Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014		Staff unable to open Pt's door on the hrs visual checks.Duress activated for assistance to open pt's door. Pt found hanging from door with a tied around neck. Pt placed on floor and CPR commence as no breathing and no pulse. Code blue called and CPR continued by nursing staff until medical team arrived.	Duress activated Code Blue called Nurse Manager notified	Incident managed by Nurse manager
	/2014	Metro South	Patient was admitted to hospital Admitted into ICU where condition continued to deteriorate. Clinicians identified required and made effort to transfer patient to alternative facility as not availble at current facility. During the transfer the patient deteriorated quickly and arrested. where resusitation was unsuccessful. Patient's family contacted Coroner reviewed and decided death 'not reportable'	Senior clinican discussed the incident/care with family	Support provided to family
	/2014	Wide Bay	Pt arrived at ward hrs from ED. Pt Deteriorating, BP Dr Attended and interventions attended, Teamleader and RMO advised of further detirioration, teamleader attended to manual BP and as pt at Drs attended	NULL	NULL
	/2014		Pt found unresponsive in . Code Blue called. When pt transferred to ICU, several medications found in patients which should have been sent home with		Patient is under the care of ICU staff.
	/2014	Townsville	Patient mobilising from room, with a . Loud noise heard from patient's room. On attending the patient, patient found laying on floor at the end of . Immediate assessment of patient: Neuro obs unremarkable, Temp heart rate elevated post fall, respirations increased post fall. Patient stated "felt faint when enetering room and fell backwards, hitting head". Nil injury observed to patient's head. Small skin tear to . Nil external/internal , nil extension or shortening of length. Patient denied any pain when asked by nursing staff. Patient able to stand with assistance of 3 staff. On standing, patient stated had pain on Patient safely transferred to laying on bed by 3 staff and slide sheet. Patient immediately transferred via QAS to nearby facility for acute assessment by Medical Officer.	Immediate assessment of patient: Neuro obs unremarkable, Temp , heart rate elevated post fall, respirations increased post fall. Patient stated "felt faint when enetering room and fell backwards, hitting head". Nil injury observed to patient's head. Small skin tear to . Nil external/internal nil extension or shortening of length. Patient denied any pain when asked by nursing staff. Patient able to stand with assistance of 3 staff. On standing, patient stated he had pain on Patient safely transferred to laying on bed by 3 staff and slide sheet.	Patient immediately transferred via QAS to nearby facility for acute assessment by Medical Officer.
	/2014	Metro North	antenally uncomplicated, since to from hospital. Whilst on Birth suite having went to established labour. presentation prior to labour & remained in labour. Patient was , decision as to confirmation of mode of delivery was to be made after examination. at that time seen by Peads.. at . Patient continued to rapidly progress to a delivery with . Baby stillborn despite 20 mins of CRP.Apgar @1min @10mins. . Impression at birth likely	Resusation of Baby without success. Follow up by Psychiatry Team & Social Workers	Stillbirth & Placenta for Histology.
	/2014	Sunshine Coast	2014 Patient transferred from Hospital – possible acute Direct surgical admission to ward . Reviewed by CNC and Surgical Registrar. ADDS score on admission. 2014 Patient transferred to hrs. No documentation to support that a surgical team review was conducted throughout the day. Patient deterioration over hrs. No PRECALL activated despite ADDS score at hrs. Further deterioration. hrs - PreCall activated, ICU attended Code Blue activated - patient in extremis. Transferred to ICU for aggressive resuscitation, intubation. /2014 hrs - Surgery for investigation of possible Patient passed away. Death reported to the Coroner.	Agressive resuscitation. ICU. Intubation. Surgery for investigation of ? . Result - extensive seen.	Provision of ongoing care. Essentially palliation.
	/2014		year old , travelling through location, admitted with history of pain in moving around to fever. Diagnosed with prior to admission. Patient deteriorated during admission, requiring transfer from for ongoing care and subsequent retrieval to a Tertiary Facility, where passed away.	Case review suggested by medical officer at , nursing staff counselled re: ADDs scoring. Await other recommendations	Nil at present
	/2014	Metro North	An year old was admitted and underwent a Category 1 elective 2014. It was noted that the reason for surgery was developed and was transferred to the unit for close monitoring and management of the . The patient was then transferred to the unit for close monitoring and management of post-operative 2014 a MET was called for a low blood pressure. The patient was noted to have been febrile, with persistent In consultation with the Surgical Consultant the patient was returned to the operating theatre for a and admitted to the Intensive Care Unit (ICU) post-operatively. Histopathology of the The patient stayed in the ICU for days, and was treated for A decision was made in consultation with the The patient died in the unit on 2014.	Patient was assessed via a MET and plan put in place and commenced.	Patient re-assessed at ward round at 14.
	/2014	Gold Coast	PT found on floor by medical staff. lying face down and unresponsive. Met call. ARP in place. R/V by ICU doctor. Pt T/F back to bed. PT found to be deceased. Family informed and coronors informed	Met call. ARP in place. R/V by ICU doctor. Pt T/F back to bed.	PT found to be deceased. Family informed and after hours coronors informed.
	/2014	Metro North	yr old admitted as a voluntary patient on 2014 due to depressive features not reponding in the community. On 30 mt visual observations. 2014 patient sighted at hrs and found at hrs unresponsive.	Medical Emergency Team alerted. Resuscitation commenced immediately.	Patient prounced deceased at hrs.
	/2014	Townsville	This was a year old patient with surgery and an immediate post operative plan, with documented observations and clinical documentation of deterioration without appropriate escalation	Patient had episodes of clinical deterioration which where recognised by ward staff but not escalated acording to hospital MEWS and MET procedures to allow for clinical review by experienced staff. The pateint was only seen by and RMO whilst on the ward who informed the registrar of the patients' issues but was not physically reviewed by the registrar. There is no enidence to suggest that the consultant was notified of the patients' deterioration.	Patient went on to have a cardiac arrest and subsequently died as a result.
	/2014	Townsville	A with a known admitted with a day history of poor feeding, has suddenly deteriorated into cardiac arrest during an attempted placement of a . A protracted resuscitation was not successful and the died	Dr's were immediately called, airway support & CPR was commenced by Dr's, MET team was called.	Patient was resuscitated for 45 mns, before Dr's pronounced death,
	/2014	Central Queensland	Foetal death	Resuscitation commenced on delivery	Unsuccessful resuscitaiton. Discussed with Coroner.
	/2014	West Moreton	PATIENT BOOKED FOR REPAIR. ENTERED THEATRE HRS. SURGICAL REMOVAL COMMENCED REMOVED, DR CALLED CARDIAC ARREST AT HRS.	CPR AND LIFE SAVING INTERVENTIONS COMMENCED. DR CALLED AT HRS. INSERTED AT HRS. DR REVIEWED RE BLOOD LOSS AND PERFORMED AT HRS. SURGICAL REGISTRAR ATTENDED CODE CALLED AT HRS.	Death of patient

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Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014	Metro North	Patient was being treated for 14 identified a perforated A .14 identified gross Discussion with family and patient around treatment options and agreement that the patient should be managed palliatively. Patient deceased on 14	When the patient was identified as having a perforated , discussions with the patient and family occurred around treatment options and palliation.	Decision made that the patient was for palliative care.
	/2014	Metro South	Term baby delivered in Birth Suites. APGAR at 1 minute and required stimulation as slightly floppy. Babe taken to resuscitair where babe improved in colour. Babe taken back to mother with APGAR at 5 minutes. Approximately minutes of age babe noted to be floppy and cyanotic.	Resuscitation commenced and paeds reg contacted. Escalation to paeds consultant who whilst in attendance contact made with QNET. Decision to discontinue resuscitation	Baby deceased and death reported to Coroner. Support provided to mother and debriefing organsied for staff
	/2014		PSO copied 'What Happpened' - Presented to HDU via ambulance in cardiac arrest at	Resuscitation continued, including cardiac compressions and ventilation, line into and normal saline infusion commenced, micrograms adrenaline adminstered via multiple shocks given adrenaline repeated x in total x micrograms. Intubated on 3rd attempt. inserted mls gastric aspirate	Nil response to resuscitation efforts time of death * What stopped the patient from being seriously harmed? Chance Family / visitor intervention Staff intervention Existing safety system Patient intervention ? Suggestions to prevent reoccurrence ( ) Enter Reported By Details Surname First Name *Staff Category Please Select Administrative Allied Health Indigenous Health Worker Medical Non QH staff/ external party Nursing Operational Oral Health Pathology Pharmacy Technical *Other Staff Category Position Held *Date Incident Reported (dd/mm/yyyy) Click the calendar icon to select date. *Time Incident Reported Hour 00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 hrs : Minutes 00 05 10 15 20 25 30 35 40 45 50 55 mins (24 hr clock)
	/2014	Gold Coast	/14 • yr , presents via planned insertion of • Hypertensive prior to procedure and given • Remained • stablised and sent to /14 • pt woke with chest pain at hrs review by RMO and Reg • • Taken to OT at • Died in OT, was appropriately reported to the coroner	during the procedure. Pain relief and sedation was given intermittently during the procedure to keep pain free and calm to perform procedure. Applied pressure on the incision site to stop bleeding and oozing during and after procedure.	Blood pressure was undercontrol with the help of Compression on the bleeding site helped in achieving haemostasis before patient leaving the Intensity of pain was reduced with analgesics and sedation helped in calming down the pt. Patients obs were stable and patient was stable while leaving the was happy with the condition of the patient before transfering.
	/2014	West Moreton	Sudden unexpected death of in-patient in a Unit on the 2014.	CPR commenced and Code Blue activated. Ambulance called.	Attended by Medical Staff and emergency equipment. Resuscitation efforts continued until QAS attended at hours and declared life extinct at hours.
	/2014		old child admitted as inpatient, hrs began to deteriorate, recognised and MO called in to assess, Clinical Coordinator contacted at approx hrs. Paediatric team tasked to retrieve child, expected to arrive at hrs. Patient deteriorated into respiratory arrest initially at hrs, recovered then deteriorated into cardiac arrest approx hrs, not able to recover, resuscitation occurring with arrival of Paediatric team at approx hrs, visiting team announced life extinct.	Appropriate resuscitation efforts made	No effect
	/2014	Gold Coast	Delay. Deterioration observed and recorded but not interpreted. Deterioration interpreted but response inappropriate	ALS	patient died
	/2014	Metro North	year old presented in extremis to ED with uncertain underlying diagnosis for acute critical illness. PEA arrest in necessitating . Referred to and accepted for admission to same. High dose started but critical instability continued. This was followed by multiple PEA arrests in necessitating . In my opinion, given the futility of the clinical circumstance (no reversible cause of multiple cardiac arrests amenable to definitive management identified) and the ongoing instability (frequent cardiac arrests necessitating CPR) this patient was clinically unsuitable for transfer. All transfer achieved was to expose transfer staff and QAS staff to a small but definite WH&S risk given the high acuity transfer (with no reasonable likelihood of change to the patient's outcome) and a worsening of the social circumstance around the unexpected death of a loved one for the family involved.	was DOA at Hospital.	
	/2014		During routine handover, n'staff could not locate the pt in the room Staff noted door locked from inside. N'staff knocked and there was no response. So n'staff opened the door and found pt slumped next to wall with a around neck. It was quite clear that pt had ceased breathing when found.	Called code blue	Pt death was the result. Relevant authorities were notified including QLD Police and the necessary processess was then underway.
	/2014		arrived in emergency department at approx EN who received it into chest, felt the baby was cold, looked at baby and noted it was "blue" and not breathing. EN ran with baby to ward/ resus bay whilst yelling for help. RN in corridoor. took baby to neonatal resus trolled in labour ward. Active resuscitation commenced. Nil history on baby, had left ED after handing baby to EN awith and further details requested. Baby had been discharged at approximately before. Medical officers Dr and Dr had been called in in the interim. and requested attendance. Dr Full active resuscitation as per notes.CN/Midwife called in at request of NUM to assist. Police also advised during this time and hospital contacted for medical history (by RN) during the resuscitation. Police in attendance also	active resuscitation as above	unsuccessful resuscitation
	/2014	Gold Coast	Patient was transfered to from a surgical ward at /14 due to an acute onset of breathlessness. CTPA exlcuded a PE, patient has a history of and some ECG changes suggestive of a MI. BP Immediate action(s) taken On /14 at hrs pt BP . R/V Cardiology registrar, ADDS score = No MET call. On /14 at BP; RMO and ICU reg R/V requested, nil documentation made by ICU medical staff. ADDS= no MET call made. hrs S/B Cardiology team BP remained nil MET call made ADDS= At hrs pt was tired sweaty and remained hypotensive both cardiac and vasuclar team aware. Nil MET call made, ICU reviewed and transfered to ICU commenced on Result of immediate action(s) On /14 at had episode ST depression, agitation ECG showed ST depression intubation and CPR performed for 40 mins. Deceased due to - PEA arrest		On /14 at had episode ST depression, agitation ECG showed ST depression intubation and CPR performed for 40 mins. Deceased due to - PEA arrest.
	/2014	Metro North	What Happened: yr old on /2014 with shock (mixed) - Large found. /2014 cardiac surgery performed to AVR & MVR performed. Patient . Patient deteriorated at hrs in . Chest opened (no tamponade), heart was asystolic. Resuscitation unsuccessful. Resuscitation efforts ceased at hrs on /2014. Immediate action(s) taken: Family notified. Cause of Death Certificate unable to be completed. Coroner & Police notified. Result of immediate action(s): Body to JTC	Family notified. Cause of Death Certificate unable to be completed. Coroner & Police notified.	Body to JTC
	/2014	Central Queensland	Patient was admitted to hospital on , 2014, for was reviewed by the medical team for acute deterioration on , 2014 - with an ADDs score of Patient was noted to be febrile with T ward round. had not been febrile before this, and was noted as being afebrile at ward round. . At blood cultures were collected. It is noted that patient was found to have Staphylococci 1+ from a taken at 2014.	Blood cultures; mobile CXR; Blood results reviewed; IV started; IV fluids given; oxygen delivered	Patient deteriorated very quickly and passed away from what was believed to be sepsis at the time.

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Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014	Cairns and Hinterland	Pt was admitted to medical ward from 15 at was flagged for on the This was cancelled due to a long list then was a public holiday . On required . Bleeding exacerbated . Had - chest pain ongoing. Unable to provide cath lab to correct situation. Pt very unwell. Sent to RIP in	sent to	RIP
	/2014	Metro North	An presented to ED with symptoms and underwent a CT . Initial preliminary report stated no haemorrhage present, therefore therapy was commenced in line with treatment. Subsequent review of these images the next during a team case review, identified markers indicative of a haemorrhage on the CT image. therapy had already been ceased, a second CT was ordered which demonstrated an extension of the initial bleed. The patient deteriorated , reversal of was attempted but unsuccessful and the patient died the following day.	ceased.	Unable to stop further bleeding.
	/2014		old , attended 2014, am.Runny nose, , eating nothing, drank water , taking the unwell, lethargic, dry mucous membranes, grunting, nasal flaring and tracheal tug, mild intercostal recession. DESTATS on NPS decreased to 90% O2 via1Phone Dr meeting for landing	Rescusitation attempted, following diagnosis the rescusitation attempts were withdrawn.	Death.
	/2014	Metro North	Elective admission year old 2014. 2014 in the Unit the patient's condition deteriorated, PEA arrest, CPR commenced, . No evidence of tamponade. Despite the cardiac surgeon maximising the current amplitude on the ventricular lead & reinstituting a coordinated rhythm at 80/min with the period of arrest already sustained there was no pulse. Resuscitation ceased after 70 minutes. Family & Coroner notified. Cause of Death Certificate completed.	On arrival of CTS established asystolic arrest with failure of capture of epicardial leads. Despite the CTS maximising the current amplitude on the ventricular lead & reinstituting a coordinated rhythm at 80/min with the period of arrest already sustained there was no pulse. Resuscitation ceased after 70 minutes.	Family & Coroner notified.
	/2014	Gold Coast	Patient suffered out of hospital cardiac arrest at 2014. PRIME Written in retrospect from EMR entry and feedback from ward staff. Pt admitted to MAU on 2014 @ . Remained in MAU Impression clinically Pt attended echo on /2014 in removed by RN for ECHO (as per Dr) then reapplied on pt's return to ward as awaiting dr review post ECHO. Pt noted by RN to be on ward during shift other than for ECHO. nursing and Dr notes below indicate patient advised against leaving the ward without monitoring and to remain in MAU: nursing entry states "patient off ward most of shift since @ commencement of shift pt stated has been taking - reinforced education that we are unable to monitor if pt leaves the ward & for accurate monitoring is best if remains on MAU - patient stated understood but wished to go - refused initially til MO offered. For admission to cardiology for further investigation. Painfree & walking around when seen.". Dr EMR entry also noted "Has been mobilising around the ward and up to the throughout today without symptoms removing Notified of admission to cardiology for further investigation of . Offered Should remain for monitoring and admission for further investigation." Immediate action(s) taken QAS called by bystanders pt admitted to ED. Result of immediate action(s) Failed resusitation in ED.	QAS called by bystanders pt admitted to ED.	Failed resusitation in ED.
	/2014		Patient presented via QAS to the Emergency Department (ED) of following being found at home in a drowsy state, it was suspected that the patient had taken an accidental overdose, the patient denied this and was assessed and monitored At the patient was assessed to be medically stable as the patient was able to cough and clear secretions; and was transferred to a allocated mental health room in the ED to wait for a formal mental health assessment. At the patient was checked by staff and found not breathing and a cardiac arrest code called. Resuscitation team arrived- full resuscitation for an hour unable to regain cardiac rhythm. cardiac	arrest code called.resus team arrived quickly. full resus for an hour	resus for 1 hour unable to regain cardiac rhythm
	/2014	Central Queensland	Patient presented from GP with an .Reduced in ED. done at the time suggesting probability of .Discharged home Immediate action(s) taken D/W surgical team for f/u in Discharged home Result of immediate action(s) Presented hrs later in	D/W surgical team for f/u in Discharged home	Presented 48hrs later in
	/2014	Central Queensland	the patient was a suspected ; came up on and had a When I came on the shift the shift had expressed to me that they had notified Med Reg multiple times as the ADDS score was , and as I had come on at hrs, got an order for , the patient appeared generally unwell- had increased work of breathing and was gasping. The staff stated that and we all believed that was not sufficient. They also stated that the patient had had in ED, and that if the patients heart rate continued to remain elevated, they would consider	Talked about a MET Call but Doctors came to reveiw the patient	Patient was taken to intubated, Given antibiotics and infusion.
	/2014	Gold Coast	Patient given prep to have at home. With background of this should have been done as an inpatient - is unable to tolerate dehydration. was seen in pre-anaes clinic for , but not separately for . The diagnosis of was clearly documented. Immediate action(s) taken Death certificate filled in. Informal query from myself to anaesthetics and resulted in request to fill PRIME	Death certificate filled in. Informal query from myself to anaesthetics and resulted in request to fill PRIME.	nil so far
	/2014	Metro North	Patient was in the nursing to help patient but patient trying to do it and lost balance. Patient had a fall. Patient has an impaired mobility and nursing was assisting patient when stepped out of the room. has sustained a subdudural haemotoma.	NULL	NULL

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DOH-DL 16/17-011
RTI Document No. 3

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014	Gold Coast	Pt sustained an unwitnessed fall at approx hrs whilst mobilising to the nurses documented to have heard a lound thud from the corridor, PHO reviewed patient, who complained of a pain at the back of head nil observations taken post fall, nil interventions, patient did have an ARP in place in relation to the treatment of presentation related to Pt deceased at hrs.	Obs attended, pt returned to bed by staff. Medical team R/V pt immediately.	Pain management instigated by team.
	/2014	Gold Coast	Patient's GCS on admission to ED was and deteriorated after the commencement of O2 therapy for a low oxygen saturation. On arrival in MAU GCS was . O2 therapy 1L/min continued until being ceased at /14, there was no improvement in the patient's conscious level. Patient passed away at	on Consultants ward round on the hrs, O2 was documented on EMR to be ceased.	pt's GCS increased as per nursing notes.
	/2014		Unexpected fetal death at delivery Difficult removal. Additional staff sought. unit in phoned. No heart rate.	Emergency nursery team phoned. resus of baby approx mins. No heart rate.	Unable to resuscitate - baby deceased.
	/2014	Gold Coast	It was noted that from approximately to the time of the incident at /14 the patient had frequent runs of increasing in frequency and length which was not actioned. The alarms being sounded on the Cardiac monitor with no documentation to esculating to Medical staff or senior nursing staff. The runs of increased with a large number of episodes being able to be accessed from the history of the Philips monitoring system. It was documented that the alarm setting was 50 - 100 therefore the rate alarm sounded frequently with approximately 25 alerts as well as the red alarm for VT	Nurse Educator immediately implemented that date of observation Inservice with staff involved on , and safe nursing practice with DETECT and esculating to Medical staff with documentation. Immediately discussed with Staff involved. Clinical Facilitator debriefed with staff involved. Regular every thursday Arrhythmia interpretation and safe Nursing practice to identify arrhythmias implemented immediately. Safety scrums identified alarm settings each shift for the fortnight. More staff sent to ALS training with all	Graduate nurses now trained in ALS competency. Every thursday Cardiac monitoring training inservice calender. Clinical Facilitator visualising the documentation of arrhythmias. New Qt ADDS chart will reflect Arrhythmia and alarm settings documented
	/2014	Townsville	The patient presented to the Emergency Department on consecutive days. was admitted on the day suffering from over whelming sepsis and died hours later.	Triage meeting conducted with	Incident requires investigating.
	/2014	Wide Bay	Pt on half hourly visual obs. Staff checked pt at hrs, was in a supine position on the bed with eyes closed. Staff went to attend to pt in next room. Staff found pt on the floor in the corridor, between rooms skin tears to area, and considerable pain to and	Dr called and attended, analgesia given, portable oxygen applied at /min via the , Dr ordered Xray, as area swelling. Trauma mat sourced and used with staff assist to return pt to bed. Skin tears cleansed with normal saline, steri-stripped and dressing applied for protection.	Pain decreased a little, evening meds given, pt attending Xray
	/2014	Cairns and Hinterland	Patient fell whilst in and was found by staff on the floor. Patinet had been left without assistance. Patient had attempted to stand and dry according to the notes	Returned to bed and reviewed by MO Dressing to haematoma on Neuro observations commenced Post falls pathway commenced by nursing staff - No CT ordered by MO -pateint met risk factors with age over 65 anticoagulants and obvious HI	Nil obvious neurological damage but pain was investigated and detected on Xray
	/2014	Metro South	pt presented to ED on /14 at with and discharged at ; pt represented on the day at with and discharged at 3rd presentation on the day at intubated, respiratory and cardiac arrested due deterioration with condition. pt is now admitted to ICU.	admitted to ICU, intubated	admitted to ICU
	/2014	West Moreton	Day post op . Pt said felt good and was being walked to when said felt dizzy and said had no pain. was sat on and immediately became unresponsive had a pulse and went stiff.	Staff assist was called. Multiple staff responded and code blue was initiated. Patient was transfered back to bed and resuscitation continued. Patient displayed some initial response to resuscitation with awareness. denied any pain then paitent again began unresponsive with no output. Resuscitation continued for aprox 1 hour total. Faimly notified during resuscitation.	Patient deceased. Coroner notified.
	/2014		year old was weeks on with severe essential hypertension superimposed with PET. The mother was on The admitting ultrasound supported a early gestation fetus with maternal hypertension. The fetal doppler studies were documented as normal. There are periods in the mother's care where the level of observational monitoring cannot be determined, nor the administration of new introduced medication as per medical orders. Terminal bradycardia was diagnosed on fetal ultrasound on with fetal death confirmed at hours. This is being reported to provide an organisational opportunity to review the patient's care and determine if there are learnings to be learnt	There are periods in the mother's care where the level of observational monitoring cannot be determined, nor the administration of new introduced medication as per medical orders.	Terminal bradycardia was diagnosed on fetal ultrasound on with fetal death confirmed at hours. This is being reported to provide an organisational opportunity to review the patient's care and determine if there are learnings to be learnt
	/2014		admitted on /2014 with increased work of breathing. deteriorated suddenly and unable to be resuscitated with bag and mask. Intubated but ETT dislodged and not recognised for approximately 15 minutes. not able to be resuscitated thereafter. Room small and difficulty with access to	As above	As above
	/2014	Cairns and Hinterland	Presentation with central chest pain radiating to back. ago excluded and interpreted as cardiac event on basis of inferolateral ST depression in 12 lead ECG. Surgeons consulted prior to and provided advice around relative contraindications. given. Significant bleeding following .Questions raised whether was appropriate in this instance	Measures taken to manage bleeding and replace lost blood. Required extensive management in ED and admission to ICU when bed available to maintain perfusion.	currently in ICU.
	/2014	Metro North	Pt given incorrect dosage of - should have been 0.1ml was given 0.4ml. Error not discovered until during ward handover pt noted to be drowsy but rousable. team leader notified.pt is palliative and vital signs not being recorded.	error not discovered until during ward handover pt noted to be drowsy but rousable. team leader notified.pt is palliative and vital signs not being recorded.	pt for close visual observations
	/2014	Metro North	CAT 2 LSCS for failure to progress. Baby born in poor condition APGARS and . Intubated at minutes and oxygen saturations improved briefly . Condition deteriorated in and baby died approximately hour post delivery.	Emergency call to & appropriate assistance obtained. Consultant also called in.	Baby intubated and ventilated but oxygen saturation level remained low. . Baby deteriorated rapidly on admission to and required CPR. Despite resuscitation baby died at hrs
	/2014	Metro North	Pt found on the tilt backward on floor. Pt appeared alert and was able to recollect fall event	NULL	NULL

RTI Released

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014		Woman presented at /14) followingt spontaneous hrs. Assessed by midwife. Not contracting. Initial BP when repeated at hrs. SMO notified. Woman advised to go home and retuirn if Advised ofneed for antibiotics if Woman represented to maternity /14) at hrs in established labour. BP BP then repoeated half hourly Woman contracted strongly, Midwife tried to obtain a fetal heart rate, however could not hear properly due to static. Woman advised to return to bed for assessment. As woman being escorted back to . Woman assisted quickly onto bed in and emergency buzzer activated. SMO and oncall team immediately notified. Woman fully dilated. SMO unable to attach baby delivered with one pull at Baby born with no signs of life. resuscitation commenced.		Despite 45 minutes of active resuscitation, there was no response, and baby showed no signs of life at any time following birth
	/2014		Patient was on 15/60 Visual observations. was last seen awake in the hrs. At hrs the visual observation sheet identifies the patient as being in room asleep. A nurse from the area where patient's room was located went to raise patient for evening medications. On arrival in patient's room the patient was found head. When the nurse removed the from the patient's head it was discovered that there was a head which had been Nurse in attendance raised for attention by pressing duress. and removed the from the patient. Patient was place onto back and CPR was commenced. A MET call was initiated by other attending staff. CPR was unsuccessful.	Nurse in attendance raised for attention by pressing duress. and removed the from the patient. Patient was place onto back and CPR was commenced. A MET call was initiated by other attending staff.	CPR was unsuccessful.
	/2014	Darling Downs	unexpected death subsequent to rapid deterioration	CPR commenced , extra medical officer and registered nurses called in.	CPR ceased and patient pronounced deceased at hrs
	/2014	Metro North	/2014 A y o was transferred from Hospital to for from viral . Patient sustained cardiac arrest just prior to initiating procedure. Post-procedure noted to have air in the venous cannula and evidence of air in the aorta.	The case was referred to the Coroner.	Body to JTC.
	/2014		Warfarin dose not charted for patient for days. On day when ward t intervened (not present for first days), the RMO ceased warfarin due to and poor prognosis). Due to reasonable response, did not question this clinical decision. days later the patient suffered a CVA(estimated days out of therapeutic INR). then questioned about cessation of warfarin. spoke about conversation with who ceased the medication. The stated that this decision to cease had not yet been confirmed with the family so the warfarin should not have stopped. Upon talking to the RMO, stated that believed had misinterpreted the doctors' discussion on the ward round and incorrectly ceased the handover. Immediate action(s) taken Team liaised with neurology r.e - recommencement of warfarin Interventions to confirm CVA INR taken (subther) Result of immediate action(s) Warfarin not to recommence Patient palliated	Team liaised with neurology r.e - recommencement of warfarin Interventions to confirm CVA INR taken (subther)	Warfarin not to recommence Patient palliated
	/2014	Wide Bay	Patient was allocated for hour special. Not enough staff were allocated to watch this pt. RN and EEN tried to keep an eye on pt. Pt was sedated with and was asleep. Attended to another pt who had been incont. Proceeded with obs as pts were awake. EEN alerted us that pt related to incident was on the floor.	Obs began immediately, dr was informed, falls pathway commenced,	Pt given 5mg IV morphine and kept on the ground, obs continued, wardies assisted with moving pt to bed, dr did physical assessment, 5mg IV morphine given prior to xray. Pt is still in radiology at time of incident report.
	/2014	Gold Coast	14 yr old admitted with hr hx chest pain BP hrs went direct to cath lab for angiogram,). Transferred to CCU at hrs BP Consultant requested nursing staff to keep a close eye on puncture site. hrs Decreased in BP given nil change in BP, Chest Xray, Bloods, BP nil bleeding noted in angio site, Consultant R/V, pulse strong and bounding ADDS modification made at documented by Reg in consultation with Consultant if ? dropped below ? 100/ twice then for echo at BP remained low was in MET criteria - not called by hrs complained of severe CTC in attendance MET call activated at Patient become unresponsive and chest compressions, T/F to ICU cardiac activity with sinus rhythm, given x units blood, abdo is tense, consider CT when possible? bleed? ICU PEA no recordable BP, RIP		Patient become unresponsive and chest compressions commenced T/F to ICU cardiac activity with sinus rhythm, given x units blood, . notified by ICU PEA no recordable BP, RIP
	/2014	Gold Coast	See EMR notes. (final report dated /2014) Despite thorough preparation & presence of advance airway maintainence equipment, extra qualified staff & a clear knowledge of plan for airway management- Advanced life support implimented & further staff called (arrest button)	See EMR notes. (final report dated /2014) Despite thorough preparation & presence of advance airway maintainence equipment, extra qualified staff & a clear knowledge of plan for airway management- Advanced life support implimented & further staff called (arrest button)	Nonresponsive patient - death
	/2014	Gold Coast	Review of incident reveals that MET call criteria was met at / 14 @ MET call at admitted to ICU. Patient deceased @ / 14	See above	See above
	/2014	Gold Coast	Patient presented to with abdominal pain, vomiting and pm. Transferred to labour ward for assessment as pregnant. Delay in assessment and diagnosis of patient in in labour ward. First blood gas and . Once diagnosed referred to medical registrar Issues with medical registrar ability to find an appropriate location to treat patient- contact team and ICU ?refused to take on patient care. No code blue made. Referred to critical care ~ Patient given over or IV Patient noted to be very difficult- refusing to have an exam for fetal wellbeing or to have extra vascular access as part of treatment. It took from presentation to when the patient in . No further critical investigations such as repeat were done One set of observations done on patient while in labour ward. Patient transferred to immediately for appropriate management	Transferred to Further vascular access obtained Commenced on Regular monitoring of resolved and	patient recovered Inutero fetal demise
	/2014	Gold Coast	was found by nursing staff in the , unconscious and not breathing properly. *Note* - Acheived MET criteria several times earlier in the day with . Immediate action(s) taken MET call activated Result of immediate action(s) Resuscitation efforts unsuccessful. Pt died.	MET call activated	Resuscitation efforts unsuccessful. Pt died.
	/2014	North West	death of yr woman post the birth of a wk foetus	resusitation attempted. hrs asystole	
	/2014	Mackay	year old diagnosed with multiple . Regular attendance of care to the service basis • receiving treatment at the time of presentation to • has presented to Hospital (accompanied with) with signs of recurrence (with a history of this). was borderline hypotensive with Admitted to ward at hours •Patient's transfer was promoted when Consultant became aware of admission	Nil	Nil

Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014	Metro North	What Happened patient found unconscious on Immediate action(s) taken patient assessed airway blocked attempted to clear airway no breaths slight pulse . met call called and resus trolley to cardiac arrest called at Result of immediate action(s) attempt to clear airway no pulse cpr commenced met team arrived and commenced cpr	patient assessed airway blocked attempted to clear airway no breaths slight pulse . met call called and resus trolley to bedside cardiac arrest called at	attempt to clear airway no pulse cpr commenced met team arrived and commenced cpr
	/2014	Darling Downs	Patient with multiple co-morbities admittted /2014. Developed a fever, blood cultures taken 2014, Treatment commenced. Patient died 2014.	Treatment commenced. Patient died /2014.	Patient died 2014.
	/2014	Metro South	/2014: Subdural haematoma post inserted. Patient experiencing ongoing headaches. /2014: Patient transferred to hospital. /2014: Pt transferred back to with subdural haematoma. Emergency evacuation. /2014: Died. Death reported to Coroner. Coroner has declared death could be health care related and is for further investigation.	Reported to Coroner	Coronial investigation
	/2014	Cairns and Hinterland		Staff attempted to Resus patient - too late in recognising the deteriation of the patient. Staff attempted - failed accessed by ward RN but too late for resus	Patient passed away due to delay in recognition and treatment of sepsis in a patient
	/2014	Darling Downs	Patient admitted for care for febrile illness. Culture collected on admission positive days later. No antibiotics on advice from consultant and delay in directed therapy on advice from another consultant. Delay in lab results.	Patient ultimately started on abx and transferred.	Patient subsequently expired at another facility
	/2014	Gold Coast	Nurse was assisting another patient . When walked out of the found the patient sitting on the floor Staff assisted patient back to bed & assessed for any injuries. Vital signs attended- ADDS score Nurse questioned patient about fall, but patient unable to recall events. Medical team informed of same. Patient educated about nurse call bell. Patient alert with confusion (confusion noted on admission). Vital signs stable. MET call @ hrs due to decreased LOC. CT head attended- . Comfort cares commenced. Patient RIP hrs.	Staff assisted patient back to bed & assessed for any injuries. Vital signs attended- ADDS score Nurse questioned patient about fall, but patient unable to recall events. Medical team informed of same. Patient educated about nurse call bell.	Patient alert with confusion (confusion noted on admission). Vital signs stable.
	/2014	Central Queensland	Patient presented to OT for , during freeing of adhersions, tear to , uncontrolable bleeding, unable to be repaired , patient demise. Extra surgeon and anaesthetist, extra equipment, MTP activated, vasopressor infusion. Stabilisation, with resusitation temporay, bleeding incontrolable, decision to that further attempts to repair futile	Extra surgeon and anaesthetist, extra equipment, MTP activated, vasopressor infusion	Stabilisation, with resusitation temporay, bleeding incontrolable, decision to that further attempts to repair futile.
	/2014	Sunshine Coast	On the /2014 an year old sustained a fractured NOF post fall at home. Post-operative management was complicated. Medical imaging was conducted to investigate why the wound was not healing. A was identified via ultrasound. A was also diagnosed during the admission. Intravenous antibiotics were commenced and a The patient was discharged home on the /2014 after removal of the dressing. On the /2014 the patient represented to hospital with confusion, an extensive hip , and a previously undiagnosed collection of infection around the surgically replaced hip. Intravenous antibiotic treatment and was commenced. The medical imaging findings, prognosis, and treatment options were discussed with the patient's family. An informed decision to cease active treatment and ensure comfort measures was made. On the 2014, the patient passed away. The death was reported to the Coroner.	Intravenous antibiotic treatment and wound management was commenced. The medical imaging findings, prognosis, and treatment options were discussed with the patient's family. An informed decision to cease active treatment and ensure comfort measures was made.	On the /2014, the patient passed away.
	/2014	Cairns and Hinterland	Patient admitted to Hospital with . Cardiac arrest and subsequent death in ICU. Died unexpectantly due to ? syndrome	Patient taken to ICU for further care post cardiac arrest	Patient died days after being admitted to ICU
	/2014	Darling Downs	A year old mother presented in labour at weeks. A infant was delivered hrs. The baby cried at birth but soon after required respiratory support. The baby's condition deteriorated and required intubation. The baby initially stabilised and arrangements were made for transfer to a hospital. The retrieval team were in attendance and preparing for transfer when the baby's condition suddenly deteriorated. Despite interventions and resuscitation efforts, the baby died at hrs.	Transfer arranged to	Baby detoriated on site prior to transfer
	/2014		presented with fever +/- convulsion to facility, transferr to and same day deceased	as above	as above
	/2014	Darling Downs	Patient presented with chest pain /14. Abnormal ECG. Sent home with diagnosis GORD. Represented in PEA arrest (arrested at home) on /14. Transferred to showed 95% Coronary Artery occlusion. Pt deceased /14	Identified on chart review Identified on chart review	N/a N/a
	/2014	Darling Downs	Death of , year old inpatient days after unwitnessed mechanical fall.	Pt was sitting out on chair and was found on floor. Physio and nursing staff immediately placed patient in hoist and returned to bed. Dr notified.	reviewed by DR. Pain relief given and x-ray attended cot sides insitu.
	/2014	Gold Coast	Infant vomited/aspirated during/following O/G tube feed overnight	Infant required reoxygenation with intubation and ventilation	Improved oxygenation and improved generalized condition
	/2014		Patient of gestation presented to with PV bleeding and abdominal and lower back pain. Was transfered to the unit from in transit. History of minimal AN care. Reportedly had one ultrasound at in hospital and one presentation in ED with PIH related symptoms. She was discharged from ED following consultation between MO and O and PHO and told to report to her GP. This admission she presented with a lot of abdominal pain associated with PV bleeding. On examination found to be head on view. Neonatal emergency alarm raised and baby born in the noted in the sac. Baby taken to for care and resus commenced by Paed PHO and ICU PHO in the form of neopuff and cardiac massage. The baby at no time showed any signs of life. Continued resus until Paed consultant in attendance at aprrox min sec after birth and confirmed demise. Resus stopped and parents informed of the outcome by Paed consultant.	Neonatal emergency alarm raised and baby born in the noted in the sac. Baby taken to resuscitaire for care and resus commenced by Paed PHO and ICU PHO in the form of neopuff and cardiac massage. The baby at no time showed any signs of life. Continued resus until Paed consultant in attendance at aprrox min sec after birth and confirmed demise. Resus stopped and parents informed of the outcome by Paed consultant.	confirmed stillborn baby
	/2014	Cairns and Hinterland	Past medical history and medication history was not adequately recorded in chart until hours after admission. was noted to have a at approximately /14. At that time no decision was made to investigate whether was not properly, a routine test in the event of . It is possible that the would have expanded anyway, but typically this happens slowly over days and weeks. It is possible that this rapid expansion could have happened in a patient who was not treated with , but it is also possible that the did contribute to the rapid expansion. The patient was assigned to an ward because main problem was identified as a fractured , not a injury. survey was delayed until the day of admission. Patient transferred to as a patient Admission at for days and was palliated and died on the 2014	patient transferred to as a patient	Admission at for days and was palliated and died on the 2014
	/2014	Wide Bay	Pt presented to ED with atypical chest pain. Investigation commenced. come back negative. Pt had 2 x whilst in the department. Pt deemed safe for discharge post a period of monitoring and serial ECG's. Pt discharged home then represented approx hour later in cardiac arrest	CPR and full resusitation measures	Pt died in ED was unable to be resused

Release RTI

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014	Metro South	year old attending the Service. The mother was high risk due to multiple comorbidities. At weeks gestation the mother was referred to the Hospital due to concerns identified on ultrasound. The mother was reviewed at the and discharged back to for ongoing care despite inability to care on site for gestational age less than weeks.	The mother received and was delivered by caesarean section. The baby was born in poor condition and required resuscitation.	The baby was transferred to the however passed away
	/2014		The suspected suicide of a person receiving inpatient health care	Full resus including Adrenaline, intubation, bloods	Deceased at hours
	/2014	Mackay	admitted to hospital post and acute Death review process undertaken Cat 1 on /2014 and referred for Cat 2 death review; which was completed on 2014. Care issues with identification of deterioration and delayed escalation of clients care.	nil	deteriorated and passed away
	/2014	Mackay	Patient admitted 14 with mild , commenced on with subsequent development of severe . Had a physical deterioration over days.	Daily reviews Medical team, management of complicated by and a medical history of	Patient had a grdaula decline, became palliative, discussions with family supported palliative pathway. Recommendation post death review for analysis regarding pt had severe post commencement on medication, and the importance of monitoring otehr electrolytes with poor feeding/oral intake
	/2014		BIBA following collapse in shower. Cardiac arrest and seizures in ED. Lengthy ALS terminated post PEA and seizures.	Recovery position, oxygen applied. Pt not responsive - DRABCD initiated. Defib required. MO notified. Extra support staff called to assist - CN and Paramedic.	MO attended immediately. Support staff arrived within minutes. Resuscitation in place until when pt announced to be life extinct.
	/2014	Gold Coast	On a year old female gestation, presented to the antenatal unit for a scheduled appointment. The patient stated she had lower abdominal pain for the past days and was concerned, and requested an earlier date for LSCS. The patients observations were within normal range and FHR was bpm. CTG was reported to be reassuring. At hours, the patient presented to the Birth Unit following rupture of membranes. Severe fetal bradycardia was identified and a category 1 caesarian section code was initiated. The baby required resuscitation at birth and was transferred to the . The neonate was identified to have sustained a , and on the baby died following cessation of active management. The year old patient sustained a and a and had an estimated blood loss of .	Take to theatre and baby born within minutes of presentation to birth suite	baby born in very poor condition. Extensive resusitation and treatment. Died days later
	/2014	Mackay	Pt prescribed without coagulation profile reviewed. Pt had active bleeding symptoms. Anticoagulation therapy continued. Massive haematoma developed on . Haemoglobin noted to dropped. Met call in due to hypotension, pt reviewed, anticoagulation ceased, blood products given and transfer to ICU. Met call due to hypotension. Condition deteriorated and pt passed away.	MET CALL DUE TO HYPOTENSION, PT REVIEWED, ANTICOAGULATION CEASED, BLOOD PRODUCTS, GIVEN TRANSFER TO ICU.	PT CONTINUES CLOSE MONITORING IN ICU PT CONTINUES CLOSE MONITORING IN ICU
	/2014	Sunshine Coast	Unwitnessed fall in the . Patient landed on Complaining of pain . Skin tare on size of entire Physical obs attended, laceration on cleaned and dressed, CNC, Ward call, Ward JHO, Team leader all notified and attended. X-ray and CT of head/neck attended. PRN analgesia received.	Physical obs attened, laceratiion on cleaned and dressed, CNC, Ward call, Ward JHO, Team leader all notified and attened.	Xray and CT of head/neck attened. PRN analgesia recieved.
	/2014	Cairns and Hinterland	Pt admitted to ward post with ? , On arrival to ward prominent , irritable, history of fevers up to Nil septic screen performed only and repeat blood in emergency Doctor rung re septic work up and indication for , advised pt dosent meet criteria for , Rung again re concern for pt due to increased irritibility, photophobia, increased pain when palpated, raised concerns re patients need for as possible , Reg reviewd and consultant called and LP taken approx hours post arrival to Emergency. Post due to prescribed , Doctor called again re dose as not typical prescription for and questioned not . Advised will discuss prescribed medication with team and to administer despite raised concerns. Doctor called again at approx hrs re increased resp rate and increased fatigue and extreme pain, asked if further analgesia could be prescribed as paracetamol not helping, pt moaning ++++ advised will discuss with team. further deteriorate during the shift resulting in a MET call and being tubed and transfered to		further deteriorate during the shift resulting in a MET call and being tubed and transfered to
	/2014	Mackay	Patient was admitted directly to ward after CT scan, suspecting with syndrome, wihtout being seen by registrar in the ED. No ED doctor has interpreted the CT scan. registrar saw the pt in the ward and thought its more of than syndrome and called reg at Because of trauma in the ed reg saw the pat at and pt had ct scan again and was sent to for further management.	pt was sent to for further management pt was sent to for further management	pt sent to for further managment pt sent to for further managment
	/2014	Mackay	Patient had at external medical imaging department on 2014. Presented to ED on 2014 with vomiting, diarrhoea, shoulder and neck pain. No temperature recorded at triage. Had BC and urine collected. D/C home on 2014 - Lab phoned " " at hrs to notify of positive blood culture. Unknown actual name or doctor who spoke to. Initial urine m/c/s available at hrs. No sensitivities available. BC and Urine results checked by an ED Doctor at hrs. No documentation if patient was recalled, etc. 2014 - patient represented septic to ED. Admitted to 2014 - patient deceased secondary to sepsis.	Patient admitted /2014 with sepsis and treated accordingly.	Patient deceased.
	/2014	Gold Coast	/14 hrs A year old well known to the Respiratory Service, was admitted to the with a dizzy episode, with nil loss of consciousness, and complaining of increasing shortness of breath since episode occurred. Transferred to Unit 14 MET call activated improved to 97% on 10 litres. Plan to continue on Hi Flow oxygen ARP documented following discussion with family, pt was transported to a without being connected to oxygen A enrolled nurse had difficulty operating Hi Flow machine, connected to air instead of oxygen. Patient become hypoxic and a MET call was activated, the patient died. RIP	MET call initiated.	Pt did not survive MET call
	/2014		Cardiac Arrest in the community - CPR at address - obese - failed intubation (ED resuscitation attempts unsuccessful	Life saving measures (CPR< intubation, defibrillation, etc)attempted, family in attendance at time of death	Patient death. Coroner and QPS notified
	/2014	Darling Downs	Death of a patient hrs after unwitnessed mechanical fall.	QAS & Dr notified. IVC inserted. Pain relief given- morphine given in incriments. Pt placed on scoop and lifted onto trolley. IDC inserted, O2 applied. Obs attended. IV fluids erected. Splint applied. Relatives in attendance.	Pt transferred to via QAS with escort in attendance. Increased pulse. O2 stats within modification regime. Graze to forehead dressed. Pupils equal.
	/2014		Loud bang heard at nurses station at approximately hrs. Nursing staff entered room was trying to open the door. Nursing staff opened the door outwards to find patient propped up against door, with a around neck. Pt unconscious appeared .Emergency button pressed , called CPR commenced. Mert team and ICU promptly arrived.	As above	CPR, Defib Adrenolin , guedels, Intubated transferred with output to ICU.
	/2014	Townsville	A year old patient has died from complications from cervical injuries sustained during an unwitnessed fall. This fall has been reported to the coroner. A SAC 1 investigation has been commissioned	NULL	NULL
	/2014	Metro South	Staff on shift went around to and found the consumer lying across the bed, non-responsive with froth coming from mouth and no pulse	Assistance of other staff summoned. Code Blue called. CPR commenced by ward staff and continued for approximately 15 minutes until the hospital emergency response team arrived to take over	Consumer declared deceased
	/2014	Darling Downs	A year old was admitted from /2014 with shortness of breath and fluid overload secondary to non compliance with 2014). Patient was being transferred from bed to bed in preparation for /2014 when arrested. A code Blue was good but the patient died hrs.	Code Blue	unsuccessful

Released

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2014		patient was admitted to the unit on with suicidal ideation. was seen by the Consultant Psychiatrist on /14 who recommended be managed on 15 minute visual observations. On the in question was sighted by staff in room at . On the next check just before door was closed with a hanging over the Staff were unable to gain immediate access Immediate action(s) taken Staff summoned help immediately the door was opened and the patient was found slumped on the floor with the tied tightly around neck. was unresponsive. Staff began CPR immediately and called for an urgent MET response Result of immediate action(s) The MET team responded but were unable to revive the patient after approximately 45 mins was pronounced dead.	Staff summoned help immediately the door was opened and the patient was found slumped on the floor with the tied tightly around neck. was unresponsive. Staff began CPR immediately and called for an urgent MET response	The MET team responded but were unable to revive the patient after approximately 45 mins was pronounced dead.
	/2014	Metro North	No fetal heart found on presentation to . Ultrasound confirmed intrauterine fetal death.	Urgent ultrasound in Confirmed IUFD.	Spontaneous labour. Transferred to
	/2015	Gold Coast	BIB QAS found at seizure lasting , no history. According to was given CPR by a prior to QAS arriving at the scene – nil documentation on QAS report.ECG – NAD, CT NAD, Bloods normal hrs S/B Med Reg History noted, D/W Neurologist Not for Neurology Admission Can be kept under observation for 6 hours in Short Stay and D/C if no recurrence OPD MRI and EEG referral to Neurology OPD Discharged from ED QAS called GCS ,VF arrest, mins CPR and DC shocks from QAS, arrived to , resus and taken to – normal coronary angiogram remained in ICU sadly died	Output maintained tho remained tachycardic.. Seizure activity managed with medication. A -Airway managed - ETT, ventilated. B -Saturating over 95%; poor resp effort prior to tubing. C pink and perfused. Pt arrived to ED . Cardiac output. Seizure, given midazolam. Intubated and ventilated. Prepped for Cath Lab. Cardiology reg attending.	Airway managed. .
	/2015	Metro South	year old, presented to emergency department on 2015 feeling unwell since insertion of a new catheter ( ) days prior. CT scan showed marked presumed secondary to located external to the bladder Patient diagnosed with acute injury, there was no urine draining from the new . Patient was admitted and surgical review deemed unfit for operation. Patient was for conservative and palliative care management, patient subsequently deceased. Coronial autopsy performed. Cause of death: Sepsis with Abscess Tissues. Coronary ; Chronic Kidney Disease.	Medical, surgical teams involved with regards to plan. Admitted under surg with plan to palliate. I am uncertain as to their notification of this event.	.
	/2015	Sunshine Coast	At the end of the procedure, patient was noted to be hypotensive (40mm/hg systolic). Haematoma (Dusky blue in colour) noted to be extending from Excessive blood loss (approx. ml). Patient noted to be peripherally shut down, extremities were blue in colour and cold to the touch.	Consultant, registrars and nursing staff were present. Patient was positioned head down in the reverse position; fluids were increased to 500ml/hr. Nursing staff initiated Pressure application to the haematoma and puncture site. Preparations made for additional interventions to manage the patient's deterioration.	After additional interventions, the patient required intubation and transfer to ICU.
	/2015	Darling Downs	Fall	NULL	NULL
	/2015	Wide Bay	procedure performed 2015 with removed. patient admitted to post procedure. subsequent days identified as having perforated	reviewed by general surgeon.	arrange transfer to due to blood disorder requirements
	/2015	Gold Coast	On 15 at hrs, a live infant was born via weeks gestation with apgars of . The infant was progressing well however on deteriorated and died on at hours. The definitive cause of death is unknown but believed to be from overwhelming sepsis.	Report of deceased neonate form completed. Submitted for discussion at perinatal morbidity and mortality	Discussed at perinatal morbidity and mortality and given questions regarding maternal illness requiring birthing and then rapid deterioration of baby felt should submitted for
	/2015	West Moreton	Patient presented to ED via ambulance with history of sudden onset of headache 8 out of 10 and faint at home. Patient had a BP recorded with ambulance. One set of observations recorded in ED with BP . Nil neurological observations recorded. Patient seen by nurse in ED. Patient not seen by medical officer.	Patient given Aspalgin x2 for headache	Patient discharged home and found deceased by on the /2015
	/2015		deteriorated in faster than what was being treated for. Upon my glance at this patient who I did not know the medical hx of, I thought required more invasive ventilation than despite this being all that was being provided. I alerted the retrieval nurse who was in eye sight and the SR of this who both reviewed pt. At this point, TL also came and SR from other side attended. An hour later, after not being in the room, I was told to take care of the patient from a nursing point of view. had a difficult airway which presented problems for the medical staff. The intensivist wasn't initially at this intubation but arrived during it. Then allowing junior staff to attempt central line access proved difficult and was abandoned an hour later - despite pt needing adrenalin 1:100000 (50mls in total in a time span of 2 hours) and albumin boluses during this extended procedure. From a nursing point of view, I was in a room by myself for the majority of the time with 3-4 doctors. The TL did not linger nor did the No other nurses on the 'medical' side came over apart from the retrieval nurse. Nurse assist was used once which brought staff from the 'surgical' side and subsequently the intensivist used the emergency button as nursing staff left and were not around. Immediate action(s) taken Nurse assist button used, emergency button used, updated educator and NUM on issues of the Result of immediate action(s) Initially staff presented to help but obviously it was not communicated effectively how sick this was and how much support needed.	Nurse assist button used, emergency button used, updated educator and NUM on issues of the	Initially staff presented to help but obviously it was not communicated effectively how sick this was and how much support needed.
	/2015	Metro South	What Happened Unexpected death of an infant Immediate action(s) taken All meausre for resusitation completed Result of immediate action(s) Acute Pulmonary haemorrage of unknown etilogy	All meausre for resusitation completed	Acute Pulmonary haemorrage of unknown etilogy
	/2015	Central Queensland	/2015 presented with pain radiating to back and jaw. Investigated with CT and Noted in operation report- appeared thick and fibrosed , discharged with referral for follow-up appointments in Surgical and clinics. Did not attend clinic, 2nd letter sent, then patient removed from list. /2016 presented to ED with sharp central chest pain and SOB. Some PV loss, productive cough, fevers on and off. OE dehydrated, tachycardic, Abdomen soft, CXR-No consolidation Plan – Aspirin, bloods, pain relief, GTN, fluids and urine. SB ICU Consultant further history unwell for cardiology review, review. CT scan performed – , suspect metastatic disease – – Fluid and debris within . /2016 – consistent with primary malignancy, /2016 Patient transferred to /2016 Patient deceased	/2016 – consistent with primary malignancy, Radiological review secondaries in Discussion ICU and team for referral to oncology and for stenting of	Patient transferred to for treatment.
	/2015	Metro North	unwitnessed fall, found pt lying on the floor after calling for help	NULL	NULL
	/2015	Mackay	Pt admitted post low speed accident, charted and administered prior to coag testing when known to have deranged	Nil	Increased bleeding tendencies
	/2015	Mackay	Developed Hospital acquired pneumonia post influenza A 	Isolated Commenced on Tamiflu CXR Barrier nursing.	Getting worse ffrom hospital acquired pneumonia

RTI Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015	Darling Downs	An year old was admitted with While out of purposes, the patient's sitting blood pressure was recorded as was returned to and lying blood pressure was checked and recorded as lying blood pressure was checked two hours later and recorded as The patient was found pulseless and unresponsive an hour later. A code blue was called but the patient did not respond to resuscitation efforts.	I immediately pressed the Emergency Buzzer,asked the Nurse Special to do set of Obs,Used my T/L Phone to call Code blue,immediate DRABC Response,Code Team in attendance, Adrenaline given,Calcium Gluconate given, CPR continued for 25mins with no Return of Life, Family Called & Consoled	ARP had been for No Resus in past Admission but had not yet been revisited by the Medical Team this Admission & we were waiting for the Rounds to begin after the Meeting(Usual Daily Routine)A fall in had been noted & was suspected there may have been a Bleed happening.RIP @ hrs.
	/2015	Darling Downs	The patient presented to the hospital in deteriorated and died despite standard management and advanced life support. was given adrenalin, which was drawn up mas appeared to be likely to arrest due to condition instead of the indtended drug morphone. deteriorated and shortly after had an episode of VT/VF. Despite ALS died.	Nil. The error is not definite. The staff member is an experienced . with an of a complex repiratory patient. was called in to assist another . is not sure whether definitely gave adrenalin instead of morhpine. realised the possibility later in the and contatced the .	The staff involved were contatcted to see if anyone had accurate recall of the event. As the gave the drug, as expected, no staff was entirely certain that it was adrenalin and not morphine. A senior clinician was contacted, myself as DMS . I considered the situ. It appeared possible but definiet an error occurred. after discussion with staff I considered it unlikely this had a major impact but that it could have. The coroner was contacted, who toolk advice from a forensic clinicaiin who stated it was unlikely to have changed the outcome and may have had a positive effect. The death certificate was not altered and the coroner was satisfied.
	/2015	West Moreton	Patient found on floor. Patient reported reached for and slipped onto the floor hitting head and sustaining a skin tear to lower leg. 	NULL	NULL
	/2015	Gold Coast	Radiology report did not fully acknowledge all potential differential diagnoses. This may have delayed transfer and definite treatment.	Case will need review at M&M. Results feed back to outsourced Radiology provider	Results unknown
	/2015	Cairns and Hinterland	old patient admitted to ED with infective exacerbation of hrs on /15. Patient had a history of Referred to medical team and admitted under consultant of the day. Seen by medical team at hrs. Treatment commenced with oxygen, and IV antibiotics. Patient's condition deteriorated The register was contacted to review patient however there was a reported delay. Instead, the consultant reviewed the patient and moved to the resuscitation area. When the medical team arrived in the department for rounds they were notified of deterioration and were contacted. The team intubated and ventilated the patient. continued to deteriorate despite resuscitation attempts and was pronounced deceased at hrs. The coroner was notified of death.	Referred to coroner by team Referred to coroner by team	As above As above
	/2015	Mackay	Pt had fall in at home Was on floor for approx hrs Presented to ED Seen in ED with incomplete examination - large wound on internal - discharging pus and infecting into fascititis ? Direct ward admit Met call for septic collapse - pt in extremis Pt urgently taken to theatre - found to have significant subcutaneous infection ICU admission Overwhelming sepsis Death	MET called on ward Urgently taken to theatre	Massive sepsis Death
	/2015	Darling Downs	Patient presented to the Emergency Department with intermittent abdo Pain and dark stools. A CT abdo identified likely , with the underlying cause needing to be identified. The CT also noted irregularities. The GP was sent a copy of the CT report, and a Colonoscopy was booked and attended in late , with a follow up appointment made in . The Patient represented in 2015 where ultimately a CT abdominal angiogram on the identified aneurysm, was transferred to ICU, then to the where passed away.	Case discussed at CCRC	Decided to enter into PRIME as a SAC 1
	/2015	Metro South	/15 at hrs: The patient was walking to mobility aid. Fell – unwitnessed. Hit head on the floor. No LOC. Patient was reviewed by MWC and treatment commenced as per post falls pathway. CT was performed at hrs. Injuries sustained: haematoma with active arterial bleeding. Additional contusions, small deep) and subdural haematomas, extensive subarachnoid and intraventricular blood causing . Vitamin K was administered. Following discussion with family members the decision was made to treat as palliative. /15: Patient died.	NULL	NULL
	/2015		PSO entry based on available records: Sepsis and metabolic acidosis pneumonia (?secondary to aspiration or primary infection and Seen in Hospital 2015 for fever, vomiting, diarrhoea, dehydration, respiratory distress and imbalance.	Given in ward on 15 - Was sent home?time. 15 Admitted in Hosp- into HDU, treatment - IVI via IO, Antibiotics and paracetemol. observations done hourly. Transferred to due to adelay in transfer relating to availability; patient en-route for transfer to as was planned and accepted by Reg	Medivac'd via QAS at to For further medivac to . Deteriorated and went into cardiac arrest at - followed by intubation and medication-assisted full resuscitation. CPR ceased at after 40 min of CPR and persistant asystole.
	/2015	Darling Downs	Initial incident noted as perforated artery while attempting with difficult access in a patient with comorbidities. Concerns raised as to possibly missed deterioration of patients condition.	conservative management, dressings and observation.	Nil immediate concerns
	/2015	Metro North	Pt to ED in for headache, associated . Nil neck stiffness or photophobia. Vital signs stable CT Head non contrast and then repeated with contrast:A of uncertain aetiology carries a broad differential..... was treated with simple analgesia and fluid. Referred back to GP with recomendation for MRI. This was carried out, however had another presentation to ED post fall at home and was discharged after an stay. Referred to /205 with ongoing headaches and unsteady gait. Diagnosed with meningitis Remained an inpatient until death in ICU on the /2015	Identified by Mort Review of potential issues re: care at ED	Coroner Case notes consider the CT should of been investigated further and the LP that was requested by the GP should have been undertaken instead of referral to GP for MRI.

Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015	Gold Coast	old, presented to MATU from clinic with history of decreased FM for days. .15 Referral from for shared care received at Antenatal services for a patient who was Recently moved from Last seen by O&G Consultant on 15 noted a kg weight gain had been referred to dietician. .15 P/C to complains of period cramps – 60 secs, normal fetal movements, reassurance given advised to call when pain increases or SROM , bleeding : P/C to tightenings, advised to see private Midwife as planned at hrs : S/B advised patient to present advised deceased FM and was dilated – Arrived to CTG commenced, reduced FM – Fetal HR dropped RMO requested Midwife to review repositioned and FH increased to . Reg reviewed CTG it is documented noted a previous baseline of 140 with borderline variability and no accelerations. No tightenings seen on CTG a possible deceleration had been noted for about 5 mins CTG sticker noted trace to be classification suspicious, no acceleration or decelerations. Plan to continue CTG. Documented busy with other ladies, other staff and went to review patient. – midwife patient on side holding USS on abdomen, FHHR then slowly dropped to bpm. Unable to locate FH with USS or CTG. Reg contacted documented baby noted to be presentation. At this stage there had been no HR detected on CTG for 6-7 mins USS performed to locate FHR and breech position was identified and no FH was found. Consultant notified. .15 Vaginal non instrumental delivery, baby grams, meconium noted, not macerated	Registrar in attendance and consultant obstatrican called to attend. Maternal position changed. Bedside USS performed resulting in no fetal heart seen.	Fetal demise at
	/2015	Metro North	fracture mid Non weight bearing for Started mobilising this week Out of hospital cardiac arrest at home. Further cardiac arrest in ED. Admitted to ICU Unstable on first Had asystolic cardiac arrest despite therapy.	Advanced life support	Death of patient
	/2015	Cairns and Hinterland	RN and nurse assisting patient to transfer. RN called away by another patient - and left to continue with patient . Patient needed to and asked nurse for privacy. : nurse left door slightly ajar and stayed around the vicinity. nurse checked on the patient who asked for a little more time - not long after this heard a noise from the and found the patient on the floor. Patient at this time was conscious. nurse alerted the RN	RN notified Registrar who attended immediately - noted small laceration to . After examination patient was Post falls clinical pathway commenced - vital signs and neuro obs. Laceration was sutured. Patient's was informed at this time.	Patient vital signs and GCS remained within normal limits until hrs when patient complained of severe headache. Drs notified. Some minutes later patient vomited and a staff assist alarm was made. Another RN came to assist and medical staff arranged for an urgent CT scan. Patient became unresponsive in medical imaging after CT scan. The CT scan demonstrated a large subdural bleed. A MET call was made - and then a decision to treat patient palliatively. Patient was returned to the ward and passed away after . Family were contacted by consultant and report made to the Coroner.
	/2015	Townsville	A year old patient had approximately presentations during the period of with abdominal pain being the principle presenting complaint. An early working diagnosis of was the considered ailment, awaiting a laparoscopy for confiirmation - done and was NAD. The patients final presentation was 15 with the same complaint, however the patient has been investigated privately and a further confirmatory CT scan by confirmed a high chronic total The patient was admitted as an inpatient and provided supportive care. died on /15	An early working diagnosis of was the considered ailment, awaiting a laparoscopy for confiirmation - done and was NAD. The patients final presentation was 15 with the same complaint, however the patient has been investigated privately and a further confirmatory CT scan by confirmed a high chronic total	The patient was admitted as an inpatient and provided supportive care. died on 15
	/2015	Townsville	a year old has suffered a serious adverse outcome following complications post total and has subsequently died as a result of those complications	Airway management. Reopened wound. called, pt returned to OT	Surgical Airway, surgical management, ICU
	/2015	Gold Coast	This clinical incident involves a year old with a medical history including 15 - At hours presented to Emergency Department with severe intermittent epigastric pain for last days with reduced oral intake and associated nausea and episodes of vomiting. weight loss over period. Admitted to MAU and reviewed by MAU Registrar at hours with: Non-specific symptoms – possibly deconditioned from poor oral intake. Recurrent presentation . Rapid AF , asymptomatic , post on BG of PAF. Deranged . Gastritis. 15 hours: HR > At approximately hours this was reviewed by the MAU Consultant - reduced urine output, marked dehydration and elevated secondary to dehydration. • ICU Registrar was asked to review patient in view of deterioration and ARP was discussed. At hours a MET call was initiated. At hours the patient was transferred to ICU. When I&V following scans occurred: 1. 2. - likely multifactorial, including cardiac failure, ARDS and aspiration. 3. is demonstrated. There is good enhancement of the throughout, making less likely, however cannot be definitively excluded. Patient had a further cardiac arrest at hours and later passed away.	Met call intiated. CPR commenced.	MET arrieved Resussitation proceded for 1hr then pt transfered to ICU
	/2015	Darling Downs	Death of patient who had been admitted to a for Withdrawl	Shift co-ordinator notified of unescalated obs. Acting DON called to notify of incident but currently uncontactable. Family contacted and aware of patient's critical status and that may not live	To be further discussed at the M&M.
	/2015	Mackay	weeks gestation presented to hospital emergency department with severe abdominal pain and with no antenatal history (patient was . Mother had been admitted to the hospital earlier with epigastric pain and abnormal function tests. On arrival at hrs patient's Abdomen rigid and foetal bradycardia present; resuscitation of baby was sadly unsuccessful. Mother transferred to syndrome.	RESUS ATTENDED	BABY DIED AND MOTHER TO

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RTI Document No. 10

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	/2015	Metro North	year old patient with a history of presented to Hospital Emergency Department unwell for days complaining of a sore throat, headache and fever and was triaged as a category 3. Observations noted at triage as: Temperature The patient was assessed medically including . Tests were noted, was noted to be clear. The clinical impression was viral). The patient was discharged home with a GP letter for follow-up of and was given advice to administer simple analgesia and oral fluids. The patient saw a GP who commenced the patient on patient presented to having been referred by another GP for ongoing and worsening). The GP also noted that the patient was dehydrated and had symptoms, but fever of unknown origin plus pain plus plus . the patient was triaged as a category 2. It was noted that had been experiencing fever for days and that had been referred by GP with "? dehydration symptoms". Observations were noted as: Temperature The patient was also noted to be and unwell at triage. Also noted were the medications administered prior to presentation as taken at nurse notes in Clinical Summary that Patient's observations were out of range, that cannulation was unsuccessful and that a blanket was provided. At nurse notes that a colleague attempted to unsuccessfully, that the patient had a hsitory of nil would be required to locate It was alos noted that Cubicle within the department was scheduled to be allocated to the patient once it became vacant. Patient was then noted to leave the waiting room distressed about having to wait. It was noted that the Emergency Senior House Officer was notified of the situation and that the patient was not able to be located in the waiting room. Records indicate that the patient had waited 1 minute in the waiting room ( ), 1 hour and 40 minutes in Triage Assessment room ( ). 2015 the patient was taken by ambulance to with septic shock and multi-organ failure secondary to in the indicated positive. Patient was ventilated and admitted to the and died on 2015.	2015 - Director of notified by Emerggency Staff specialist from regarding this case additional patient history of /2015 Case reported as a	SAC 1 event and escalated locally.
	/2015		Pt had been in Hospital for 7 with ? bleed. Pt ceased taking oral fluids and developed acute failure. unable to gain IV access, and for IV access and management. unable to provide Pt was reported to Hospital as 'stable'. Once commenced, pt 'unstable'-ALOC, SOB ++, peripherally shut down. On pt has NO IV access- no attempt at IO at . Pt with 1 RN from ward. Pt severly dehydrated, BGL , hyponatraemic on	IO inserted in Hospital- bloods collected, administered. given to achieve SBP infused for	Pt continued to further deteriorate quickly despite basic measures- pt died in ED at hrs.
	/2015	Mackay	was admitted on the 2015 with discoloration odema ++ some skin tears O/A reports nocturnal wandering. Not sleeping and lethargic. Fell on the /2015 apparently return from ? Staff on at the time with other patient	Emergency buzzer pressed staff assisted to assist apparently no obvious bruising or deformities to any area of body. C/O pain on side of head only at that time. hrs Subsequently complained of pain in Observation taken. BP 10minutes later	Dr notified Rx for commenced and tissued. Dr and RX observe patent and check BP. notified. nursed in bed and observed.
	/2015	Wide Bay	hrs, it was reported that patient had an inserted on the /15 at cxray at commenced at on confirmation of placement by RMO, approx infused over or more hours. Radiology informed pho at on /15 placement is in stopped. contacted at hrs.	Patient transferred at hrs, commenced on Bipap. IAL inserted. Patient	Respiratory rate and oxygen saturation stable.
	/2015	Cairns and Hinterland	Inpatient found unresponsive on the Unable to resuscitate, deceased at hours.	Met call made	Client deceased at hrs
	/2015		There was a delay in diagnosis and treatment of a and the patient subsequently developed and did not respond to treatment.	inserted on admission. Trial of void unsuccessful. reinserted. Pain relief reviewed and 'as required' pain relief doses ordered. Patient continued to verbalise pain.	Some pain relief given; concerns escalated to Medical Officer from nursing staff - patient did not appear to be receiving as much pain relief as expected (from the medications given). Patient very anxious and agitated.
	/2015	Metro North	Patient was found unconscious at home on the /2015. The patient had been discharged from Hospital ( ) the previous day. The patient was	QAS was called and resuscitation began and was transferred to	The patient was transferred to Hospital as there were no ICU beds. The patient died days later.
	/2015		Unknown to staff, the patient was under the The patient signed out against medical advice	.	The patient represented the following day but had deteriorated. Ended up getting appropriate surgery & therapy but ended up dying
	/2015	Metro North	At 2015, an year old was brought in by ambulance to the Hospital Emergency Department presenting with; inflammation and pain that was aggravated by walking and an unsteady gait. The patient was noted to have a on The patient had a medical history of: At the patient was re-admitted to the Ward for management of with a plan for surgical noted. The patient's regular medications, antibiotics and Clexane were prescribed on Medication charts. Pro thrombin time was reported as seconds and an INR result was reported as Warfarin and Clexane were not administered on this day. On 2015 the ward round review noted that Clexane was to be ceased as per the team advice and it was noted that the patient was to continue Warfarin and be held nil by mouth from was likely to be for the Operating Theatre The patient was administered Warfarin as prescribed. On 2015 the patient's medications were reviewed and adjusted by the team in consultation with the team in light of the patient's deteriorating . Warfarin was administered as prescribed. Pro thrombin time was reported as seconds and an INR result was reported as The patient was noted to be experiencing chest pain and shortness of breath and was reviewed by the team in consultation with the team who advised that the patient be administered a loading dose of Aspirin. Pro thrombin time was reported as seconds, INR as and Troponin as . The patient was administered Aspirin and Warfarin as prescribed. The patient was reviewed by the Consultant who advised that the patient was likely experiencing Disease and a plan to adjust medication and repeat troponin levels the next day was made. The patient noted as not being for the Operating theatre that day. On 2015 the patient was reviewed by the diseases team and a plan to continue antibiotic therapy was noted. The team review noted a troponin level of . Warfarin was administered as prescribed.	On 2015 the patient's medications were reviewed by the team and it was noted that the patient would not be able to be taken to theatre as there was no theatre time. A plan for the patient to eat and drink and to be held nil by mouth from in preparation for going to the Operating theatre was noted. PT time was reported as seconds and an INR result was reported as . Warfarin was withheld. On 2015 the patient was reviewed by the team and it was noted that was scheduled to be taken to the Operating Theatre that IVC had become tissued and would require ultrasound guided re-insertion by the Medical Imaging department and that could continue warfarin. Warfarin was withheld. Patient was not taken to the Operating Theatre as there was insufficient operating time available. On 2015 the patient was reviewed and it was noted that it was A plan for the patient was to be held nil by mouth from in preparation for going to the Operating theatre was noted. PT time was reported as seconds and an INR result was reported as . On 2015 the patient was taken to the operating Theatre for the Warfarin was not administered on this day.	On 2015 the patient was reviewed by the team. Pro thrombin time was reported as seconds and an INR result was reported as . The Disease team reviewed the patient and noted that were improving however they were concerned that the patient had experienced a stroke and recommended that a Computed tomography (CT) with reduced contrast be conducted. The patient was taken to medical imaging and a non-contrast head CT was conducted, results of which noted: no definable acute infarct and no acute intracranial haemorrhage evident. The patient was noted to be drowsy, difficult to rouse with incoherent speech, a Glasgow Coma Scale (GCS) score of 15, and to be exhibiting sided weakness. The patient was reviewed by the team in consultation with the team and it was noted that the patient was experiencing an acute cerebrovascular accident, that thrombolysis was contraindicated with the patient's INR at and a plan to administer Aspirin) then to continue on daily, to continue on Warfarin if the patient could swallow otherwise administer Clexane twice daily. A meeting was held with the patient's next of kin and team regarding the patient having experienced a stroke, the lack of resolution of symptoms and poor prognosis. A plan to provide comfort measures was noted and in the event of cardiorespiratory arrest the patient was not to have Cardiopulmonary resuscitation (CPR), defibrillation, intubation or Medical Emergency team intervention. The patient's condition continued to decline and on the patient's care was referred to the Palliative Care team. At 2015 the patient died.

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	/2015	Wide Bay	Pt appears to have become displaced, pt rapidly deteriorated and passed away later the day was MET called. Pt was xrayed on and was in pts xray taken on showed higher in either the . Pt was MET called due to falling SpO2, decreased ALOC. Nursing staff had to maintain pts airway throughout day Pt passed away shortly after discussion with family regarding resus status	Pt was xrayed on and was in pts xray taken on showed higher in either the . Pt was MET called due to falling SpO2, decreased ALOC. Nursing staff had to maintain pts airway throughout day	Pt passed away shortly after discussion with family regarding resus status
	/2015	Metro North	On /2015 a yo had an unwitnessed fall. BIB QAS to ED - #NOF. Co-morbidities included Pre-operatively the patient was hypertensive and showing signs of an infective process. These do not appear to have been investigated adequately. /2015 a was successfully performed. Over the following hours the patient had several MET calls for hypotension, low GCS, low urine output and seizure activity. On /2015 the patient's condition was discussed with the family and a decision to palliate the patient was made. The patient died on /2015.	Investigations and antibiotics were given in response to the patient's deteriorating status.	Family discussions were held and a decision made not to pursue aggressive treatment was made and the patient died.
	/2015	Mackay	The patient had a obstruction secondary to adhesions and suffered aspiration whilst an inpatient on and later died from this complication in Concerns that have been raised by the death review process include: delay in insertion of and the dose of analgesia and sedation given prior to aspiration.	CAT 2 death review commenced	
	/2015	West Moreton	This patient was admitted with and was meant to have active treatment. was due to have a had an ARP that stated was not for However was for . The patient had ongoing deterioration from , no MET call was called, and no medical doctor was contacted. The nursing notes stated the patient was not for resuscitation and therefore no MET call was required. This patient subsequently died at when the surgical team came to review	The patient had to be palliated at that point because condition was irreversible at this stage. The family was present and informed at this time.	This has been discussed at the meeting
	/2015		Person died from suspected suicide by hanging. At the time of death, the person was an patient in a mental health facility.	Staff found hanging at and called for help. MET called and CPR commenced. CPR attempted for approx 1 hour but staff not able to resucitate	Time of death called at
	/2015	Wide Bay	year old patient admitted and diagnosed with stroke and infection/sepsis of unknown origin. Cardiac dysrhythmias observed and assess by ICU medical officer. Did not meet ICU admission guidleines however had ongoing cardica monitoring On /2015 Patient was admitted to the and then transferred between the and unit twice during admission. Patient passed away on on /2015.	Patient was transferred back and forward between units twice.	The above situation created confusion between staff regarding the best course of action to adequately diagnose the patients condition.
	/2015	Metro North	Pt walked across room and fell. Staff was attending to another pt on far end of corridor for chest pains and others were attending to other pts.	NULL	NULL
	/2015	Sunshine Coast	patient was found unresponsive, colour, oxygen tubing attached to medical air and to patient IVC, air turned off, code blue alert initiated,resuscitation commmenced patient pronounced deceased @ hrs, nurse manager aware, police notified , paperwork commenced, family notified, coroner notified	air turned off, code blue alert initiated,resuscitation commmenced	patient pronounced deceased @ hrs, nurse manager aware, police notified , paperwork commenced, family notified, coroner notified
	/2015	Metro North	Pt having a . Device perforated pt's . Cardiac tamponade - resuscitation. Pt t/f to Operating Theatre to have a stitch repair of the perforation. Pt t/f to ICU & died	Pt required an hour of resuscitation before pt was able to be transferred to Cardiac Surgical Theatre to have a stitch repair of the perforation.	Pt was managed in ICU until passed away on 2015. Coroner was notified. Death was reportable to the Coroner, but did not require further Coronial Investigation.
	/2015	Metro North	/15 review in Hospital following seizure and likely Previous Medical History of . Attended for review of pregnancy and to discuss pregnancy options. Transferred to DEM for review of SOB. Admitted to Medical Ward for ongoing management. /15 Patient complained of feeling dizzy, appeared Blue on Lips and Hyperventilating. SATS dropped to 60% MERT activated. Cardiac Arrest on Ward.	CPR for 55 minutes. Ceased following discussions with Consultant and ICU Consultant.	Patient passed away.
	/2015	Central Queensland	Presented on the with . Multiple cardiac risk factors including Diagnosed with and discharged home. Represented with an out of hospital VF arrest caused by a large myocardial infarction. Currently in the intensive care unit. Intubated and ventilated. Requiring support	Currently in the intensive care unit. Intubated and ventilated. Requiring support.	.
	/2015	Metro North	Patient undergoing for examination of the and investigation of abdominal pain of suspected and suspected . During the procedure a small tear/perforation was sustained in the were applied to close the perforation. The patient went on to develop sepsis and subsequently died on 15.	were applied and the patient was referred to surgical services for laparotomy, washout and repair of perforation.	Patient transferred to ICU for follow up care
	/2015	Metro North	pt presented to ED on the 15 at with shoulder pain. triaged as cat 4 temp EXcerbation of shoulder pain for past /7 nil obvious distress nil guarding of arm has S/B DR at - exam normal ECG normal. CAse D/W consultant agreed plan:for physio review & discharge home with GP FU. Pt seen by physio and discharged home at with GP letter. 15 QAS arrived . triaged category 4 pain 10/10 presented with abdominal pain, nausea and vomitting. taken to cubilce - went into VF Cardica arrest and subsequently died.	assessed triaged taken to cublicle	await Dr review - arrested
	/2015	Wide Bay	patient presented to unit with complaint of no foetal movement. Foetal death in utero confirmed with ultrasound. Past history of and .	None	None
	/2015	Wide Bay	Recent presentation on the – appears that a raised troponin was missed. At that time presented with collapse – head injury and transferred to for a CT head (was warfarinised). Admitted to and the second troponin was and patient was discharged home Pt presented to ED then arrested and died	CPR as per algorythm with no	Pt died
	/2015	Metro North	Year old with known . Offered but patient declined, therefore admitted for /15 surgical insertion of - surgery uncomplicated. C/O pain when and a /15 returned to on X Ray and outside the Post operatively treated for respiratory distress and sepsis from contamination with .Patient deteriorated and died /15	Transferred to ICU following surgery on /15 for management of respiratory distress and sepsis.	Patient deteriorated and died /15
	/2015	West Moreton	Patient admitted to ward for monitoring and work up for cardiac review at a facility. There was no record or escalation of days following admission. On /2015 the patient experienced pain associated with vomiting. The patient was reviewed by a medical officer and an was inserted with aspirate present on insertion. An was identified. The patient had a CT scan which confirmed a that was non reducible on the ward. A decision was made to consent for urgent theatre to reduce The patient was consented for theatre by family member who is not the patients . The patient was transferred to theatre at for an open repair . Surgeon's report identifies - . The patient was transferred to ICU post theatre, intubated and ventilated though Acute Resuscitation Plan (ARP) documented for no Patient remained in ICU days. During ICU, the patient developed and septic shock, wound breakdown and on day post op. The patient was transferred to from ICU where the patient developed . The patient was transferred back to and BiPAP. The patient continued to deteriorate over next days and passed away at 2015. Coroner informed by treating team of death.	Coroner requested Patient Safety Officers be informed of case. Coroner gave permission for death certificate to be issued.	Case presented to Executive Clinical Incident Triage /2015. Case decided as being a SAC 1 incident for entry into PRIME

Released under RTI