daughter.

The third being IDR 13832628 on the 30 January 2021 the last case being signal 4 at the patient's residential address

## Incident Review/Investigation:

- **Scope:**
  - Gold Coast reviewed the response, case 138322628 was coded a 1A – 09E03 as per available data for a patient hanging. This was correctly coded.
  - Gold Coast reviewed the response, case 13832555. A case was not created and coded, is was an information request from a bystander. Notes indicate the information was supplie o the caller that the patient was not transported to a QHealth facility.
  - Gold Coast reviewed the response, case 13830008, was correctly coded as a 2A determinant 25B03. A Mental Health Co-responder was attached and carried out an assessment on site and put in place an action plan, this action plan will need to be reviewed via Dr Rashford's office.

**Background:**

- **Case 13832628 – 1A - 30 January 2021**
- QAS called for service to a Irrelevant female hanging nil life signs.
- Aces to the patient was difficult and force entry to the site was required.
- Once forced entry was gained the patient was declared signal 4 by QAS officers on site.

- **Timeline:**
  - 1st key stroke: 11:26
  - In waiting queue: 11:26
  - Assigned 1st unit: 11:27
  - Enroute 1st unit: 11:27
  - At scene 1st Unit: 11:40
  - Deceased: 11:44

- **Review:**
  - Alpha unit on sc ne 14 minu s after call
  - HARU, Bravo nit and OS spatched
  - Acting Operati s Super OS aware of incident

- **Outcomes:**
  - The patient was decla d deceased at the scene and left with police for forensic i estigation

- **Po OIRR ac ns**:
  - Peer S port to contact QAS officers

- 11:26:58 09e03 anging) response text: 1a QPS
- 1 27:36 Caller not with pt.
- 11:2 16 Carer on scene Irrelevant
- 11:28: Calling carer on scene
- 11:29:25 Call back to scene carer states she cannot get into house but can see pt. still hanging
- 11:30:55 pt. can be seen hanging inside residence no one can get in QAS proceeding L&S
- :30:58 Irrelevant male, not conscious, breathing status unknown.
- 11:31:15 ICEMS response >fire-q> fire-q has been attached to the incident
- 11:31:36 SOS notified
- 11:32:41 ICEMS response fire-q enroute
- 11:32:58 >pol-q> call from carer advising pt. can be seen hanging inside residence - unable to access pt. Irrelevant
- 11:33:33 ICEMS response <fire-q< QFES eta approx.: 7min



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- 11:35:09 ICEMS response >pol-q> pol-q has been attached to the incident
- 11:43:45 606692 haven't gained entry yet can see that pt. is signal 4 stand down back up looks like pt. has been there a while
- 11:44:41 pol-q on-scene
- 11:45:11 call from QPS - adv they have a Irrelevant f registered to address - adv job is for Irrelevant m
- 11:47:04 fire-q on-scene
- 11:51:21 606692 forced entry \
- 11:57:54 call to CDS from OS on scene - pt. confirmed to be Irrelevant
- 12:03:54 607843 signal 4 Irrelevant f

- **Background:**
  - **Case 13832555 – 30 January 2021**
  - Nil code assigned
  - Nil call for QAS services – Patients daughter contacted QAS operations centre requesting patient information from a request for service 29th January 2021.
  - Per IDR patient's daughter advised nil transport of this patient.

- **Timeline:**
  - 1st key stroke: 11:02
  - In waiting queue: 11:02
  - Assigned 1st unit: N/A
  - Enroute 1st unit: N/A
  - At scene 1st Unit: N/A
  - Cleared N/A

- **Review:**
  - OCS following up with EMD re this incident number
- **Outcomes:**
  - 30/01/2021 11:0 :15 Call from pt. daughter req information if she had been Tx to hospital yesterda advised aller that pt. had not been Tx
  - 30/01/2021 13:38:08 OCS has reviewed the 000-call taken by Irrelevant caller was a suppor worker, OC sp ke with EMD and she advised that she could not hear well and thought she aid d ghter. evid in the recording that it was a bad line
- **Post OIRR actions**:
  - OpCen case review follow up through OpCen EM
- **Backgro nd:**
  - **Ca 13830008 – 2A - 29 anuary 2021**
    QAS lled for service to a Irrelevant female suicidal – threatening to overdose her medica ns – History of Mental health.
  - QAS disp hed Gold Coast mental health Co-responder to the case
  - Co-responde ttended the patient during an extensive on site assessment and an action plan put in plac .

- **Timeline**
  - 1st y stroke: 17:04
  - In waiting queue: 17:10
  - Assigned 1st unit: 17:22
  - Enroute 1st unit: 17:22
  - At scene 1st Unit: 18:07
  - Delayed Available 19:53

- **Review:**
  - LARU Co-responder model attached to this case

- **Outcomes:**

- The patient was left at the address with a friend coming over
- 17:10:04 Threatening to overdose on her medications - hx mental health
- 17:11:47 Call from health care Australia - pt. is a regular client of theirs, long hx mental health, came off EEA 6months ago
- 17:11:57 pt. has support worker with her
- 17:12:36 Support worker, Irrelevant
- 17:15:44 Support worker has been texting manager with details of what is happening - stated it will make the pt. worse if we were to call her - nil violence concern - pt. unawa QAS attending, she will be unhappy when QAS arrive but no concerns of violence
- 18:02:28 pls review id Irrelevant - as per crew request 601532
- 18:07:11 608568 MH LARU won't be avail for a few more hours
- 18:41:15 welfare check - all good on scene?
- 18:54:18 608568 delayed still assessing
- 19:42:15 608568 pt. left home friend coming over referred

## Review Recommendations:

- Gold Coast Mental Health Co-responder will be conducting their own review of the incident.
- Request GCLASM Education units carries out a review of QAS ARFs.
- Peer support for Co-responder and LARU officer involved

## Appendix of relevant documents/files:

| | |
|---|---|
| **Incident Details Report** | Incident Report 13832628.pdf; Incident Report 13832555.pdf; Incident Report 13830008.pdf |
| **GCLASN Notifiable PSDU Notification** | Notifiable Inc nt Tuesday 26 J |
| **dARF/dCRF** | CN 30008 29_01_2 pdf; CN 13832628.pdf |
| **Voi e Logs** | INC 13832628 Audio Call to scene.; INC 13832628 000 Audio.wav; INC 13832555 000 Call Audio.wav; INC 13830008 000 Audio call.wav; 210130_13832628_N olan_M_Review PC.; 210129_13830008_C arroll_J_Review NC.p |
| **S uthport OpCen Brief** | 300121 DAY SOUTHPORT OPCEN |
| **Supporting Documentation** | FW_ LARU Mental Health Co responder .msg |



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| | |
|---|---|
| **Clinical Review** | QAS GOL CEU Clinical Review 1383<br>QAS GOL CEU Clinical Review CIM |
| **Resource Reports** | 6. GOL LASN Resource Report - S<br>5. GOL LASN Resource Report - Fi |

## 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 | Assistant Commissioner | Irrelevant | 24/06/2021 |
| A/Director Operations | Rachel Latimer | Superintendent | | 25/06/2021 |

# Incident Assurance Review Version 1.0 July 2020

## Sunshine Coast Local Ambulance Service Network

**Authority:**

By authority of Sunshine Coast Local Ambulance Service Network (SCT LASN) Assistant Commissioner (AC) Mr Stephen Gough, this review was completed by Senior Operations Supervisor (SOS) Shane Kropp.

**Executive Summary:**

At 14:11 1st February 2021 Queensland Ambulance Service (QAS) received an Inter-agency Computer Aided Dispatch Electronic Messaging System (ICEMS) Queensland Police request to attend an incident located at Irrelevant mbil. A multi-service response was initiated ICEMS with QAS, Queensland Police Service (QPS) and Queensland Fire and Emergency Services (QFES) attendance required.

The incident was categorised through the Medical Priority Dispatch System (MPDS) as a 29D02; Semi-trailer rollover; Code 1B response; Incident Detailed Report (IDR) 13841080.

Based on initial caller information, the Maroochydore Operations Centre (OpCen) dispatched several units including one (1) Advanced Care Paramedic (ACP) crew; one (1) Critical Care Paramedic (CCP) and an Operations Supervisor (OS) to oversee the incident. Additional information indicating one Irrelevantdriver trapped in vehicle not responding.

This was a protracted incident with limited access to One Irrelevantpatient trapped in upturned cabin. Once able to access the patient QAS officers confirmed that patient was deceased.

**Terms of Reference:**

This review will investigate all aspects of the ambulance response to incident 13837467 to examine the appropriateness of the QAS response and identify (if any) operational or clinical issues.

This review will include all requirements outlined in the Operational Incident Review Process.

**LASN Clinical Incident Summary Report:**

At the time of writing this report SOS able to access electronic Ambulance Report Form (eARF) documentation completed by B401963 and B405994.

Evaluating Clinical Improvement and Patient Safety (ECLIPSE) has not been requested for this incident.

## Incident Review/Investigation

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

SOP03.3 Notification to Senior officers was adhered to with an SMS page notification being sent at 14:20.

Unit activity for the Sunshine Coast LASN has been reviewed by SOS. The initial QAS respons to this incident was timely and appropriate.

Units were dispatched in accordance with State Operations Centre Standard Operating Procedure (SOP) SOP02.

## Background

At 14:11 1st February 2021, Queensland Ambulance Service received a call for service to attend a Semi-trailer rollover at Imbil.

QAS resources attending this incident included:

401963 Irrelevant

405994 Irrelevant

407848 Irrelevant

8511 Irrelevant

## Chronology

Below is a chronological sequen of events:

14:11 ICEMS for a Semi-trailer ro ver Irrelevant is trapped in the vehicle driver not responding to informant Oil and fuel going ev ywhere. Location is 1 km west from Imbil town.

14:11 I ident “in wa g” queue

14: 6 B 1963 and B 405 94 dispatched from QAS Cooroy

14:17 B4019 and B 405994 responding

1 18 A407484 dispatched from QAS Cooroy

:19 A407484 responding

14:20 Level 1 page sent, 8511 dispatched from Sunshine Coast Airport

14:41 B401963 and B 405994 on scene

14:42 A407484 on scene

14:46 SR - B405994 SR at this stage unable to get to patient - only get to his ankle - unknown number of occupants due to entrapments – aircraft has landed on road approximately 110 meters east of scene

8511 has landed at the showgrounds

14:48 SR - 407848 managed to get minor access to patient limbs - appears to be pulseless nd cyanotic - GCS 3 - backup not required

15:03 SR- 848 still trying to get access to patient. QFES trying to make more space to at least ge access to a pulse. will be protracted

15:12 407848 male patient - code 0 confirmed - QFES just checking in behind the cab making sure there are no other occupants - aircraft is clear

15:34 CDS spoke to do at scene- QFES still trying to open cab enough to get access to check the back of the cab. all crews will remain at scene at this stage

15:49 SR - 405994 primary search confirmed solo occupant

15:30 8511 clear

15:57 B401963 and A407848 clear

16:36 SR 405994 - have got deceased removed from truck, just using heavy lifting equipment to lift truck up and conduct a secondary search. DO will remain on scene until complete

19:05 SR 405994 still conducti g fina sweep. Have cleared the cabin area, conducting search through trailer load. Be eves will completed in next 30 mins. All services are still on scene + Claytons Towing

19:19 SR 405994 secondary s ey completed nil other patients found; incident closed

## Events since I ident

A post in dent discu ion between SOS and officer Irrelevant undertaken at Birtinya. Further follow up call 2/02/2021 with relevant Nil clinical or operational issues were identified.

Pri ity 1 tification was ac ned by the Operations Centre Supervisor for all attending officers.

A dot point br f was completed and forwarded to acting Executive Manager Operations (a/EMO) Dianne Rigby.

## cid nt Outcomes

One Irrelevant patient deceased.

## Review Recommendations:

That this Incident Assurance Review be noted and filed.



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

- Incident Detail Report 13841080
- electronic Ambulance Report Form (eARF) pertaining to patient assessment and scene standby B401963 and A405994
- Dot point brief

**LASN Endorsement:**

| Role | Name | Position | Signature | Date |
|---|---|---|---|---|
| Assistant Commissioner | Stephen Gough | General Manager | Irrelevant | 02/02/2021 |


DARF_503119881.pdf


RE IDR 13841080 RTC Imbil.msg


IDR 13841080.html


FW IDR 13841080 RTC Imbil.msg


DARF_503121488.pdf

# 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 13850965) located at Irrelevant Redcliffe, at 7:42pm on Wednesday 3 February 2021 to Irrelevant female post fall with a potential fractured neck of femur.

There was an extensive delay of 5 hours and 51 minutes in responding to this case with the patient still on the floor.

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13850965.
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:
N/A

## State OpCen ProQA:
- First vehicle was diverted to a code 1B for a patient who had a fall and was currently fitting on the initial call.
- Second vehicle was diverted to a code 1B, which was upgraded from a 2A by the Deployment Supervisor (DS) as whilst doing a call back, the patient self-harmed Irrelevant with a knife in front of the caller so the DS upgraded the case to a 1B and that vehicle was sent.
- 15-minute snapshot showed that the pending incidents averaged 41 code 2 cases pending for each 15 min interval from 19:45 to 00:44. Also during this time there were 9 pending code ones as well.
- The demand for services exceeded the number of QAS resources available on the night resulting in this delay, however, the response was deemed appropriate.

## Incident Review/Investigation:

### Scope
- Metro North LASN reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved.
- Metro North LASN will identify any operational or clinical performance issues with this case and ensure appropriate actions are taken to return performance to the required standards.

### Background
- Brisbane OpCen received a call to an Irrelevant patient, who had an unwitnessed fall, was on the floor and unable to move due to pain.
- Significant delay in response of 5 hours and 51 minutes.
- Brisbane OpCen received three call backs from the Residential Aged Care Facility requesting an estimated time of arrival.



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## Timeline

**1st Key Stroke:** 7:42pm
**In waiting queue:** 7:44pm
**Assigned:** 1:04am (2 diversions from case throughout pending time)
**Enroute:** 1:05am
**At scene:** 1:33am
**Departed scene:** 2:00am
**At hospital:** 2:04am

## Review

- Case re-assigned twice during pending time:
  - 501363 attached to case at 9:02pm – diverted at 9:05pm.
  - 501173 attached to case at 12:17am – diverted at 12:48pm
- High workload with extensive hospital delays throughout the evening – leading to long delay in response.

## Outcomes

- Patient transported to Redcliffe Hospital (RDH) without incident.

## Post review actions

- Operations Supervisor (OS) met with patient at RDH for a welfare check and apologised for the delay.
- Patient disappointed with delay however appeared in good spirits.
- OS contacted the RACF to apologise for the delay and advise that the patient was settled in the Emergency Department without further incident.
- RACF staff advised that patients Irrelevant was very distressed by delays given Irrelevant was on the floor and requested that he be contacted in the morning by QAS to discuss further.
- A Senior Operations Supervisor made further contact with the patients Irrelevant on 4 February 2021 to discuss the cause of the delay. Irrelevant was extremely understanding of the delay and thankful to receive a call explaining what had occurred.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Workforce planning reports;
- 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 | 04/02/2021 |
| Warren Painting | Acting Director Operations | | 04/02/2021 |

# 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 13855395 at Irrelevant Beenleigh QLD 4207 at 18:52hrs on 4 February 2021 to a Irrelevant male unconscious, bleeding from the head. On QAS assessment, pt in arrest with significant head injury, blood loss and cold. Patient declared deceased. QPS attended scene due to suspicious circumstances.

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13855395. 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:
- 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:**

| | |
|---|---|
| Received: | 18:51hrs |
| Dispatched: | 18:52hrs |
| On Case: | 18:52hrs |
| On Scene: | 19:01hrs |
| Cleared: | 20:44hrs |

**Review:**
- 1 X ACP units, 1 X CCP attended scene.
- Response time for first unit on scene was 9mins.

**Outcomes:**
- Nil operational concerns with case.
- Nil clinical concerns with case.
- Peer Support activated through OpCen.

- Debrief occurred on scene with OS.

**Post OIRR actions:**

- Nil.

## Review Recommendations:

- Nil.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- OpCen Brief

## 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 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 13981986 at Munchow Road and Moffatt Road Waterford West QLD 4133 at 08:50hrs on 4 February 2021 to a Irrelevant female with severe, Irrelevant burns from a house fire. The patient was treated for burns including rapid sequence induction and transported to the Royal Brisbane Hospital

**Terms of Reference:**
This review will investigate all aspects of ambulance response to incident 13981986. 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:**
- 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:**

| | |
|---|---|
| Received: | 08:50hrs |
| Dispatched: | 08:51hrs |
| On Case: | 08:51hrs |
| On Scene: | 09:01hrs |
| Depart: | 09:30hrs |
| Hospital: | 09:58hrs |
| Cleared: | 11:47hrs |

**Review:**
- The response time was 13 minutes. The closest available units were dispatched. There was a delay in dispatching a transport unit due to the lack of resources.
- The patient had 90 percent burns with significant face, neck and torso burns.
- The clinical management of the patient was sound.



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**Outcomes:**

- Nil operational concerns with case.
- Nil clinical concerns with case.
- Peer Support activated through OpCen.
- Debrief occurred on scene with CSOs.

**Post OIRR actions:**

- Nil.

## Review Recommendations:

- Nil.

## Appendix of relevant documents/files:

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

## 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)

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 13859707 at Irrelevant Beaudesert QLD 4285 at 17:15hrs on 5 February 2021 to a Irrelevant male reported to be deceased by self-inflicted gunshot wound. Request came from QPS who arrived on scene prior to QAS and confirmed patient was deceased. QAS arrived on scene and confirmed patient deceased with ROLE completed and handed over to QPS.

### Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13859707. 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:
- 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:**

| | |
|---|---|
| Received: | 17:15hrs |
| Dispatched: | 17:17hrs |
| On Case: | 17:19hrs |
| On Scene: | 17:32hrs |
| Cleared: | 18:08hrs |

**Review:**
- 2 X Single ACP units responded with single ACP arriving on scene.
- Case downgraded to Code 2 once QPS confirmed patient was deceased.
- Response time for first unit on scene was 16mins.

**Outcomes:**
- Nil operational concerns with case.
- Nil clinical concerns with case.

- Peer Support activated through OpCen.

**Post OIRR actions:**

- Nil.

## Review Recommendations:

- Nil.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- PSDU Notification
- OpCen Brief

## LASN Endorsement

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

# 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 13861736** – At 7:40hrs on Saturday 6th February 2021 the Queensland Ambulance Service (QAS) received a request for service from Mermaid Beach Surf Life Saving Club. This request was for a Irrelevant M not breathing and unconscious, CPR was in progress.

A further call to QAS from a passer-by identified the patient was post drowning.

This case was coded 1A Determinant 09E01 in response to the information provided. An ambulance was dispatched to the address at 07:42hrs, including a second ambulance, a Critical Care paramedic, a High Acuity Response unit and a Senior Operations Supervisor. The patient was confirmed to be in cardiac arrest and after resuscitation attempts was declared signal 4 on scene.

There was no delay in responding to this case with a time of call to time on scene being 9 mins.

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident 13861736. 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:

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

### State OpCen ProQA:

Outline of report (the LASN Manager must request this from the Assistant Commissioner State Operations Centre (OpCens) as early as possible following the incident).



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## Incident Review/Investigation:

**Scope:**

The process of this SIR is to determine if any clinical or operational failures or exceptional management of this incident has been identified to ensure that best practice in prehospital care is provided to stakeholders.

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:**

Unknown male estimated to be aged in his Irrelevant witnessed to be swimming in a non-patrolled beach area outside of patrol times. At the time of this incident members of the SLSC were performing pre shift beach checks and the patient was observed by one of these members to be in difficulty and as such a surf rescue was initiated. Surf conditions were hazardous and the rescue was challenging. Upon retrieval to shore the patient was reported to be in cardiac arrest.

CPR initiated by SLSC members

Initial call for service received from Irrelevant SLSC member who was not in attendance of patient.

Case coded as 1A 09E01 Nil breathing QAS response 2 x Bravo ambulances, 1 x CCP, 1 x HARU 1 x SOS.

Patient located on beach just south of Mermaid beach Surf Club approximately 50metres from beach access point.

Patient assessed as being in cardiac arrest.

Resuscitation attempts on scene

Patient declared signal 4 on scene.

- **Timeline:**
  - 1st key stroke 07 0:36
  - In waiting q ue: 07 1:35
  - Assigned 1 nit:
  - Enroute 1st uni 07:42:15
  - At scene 1st Unit: 07:49:40
  - Deceased: 08:21:20

  - 41:35 Call for service from Mermaid Beach SLSC Male Irrelevant old not breathing an nconscious.
  - 07:42:0 601523 (Bravo) and 606692 (CCP) assigned to case
  - 07:42:23 Confirmation from SLSC CPR in progress
  - 07:43:31 SOS advised and attached to case
  - :44:21 Call to QAS from passer-by confirming patient post drowning
  - 07:44:24 Confirmation defibrillator on scene.
  - 07:44:47 606853 assigned to case (HARU)
  - 07:47:41 607313 assigned to case (SOS)
  - 07:48:06 Informant states there may be another patient in the water.
  - 07:49:40 B601523 arrives on scene (First unit)



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- 07:49:51 Informant states there is an off duty lifeguard on scene.
- 07:50:21 QAS common call for second Bravo unit – nil response
- 07:50:21 Confirmation received access via the southern side of the surf club
- 07:51:16 Sitrep from 6523 keep back up unit coming code 1 CPR in progress
- 07:52:09 From ICEMS - Drowning at beach Irrelevant M CPR in progress
- 07:52:37 A606692 arrive on scene (CCP)
- 07:52.50 B601306 cleared from GCHRB and assigned to case.
- 07:53:07 From SLSC Operations Centre request for service – duplicate case.
- 07:58:23 Transmission from 606853 'Gone to wrong surf club' heading down now.
- 07:59:43 ICEMS QPS on scene.
- 08:00:16 A606853 arrive on scene (HARU)
- 08:04:04 B601306 arrive on scene (BRAVO)
- 08:05:43 B607313 arrive on scene (SOS)
- 08:10:51 Sitrep from 607313 Confirm patient still in cardiac arrest remains in asystole.
- 08:21:10 Sitrep from 607313 Patient Signal 4 – QPS on scene

- **Review:**
  - Bravo unit on sce 9 min om time of call; Alpha POD on scene 11 minutes from time of call.
  - HARU, addi nal Bravo un and SOS dispatched
  - Priority On ctivated

- **Outcomes:**
  - The patient was decla d deceased at the scene and left with police for forensic nvestigation

**Post OIRR a ons**:
- Manag of Clinical Education to review incident and provide further recommendations.

## Review R ommendations:

- Peer sup t to be provided to attending crews.

## Ap dix of relevant documents/files:

- Incident detail report (IDR)
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);

- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- 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);

## 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 |
|---|---|---|---|---|
| | | General Manager | | |
| | | | | |

# 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:

QAS were responding to an incident on the 6th of February at Redbank Plains (13861888) where a vehicle vs truck with entrapments with multiple responding units. On scene, one female patient was seriously entrapped in the vehicle requiring extensive intervention by QFES to extricate the patient. One officer was seriously injured during the extrication with a significant laceration to their arm and a second officer experienced minor abrasions to their hand. Both officers were assessed at the PAH with the more serious injury receiving surgery at St Andrews Brisbane.

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident 13861888. The review will examine ambulance operations prior to during and following the response. This review will include all requirements outlined in the *Operati al In dent Review Process*.

### LASN Clinical Incident S mmar Repo

N/A

### State OpCen oQA:

Quality Ass ance Re w of the Southport OpCen EMD dispatch decision was compliant. No triple zero calls wer made to QAS th the case being received from ICEMS.

### Incident Re ew/Investigation:

**ope:**

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

**Background:**

- On the 6th of February 2021 QAS responded to an incident at Irrelevant Redbank Plains to reports of a serious RTC involving a car and a truck.
- The patient in the car was seriously injured and entrapped in the vehicle. The scene was quite complex with QFES making multiple attempts to make the vehicle as safe as possible.
- During extrication of the patient, the QAS officer arm contacted the B pillar of the car that was uncovered resulting in a large laceration to their left forearm approx. 15 cm deep.
- The injured officer on scene received immediate care on scene by a Paramedic.
- The entrapped patient was removed safely and transported code 1 to PAH.
- The injured officer was transported by their partner to PAH with the partner later reporting minor abrasions to his hands requiring assessment at PAH.

**Timeline:**

Case 13861888

| | |
|---|---|
| Received: | 08:36:41 |
| Dispatched: | 08:37:06 |
| On Case: | 08:38:12 |
| On Scene: | 08:51:39 |
| Depart: | 09:51:33 |
| Destination: | 10:20:09 |

Injured officer

| | |
|---|---|
| Depart: | 09:52:01 |
| Destination: | 10:21:43 |

**Review:**

- 2 x Bravo Unit, CCP, ARU and S S t nded scene.
- Response time of 00:15 2 for t e first QAS u t to arrive on scene.
- A review of rostering at the e was appropriate.

**Outcomes:**

- Th entrapped atient was transported code 1 to PAH with serious head and limb injuries.
- T e QAS officer s transported to PAH with a large laceration to his left forearm that penetrated ep muscle.
  The injured of r was subsequently transported to St Andrews Brisbane and received surgery the day of the injury and was discharged.
- A secon QAS officer was assessed at the PAH after later reporting minor cuts to their hand requiring f aid/wound cleaning only and precautionary blood test.
- The MS SOS met both officers at the PAH for a welfare check.
- WM SOS initiated SHE report and WorkCover paperwork on behalf of the injured officer.
- WM SOS visited injured officer at St Andrews Brisbane.
- ng support provided by OIC and LASN management.
- Priority one activated for all involved.
- OIC discussed incident with QFES who conducted their own review into the injury.



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## Review Recommendations:

Nil.

## Appendix of relevant documents/files:

| | |
|---|---|
| Incident Detail Report | IDR 13861888.pdf |
| Ambulance Report Form | Not provided |
| PSDU Notification Email | |
| LASN Notification Email | WM Incident Notification - Officers |
| OpCen Brief | 050221 NIGHT SOUTHPORT OPCEN I |
| Workforce Planning Report | WTM Resource Report - Saturday 6th |
| State OpCen ProQA | OpCen review FW_ WM Incident Notificat |
| Radio transmissions of RTC | 06.02.2021 08.37.25 Radio - EMD Dispatcf<br>06.02.2021 10.18.46 Radio - 601637 Sitrep<br>06.02.2021 10.14.57 Radio - 607696 Sitrep<br>06.02.2021 10.08.16 Radio - 606698 Sitrep<br>06.02.2021 09.50.59 Radio - 601665 Sitrep<br>06.02.2021 09.46.47 Radio - 607696 Sitrep<br>06.02.2021 09.23.58 Radio - 607696 Sitrep<br>06.02.2021 09.16.16 Radio - 607696 Sitrep<br>06.02.2021 09.06.55 Radio - 606698 Sitrep<br>06.02.2021 09.02.41 Radio - 601665 Sitrep<br>06.02.2021 08.54.09 Radio - 606698 Sitrep<br>06.02.2021 08.48.45 Radio - Confirming lo<br>06.02.2021 08.40.28 INC 13861888 Call fro |

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|



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| | | | |
|---|---|---|---|
| Andrew Hebbron | LASN Manager | Irrelevant | 24/2/2021 |
| Lisa Dibley | A/Executive Manager Operations | | 24/2/2021 |

Department of Health
Queensland Ambulance Service

# Significant Incident Review

Version 1.0 August 2020

## 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 13877486) located at Regis The Gap Aged Care Facility, 6 Kilbowie Street, The Gap, at 8:47pm on Tuesday 9 February 2021 to Irrelevant emale post fall.

There was an extensive delay of 3 hours and 7 minutes in responding to this case.

### Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13877486.
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:
N/A

### State OpCen ProQA:
Attached.

### Incident Review/Investigation:

#### Scope

- Metro North LASN revie d the resp se linical performance and operational decision making to ensure the appropriate resp se a managem of this case was achieved.
- Metro North LASN will identify operational or clinical performance issues with this case and ensure appropriate actions are taken to urn performance to the required standards.

#### Background

- Brisb e OpCen r eived a call to a Irrelevant female patient, who had an unwitnessed fall, with nil ob us injury.
- gn cant delay in resp se of 3 hours and 7 minutes.
- The pa nt passed away l ter that day.
- Regis Ag Care Facility had nil concerns regarding QAS response time.

#### T meline

| | |
|---|---|
| **Key :** | 8:47pm |
| **In waiting queue:** | 8:48pm |
| **Assigned:** | 11:43pm |
| **Enroute:** | 11:43pm |
| **scene:** | 12:04am (HARU) |
| **Departed scene:** | 12:41am |
| **At hospital:** | 12:57am |


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## Review

- At the time, no alternative more suitable resources available.
- Crew turnouts within acceptable timeframes.
- Call back conducted at 10:01pm – patient PMHX Hypertension, currently 190/11o, other vitals within normal limits. Advised of delays.
- Call back from aged care facility at 11:40pm – patient is unconscious, BP208/101.
- Case upgraded at 11:40pm.

## Outcomes

- Patient was found to be critically unwell with HARU.
- Transported to the Royal Brisbane and Women's Hospital.
- Aged care facility advised Senior Operations Supervisor (SOS) that patient passed away later that day.

## Post review actions

- SOS reviewed case with CDS
- Follow up call conducted by SOS to Nurse in charge at aged care facility.

## 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 | Electronically endorsed | 08/03/2021 |
| Warren Painting | Acting Director Operations | Electronically endorsed | 08/03/2021 |

# 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 Stephen Gough, in compliance with LASN directive 08-15, this review was completed by Senior Operations Supervisor (SOS) Kristy McAlister.

### Executive Summary:

At 07:30 on the 14th February 2021 Queensland Ambulance Service (QAS) received a request to complete an Inter-Facility Transfer (IFT) from Nambour General Hospital to Sunshine Coast University Hospital (SCUH).

The incident was categorised through the Medical Priority Dispatch System (MPDS) as a Medically Authorised Transport (MAT); RED 2C response; Incident Detailed Report (IDR) 13896513.

B401962 was already located at NGH and were dispatched to perform the IFT however, officers did not follow Personal Protective Eq nt (PPE) application as per QAS COVID-19 Risk Assessment Matrix because they did not a nowled e dispatch information regarding COVID. This breach was escalated to the Patient Ac ess Co-ord ation Hub (PACH) by a Registered Nurse (RN) after the crew arrived at SCUH. SOS was noti ed of the PPE breach at 09:56 by the PACH Operations Supervisor (OS). SOS co acted B 09:59 to discuss the incident. SOS provided SIMR Medical Services number an re ested SIMR be contacted direct by crew. SOS also contacted Maroochydore Operations Cen and requested B401962 be placed Out of Service (OOS) until further notice while vehicle was ing appropriately cleaned and awaiting additional advice from SIMR regar g infection requiremen for officers.

### Term of Refere e:

T eview will investig e all aspects of ambulance response to incident 13896513.
This r iew will include al quirements outlined in the *Operational Incident Review Process*.

### LASN Clini l Incident Summary Report:

Digital Ambulance Report Form (DARF) 503155295 was completed by officer Gary Axsentieff. The patient was transported with a RN escort. Nil patient examination or observations have been ecorded on the DARF during QAS transport, (all vital signs were taken and recorded by the RN onto the h tal notes.)

A clinical review Evaluating Clinical Improvement and Patient Safety (ECLIPSE) has not been requested for this incident.



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## Incident Review/Investigation:

The Senior Operations Supervisor immediately contacted B401962 after being notified of the PPE breach to discuss the incident with the crew.

- Patient was attended by 2 Officers and a nurse escort who was wearing PPE
- The patient was short of breath with a history of asthma
- There was a note in the IDR that the patient is currently awaiting COVID19 test results. The crew stated they did not see this.
- The patient was on an oxygen mask prior to transfer, whilst in QAS care and on nasal cannula during transport
- Patient did not have a cough and crew were not exposed to any body fluids
- Close contact time with patient approximately 30 - 40 minutes
- No PPE was worn at any time whilst with the patient

## Background

Queensland Ambulance Service received an Inter-Facility Transfer request at 07:30

Patient Irrelevant Date of Birth Irrelevant
History of asthma; oxygen required
RN escort
Patient tested for COVID; waiting results

QAS resource dispatched to this incident:

B401962 Irrelevant

## Chronology

Below is a chronological quence of

07:30 Request for QAS serv perform IFT from NGH DEM to SCUH DEM

07:33 Incident “In Waiting Queu

07:47 B4019 2 dispatched, (already cated at NGH)

08:37 B401962 d arted NGH with patient and RN escort

09 5 B401962 arriv at SCUH

09:49 401962 cleared fr m incident

10:06 B4 962 placed Out of Service

11:41 B40196 placed ‘on station’ (available to respond)

## Incident Outcomes:

SIMR Medical Services were notified of the PPE breach by B401962

- Officers were advised to perform correct hand hygiene including arms and any other surfaces that may have been exposed
- Officers completed a 'COVID-19' clean of their vehicle and equipment
- Officers changed uniform as per SIMR request
- Follow up email was sent to Officers with general advice to monitor for any COVID symptoms

## Review Recommendations:

As part of a proactive review, the OIC Coolum has been requested to provide follow up with officers Irrelevant and Irrelevant to ensure they are aware of their responsibilities to provide a safe working environment through the application of appropriate infection control measures.

A review of the following pertinent documents should also be undertaken by the officers:

- QAS COVID-19 Risk Assessment Matrix, (last updated 01/10/2020 – Version 22)
- QAS Medical Director Circulars relating to COVID-19
- QAS COVID-19 Clinical Resources, (03/2020 – Clinical Priorities for suspected or confirmed COVID-19 patients)
- QAS COVID-19 Updates, (04/09/2020 – Safe donning and doffing of PPE for QAS clinicians
- QAS Infection Control Alerts

That this Significant Incident Review be noted and filed.

## Appendix of relevant documents/files:

- Incident Detail Report 13896513
- DARF 503155295
- Senior Operations Supervisor end of shift report 14/22/2021 (0600-1800)
- SIMR Medical Services notification Sunshine Coast LASN – PPE not worn
- SHE Report requested

## 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 | 15/02/2021 |

# 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 13901582) located at Irrelevant Indooroopilly, received at 12:32pm on Monday 15 February 2021 to Irrelevant female patient who was suffering from suicidal ideation.

There was an extensive delay of 2 hours and 19 minutes in responding to this case, where the paramedics located a deceased patient.

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 13901582.
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:
N/A

## State OpCen ProQA:
- Attached.

## Incident Review/Investigation:

### Scope
- Metro North LASN reviewed the response, clinical performance and operational decision making to ensure the appropriate response and management of this case was achieved.
- Metro North LASN will identify any operational or clinical performance issues with this case and ensure appropriate actions are taken to return performance to the required standards.

### Background
- At 12.32 pm on 15 February 2021, the QAS received a request for assistance to a female patient located at an Indooroopilly residence who was suffering from suicidal ideation.
- The case was coded by the Medical Priority Dispatch System (MPDS) as Threatening Suicide, requiring a Code 2A (immediate response without lights and/or siren).
- The QAS was experiencing extreme demand for service and HHS ED pressures across SEQ which affected paramedic availability at the time of the request, with a high number of pending Code 2A cases in the community being delayed.
- Although a single Officer-in-Charge (OIC) was available to respond and located at Kenmore Ambulance Station at the time of the incident, the Emergency Medical Dispatcher did not utilise the Computer Aided Dispatch (CAD) recommend function, which would have identified the Kenmore OIC as the closest unit response to the incident.
- The Operations Centre Mental Health Liaison Clinician reviewed the patient's history at 12.38pm and at 1.12pm, and QAS also attempted to contact the patient to complete a welfare check and to advise of the delay, however, were unable to reach the patient.





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