**Review:**

Request for QPS

Retrospectively, QAS attended a Irrelevant who was time critical as the patient was confirmed to be unconscious with a partial airway obstruction, hypotensive due to a polypharmacy drug overdose. On review of this case, both paramedics made the right decision based on recent history supplied by the QAS OpCen and MH history to definitively complete a welfare check on the patient.

After discussions with ACP² Gleeson regarding the paramedic decisions that evening, requesting QPS attendance for scene safety was warranted and within scope of the Interagency Agreement between QAS/QPS for services.

ACP² Gleeson decision not to enter the premises was reasonable for their safety. ACP² Gleeson did try to explore the possibility on entering after a considerable time waiting but found the dog was too much of a risk after opening the front door.

Under Queensland Ambulance Services Act 1991 gives provision for an authorised officer to enter any premises to protect persons and protect themselves or others from danger. This dog was a danger to responding QAS/QPS staff and was outwardly aggressive. QAS are not trained in or possess any form of self-defence (e.g.- capsicum spray) for this type of circumstance.

Interagency OpCen Interactions

This incident was "In waiting Queue" at 01:26 with 4509 being assigned at 01:40. 4509 were responding at 01:47 and arrived on scene at 02:01. During this time the QAS OpCen tried to phone the residence numerous times with no success. Further, they also contacted the MHLC and requested any pertinent information at 01:50 MHLC noted into the IDR that the patient had a long Hx of depression, alcoholism and recent EEA following a drug OD. They also reported recent social issues such as Irrelevant dying.

Post review of the IDR reveals numerous interactions via ICEMS between the agencies before a final call from Irrelevant to OCS Beaumont secured the QPS response as requested.

QAS OpCen requested QPS assistance at 01:47. OCS Beaumont sent a message asking for any "flags" QPS have and noted the patients name, age and how the patient had been talking with a friend two hour ago about suicidal tendencies. QPS responded at 01:55 stating "no flags for violence only HIV positive and has another form of hepatitis".

At 02:04 4509 had completed their scene survey and gave a situation report stating they needed QPS to gain access due to a large dog present inside the house.

Irrelevant

Irrelevant



This review did not utilise the Interagency Agreement to decide if the information in the IDR is sufficient as per the agreed policy.

**Outcomes:**

This patient had overdosed on alcohol and benzodiazepines which subsequently rendered the patient unconscious and hypotensive. The risk profile for this condition is high and the delay accessing the patient could have been fatal, it is fortunate that this was not the case on this occasion.

## Review Recommendations:

1. A determination should be made if the IDR information was sufficient as per the QAS/QPS Interagency Agreement Policy 2019. If correct terminology was missing e.g.- QAS require QPS to forcefully enter a dwelling.
2. As per Sergeant McLoughlin comments "perceived verses actual threats" this statement should also be determined if correct. Waiting for a perceived threat to become actual in this case could have led to safety concerns for the paramedics.
3. Discussions with QPS management regarding this review's outcomes.

## POST Review Outcomes:

In liaison with QPS Bundaberg Patrol Inspector, Anne Vogler and Senior Sergeant Julie Marsh, Maroochydore Police Communications Centre, the QPS audio files and incident were reviewed. On review QPS found sufficient information was clearly outlined in the incident details by QAS to activate QPS officers without delay. Appropriate management has been conducted by QPS to concerned parties. Furthermore, QPS acknowledge that the situation could have been managed better and future occurrences have now been mitigated.

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

Appendix A IDR 15122944

Appendix B Unit Snapshot

Appendix C eARF 503911557

Appendix D ECLIPSE ID 46229

Appendix E Wave Files QPS ICEMS Issue

## LASN Endorsement

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

| Role | Name | Position | Signature | Date |
|---|---|---|---|---|
| A/Director | Hayley Salethorne | General Manager | Irrelevant | 4/1/2021 |
| A/AC | Russell Cooke | A/AC | | 4/1/2021 |

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# Significant Incident Review

**Version 1.0 August 2020**

## Metro North Region
## Queensland Ambulance Service

### Authority:
By authority of the Acting Assistant Commissioner, Metro North Region, Queensland Ambulance Service (QAS).

### Executive Summary:

On 16 December 2021 at 16:57hrs, the QAS received a Triple Zero (000) call for as istan (Incide t 15219974) at Irrelevant Kenmore to attend aIrrelevant patient who ad colla s d on the floor with cuts to his arms and hands and was reported to be unable to move.

The case was initially prioritised in the Medical Priority Dispatch System (MPDS) as M DS De erminant 31A01 Fainting Episode, alert >=35 requiring a 2A response. A secon triple z (000 ll was received from a Medical Centre at 18:18hrs with the patient reported to be unc nsciou and not breathing. The case was upgraded to MPDS Determinant 1A. At 18:31, approx ately 1 h and 1 minu s after the initial 000 call was received, the first QAS resource arrived on scene.

Upon arrival, QAS paramedics reported locating the patient kneel on the floor hunched over a bathtub unconscious, unresponsive and pulseless with the pati lared d ceased at 18:34. QAS Paramedics contacted the General Practitioner who issued a dea h certific e.

The Brisbane OpCen at the time of the fi t call rev led high d mand for service across the Metro North and South Regions with South East Queen nd Esc tion of "E treme Hospital Delays" affecting paramedic availability.

The Quality Assurance of the 0 call not h itial call to be incorrectly coded 2A and should have been coded 1C with a lights and siren espo e.

### Terms of Reference:
This review will in stigate all aspects of bulance response to incident 15219974.
The review will exam e ambulance operati ns prior to, during and following the response.
This review will includ ll requirements outlined in the *Operational Incident Review Process*.

### Reg n l Clinical Incid nt Summary Report:
A gional ical review was u dertaken on this case which identified all documentation and clinical practice were perform at the standard required.

### S ate OpCen Pr QA:
Th State Quality Assurance Unit were requested to provide a special review and provide an evaluation of th call performance with the below summary results extracted. There were two 000 calls received.

17:00 1st Triple Zero call received by Townsville. ProQA utilised to assess the call. Deemed non-compliant with critical deviation – Determinant Level incorrect. The QAS priority was deemed to be incorrect at the time of the call entering the Waiting Incident Queue. The incident was created as a QAS Code 2A (Non-Lights nd Sirens response) however was reviewed as a QAS Code 1C (Lights and Sirens response).

18:18 2nd Triple Zero call received by Rockhampton. ProQA utilised to assess the call. Deemed to be of Low-Compliance, however the response priority was correctly amended to a code 1A (lights and sirens) response following this call.

18:26 3rd Triple Zero call received by Rockhampton. ProQA utilised. Deemed compliant.

## Incident Review/Investigation:

### Scope

- Metro North Region reviewed the response, clinical performance and operational decisi maki to ensure the appropriate response and management of this case was achieved.
- Metro North Region will identify any operational or clinical performance issues wi is case and ens e appropriate actions are taken to return performance to the required standards

### Background

On 16 December 2021 at 16:57hrs, the QAS received a 000 call for assi at Irre evant Kenmore to attend a Irrelevant patient who had collapsed on the floor. T e call en red th aiting Queue (enough information has been obtained to be able to dispatch a vehi e) at 17 00.

### Timeline

| | |
|---|---|
| **1st Key Stroke:** | 16:47 |
| **In waiting queue:** | 17:00 |
| **Assigned:** | 18:15 |
| **Enroute:** | 18:15 |
| **At scene:** | 18:31 |
| **Departed scene:** | N/A |
| **At hospital:** | N/A |
| **Partially available:** | N/A |

### Review

A comprehensive investigation of the in dent has been undertaken including Call Taker, Dispatch, and a resource review to why the incident oc rred, outcomes/findings and actions recommended to ensure that a similar incide does not reoccur.

### CAD eline

16:57 1st ke troke
17:00 000 cal ntered the Waiting Queue, Irrelevant fainting episode without cardiac history, coded 2A.
7:25 Delay in d atch due to workload
1 27 Dispatch pla 18:00 log on Ashgrove if nothing avail sooner
18 5 First unit attached
1 18 Second 000 call received from medical centre, patient unconscious.
e upgraded code 1
18:21 QAS call back to scene, patient unconscious and not breathing, coded 1A
18:22 Second crew and CCP attached
18:23 Caller unable to move the patient to commence CPR
8:31 First crew arrived on scene
1 :34 Crew declare life extinct
18:42 QPS requested.

## Call taker performance

During the first call for QAS assistance the EMD generated a Final Coding of 31-A-1 (Fainting episode (s) and alert >=35 without cardiac history which is a QAS Code 2A (non-lights and sirens) response. The EMD should have selected unknown heart problems as the caller did not provide a clear response. This would have generated a Final Coding of 31-C-2 (Fainting episode (s) and alert >=35 (with cardiac history) which is a QAS Code 1C (QAS Lights and Sirens) response.

The EMD received feedback and training from a Professional Development Officer on the 30th of December 2021.

## Resource Review

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time |
|---|---|---|---|---|
| 17:00 to 17:13 (16/12/2021) | QE11 Hospital | 8 | 4 | 3hrs |
| | Ipswich | 11 | 4 | 4hr 2 mins |
| | Logan Hospital | 7 | 5 | 2hr 11mins |
| | Princess Alexandra Hospital | 6 | 3 | 1hr 18mins |
| | Redlands Hospital | 5 | 3 | 1hr 32 mins |
| | RBWH | 4 | 1 | 33 mins |
| | Redcliffe Hospital | 2 | 1 | 42 mins |
| | Caboolture Hospital | 6 | 5 | 1hr 1min |
| | Prince Charles Hospital | 4 | 2 | 48 mins |
| 17:30 to 17:44 (16/12/2021) | QE11 Hospital | 6 | 5 | 3hr 30mins |
| | Ipswich | 7 | 3 | 2hr25 mins |
| | Logan Hospital | 10 | 5 | 2hrs 20mins |
| | Princess Alexandra Hospital | 5 | 2 | 1hr 20mins |
| | Redlands Hospital | 3 | 2 | 2hrs 03 mins |
| | RBWH | 4 | 0 | 9 mins |
| | Redcliffe Hospital | 3 | 1 | 43 mins |
| | Caboolture Hospital | 7 | 4 | 1hr 28mins |
| | Prince Charles Hospital | 6 | 1 | 55mins |
| 18:00 to 18:14 (16/12/2021) | QE11 Hospital | 5 | 3 | 1hr 5mins |
| | Ipswich | 11 | 5 | 2hr 55mins |
| | Logan Hospital | 10 | 7 | 2hr 50mins |
| | Princess Alexandra Hospital | 4 | 3 | 1hr 28 mins |
| | Redlands Hospital | 5 | 2 | 2hr 33mins |
| | RBWH | 4 | 3 | 39 mins |

| | | | | |
|---|---|---|---|---|
| 18:15 to 18:29 (16/12/2021) | Redcliffe Hospital | 2 | 0 | 27 mins |
| | Caboolture Hospital | 5 | 2 | 1hr 30 |
| | Prince Charles Hospital | 4 | 3 | 1hr 25mins |
| | QE11 Hospital | 8 | 4 | 1hr 35min |
| | Ipswich | 12 | 6 | 3 hrs 10 minutes |
| | Logan Hospital | 10 | 6 | 3hr 20mins |
| | Princess Alexandra Hospital | 5 | 1 | 1hr 58mins |
| | Redlands Hospital | 5 | 3 | 1hr 32 mins |
| | RBWH | 4 | 0 | 18 mins |
| | Redcliffe Hospital | 0 | 0 | 0 |
| | Caboolture Hospital | 2 | 2 | 1hr 4mins |
| | Prince Charles Hospital | 4 | 2 | 1hr 55mins |

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 17:00 to 17:13 (16/12/2021) | 1 | 3 | 1:24:57 | 4:07:57 |
| | 2 | 20 | 0:39:15 | 4:06:27 |
| 17:30 to 17:44 (16/12/2021) | 1 | 2 | 0:13:09 | 0:19:28 |
| | 2 | 20 | 0:48:31 | 4:36:25 |
| 18:00 to 18:14 (16/12/2021) | 1 | 4 | 0:06:51 | 0:26:10 |
| | 2 | 30 | 0:50:07 | 5:06:21 |
| 18:15 to 18:29 (16/12/2021) | 1 | 3 | 1:04:24 | 2:36:37 |
| | 2 | 31 | 0:55:09 | 5:36:26 |

## Outcomes

- Deterioration of a Irrelevant patient who suffered a cardiac arrest.
- High 000 demand and incorrect initial coding resulted in a response time of 1hr 31 minutes.
- Resuscitation not attempted, time of death 18:34.

## Post review actions

- SOS review of case post notification of incident.
- Family member spoke with SOS the following day and was appreciative of the contact with no further contact required.
- Feedback provided to the EMD who took the initial 000 call.

## Review Recommendations:

- Nil further required. Follow up with the EMD has occurred.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- LASN Incident Notification – Dot point report
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- State level clinical review (for complex clinical cases or incidents with deviations from clinical policy and procedure);
- Audio files;
- Workforce planning reports;
- AVL tracking of unit positions at time of incident;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active; and

## Regional Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| David Hartley | A/Assistant Commissioner | Email endorsement 14/02/2022 | 01/02/2022 |
| Lisa Dibley | A/District Director | Email endorsement 14/02/2022 | 01/02/2022 |

Department of Health

Queensland Ambulance Service

# Significant Incident Review Version 0.3

## Metro South Local Ambulance Service Network

### Authority:

By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region.

### Executive Summary:

On 23 December 2021 at 02:14:49 hrs, QAS received a Triple Zero (000) call for a sistanc (inciden . 15248679) at Irrelevant Newtown, QLD, 4305, to attend rrelevan patient who had a shortness of breath. The call entered the In Waiting Queue at 02:17:2 This s whe ough information has been obtained to be able to dispatch a resource.

The case was initially prioritised in the Advanced Medical Priority Dis atch Sys m as 0 01 requiring a Code 1C response. Nil common calls or CDS call backs w re noted the IDR.

There was a delay to identify an available paramedic unit to re ond to e case g en existing ambulance workload across Metro South Region and Metro South Health an Hospit ce (HHS) hospital Emergency Department (ED) delays were experienced at some in ope hospitals, affecting paramedic availability.

### Terms of Reference:

This review will review all aspects f ambula e respon to in dent 15248679. The review will examine ambulance operations prior to uring and fo owing the response. This review will include all requirements outlined in the *Operational Inc ent Review P s*

### Region Clinical Review:

- Case ref ed to CEU due to resp se interval and patient in cardiac arrest on arrival of first crew.
- Documenta n at a high standard and meets QAS documentation standards.
- Clinical interve ons in line with QAS Clinical guidelines and practices.

### OpCen Review:

ll Taking Performance

Th initial Triple Zero (000) call was found to be **Non-Compliant**.

**Critica tions**
1 x Determinant Level incorrect
1 x Did not follow Appropriate DLS Links

**ajor Deviations**
Nil

**Moderate Deviations**
1 x Calming Techniques not used
1 x Post-dispatch Instructions not used or incorrectly given
1 x Case Entry & Key Question response errors

**Minor Deviations**
Customer Service – Display Service Attitude

The QAS priority was deemed to be incorrect the time of the call entering the Waiting Incident Queue. It s created as a QAS Code 1C (Lights and Sirens response) and as reviewed, the priority should have been a a QAS Code 1A (Lights and Sirens response).

The reviewers noted that the comments entered by the EMD; "PT STATES SOB - SPEAKIN FULL SENTENCES – ALERT" do not accurately reflect the patient condition nor any reflection of the ied gravity of the situation in the caller's (patient) comments in the call. This comment is lik ly biased the actio s of dispatchers and resource allocation efforts. There is a distinct lack of any sense f urg cy in th EMDs speech patterns, his written comments and the apparent indifferent tone later in t e call.

The reviewers also noted that EMD responses were not reassuring or calming for the aller/pa ent.

While the reviewers were unable to locate any attempted call backs to he scen it wa mmended that Chris Dawkins undertake a search to eliminate any uncertainty with t e QAU earch methodology. Following this recommendation, Chris Dawkins did not find any furth evidenc of re eat ca associated with this incident and was satisfied with the integrity of the QAU searc method gy.

**Timings;**

| | |
|---|---|
| Call received to IWIQ | 2min 40sec |
| IWIQ to first Unit Assigned | 1 hr 11min 4 sec |
| Call received to OnScene | 1hr 24min 47sec |

**Dispatch Review**
A review of dispatch arrangemen was und aken by M D Hebbron (West Moreton District), Ms Brina Keating (Brisbane OpCen) an Ms Kym Me dith (Southport OpCen). Ms Meredith has provided the background information for the formatio

At the time of this incident there we wo vehicles marked as outliers in this incident:

- 601606 was marked out-of-ser e at 0207hrs – to allow a staff member who had completed a 12-hour shift t e dropped by to Sprin ield Station in order to finish on time.
    - o The rect process was followed by the dispatcher by placing the crew OOS at end of shift to allow e single officer to finish on time.
    - o The incide was not upgraded to a 1A response until 0344.
    - o There is no k wn aversion from the remaining single officer to responding to cases as a single officer.
    - o After dropping the second officer to Springfield, the remaining staff member was sent to Ipswich Hospital to assist with offloads to free up acute units.
- 606861 – CCP shows at Ipswich station from 0210hrs until next job at 0300hrs to Lowood
    - o Ms Meredith has discussed with the dispatcher and they have advised that the West Moreton area was busy at the time of the incident pending.
    - o The dispatcher and CDS discussed maintaining the CCP for availability vs attending to this incident.
    - o The dispatcher has advised that the CDSs decision to not dispatch the CCP was based on the comments in the audit trail noting the patient was speaking in full sentences at the time of the call and the CCP should remain available as area coverage.

- Ms Meredith discussed with the dispatcher that any available units should be dispatched to code one incidents.

- The dispatcher states there are varying practices between CDS regarding the usage of CCPs.
- Ms Meredith will re-distribute SOP02 Dispatching of Ambulance Resources with reference to utilising available CCPs.
- The CDS from this incident is currently on leave and their first shift back is the 01/03/2022. Ms Meredith will meet with CDS to discuss the decision making around the dispatch of the incident.

**Outcome of CDS Interview:**

- On 9 March 2022, Ms Meredith met with the CDS involved in this case – he advised that due to he time that has passed he is unable to recall specific details. The following has been provided follow that interview:
    - "Unit 601606 proceed to IGH as opposed to pending code one incident" – CD advised that he would not provide direction for a unit to proceed to the hospital as oppose to att ng to a code one incident. CDS advised that his routine decision making is to att rgent pending incidents prior to arranging hot tags/hospital tasks. CDS did ntion the only tim he would alter this process was if the single officer was unable to a end t atients
    - "CCP availability" – CCDS states that due to the CCP unit bein the on a ilable unit, he most likely opted to maintain the unit for coverage as opposed o sending t CCP to the 1C. CDS advised he reviewed the notes in the audit trail stating the atient c uld speak full sentences and the patient was alert, based on this inform n he de ded it as unlikely the patient required CCP intervention. CDS stated he w s the on CDS hift this night and his ability to conduct call-backs to reassess patients as limit d. CDS stated he was verbally requested to downgrade the incident ho ever wo d n down ade an incident without conducting a call-back to further assess pati ts there e left the sponse code as 1C.
- CDS did advise that the dispatcher, the OCS and himse condu d an i formal debriefing after the incident to reflect on their decision making throughout this ocess. There were many contributing factors discussed, in hindsight, and all parties r eling v y saddened and deflated at the outcome of the patient. CDS also advised t e attend g crew c led with some concerns, the incident was discussed and the CDS check d on the crew s well-being. Peer support was arranged for all involved.
- OCM has reaffirmed with C S that availab resource are to be dispatched to waiting incidents in future.

## Incident Review/Investig tion:

**Scope:**

Metro South revi ed the response, clini l performance and operational decision making to ensure the appropriate ambula e response and management of this case was achieved. It is intended that any operational or clinical p rformance issues identified with this case are addressed to ensure lessons are learnt to improve future r ponses.

**Background:**

QAS was called to attend a Irrelevant patient who had shortness of breath, speaking in full entences and alert.

**Ti eline:**

9 hrs - Triple Zero (000) call received.
02:17:29 hrs - In waiting queue.
03:28:33 hrs – First unit 601662 assigned
03:39:36 hrs – 601662 arrives on scene
03:43:52 hrs – 601662 sit-rep CPR in progress
0 43:36 hrs – CCP 506035 assigned
03:43:44 hrs – Second unit 601617 assigned
04:22:18 hrs – 601617 signal 4

**Operational Review:**

Operational dispatch to incident:
There was a delay of 1 hour and 11 minutes to dispatch of first unit and a further 11 minutes for first unit to arrive on scene. This is due to existing ambulance workload across Metro South Region and West Moreton Hospital and Health Service (HHS). Hospital Emergency Department (ED) delays were experienced at some in scope hospitals, affecting paramedic availability.

Fifteen-minute snapshots for pending cases within the Southport Operations Centre response area prior the call, at the time of the call, while the call was pending and at the time the first unit (to arrive on scene) was dispatched reveal high numbers of priority 1 and 2 pending cases within the community as f s:

| | Priority | Number of Incidents | Average Wait (hh:mm | M um Wait (hh:mm:ss) |
|---|---|---|---|---|
| 01:15 to 01:29 | 1 | 5 | 0:3 :15 | 1:55:17 |
| | 2 | 27 | 2:25:36 | 5:29:45 |
| 02:15 to 02:29 (IWIQ 02:17) | 1 | 5 | 18:04 | 0:44:13 |
| | 2 | 23 | 3:12 7 | 6:29:46 |
| 02:45 to 02:59 | 1 | 4 | 0:50 38 | 1:14:18 |
| | 2 | 23 | 3:43:02 | 6:59:51 |
| 03:15 to 03:29 (dispatched 03:28) | 1 | 1 | 1:02:44 | 1:02:44 |
| | 2 | 2 | 3:58:55 | 7:29:47 |

Hospital Status
At the time of the call, there w e 7 param c nits at hospital, with 1 'ramped' for 2 hours following arrival at hospital, affecting QAS param dic av ability to r nd to emergency cases in the community.

The significant hospital delays QAS perienced at West Moreton HHS Emergency Departments on this day are demonstrated by the following snap hots which were taken at the following times: prior to the Triple Zero (000) call, a he time of the Triple Z o (000) call, while the QAS response to the patient was pending and at the time the t unit (to arrive on scene) was dispatched:

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 01:15 to 01:29 | Ipswich Hospital | 6 | 6 | 4 hrs 22 mins | 3 |
| 5 to 02:29 (IWIQ 7) | Ipswich Hospital | 7 | 2 | 2 hrs | 3 |
| 02:45 to 02:59 | Ipswich Hospital | 6 | 5 | 2 hrs 31 mins | 3 |
| 03:15 to 03:29 (dispatched 03:28) | Ipswich Hospital | 6 | 4 | 3 hrs | 3 |

On 23 December 2021, the QAS Metro South Region experienced 108.95 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes.

This 'Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound as pending incidents continue to accrue as more Triple Zero (000) requests are received; however, ambulance crews are unable to be released from hospitals.

In the period leading up to the time of this incident, significant pressures (hospital delays and mbulan 'ramping') were being experienced throughout southeast Queensland (SEQ), leading to SEQ q g escalation to "Extreme" as of 23:15 hrs 19.12.2021 and returned to "Normal" as of 14:15 hrs on 25.12.21

Metro South Region Staffing:

- At the time of the call coming in (02:14hrs) West Moreton District had the ollowing re urcing:
  - Twilight shifts – 18 officers (equivalent to 9 crews)
    - 17 were due to finish at 0200hrs some were likely incurred sh t exten ons due to workload; and
    - 1 was due to finish at 0400 hrs.
  - Night shifts – 5 full crews + 2 x single offi rs (Gatto & lps ch)
  - EA was fully covered at EA stations.
- On a typical Thursday, West Moreton District approve ight s rosters ould see ten-night shift crews (excluding EA) across the district. As such staffing n this n g ncluding twilight staffing) was above our usual complement.

**Outcomes:**

- 1 hour and 22-minute protracted response me l Waitin Queue to first unit on scene) resulted from impacts on paramedic aila y due t Metro Sout workload, and hospital delay pressures.
- Review of the Operations entres m ageme f the i cident revealed both call taking and dispatch issues.
- West Moreton Distric irector was bl to locate the male person who was reported to be on scene and confirmed with the p rson th t he did n ake any calls to QAS on behalf of the patient.

## Review Recommendations:

- Inform co lainant of the review o he delayed response.
- Cont nue wo with Metro South Hospital and Health Service regarding hospitals delays and fa itated offloa
- ontinually review affing in Metro South Region to meet demand.
  B bane OpCen Dir or to ensure appropriate follow up occurs with call-taker upon return from ann l leave.
- Southp rt OpCen Executive Manager to follow up with CDS for review and feedback regarding utilisation f the CCP (unit 606861) and single officer (601606).
- Southport O Cen Executive Manager to recirculate SOP02 – Dispatching of Ambulance Resources – actioned 10 February 2022.
- As part of the complaint's management process the West Moreton District Director, Manager Clinical Education and Brisbane OpCen A/Director met with the complainant (pt's sister) via TEAMS on M ay 7 February as she resides in Irrelevant
  - Note further follow up will be required to pass on new information regarding dispatch information.

**Final Outcomes:**

- Updated as of 16 March 2022, to include follow up details with EMD call-taker and CDS.
- Brisbane OpCen Director provided feedback regarding the review to EMD call-taker on 21 February 2022.
- Southport OpCen Executive Manager provided feedback to CDS on 9 March 2022.
- All outstanding outcomes have been finalised.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Special review documents x 7.
- eARF x 2
- File note from complainant Andrea Thomas

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Irrelevant | 16/03/2022 |
| Drew Hebbron (SIR review & update) | District Director - WMD | | 16/03/2022 |
| Michelle Holsworth (Initial Author) | Acting District Director -WMD | | |

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# Gold Coast Region

## Authority:

By authority of Assistant Commissioner, Gold Coast Region, Queensland Ambulance Service

## Executive Summary:

**IDR 15294692**– At 10.38pm on Sunday 2 January 2022, Queensland Ambulance Service (QAS) received a request for service to a residential address in Elanora to attend a Irrelevant reportedly breathing loudly and unable to be woken. The Service had attended this patient the same afternoon and identified a COVID positive patient who was complaining of vomiting and was treated with an antiemetic and left in the care of Irrelevant partner.

A CCP POD, Acute Unit, and HARU were dispatched – an Operational Supervisor also attended. On arrival the patient was confirmed to be in cardiac arrest with effective CPR being performed by the patient's partner. After nearly 40 minutes of CPR, and consultation with the QAS Medical Director, CPR was terminated, and the patient was declared deceased. QPS were notified.

## Terms of Reference:

This review will review all aspects of ambulance response to incident **15294692** and the previous case **15292460**. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements outlined in the *Operational Incident Review Process*.

## Gold Coast Region Clinical Incident Summary Report:

The Gold Coast Manager of Clinical Education allocated the clinical review to a Clinical Support Officer

**Actions to date:**

Clinical review:

- The Gold Coast Clinical education unit have undertaken a comprehensive review of the clinical and operational aspects of the cases.
- The Gold Coast Manager Clinical Education has followed up with the Subject officer regarding managerial enquiry. GC Region liaised with Medical Directors officers; the outcome determined was that the officer was to be placed on supervised practice until the review is completed.
- A Gold Coast Senior Operations Supervisor has contacted the Irrelevant and family to offer welfare support and has advised a review of the incident is being undertaken. The Irrelevant was appreciative of the call.
- Dr Stephen Rashford, QAS Medical Director has met with the LARU paramedic to check on his wellbeing and discuss relevant clinical learnings from the case.

## Southport Operations Centre Review:

A/Assistant Commissioner has liaised with Operations Manager Gold Coast to request Ops Centre review of the case and request a copy of the voice logs (voice logs attached).

Review completed with nil Operations Centre concerns.

On 2 January 2022, a triple zero request for service was received at 12:15 and actioned by a Brisbane EMD. The case presented in the clinical hub queue at 12:18.

- The incident was actioned and coded correctly as a 26A11 with a 2CL response based on the information provided by the caller.
- A review/call back was performed by clinical hub. The clinical hub paramedic deemed the coding to be appropriate for acute dispatch, case placed in the acute queue at 12:38.
- 1255 Unit 601524 dispatched/ Reassigned Diverted to higher priority
- 1325 Unit 608308 dispatched/ On Scene 1403
- 1449 Unit 608308 Cleared Scene- Treatment only No Transport

A second triple zero request for service was received at 22:38 and actioned by an EMD in the Southport OpCen.

- The incident was actioned and coded correctly as a 06E02 with a 1A response priority based on the information provided by the caller.
- Case was in Acute queue at 2240.

- The Dispatch Sequence is as follows:
  - 2240 Unit 606415 Dispatched 2249 On Scene
  - 2242 Unit 601593 Dispatched 2255 On Scene
  - 2251 Unit 606573 Dispatched 2308 On Scene
  - 2254 Unit 607563 Dispatched 2315 On Scene

  - 2256 Initial Sitrep Code 1 Backup – Cardiac Arrest
  - 2328 Secondary Sitrep- Patient Deceased QPS Required.

## Incident Review/Investigation:

**Scope:**

The process of this SIR is to review the clinical and operational aspects of this incident in the interest of generating learning where possible and to ensure best practice in prehospital care is provided to stakeholders whilst ensuring the safety of QAS staff is upheld.

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

**Background:**

QAS LARU attended the patient on 2 January 2022, at 2.03pm and assessed the patient who was complaining of vomiting and diarrhoea. The patient had taken a Rapid Antigen Test for COVID-19 which was positive and was awaiting the results of a PCR test. The patient was treated with Ondansetron for nausea, to assist with the symptoms and was advised to take oral paracetamol to assist with Irrelevant current temperature and the patient was left in the care of Irrelevant

The patient's Irrelevant later contacted triple zero for the patient on 2 February 2022 at 10.38pm – it was noted that the patient was breathing loudly, and the caller couldn't wake the patient up. During the call, the patient was determined to be in cardiac arrest and CPR was commenced. Following interventions from the responding units the patient was unable to be revived and was declared deceased at scene.

**Timeline:**

- First Incident (non-transport):
- 1st key stroke: 12.15pm
- In waiting queue: 12.18pm
- First unit assigned: 12.55pm
- First unit diverted: 1.01pm
- LARU unit assigned: 1.25pm
- LARU unit at scene: 2.03pm
- LARU unit cleared: 2.35pm
- Incident closed: 2:49hrs

- Second Incident (cardiac arrest):
- 1st key stroke: 10.38pm
- In waiting queue: 10.40pm
- First unit assigned: 10.40pm
- First unit at scene: 10.49pm
- CPR Discontinued 11.28pm
- Incident closed: 1.33am

**Review:**

The review will consider available documentation, including IDR and the EARF. Patient care records will be assessed by the GC Regional Clinical Education Unit and/or the Office of the Medical Director. Findings based on documentation review, and the details provided in the Incident Detail Report indicate appropriate QAS resources were responded, and clinical interventions provided were appropriate.

Clinical review identified some learning for the LARU officer regarding his patient care assessment, treatment, and documentation. Officer has been placed on a 3-month clinical support plan and placed on supervised practice.

Further review is being completed by the Medial Directors office and a plan has been put in place to support the officer. Further review is occurring by the Medical Directors officer and the case is being treated as a CAT-3 compliant.

- Nil operational concerns identified
- Nil Operation Centre concerns

**Follow up with family of deceased patient:**

The Gold Coast Regional A/Senior Operations Supervisors, Jayney Shearman attended the patient's family residence and took up with the partner and parents of the family, to offer support and gain further intelligence regarding the incidents.

## Officer Welfare:

- The Gold Coast Region CEU and Operations teams followed up with officers who attended the scene in real time with peer support provided to attending crews.
- Gold Coast Manager Clinical Education followed up with subject officer regarding managerial enquiry and offered staff welfare to the officer
- Mermaid Waters Officer in Charge has liaised with subject officer to discuss welfare and will continue to engage officer with further follow regarding his welfare.

## Review Recommendations:

- Medical Director is managing Clinical aspects noted as Cat 3 complaint.

## Appendix of relevant documents/files:

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

| | |
|---|---|
| **Incident Details Report** | IDR - 15292460 - Non transport - Dec; IDR 15294692.pdf |
| **GCLASN Notifiable PSDU Notification** | |
| **dARF/dCRF** | eARF- 15292460 - Non transport - Dec; eARF- 15294692 - Non transport - Dec; eARF 2 - 15294692 - Non transport - Dec |
| **Voice Logs** | 02.01.2020 12.24.55 CHUB Callback (2CL)000; 02.01.2020 12.18.00 (2CL) Elanora.w |
| **Southport OpCen Brief** | RE_ SIR Requested - Case 15294692.msg |
| **Clinical Review** | Local review completed now being managed by Med Director Office |
| **Other Documents** | SIR Requested - Case 15294692.msg; Hot Brief - 15294692 - Non tran |

## LASN Endorsement

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

| Role | Name | Signature | Date |
|---|---|---|---|
| Assistant Commissioner | Peter Warrener | Irrelevant | 19/01/2022 |
| | | | |

Department of Health

Queensland Ambulance Service

# Significant Incident Review

## Metro South Local Ambulance Service Network

### Authority:

By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region.

### Executive Summary:

On 04 January 2022 at 19:54:44 hrs, Queensland Ambulance Service (QAS) recei ed a T e Zero ( 0) call for assistance to attend a Irrelevant patient who had fallen, not alert consc us and bre ing. (Incident 15303921).

The case was initially prioritised in the Advanced Medical Priority Disp h tem 1 as 17D02 requiring a Code 1 response. There was a delay to dispatch of 22 minutes.

There was a delay to identify an available paramedic unit respon to he case iven existing ambulance workload across Metro South Region and Metro South Health nd Hos al Servic (HHS) and West Moreton HHS hospital Emergency Department (ED) delays were experi ced at n scope hospitals, affecting paramedic availability.

### Terms of Reference:

This review will review all aspects amb ance re onse to in ident 15303921. The review will examine ambulance operations prior to, d ing and owing th resp se. This review will include all requirements outlined in the *Operational Inci ent Review ocess*.

### Region Clinical Review:

**Synopsis:**

- QAS res nding to Irrelevant w has collapsed unresponsive on toilet post complaining of chest pain all day
- Cr s dispatc d as below:
  - ACPII's relevant @ 20:20hrs, scene @20:37hrs
  - ACPII's - Ir levant @ 20:25hrs, scene @ 20:48hrs
    SOS Irreleva t @ 20:25hrs, scene @ 20:42hrs

**Pertinent Infor tion:**

- Initial crew ttached at 20:16hrs and call taken at 19:54hrs.
- Crew cancel d and attached officers Irrelevant and Irrelevant due to being closer to scene
- Crew on case and responded in appropriate amount of time
- Nil CPR commenced prior to QAS crews arriving on scene

**Clinical Education Unit Supportive Processes / Outcomes:**

- Crews have attended job within appropriate response times
- Back up crews have arrived for assistance in appropriate response times
- Delays in attaching initial crew for case.
- Crews have initiated treatment as per QAS policy and procedures from DCPM.

## OpCen Review:

The initial Triple Zero (000) call, taken in Brisbane OpCen, was found to be **Non-Compliant**

**Critical Deviations**
1 x Protocol selection incorrect
1 x Incorrect DLS link

**Major Deviations**
Nil

**Moderate Deviations**
1 x KQ not asked
1 x KQ answer incorrectly recorded
1 x EIDS tool incorrectly used

**Minor Deviations**
Nil

The incident was created as a QAS Code 1B (Lights and S ns resp se) t is un ely that the priority would have been different if the EMD had utilised the Chest Pain pr ocol.

The reviewers felt that the experience of the EMD should have g ded him to the Chest Pain protocol, even though the caller had stated a fall from the toilet had o d The ation and circumstances would clearly indicate a potential/likely cardiac event.

An outgoing call was made by a CDS T CDS ha ma e some otes appropriate to the incident. The CDS appears to have asked an EMD to all ba to sc and pro de support to the caller as there was the appearance of a possible cardiac espiratory rrest.

The outgoing call to scene, fro the South Cen was found to be **Non-Compliant**

**Critical Deviations**
Nil

**Major Deviations**
1 x Pre-Arriv Instru ns
1 x Proto Links ('Una e to Move Patient')

**Mod at Deviations**
N

**Minor Deviation**

Th incident was reconfigured to a QAS Code 1A (Lights and Sirens response). This was the correct priority.

The DLS ation around the PAIs as largely technical in nature. The expectations of EMDs on call backs, in which ProQA is utilised, are not well known as it is not often used. The EMD utilisation of the '**Unable to Move Patient**' DLS link is likely to have given the EMD more precise directions.

e '**Unable to Move Patient**' continues to be a point where EMDs are unpractised and often omit these instructions in calls where required.

The reviewers did note a call, from the Southport OpCen (SPOC) OCS to the Brisbane OpCen (BNOC) OCS, after the incident was effectively complete. The timing of that call and the content of that call appears to be one better managed though the chain of command of OCM to OCM.

**Timings;**

| | |
|---|---|
| Call received to IWIQ | 2min 02sec |
| IWIQ to first Unit Assigned | 19min 37sec |
| Call received to OnScene | 42min 31sec (20min 14sec after the upgrade to Code 1A occurred) |

## Incident Review/Investigation:

**Scope:**
Metro South reviewed the response, clinical performance and operational decision makin to e re e appropriate ambulance response and management of this case was achieved. It is inte d that a operational or clinical performance issues identified with this case are addressed to e e lessons are le nt to improve future responses.

**Background:**
QAS was called to attend a Irrelevant patient who had fallen, not alert conscio and b eathing.

**Timeline:**
19:54:44 hrs - Triple Zero (000) call received.
19:56;46 hrs - In waiting queue.
20:16:23 hrs – First unit B501322 assigned and cancelled for closer il at 20:2 44 hrs
20:20:44 hrs – B501321 assigned as closer unit
20:20:38 hrs – A607691 assigned as SOS
20:37:15 hrs - B501321 arrives on scene
20:42:38 hrs - A607691 arrives on scene
20:52:34 hrs – A607691 signal 4

**Operational Review:**

Operational dispatch to incide :
There was a delay of 22 minu s to disp nit and a further 17 minutes for first unit to arrive on scene, there were no available pa me c units to dispatch to the incident due to existing ambulance workload across Metro South Region and Met South and West Moreton HHS's. Hospital Emergency Department (ED) delays were experienced at some in sc e hospitals, affecting paramedic availability.

Fifteen-minute snap ots for pending cases within the Southport Operations Centre response area prior to the call, at the me of the all and while the call was pending reveal high numbers of pending cases within the commun as follows:

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 19:45 to 19:59 (04/01/2022) | 1 | 7 | 00:27:06 | 0:46:12 |
| | 2 | 40 | 1:29:43 | 6:41:01 |
| 20:00 to 20:14 (04/01/2022) | 1 | 11 | 00:21:54 | 1:01:12 |
| | 2 | 43 | 1:35:13 | 6:56:01 |
| 20:15 to 20:29 (04/01/2022) | 1 | 12 | 0:36:03 | 1:16:13 |
| | 2 | 43 | 1:44:00 | 7:11:02 |
| 20:30 to 20:44 (04/01/2022) | 1 | 9 | 0:42:54 | 1:30:29 |
| | 2 | 46 | 1:42:33 | 7:26:00 |

Hospital Status

At the time of the call, there were 49 paramedic units at hospital, with the longest at Mater Adults at 5 hours and 42 minutes ramped, affecting QAS paramedic availability to respond to emergency cases in the community.

The significant hospital delays QAS experienced at Metro South and West Moreton HHS Emergency Departments on this day are demonstrated by the following snapshots which were taken at the following times: prior to the first Triple Zero (000) call, at the time of the Triple Zero (000) call, and while the QAS response to the patient was pending:

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 19:45 to 19:59 (04/01/2022) | Logan Hospital | 12 | 5 | 0:51:01 | 3 |
| | Princess Alexandra Hospital | 7 | 7 | 3:05:08 | 3 |
| | Mater Adults Hospital | 7 | 5 | 5:42:26 | 3 |
| | Ipswich Hospital | 10 | 8 | 2:37:59 | 3 |
| 20:00 to 20:14 (04/01/2022) | Logan Hospital | 13 | 8 | 1:06:00 | 3 |
| | Princess Alexandra Hospital | 5 | 5 | 3:20:07 | 3 |
| | Mater Adults Hospital | 6 | 5 | 1:38:42 | 3 |
| | Ipswich Hospital | 13 | 8 | 2:52:58 | 3 |
| 20:15 to 20:29 (04/01/2022) | Logan Hospital | 13 | 10 | 1:21:01 | 3 |
| | Princess Alexandra Hospital | 7 | 4 | 3:35:08 | 3 |
| | Mater Adults Hospital | 6 | 6 | 1:53:43 | 3 |
| | Ipswich Hospital | 14 | 10 | 3:07:59 | 3 |
| 20:30 to 20:44 (04/01/2022) | Logan Hospital | 10 | 7 | 1:34:15 | 3 |
| | Princess Alexandra Hospital | 7 | 2 | 3:50:08 | 3 |
| | Mater Adults Hospital | 7 | 6 | 2:08:43 | 3 |
| | Ipswich Hospital | 15 | 10 | 3:22:59 | 3 |

On 04 January 2022, the QAS Metro South Region experienced 87.58 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes.

This 'Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound as pending incidents continue to accrue as more Triple Zero (000) requests are received; however, ambulance crews are unable to be released from hospitals. The outcome results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

In the period leading up to the time of this incident, significant pressures (hospital delays and ambulance 'ramping') were being experienced throughout southeast Queensland (SEQ), leading to SEQ requiring escalation to "Extreme" as of 19:32 hrs 01.01.2022 and returned to "Normal" as of 07:35 hrs on 15.01.22

Metro South Region Staffing:

- The Metro South Region West Moreton District had the following resourcing against approved rosters;
  - Afternoons – 6.5 crews
  - Twilight shifts – 3 crews.
  - Night shifts – 4 crews.
  -

**Outcomes:**

- 43-minute protracted response (receipt of triple zero (000) call to first unit on scene) resulted from impacts on paramedic availability due to Metro South workload, staffing and hospital delay pressures.

## Review Recommendations:

- Inform complainant of the review of the delayed response.
- Continue work with Metro South and West Moreton Hospital and Health Service regarding hospitals delays and facilitated offloads.
- Continually review staffing in Metro South Region to meet demand.
- State OpCen's to provide feedback as relevant to the call-taking special review.

## Appendix of relevant documents/files:

| | |
|---|---|
| Incident Detail Report | IDR 15303921.pdf |
| Ambulance Report Form | DARF_504019086.pdf |
| OPCen Special Review | 220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN |
| Audio Files | 220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN<br>220104_SR18228358_15303921_GREENBAN |
| Clinical Review | CIR 15303921.docx |

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Irrelevant | 04.02.2022 |
| Drew Hebbron (reviewer) | District Director | | 04/02/2021 |
| Michelle Holsworth | Acting District Director | | |

# Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **15303921**
ProQA number: **18228358**
Console name: **QA541**
Incident Date: **04/01/2022 19:54:44**
Last Updated:

## Incident Information

| | | | |
|---|---|---|---|
| **Incident Type:** | ACUTE AND CCP IF AVAILABLE | **Alarm Level:** | |
| **Priority:** | 1A | **Problem:** | FALL ARREST |
| **Determinant:** | 17D02 | **Agency:** | QAS |
| **Base Response#:** | 018102 | **Jurisdiction:** | 6 Southport West |
| **Confirmation#:** | 00015136 | **Division:** | 6 Springfield |
| **Taken By:** | Gough, Rick | **Battalion:** | 6 Springfield |
| **Response Area:** | 6 Springfield | **Response Plan:** | 1A |
| **Disposition:** | A Case Completed | **Command Ch:** | |
| **Cancel Reason:** | | **Primary TAC:** | TLK GRP 115/U F Ch 116 |
| **Incident Status:** | Closed | **Secondary TAC:** | |
| **Certification:** | ACUTE | **Delay Reason (if any):** | |
| **Longitude:** | 27060958 | **Latitude:** | 62305556 |
| **Patient Name:** | Irrelevant | **Patient DOB:** | Irrelev |

## Incident Location

| | | | |
|---|---|---|---|
| **Location Name:** | | **County:** | OGAN |
| **Address:** | Irrelevant | **Location Type:** | |
| **Apartment:** | | **Cross Street:** | eleva |
| **Building:** | | **Map Reference:** | B257M 1 |
| **City, State, Zip:** | Irrelevant QLD 4124 | | |

## Call Receipt

| | | | |
|---|---|---|---|
| **Caller Name:** | Irrelevant | **Original CLI Phone** | Irrelevant |
| **Method Received:** | | **Call ack Phone:** | |
| **Caller Type:** | | **Calle cation:** | |

## Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| **Phone Pickup** | 04/01/2022 | 19:54:44 | |
| **1st Key Stroke** | 04/01/2022 | 19:54:44 | |
| **In Waiting Queue** | 04/01/2022 | 19:56:46 | |
| **Call Taking Complete** | 04/01/2022 | 20:00:30 | Gough, Rick |
| **1st Unit Assigned** | 04/01/2022 | 20:16:23 | |
| **1st Unit Enroute** | 04/01/2022 | 20:16:39 | |
| **1st Unit Arrived** | 04/01/2022 | 20:37:15 | |
| **Closed** | 04/01/2022 | 22:50: | L eier, Rac |

## Elapsed T s

| Descript | Time |
|---|---|
| **eived to In eue** | 00:02:02 |
| **Ca ing** | 00:05:46 |
| **In Qu to 1st As** | 00:19:37 |
| **Cal eceived to 1st Assign** | 00:21:39 |
| **A igned st Enroute** | 00:00:16 |
| **nroute to t Arrived** | 00:20:36 |
| **Incident D tion** | 02:55:40 |

## Resources Assigned

| Unit | Assigned | Disposition | En e | Staged | ived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 501322 | 20:16:23 | Back Up Not Required | 20:1 | | | | | 20:20:34 | | | Vehicle Change |
| B501321 | 20:20:04 | A Case Completed | 20:20:44 | | 20:37:15 | | 22:50:12 | 22:50:24 | | | |
| A607691 | 20:20:38 | Assistance Only | 20:20 53 | | 20:42:38 | | | 21:00:15 | | | |
| B601604 | 20:22:24 | A tance On | 20:25 07 | | 0:48:33 | | 20:59:43 | 20:59:45 | | | |

## Personnel Assi d

| Unit |
|---|
| 501321 |
| 501322 |
| 60160 |
| 607 |

Irrelevant

## Pre-Scheduled Infor ion

**No Pre-Scheduled Info tion**

## T sports

**No ansports**

## Co ments

| D e | Time | User | Type | Comments |
|---|---|---|---|---|
| | 6 46 | 5RICGOU | Response | [ProQA Dispatch] Dispatch Level: 17D04 (Not alert) Response Text: 1B Irre Irrelevant Conscious, Breathing. Problem Description: CHEST PAINS - HX HEART ATTACK 2 YR AGO - FALL |
| 04/01/2022 | 19:56:46 | 5RICGOU | Response | [ProQA: Key Questions] 1. This happened now (less han 6hrs ago). 2. It's reported that Irrele fell at ground level. 3. The reason for the fall is not known. 4. There is no bleeding now. 5. No special concerns have been reported. 6. Irrelev is not completely alert (not responding appropriately). 7. The injury is to a POSSIBLY DANGEROUS area. 8. Irrelev is no longer on the floor/ground. |
| 04/01/2022 | 19:57:34 | 5RICGOU | Response | " PT NOT REAL WITH IT " - NOT ALERT |
| 04/01/2022 | 19:58:57 | 5RICGOU | Response | [ProQA: Key Questions] 1. This happened now (less han 6hrs ago). 2. It's reported that Irrelevant at ground level. 3. The reason for the fall is not known. 4. There is no bleeding now. 5. No special concerns have been reported. 6. Irrelev is not completely alert (not responding appropriately). 7. The injury is to a POSSIBLY DANGEROUS area. 8 Irreleva is no longer on the floor/ground. |
| 04/01/2022 | 19:58:57 | 5RICGOU | Response | [ProQA] : Irrelevant , Conscious, Breathing. |
| 04/01/2022 | 20:00:29 | 5RICGOU | Response | |

| | | | |
|---|---|---|---|
| | | | Irrelevant EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS |
| 04/01/2022 | 20:01:16 | 6RACLIE | Response [Private] EMD DISCUSSED WITH OCS |
| 04/01/2022 | 20:01:23 | 6RACLIE | Response [Notification] [QAS]-[Private] Resource notification - EMD notified CDS nil available resources to respond |
| 04/01/2022 | 20:08:26 | 6RACLIE | Response [Private] COMMON CALLED |
| 04/01/2022 | 20:14:12 | 5MARSTE | Response [Notification] [QAS]-/CDS10- PT IS ALERT SITTING ON THE TOILET SWEATING ALOT PT HAS HAD CHEST PAIN ALL DAY AND TAKING GTN ALL DAY AT THE END OF TE CALL PT IS SAID TO SLUMPED AGAINST THE WALL ARM HANGING DOWN |
| 04/01/2022 | 20:16:24 | PS | Response [Page] Dispatch page sent to Unit:501322, Sent From: KEDCADQASPIS01 |
| 04/01/2022 | 20:16:25 | 501322 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:16:31 | PS | Response [Page] Dispatch page to Unit 501322 complete to Irrelevant Message sent successfully to Whispir |
| 04/01/2022 | 20:16:33 | PS | Response [Page] Dispatch page to Unit 501322 complete to Irrelevant Message sent successfully to Whispir |
| 04/01/2022 | 20:16:45 | RL | Response [Page]Response Times Sent To Units: 373, Sent From: PA608, Please ch ge to talk group 115 |
| 04/01/2022 | 20:17:02 | 501322 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:18:00 | 5MARSTE | Response [Notification] [QAS]-CDS - POSSIBLE ARREST PT IS SLUM ED N THE TOILET SLUMPED AGAINST THE WALL POSSIBLE AR REST CALL TAKER CALLING WHILST CDS ATRRANGED RESOURCES |
| 04/01/2022 | 20:18:01 | 501322 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT REC VED BY T. |
| 04/01/2022 | 20:20:05 | PS | Response [Page] Dispatch page sent to Unit:501321, Sent From: KE ASPIS01 |
| 04/01/2022 | 20:20:06 | 501321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:20:13 | PS | Response [Page] Dispatch page to Unit 501321 compl levant Message sent successfully to Whispir |
| 04/01/2022 | 20:20:39 | PS | Response [Page] Dispatch page sent to Unit:6076 , Sent Fro DCADQASPIS01 |
| 04/01/2022 | 20:20:40 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT O NCIDENT EC ED BY MDT. |
| 04/01/2022 | 20:20:41 | 6LISNG | Response CALLER STATES PT NOT BREATHIN |
| 04/01/2022 | 20:20:47 | 501321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCID T RECEI ED BY MDT. |
| 04/01/2022 | 20:20:49 | PS | Response [Page] Dispatch page to Unit:607691 comple o Irrelevan Message sent successfull ir |
| 04/01/2022 | 20:20:55 | 607691 | Response [PRIVATE] ACKNOWL GEMEN F INCID R EIVED BY MDT. |
| 04/01/2022 | 20:21:03 | RL | Response [Page]Response Tim Sent To U 372, Sent F om: PA608, Please change to talk group 115 |
| 04/01/2022 | 20:21:20 | 6LISNG | Response EMD TEMPTING GET ALLER T ET PT ON THE GROUND TO COMM E CPR |
| 04/01/2022 | 20:21:21 | 501321 | Response [PRIVATE KNOWL EMENT OF CIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:21:21 | 607691 | Response [PRIVATE] A NOWLED MENT O NCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:21:48 | 501321 | Response [PRIVATE] ACK WLEDGE OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:21:48 | 607691 | Response [PRIVATE] ACKN LEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:21:48 | 6LISNG | Response LSE IN H SE AND NEIGHBOUR ON ACREAGE - NO NUMBER AVAIL TO LL FOR A ISTANCE |
| 04/01/2022 | 20:22:25 | PS | Response [Page] D atch page sen to Unit:601604, Sent From: KEDCADQASPIS01 |
| 04/01/2022 | 20:22:26 | 601604 | Response [PRIV E] ACK OWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:22:33 | PS | Response [Pa Dispatch ge to Unit:601604 complete to Irrelevant M sage sent s cessfully to Whispir |
| 04/01/2022 | 20:22:38 | PS | Respo age] Dispatc age to Unit:601604 complete to Irrelevant M ge s successfully to Whispir |
| 04/01/2022 | 20:22:57 | 6RACLIE | R ponse [Priva ] UTH BY CDS TO DISPATCH 601604 AS SINGLE WHILST RAMPED AT IGH |
| 04/01/2022 | 20:23:34 | 6LISNG | sponse PT 110KGS AND 6FT 3 - CALLER UNABLE TO GETIrrelevan OFF THE TOILET |
| 04/01/2022 | 20:23:35 | 501321 | R onse VATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:23:35 | 607691 | Res se [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:23:43 | 6LISNG | Respo CALLER GOING TO TRY MESSAGE NEIGHBOUR TO COME HELP |
| 04/01/2022 | 20:23:44 | 501321 | Respons [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:23:44 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:24:06 | 6LISNG | Response Irrelevant CONTINUES TO SAY UNABLE TO BUDGE PT FROM TOILET |
| 04/01/2022 | 20:24:07 | 7691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:24:08 | 21 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20 10 | 60 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 6:03 | 6LISN | Response [Private] CDS ADVISED WILL BE INAFFECTIVE TO ATTEMPT CPR IN THAT POSITION |
| 04/01/202 | 20:26:28 | 6LISNG | Response [ProQA Reconfigure] Reconfigure Level: 17D02 (Arrest) Response Text: 1A Irrelev Irrelevant Not Conscious, Not Breathing. Problem Description: CHEST PAINS - HX HEART ATTACK 2 YR AGO - FALL |
| 04 2022 | 20: 8 | 6LISNG | Response [ProQA: Key Questions] 1. It's reported that Irrele fell at ground level. 2. The reason for the fall is not known. 3. There is no bleeding now. 4. No special concerns have been reported. |
| 4/01/2022 | 20:26:29 | 01321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 1/2022 | 20:26:30 | 04 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04 2022 | 20:26:30 | 50 1 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/ 2022 | 20:26:32 | 601604 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04 2022 | 20:27:29 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 0 1/2022 | 20:27:30 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| | 20:30:00 | 6LISNG | Response CREW TO COME THROUGH GATES - HOUSE DOES NOT FACE ROAD - NEIGHBOURS COMING TO ASSIST |
| 04/01/2022 | 20:30:02 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:30:02 | 501321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:30:02 | 601604 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:30:44 | 6LISNG | Response PT DOES NOT HAVE STENTS RELYING ON MEDS ONLY POST LAST HEART ATTACK |
| 1/2022 | 20:30:45 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:30:46 | 601604 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:30:48 | 501321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:32:17 | 6LISNG | Response BARRY NEIGHBOUR ON SCENE |
| 04/01/2022 | 20:32:18 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:32:18 | 601604 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:32:19 | 501321 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:07 | 607691 | Response [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:07 | 6LISNG | Response NEIGHBOUR ON SCENE STATES PT HAS DEF GONE - NOT WILLING TO PROCEED WITH CPR - THEY DO NOT WNAT TO DRAG IrrelevanFROM TOILET |

| | | | | |
|---|---|---|---|---|
| 04/01/2022 | 20:35:08 | 501321 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:08 | 601604 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:17 | 6LISNG | Response | [ProQA: Key Questions] 1. It's reported that Irrelevant ell at ground level. 2. The reason for the fall is not known. 3. There is no bleeding now. 4. No special concerns have been reported. |
| 04/01/2022 | 20:35:17 | 6LISNG | Response | [ProQA] : Irrelevant Not Conscious, Not Breathing. |
| 04/01/2022 | 20:35:18 | 601604 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:18 | 607691 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:35:19 | 501321 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 04/01/2022 | 20:52:34 | 6RACLIE | Response | 607691 606698 SR - SIG 4 |
| 04/01/2022 | 20:59:39 | 6RACLIE | Response | 601604 CLEAR SCENE |
| 04/01/2022 | 21:00:13 | 6RACLIE | Response | 607691 CCP BACK ON BOARD CLEARING SCENE - BRAVO UNIT ON SCENE |
| 04/01/2022 | 21:09:58 | 6LISNG | Response | 501321 QPS REQ - UNABLE TO MAKE GP CONTACT |
| 04/01/2022 | 21:13:00 | ICEMS | Response | POL-Q Request for Attendance sent for Incident Q22-A000584 |
| 04/01/2022 | 21:13:01 | 6LISNG | Response | >POL-Q> HI QPS - QAS ON SCENE WITH DECEASED PT Irrelevant Irrelevant - CREW UNABLE TO MAKE CONTACT WITH GP - THANKS COMMS |
| 04/01/2022 | 21:14:24 | 6CHEBAT | Response | [Private] Q6 OCS CONTACT Q5 TO CHECK INTIAL PROTOCO CHOICE FALL? |
| 04/01/2022 | 21:17:12 | ICEMS | Response | >POL-Q> POL-Q has been attached to the incident |
| 04/01/2022 | 22:04:52 | ICEMS | Response | POL-Q EnRoute |
| 04/01/2022 | 22:12:00 | 6RACLIE | Response | [Page] Units: 501321, Sent From: PA608, QPS ENROU |
| 04/01/2022 | 22:30:12 | ICEMS | Response | POL-Q OnScene |

**Priority Changes**

| Date | Time | Changed from Priority | Reason | |
|---|---|---|---|---|
| 04/01/2022 | 20:17:01 | 1B | Patient Condi ion | Stephens, Mark (CDS) |

**Call Activities**

| Date | Time | Radio | Activity | Location | Comments | User |
|---|---|---|---|---|---|---|
| 04/01/2022 | 19:54:44 | | AML Data Received | | Cente rea HEL 27 41.62 00, 152 .329200 CAD: # .69381/152 3882 | SDSIAML |
| 04/01/2022 | 19:56:46 | | Incident in Waiting Queue | | | |
| 04/01/2022 | 19:56:46 | | Waiting Pending Incident Time Warning | | W ing P ding Incid Time Warning timer ex ed | |
| 04/01/2022 | 19:56:47 | | ANI/ALI Statistics | | INT rt:Jan 04 20 19:54:40 / INT SendN n 04 20 19:54:39 / WS RecvNP:J 022 19:54:40 / WS ocess:Jan 04 2022 19:56:46 | 5RICGOU |
| 04/01/2022 | 19:56:47 | | Read Comment | | C ment for Incident 358 was Marked as Rea | 5RICGOU |
| 04/01/2022 | 19:56:47 | | ProQA | 365 Tho pson Rd | ProQA determinant sent | 5RICGOU |
| 04/01/2022 | 19:56:51 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 19:56:56 | | Remove Waiting Pendi g Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 04/01/2022 | 19:56:56 | | Incident in W g Queue Timer Clea | | | |
| 04/01/2022 | 19:57:32 | | UserActi | | User clicked Initial Assign | 6RACLIE |
| 04/01/2022 | 19:57:35 | | Initial ignment | | The following unit(s) is (are) recommended for assignment: 601450 (00:18:04) | 6RACLIE |
| 04/01/2022 | 19:57:46 | | Pending dent Tim Warning | | Pending Incident Time Warning timer expired | |
| 04/01/2022 | 19:57:46 | | Incident Late | | | |
| 04/01/2022 | 19:57:48 | | UserAction | | User clicked Initial Assign | 6RACLIE |
| 04/01/2022 | 19:57:50 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 601450 (00:18:04) | 6RACLIE |
| 04/01/2022 | 19:58:13 | | VisiCAD Recommendat | | 601421: 00:19:17, 508025: 00:19:33, 507332: 00:21:07, 501225: 00:21:17, 507085: 00:22:45, | 6RACLIE |
| 04/01/2022 | 9:27 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | :59:55 | | d Comment | | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2 2 | 00:30 | | Use on | | User clicked Exit/Save | 5RICGOU |
| 04/0 22 | 2 :46 | | UserA | | User clicked Initial Assign | 6RACLIE |
| 04 2022 | 20: 0 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 601450 (00:18:04) | 6RACLIE |
| 04/01/2022 | 20:00:56 | | VisiCAD Recommendation | | 601421: 00:18:23, 501225: 00:21:17, 502182: 00:21:55, 501324: 00:23:03, 936307: 00:30:10, | 6RACLIE |
| 04 2022 | 20:01:01 | | Initial Assignment | | The following unit(s) is (are) cleared from assignment: 601450 | 6RACLIE |
| 04 2022 | 20:01:24 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 0 1/2022 | 20:06:43 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6RACDEV |
| 04/01/2022 | 54 | | UserAction | | User clicked Exit/Save | 6RACDEV |
| 04/01/2022 | 20:07:31 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:08:27 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:09:00 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6CHEBAT |
| /01/2022 | 20:09:13 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLIE |
| 1/2022 | 20:09:17 | | UserAction | | User clicked Exit/Save | 6CHEBAT |
| 04/01/2022 | 20:09:25 | | UserAction | | User clicked Initial Assign | 6RACLIE |
| 04/01/2022 | 20:09:28 | | UserAction | | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:09:30 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 501165 (00:19:17) | 6RACLIE |
| 04/01/2022 | 20:10:01 | | VisiCAD Recommendation | | 501349: 00:20 50, 501322: 00:21:04, 507332: 00:21:06, 608401: 00:21:58, 501321: 00:21:58, | 6RACLIE |
| 04/01/2022 | 20:10:18 | | UserAction | | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:10:32 | | Initial Assignment | | | 6RACLIE |

| | | | | | |
|---|---|---|---|---|---|
| | | | | The following unit(s) is (are) cleared from assignment: 501165 | |
| 04/01/2022 | 20:10:49 | | UserAction | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:14:14 | | UserAction | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:14:39 | | Read Comment | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:14:41 | | UserAction | User clicked Initial Assign | 6RACLIE |
| 04/01/2022 | 20:14:45 | | Initial Assignment | The following unit(s) is (are) recommended for assignment: 501322 (00:19:12) | 6RACLIE |
| 04/01/2022 | 20:16:23 | 501322 | Dispatched | Irrelevant | Response Number (018102) | 6RACLIE |
| 04/01/2022 | 20:16:24 | | Incident Timer Clear | | Incident Timer Cleared | |
| 04/01/2022 | 20:16:39 | 501322 | Resp | Irrelevant | Responding From = BEENLEIGH RD\LENSWORTH ST | VisiNET |
| 04/01/2022 | 20:16:54 | | UserAction | | User clicked Exit/Save | 6LISNG |
| 04/01/2022 | 20:16:55 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 5MARS |
| 04/01/2022 | 20:17:00 | | UserAction | | User clicked Exit/Save | 6RACL |
| 04/01/2022 | 20:17:02 | | Incident Priority Change | | Incident priority changed from 1B to 1A due to Patient Condition | 5MARS |
| 04/01/2022 | 20:17:02 | 501322 | Priority Change | | The priority of incident 358 has been ch ged from 1B to 1A. Unit 5322 is respondin HOT1A | siNET |
| 04/01/2022 | 20:17:03 | | Priority Upgrade/Downgrade Prompt | | Change From 1B to 1A? - User click OK | RSTE |
| 04/01/2022 | 20:17:07 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6JAMPRI1 |
| 04/01/2022 | 20:17:31 | | UserAction | | User clicked Exit/Sav | I1 |
| 04/01/2022 | 20:18:07 | | Read Comment | | Comment for Incide 358 was M as Read. | 5ANATAY |
| 04/01/2022 | 20:18:14 | | UserAction | | User clicked Exit/S | 5ANATAY |
| 04/01/2022 | 20:18:47 | | UserAction | | User clicked Add Resource | 6RACLIE |
| 04/01/2022 | 20:18:52 | | VisiCAD Recommendation | | 607691: 00:20 54, 50611 0:29:41, 9 6307: 00:30: 2: 00:33: | 6RACLIE |
| 04/01/2022 | 20:19:08 | | UserAction | | Us licked Ad esource | 6RACLIE |
| 04/01/2022 | 20:19:15 | | VisiCAD Recommendation | | 50 321: 00:16: 607691: 00: 0:54, 507332: 0 1:06, 50 45: 00: :58, 507085: 0 1:58 | 6RACLIE |
| 04/01/2022 | 20:19:20 | 501322 | Calculate Vehicle ETA | BEAUDESERT RD YLAND AVE | E o ene Addres relevant GR BANK is 00: 56 | 6RACLIE |
| 04/01/2022 | 20:19:58 | | UserAction | | User A pted 50 1 | |
| 04/01/2022 | 20:19:58 | | Add Resources | | The follow (s) is (are) recommended for signment: 501321 (00:16:37) | 6RACLIE |
| 04/01/2022 | 20:20:04 | 501321 | Dispatched | Irrelevant | R onse Number (018114) | 6RACLIE |
| 04/01/2022 | 20:20:05 | | UserAction | | Use cked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:20:14 | | Read Comment | | Comm nt for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:20:16 | | UserAction | | User clicked Add Resource | 6RACLIE |
| 04/01/2022 | 20:20:21 | | VisiCAD Recom | | 607691: 00:20:16, 506422: 00:25:23, 506111: 00:29:41, 506084: 00:29:49, 936307: 00:30:09, | 6RACLIE |
| 04/01/2022 | 20:20:32 | | UserActi | | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:20:34 | 501322 | Dispo n | Irrelevant | Back Up Not Required | 6CHEBAT |
| 04/01/2022 | 20:20:34 | 501322 | Availa | | Unit Cleared From Incident 15303921 | 6CHEBAT |
| 04/01/2022 | 20:20:35 | 501322 | Reassig hicle | GRA BALHAM RD | ReAssign Reason: Vehicle Change | 6CHEBAT |
| 04/01/2022 | 20:20:35 | 501322 | Reassign R ons | GRANARD RD\BALHAM RD | ReAssign Reason: Vehicle Change | 6CHEBAT |
| 04/01/2022 | 20:20:35 | 501322 | Reassign Res | GRANARD RD\BALHAM RD | Clearing Primary Vehicle Flag | 6CHEBAT |
| 04/01/2022 | 20:20:36 | | UserAction | | User Accepted 506422 | |
| 04/01/2022 | 20:20:36 | | Add Resources | | The following unit(s) is (are) recommended for assignment: 607691 (00:20:16) | 6RACLIE |
| 04/01/2022 | 20:20:38 | 7691 | Dispatched | Irrelevant | Response Number (018116) | 6RACLIE |
| 04/01/2022 | 20:20:44 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 5MARSTE |
| 04/01/2022 | 2 0:44 | 50132 | Resp | | Responding From = IPSWICH MWY WB\IPSWICH MOTORWAY ON RAMP | VisiNET |
| 04/01/202 | 20:20:53 | 607691 | R | | Responding From = WARWICK RD\WARWICK ROAD EXIT | VisiNET |
| 04/0 22 | 2 :58 | | UserA | | User clicked Exit/Save | 6JAMPRI1 |
| 04 2022 | 20:2 2 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:21 | 501321 | Calculate Vehicle ETA | IPSWICH MWY WB\IPSWICH MOTORWAY ON RAMP | ETA to Scene Address Irrelevant GREENBANK is 00:14:23 | 6RACLIE |
| 4/01/2022 | 20:21:29 | 7691 | Calculate Vehicle ETA | WARWICK RD\UNILINK VILLAGE ACCOMMODATION ACCS | ETA to Scene Address Irrelevant GREENBANK is 00:21:10 | 6RACLIE |
| 04/ 2022 | 20:21:35 | | UserAction | | User clicked Exit/Save | 5MARSTE |
| 04 2022 | 20:21:40 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 5MARSTE |
| | 0:21:48 | | UserAction | | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 24 | 601604 | Dispatched | Irrelevant | Response Number: 018122; | 6RACLIE |
| 04/01/2022 | 20:22:28 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:22:59 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:23:22 | | Read Comment | | Comment for Incident 358 was Marked as Read. | PSDUPRO |
| 1/2022 | 20:23:31 | | UserAction | | User clicked Exit/Save | PSDUPRO |
| 04/01/2022 | 20:25:07 | 601604 | Resp | | Responding From = Chelmsford Ave [IGH (A&E 38101118)] | VisiNET |
| 04/01/2022 | 20:25:15 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:25:21 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:26:28 | | ProQA | | ProQA determinant sent | 6LISNG |
| 04/01/2022 | 20:26:32 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 5MARSTE |
| 04/01/2022 | 20:26:32 | | Read Comment | | | 5MARSTE |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Comment for Incident 358 was Marked as Read. | |
| 04/01/2022 | 20:27:37 | | UserAction | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:29:02 | | Read Comment | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:29:41 | | UserAction | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 20:32:35 | | UserAction | User clicked Exit/Save | 5MARSTE |
| 04/01/2022 | 20:34:48 | 501321 | Calculate Vehicle ETA | Irrelevant | ETA to Scene Address Irrelevant GREENBANK is 00:02:46 | 6RACLIE |
| 04/01/2022 | 20:34:48 | 607691 | Calculate Vehicle ETA | SPRINGFIELD GREENBANK ARTL\STEVE CROFT CCT | ETA to Scene Address Irrelevant GREENBANK is 00:06:25 | 6RACLIE |
| 04/01/2022 | 20:34:49 | 601604 | Calculate Vehicle ETA | CENTENARY HWY\CENTENARY HWY SB | ETA to Scene Address Irrelevant GREENBANK is 00:13:04 | 6RACLIE |
| 04/01/2022 | 20:36:24 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:37:13 | | UserAction | | User clicked Exit/Save | 6RACL VisiNE |
| 04/01/2022 | 20:37:15 | 501321 | At Scene | Irrelevant | | |
| 04/01/2022 | 20:37:28 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLI |
| 04/01/2022 | 20:38:01 | | UserAction | | User clicked Exit/Save | 6LISNG siNET |
| 04/01/2022 | 20:42:38 | 607691 | At Scene | | | |
| 04/01/2022 | 20:45:21 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 20:45:56 | | UserAction | | User clicked Exit/Save | 6RA ET VisiNET |
| 04/01/2022 | 20:48:33 | 601604 | At Scene | | | 6RACLIE |
| 04/01/2022 | 20:59:43 | 601604 | Partially Av | | | |
| 04/01/2022 | 20:59:45 | 601604 | Available | | | |
| 04/01/2022 | 20:59:45 | 601604 | Disposition | | Assistance Only | 6RACLIE E |
| 04/01/2022 | 21:00:15 | 607691 | Available | | | |
| 04/01/2022 | 21:00:15 | 607691 | Disposition | | Assistance Only | 6RACLIE |
| 04/01/2022 | 21:03:54 | | UserAction | | User clicked Exit/S e | 6LISNG |
| 04/01/2022 | 21:05:31 | | UserAction | | User clicked Exit/S | 5MARSTE |
| 04/01/2022 | 21:10:03 | | Read Comment | | Comment for Incident 358 s Marked s Read. | 6LISNG |
| 04/01/2022 | 21:13:00 | | [ICEMS] | | [ICEM cident At dance to OL-Q : Inci nt Q22-A 584 | ICEMS |
| 04/01/2022 | 21:13:03 | | UserAction | | U clicked Ex ave | 6LISNG |
| 04/01/2022 | 21:14:24 | | UserAction | | U r clicked t/Save | 6CHEBAT |
| 04/01/2022 | 21:17:12 | | [ICEMS] | | [ MS] R eived In nt Request A ow gment from OL-Q : Incident Q22-A00 4 | ICEMS |
| 04/01/2022 | 21:17:18 | | [ICEMS] | | [ICEM eceived source Status Query from POL cident Q22-A000584 | ICEMS |
| 04/01/2022 | 21:17:25 | | [ICEMS] | | EMS] Received Resource Status Update f POL-Q for Incident Q22-A000584, Res ce Status: WillAttend | ICEMS |
| 04/01/2022 | 21:31:19 | | UserAction | | User c cked Exit/Save | 5BREHER |
| 04/01/2022 | 21:35:56 | | Read Comment | | Comment for Incident 358 was Marked as Read. | 5BREHER |
| 04/01/2022 | 21:40:20 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 21:41:24 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 21:41:35 | | UserAction | | User clicked Exit/Save | 6LISNG |
| 04/01/2022 | 21:53:14 | | UserActi | | User clicked Exit/Save | 214MICSTE |
| 04/01/2022 | 21:55:16 | | UserA n | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 22:04:52 | | [ICEM | | [ICEMS] Received Resource Status Update from POL-Q for Incident Q22-A000584, Resource Status: EnRoute | ICEMS |
| 04/01/2022 | 22:12:03 | | UserAction | | User clicked Exit/Save | 6RACLIE |
| 04/01/2022 | 22:13:24 | | UserAction | | User clicked Exit/Save | 5BREHER |
| 04/01/2022 | 22:30:12 | | [ICEMS] | | [ICEMS] Received Resource Status Update from POL-Q for Incident Q22-A000584, Resource Status: OnScene | ICEMS |
| 04/01/2022 | 22:41:42 | | Read Incident | | Incident 358 was Marked as Read. | 6RACLIE |
| 04/01/2022 | 22: 2 | 501 | Partially Av | Irrelevant | | VisiNET |
| 04/01/2022 | 2 0:24 | 50132 | vailable | | | 6RACLIE |
| 04/01/2022 | 2:50:24 | 501321 | position | | A Case Completed | 6RACLIE |
| 04/01/202 | 22:50:24 | 501321 | R nse Closed | | Response Disposition: A Case Completed | 6RACLIE |
| 04/01/2 2 | 50:28 | | [ICE | | [ICEMS] Sent Incident Status Update to POL-Q for Incident Q22-A000584, Status: Closed | ICEMS |

**Edit Log**

| e | Time | Field | Changed From | Changed To | Reason | Table | Workstation | User |
|---|---|---|---|---|---|---|---|---|
| 04 | 202219:54:44 | Call_Back_ hone | | Irrelevant | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04 | 202219:54:54 | City | | GREENBANK | Updated City | Response_Master_Incident | QA541 | 5RICGOU |
| 0 | 1/202219:54:54 | City | | GREENBANK | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/20221 | | Address | (Blank) | Irrelevant | New Entry | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01 | | Jurisdiction | | 6 Southport West | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| /01/202219:55:01 | | Division | | 6 Springfield | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01 | | Battalion | | 6 Springfield | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01 | | Response_Area | | 6 Springfield | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01 | | ResponsePlanType | 0 | 0 | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01 | | Primary_TAC_Channel | | TLK GRP 115/UHF Ch 116 | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |

| | | | | | | |
|---|---|---|---|---|---|---|
| 04/01/202219:55:01Address | | Irrelevant | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01Latitude | 0 | 62305556 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:01Longitude | 0 | 27060958 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:08Apartment | 379 | | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:55:10ProQaCaseNumber | | 18228358 | (Response Viewer) | Incident | QA541 | 5RICGOU |
| 04/01/202219:56:46Problem | | FALL NOT ALERT | (Response Viewer) | Response_Master_Incident | QA541 | 5RICG U |
| 04/01/202219:56:46Response_Plan | | Acute | (Response Viewer) | Response_Master_Incident | QA541 | 5RI OU |
| 04/01/202219:56:46DispatchLevel | | Normal | (Response Viewer) | Response_Master_Incident | QA541 | 5RIC U |
| 04/01/202219:56:46ResponsePlanType | 0 | 1 | (Response Viewer) | Response_Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:56:46Incident_Type | | ACUTE | (Response Viewer) | Response_Master_Incident | QA541 | 5 OU |
| 04/01/202219:56:47Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA541 | 5RICG |
| 04/01/202219:56:47Priority_Number | 0 | 2 | Updated by ProQA | Response_Master_Inciden | 41 | 5RIC U |
| 04/01/202219:56:47Determinant | | 17D04 | (Response Viewer) | Response_Master_In ent | QA5 | 5RICGOU |
| 04/01/202219:56:47EMD_Used | 0 | 1 | (Response Viewer) | Response_Master_I dent | 541 | 5RICGOU |
| 04/01/202219:56:47CIS_Used | 0 | null | (Response Viewer) | Response Master_Incident | QA541 | 5RICGOU |
| 04/01/202219:56:47Pickup_Map_Info | (Blank) | B257M11 | | Resp e_Transp | L QASCXA275 | RICGOU |
| 04/01/202219:56:47Map_Info | | B257M11 | | Res nse_Maste ncident | POLCADQASCXA275 | RICGOU |
| 04/01/202219:56:51Read Call | False | True | (Response Viewe | Re nse_Ma _Incid nt | PA608 | 6RACLIE |
| 04/01/202219:58:53Field_Data | | Irrelevant | Patient N e: | Res s ser_Data_ ds | QA541 | 5RICGOU |
| 04/01/202219:58:57CIS_Used | 0 | null | (Response Viewer) | Respon Master I dent | QA541 | 5RICGOU |
| 04/01/202219:58:57ProQATerminationStateCode | | C | (Response V | dent | QA541 | 5RICGOU |
| 04/01/202219:59:55Read Comment | False | True | Response Viewer) | Resp Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:00:25Field_Data | | Irrelevant | Patient B: | Response_User_Data_Fields | QA541 | 5RICGOU |
| 04/01/202220:06:43Read Comment | False | True | (Res nse Vi er) | esponse_Master_Incident | PA614 | 6RACDEV |
| 04/01/202220:09:00Read Comment | F e | e | sponse V ) | Response_Master_Incident | PA602 | 6CHEBAT |
| 04/01/202220:12:10Field_Data | | 2 2 MS S | Call B | Response_User_Data_Fields | PA601 | 5MARSTE |
| 04/01/202220:14:39Read Comment | False | | (Response er) | Response_Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:16:37Current_UnitRespPriorityDe 132 B | | HOT1B | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 04/01/202220:16:55Read Comment | F | True | (Response Viewer) | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:17:01Priority_Description | 1B | 1A | Patient Condition | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:17:01Prior Number | 2 | 1 | Patient Condition | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:17:02Curre nitRespPriorityDesc | 501322: HOT1B | OT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 04/01/202220:17 riority_De tion | 1B | 1A | Priority Change Accepted | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/20222 7:07Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA617 | 6JAMPRI1 |
| 04/01/2 22 07Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA513 | 5ANATAY |
| 04 202220:20: ead Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:20:39Ca Name | | Irrelevant | (Response Viewer) | Response_Master_Incident | PA607 | 6LISNG |
| 04 202220:20:44Read Com nt | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 5MARSTE |
| 04 202220:20:45Current_UnitRespPriorityDesc | 501321: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 0 1/202220:20:54Current_UnitRespPriorityDesc | 607691: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 21:40Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:22:28Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:23:22Read Comment | False | True | (Response Viewer) | Response_Master_Incident | NB900802 | PSDUPRO |
| /01/202220:25:08Current_UnitRespPriorityDesc | 601604: 1A | HOT1A | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 1/202220:25:15Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:26:20ProQATerminationStateCode | C | | (Response Viewer) | Incident | PA607 | 6LISNG |
| 04/01/202220:26:28Response_Plan | Acute | 1A | Updated by ProQA | Response_Master_Incident | PA607 | 6LISNG |
| 04/01/202220:26:28Incident_Type | ACUTE | ACUTE AND CCP IF AVAILABLE | Updated by ProQA | Response_Master_Incident | PA607 | 6LISNG |
| 04/01/202220:26:28Problem | | | | Response_Master_Incident | PA607 | 6LISNG |

| | | | | | | |
|---|---|---|---|---|---|---|
| 04/01/202220:26:28Determinant | FALL NOT ALERT 17D04 | FALL ARREST 17D02 | Updated by ProQA (Response Viewer) | Response_Master_Incident | PA607 | 6LISNG |
| 04/01/202220:26:28CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA607 | 6LISNG |
| 04/01/202220:26:28ProQATerminationStateCode | C | | (Response Viewer) | Incident | PA607 | 6LISNG |
| 04/01/202220:26:32Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:26:32Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 5MARSTE |
| 04/01/202220:29:02Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6RACLIE |
| 04/01/202220:35:17CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA607 | 6LIS G |
| 04/01/202220:36:24Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6RA IE |
| 04/01/202221:10:03Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA607 | 6LISN |
| 04/01/202221:35:56Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA502 | 5BREHER |

# Significant Incident Review Version 1.0 August 2020

## Gold Coast Region

### Authority:

By authority of Acting Assistant Commissioner, Mr Peter Warrener, Gold Coast Region, Que sla Ambulance Service

### Executive Summary:

On Thursday 6 January 2022 at 9.21pm, the Queensland Ambulance Se (QAS) ceived a Triple Zero (000) call for an Irrelevant patient who had fallen out of bed, re ulting in lacer to Irrelevant left temple and minor grazing, at Irrelevant home Irrelevant Southport he call r identified themselves as a Register Nurse (RN) and described the patient as conscio and talk g.

The incident (reference number 15314706) was prioritised by t Medic Priority ispatch System (MPDS) as requiring a Code 2A response.

At 10.56pm the Operations Centre Supervisor (OCS) onduc d a cal ack to Irrelevant and spoke to a RN who described the patient as having a slight temperature of 37.6 degrees and currently sleeping with a pressure bandage on Irrelevant head. The RN was advise of si nifican delays and confirmed that Irrelevant were monitoring the patient.

Irrelevant placed a duplicate l on 7 Jan ry 2022, a am, advising the patient had vomited and Irrelevant eye was swollen, with no othe changes.

At 12.59pm the QAS Clinical HU (CHU ) conducted call back to Irrelevant to gather more information in relation the patient's condition. A N reiterated the mechanism of injury and advised that from 10.00am the patient had started to become qui drowsy, rousable but sleepy, which was abnormal for Irrelevant and that Irrelevant been vom ing, febrile with a temp rature of 38.8 degrees. It was also mentioned that the patient could have a Urina Tract Infection (UTI) using Irrelevant temperature. During this call the case was upgraded to a 1C respon and a cute ambulance unit was assigned immediately.

The ass ned unit arrived scene eight minutes later, and in the attending paramedics noted their respo o a severely frail Irrelevant patient with a laceration tc Irrelevant left temple with continual bleeding, the pat nt wa omiting bile and w described as having a slightly altered conscious state (GCS 13-14). The patient was a ministered 4mg ondansetron and transported to Gold Coast Private Hospital, arriving at 1.56pm.

### G ld Coast Region Clinical Incident Summary Report:

The Go st Clinical Education Unit (CEU) assessed the patient record to determine if the care provided was appropriate, with no clinical issues noted and documentation completed to the standard required.

## State Operations Centre ProQA Review:

The QAS State Communications Development, Quality Assurance Unit undertook as ProQA review of the calls associated with this incident.

The initial Triple Zero (000) call, taken at Maroochydore Operations Centre (OpCen), was found to be non-compliant with one major deviation (a question asked incorrectly) and some moderate and minor deviations identified as questions asked incorrectly or recorded incorrectly and an error in the post-dispatch instructi ns given by the Emergency Medical Dispatcher (EMD). The review identified there was an opportunity to ha this case reviewed by a Clinical Deployment Supervisor (CDS), however this was not requested. The cod g QAS Code 2A (QAS non-Lights and Sirens) response was correct.

During the OCS call-back at 10.56pm, the OCS did not reopen ProQA to confirm the patient' current circumstance and clinical condition, to identify key changes or updates that may have resulte in a reconfiguration of the MDPS Determinant and/or QAS response priority for the incident. The re w found that if this had been done, it's unlikely that there would have been a change to priorit e time of this c .

The duplicate Triple Zero (000) call, taken at Brisbane OpCen at 7.55am was una le to b a essed using Advanced Quality Assurance (AQUA) software. The EMD did not reopen ProQA conf m the tient's current circumstance and clinical condition, to identify key changes or updates that ma have r sulted in a reconfiguration of the MDPS Determinant and/or QAS response priority f incide The r view found that if this had been done, it's likely that there would have been a change to pri ty at t me of this call.

During the CHUB call-back at 12.59pm the CHUB officer graded t inci nt fro a Code 2A to a Code 1C, which was deemed appropriate.

## Southport Operations Centre Summary R port

Southport OpCen conducted a comprehensive inve igatio of th incident to determine if the operational response was appropriate.

### Timeline

Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| Phone Pickup | 06/01/2022 | 21:21:56 | |
| 1st Key Stroke | 06/01/2022 | 21:21:57 | |
| In Waiting Queue | 06/01/2022 | 21:25:15 | |
| Call Taking Complete | 06/01/2022 | 21:27:50 | Gale, Luke (ECH) |
| 1st Unit Assigned | 07/01/2022 | 13:04:54 | |
| 1st Unit Enroute | 07/01/2022 | 13:05:06 | |
| 1st Unit Arrived | 07/01/2022 | 13:13:16 | |
| Closed | 07/01/2022 | 14:56:54 | Patching, Nicole |

Elapsed Times

| Description | Time |
|---|---|
| Received to In Queue | 00:03:18 |
| Call Taking | 00:05:53 |
| In Queue to 1st Assign | 15:39:39 |
| Call Received to 1st Assign | 15:42:58 |
| Assigned to 1st Enroute | 00:00:12 |
| Enroute to 1st Arrived | 00:08:10 |
| Incident Duration | 17:34:58 |

Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 601536 | 13:04:54 | A Case Completed | 13:05:06 | | 13:13:16 | | 14:56:06 | 14:56:54 | | | |

### Di patch

The incident pen d as a 2A response due other incidents being higher acuity or longer wait times. When e incident was up aded to a 1C response, the unit recommended in CAD was assigned within the ap ropriate timefram and was on scene in eight minutes.

T e pending workload in all areas was high therefore there was no opportunity for dynamic deployments

### OpCen m gement while pending

The initial call back by the OCS at 10.56pm was timely, however the second call back by the CHUB wasn't conducted until almost 14 hours later.

A per the State Operations Centre Standard Operating Procedure Call Taking – Incident Call Back, an incident call back should be initiated when it is established or recognised that further contact with a



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caller/patient is required under a number of circumstances, including where there are extended response times or potential delays that may be detrimental to a patient's reported condition. Taking into consideration the duplicate call from Irrelevant to QAS at 7.55am, the 14 hour lapse between initial call and second call back is still not deemed appropriate.

Furthermore, during the OCS call back and duplicate call, ProQA was not utilised to confirm the patient's current circumstance and clinical condition, to identify key changes or updates. Had this have happened during the duplicate call, it is likely to have resulted in a reconfiguration of the QAS response priority for the incident.

Given the volume of calls received on this evening, the OpCen's capacity to conduct regular call backs was severely impeded, with the CDS and OCS required to prioritise cases based on existing intelligence. There was a significant number of high priority cases requiring call backs at the time when this incident was pending as outlined under System Pressures.

**System Pressures**

On 6 and 7 January 2022, the QAS experienced an extremely high Triple Zero (000) call volume, receiving 3,847 and 3,787 Triple Zero (000) call respectively. This is a 43% and 38% increase compared to Triple Zero (000) call volume throughout January 2021 (2,784).

The demand surge and hospital pressures occurring throughout these two days was unexpected and significant, affecting paramedic availability to respond to emergency cases throughout the Brisbane community.

On this particular night the Gold Coast Region received an unprecedented volume of requests for service resulting in massive system pressures. The Gold Coast Hospital and Health Service (HHS) was also impacted, with hospitals on internal escalations.

It's identified that the delayed response was due to significant system pressures being experienced within the Gold Coast Region at the time the call was received and while it was pending.

A snapshot of cases pending across the three OpCen 6 areas (Ipswich, Beenleigh and Gold Coast) on 6 January 2022 reveal extremely high numbers of pending cases within the community as follows:

| Time | Code | Pending Cases |
|---|---|---|
| 9.12pm | Code 1 | 14 (longest pending 47 minutes) |
| | Code 2 | 64 (longest pending 10 hours and 31 minutes) |
| | Hospital transfers | 7 (longest pending 14 hours and 14 minutes) |
| 2.56am | Code 1B<br>Code 1C | 2 (longest pending 2 hours, 5 minutes)<br>7 (longest pending 2 hours, 31 minutes) |
| | Code 2A<br>Code 2B<br>Code 2C<br>Red Code 2C | 3 (longest pending 12 hours, 20 minutes)<br>3 (longest pending 8 hours, 9 minutes)<br>11 (longest pending 11 hours, 27 minutes)<br>2 (longest pending 10 hours, 11 minutes) |
| | Hospital transfers | 8 (longest pending 21 hours) |
| 4.55am | Code 1B<br>Code 1C | 8 (longest pending 1 hour, 49 minutes)<br>8 (longest pending 3 hours, 57 minutes) |



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| | | |
|---|---|---|
| | Code 2A<br><br>Code 2B<br><br>Code 2C | 31 (longest pending 16 hours, 22 minutes)<br>2 (longest pending 2 hours, 13 minutes)<br>16 (longest pending 13 hours, 24 minutes) |
| | Hospital transfers | 7 |

**Operational Response**

On 6 January 2022, there were shortfalls in the Gold Coast Region operational roster. Generall , a Gold Coast Region Thursday night shift would include a total of 12 operational crews (24 officers) s well as t o POD and one HARU. The Region was down seven officers, including three who were furloug ed cted y the Omicron COVID-19 variant which was spreading across the coast at the time. The reduced capacity to l shifts resulted in reduced capability at the Southport OpCen and reduced operational nse capability

The Southport OpCen had two OCS, (one was additional and had been requeste to com t work to assist with call backs, due to the large number of pending cases) one CDS, eight EMDs nd o e stud EMD.

The Southport Operations Centre utilised a number of strategies to mitigate the risk a ociate with the high call volume that was being experienced, this included rostering the ad tional S an ll verflow into available OpCens to ensure Triple Zero (000) calls were answered.

The assigned unit was dispatched from Gold Coast Univers Hospit (G UH), th actual travel time for this unit, from GCUH to Estia Health Southport was eight minutes, as wo d be exp ted.

## Review Recommendations:

The ProQA review determined that the i itial call w no compli t The duplicate call and the OCS call back failed to utilise ProQA to confir the p ent's c ent circum tance and clinical condition, to identify key changes or updates that may hav resulted a reconfig atio of the MDPS Determinant and/or QAS response priority for the incide

The ProQA outcome is to be di buted discus th the two EMDs (Maroochydore OpCen and Brisbane OpCen). Follow-up has u ed with the OCS (Southport OpCen).

## Appendix of re vant documents/ es:

- In dent Detail R port (IDR);
- lectronic Ambula e Report Form (eARF);
  O rations Centre B f 06 and 07 January 2022;
- Pro Review;
- Audio av) files;
- Clinical R iew (Eclipse);
- PACH Logs;
- Gold Coast Region Resource Report.

| | |
|---|---|
| **Incident Detail Report** | IDR 15314706 - Trip Fall Significant Dela |

| | |
|---|---|
| **eARF** | EARF 15314706 - Trip Fall Significant |
| **Southport OpCen Brief** | 060122 NIGHT SOUTHPORT OPCEN<br>070122 DAY SOUTHPORT OPCEN |
| **ProQA Review** | 220106_SR18240040_15314706_SOUTHP<br>220106_SR18240040_15314706_SOUTHP<br>220106_SR18240040_15314706_SOUTHP<br>220106_SR18240040_15314706_SOUTHP |
| **Audio files** | 220107_SR18240040_15314706_SOUTHP<br>220107_SR18240040_15314706_SOUTHP<br>220106_SR18240040_15314706_SOUTHP<br>220106_SR18240040_15314706_SOUTHP |
| **Clinical Review** | QAS GOL CEU Clinical Review Tem |
| **Other Documents** | PACH 06.01.2022.xlsm<br>PACH 07.01.2022.xlsm<br>GC Region Resource Reports fo<br>GC Region Resource Reports fo |

## LASN Endorsement

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

| Role | Name | Signature | Date |
|---|---|---|---|
| Assistant Commissioner | Peter Warrener | Irrelevant | 13/04/2022 |

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s47(3)(b)

# Significant Incident Review Version 0.3

## Metro South Local Ambulance Service Network

### Authority:

By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region.

### Executive Summary:

On Friday 7 January 2022 at 06:09hrs QAS received a Triple Zero (000) call for a sistanc (inciden mber 15316005) at Irrelevant W hart 4122 attend an Irrelevant Irrelevant patient who had a fall, cannot get up query fractured knee. Patient as ha a CO test and is negative.

There was a response time of 6 hours and 42 minutes to respond an vailable aramed unit to the incident (from when the incident entered the waiting queue to whe they arriv d on s ene)

At the time the call came in there was significant workload acr s south ast Quee sland (SEQ) with multiple Code 1 and Code 2 cases pending in the community.

The case was initially prioritised in the Advanced Me cal Pr ity Disp tch System (AMPDS) as 17B01G (fall on floor possible dangerous area) requiring a Code A respo se.

The Clinical Deployment Supervisor ed a ca b k at 07: and obtain the patient's observations are stable and is still on the floor.

The first ambulance was assi ed at 11:20h s and was diverted at 11:35hrs to a higher priority incident.

A second triple-zero call was rece d om the original caller at 11:46hrs. During this call the patient was said to have improved.

The CDS approv for the incident to be u graded to a Code 1C (emergency response with lights and sirens) at 12:44hrs.

A secon ambulance wa dispatched at 12:44hrs and arrived on scene at 12:54hrs.

On AS a val patient was in d, calm and well perfused. Irrelevant had hoisted patient back into bed, where p ent had been administered paracetamol and ate lunch. On examination left leg shortening and rotation was no d with good distal pulse and perfusion. Patient administered pain relief and transported to the Queen Elizabeth H spital in a stable condition arriving at 13:41hrs.

Th incident occurred on one of the two busiest days on record (occurring on 6 and 7 January 2022) for Triple Z o (000) calls received by QAS. Additionally, at that time, QAS had approximately 160 employees furloughed OVID-19 exposure or isolation requirements.

On the 27 January 2022, the patient's niece wrote to the QAS complaining about the delayed response and advised the patient had sadly passed away in hospital the following day.





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## Terms of Reference:

This review will review all aspects of ambulance response to incident 15316005. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements outlined in the *Operational Incident Review Process*.

## Region Clinical Review:

The Metro South Region Clinical Education Unit have undertaken a clinical review of this incident. The cl cal assessment, treatment and documentation was completed to an appropriate standard. There are no conc s with the clinical management of this case. ECLIPSE ID # 48329.

## OpCen Review:

The Quality Assurance Unit have reviewed the primary and secondary Triple Zero (000) calls a d call ba completed by the CDS. The initial Triple Zero (000) call and the CDS call back was found to be compliant. T e second Triple Zero (000) call was found to be non-compliant as the Emergency M ical D patcher (EM ) is expected to ask appropriate case entry and key questions to confirm the patient' current i umstances and condition, which did not occur. There was no information supplied by the caller to ugge the d to update any of the questions and/or responses, given the caller stated the patient had improve

## Incident Review/Investigation:

**Scope:**

Metro South Region reviewed the response, clinical performan and op tio decision making to ensure the appropriate ambulance response and management of this c e was achieved. It is intended that any operational or clinical performance issues identified wi thi ase are ddressed to ensure lessons are learnt to improve future responses.

**Background:**

QAS was called to attend an Irr evant patient w a fall at a Irrelevant who could not get up with a query fractured knee.

**Timeline:**

06:09 – Triple Zero (000) call received
06:12 – In waitin ueue
06:42 – Delay in di tch noted due to work oad
07:26 – CD perform call back and confirmed patient's observations were stable.
11:46 – S cond Triple Z o (000) call received advising the patients condition had improved and requesting TA.
11:2 – B 1163 dispatched
1 35 – B50 63 diverted to a higher priority incident.
12:44 – CDS ap roved upgrade of incident to Code 1C.
12:44 – B501169 patched to incident.
1 54 – B501169 ar ed on scene.
13 5 – B501169 transported patient to the Queen Elizabeth Hospital.
13 41 – B501169 arrived at the Queen Elizabeth Hospital.
3 Case completed.

**Operational Review:**

Operational Dispatch to Incident
ere was a protracted response of 6 hours and 42 minutes to respond an available paramedic unit to the incident (from when the incident entered the waiting queue to when they arrived on scene) due to existing ambulance workload across Metro South Region and Metro South Health and Hospital Service (HHS). There

was a 10-minute response from the time of the incident being upgraded by the CDS to the arrival on scene. Hospital Emergency Department (ED) delays were experienced at some in scope hospitals, affecting paramedic availability.

There were significant wait times for code 1 and 2 incidents throughout the day of the 7 January 2022. Fifteen-minute snapshots for pending cases within the Brisbane Operations Centre (BOC) response area prior to the call, at the time of the call and hourly until dispatch reveal high numbers of pending cases within the community as follows:

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 06:00 to 06:14 (07/01/2022) | 1 | 8 | 0:33:40 | 1:02:19 |
| | 2 | 48 | 3:19:31 | 7:54:56 |
| 07:00 to 07:14 (07/01/2022) | 1 | 7 | 0:23:03 | 0:46:06 |
| | 2 | 45 | 2:44:24 | 7:25:45 |
| 08:00 to 08:14 (07/01/2022) | 1 | 2 | 0:17:28 | 0:20:07 |
| | 2 | 46 | 3:02:25 | 7:21:42 |
| 09:00 to 09:14 (07/01/2022) | 1 | 3 | 0:05:52 | 0:07:45 |
| | 2 | 47 | 2:28:29 | 8:09:21 |
| 10:00 to 10:14 (07/01/2022) | 1 | 6 | 0:17:10 | 0:37:08 |
| | 2 | 40 | 2:28:02 | 8:02:09 |
| 11:00 to 11:14 (07/01/2022) | 1 | 6 | 0:04:01 | 0:08:14 |
| | 2 | 47 | 2:15:44 | 8:31:18 |
| 12:00 to 12:14 (07/01/2022) | 1 | 2 | 0:12:14 | 0:17:57 |
| | 2 | 56 | 1:56:09 | 8:04:24 |

Hospital Status

At the time of the call, the following hospitals within the Metro South Health and Hospital Service (HHS) were delayed in offloading ambulance patients:

- Logan Community Hospital
- Princess Alexandra Hospital

The hospital delays QAS experienced at Metro South HHS Emergency Departments on this day are demonstrated by the following snapshots which were taken prior to the first Triple Zero (000) call and while the QAS response to the patient was pending:

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 06:00 to 06:14 (07/01/2022) | Logan Hospital | 2 | 1 | 1:58:50 | - |
| | Mater Adults Hospital | - | - | 0:00:00 | - |
| | Princess Alexandra Hospital | 2 | 1 | 2:00:02 | 3 |
| | Queen Elizabeth Hospital | 1 | - | 0:02:48 | - |
| | Redlands Hospital | - | - | 0:00:00 | - |

| | | | | | |
|---|---|---|---|---|---|
| 07:00 to 07:14 (07/01/2022) | Logan Hospital | 2 | - | 0:22:05 | - |
| | Mater Adults Hospital | 1 | - | 0:27:48 | - |
| | Princess Alexandra Hospital | 1 | 1 | 0:52:04 | - |
| | Queen Elizabeth Hospital | 2 | 1 | 1:02:48 | - |
| | Redlands Hospital | 3 | - | 0:22:08 | - |
| 08:00 to 08:14 (07/01/2022) | Logan Hospital | 4 | 2 | 1:22:06 | - |
| | Mater Adults Hospital | 3 | 2 | 0:54:39 | - |
| | Princess Alexandra Hospital | 1 | - | 0:05:34 | - |
| | Queen Elizabeth Hospital | 3 | 1 | 1:07:43 | - |
| | Redlands Hospital | 1 | - | 0:24:17 | - |
| 09:00 to 09:14 (07/01/2022) | Logan Hospital | 5 | 3 | 1:32:14 | 2 |
| | Mater Adults Hospital | 1 | 1 | 0:41:12 | - |
| | Princess Alexandra Hospital | 3 | 1 | 0:42:06 | - |
| | Queen Elizabeth Hospital | 2 | 2 | 1:03:14 | - |
| | Redlands Hospital | 3 | 2 | 1:24:14 | 2 |
| 10:00 to 10:14 (07/01/2022) | Logan Hospital | 4 | 3 | 2:32:16 | 2 |
| | Mater Adults Hospital | 4 | 1 | 0:43:02 | - |
| | Princess Alexandra Hospital | 2 | 2 | 1:22:38 | - |
| | Queen Elizabeth Hospital | 2 | - | 0:24:55 | - |
| | Redlands Hospital | 3 | 3 | 2:24:16 | 2 |
| 11:00 to 11:14 (07/01/2022) | Logan Hospital | 8 | 1 | 1:01:42 | 2 |
| | Mater Adults Hospital | 3 | 2 | 1:06:15 | 2 |
| | Princess Alexandra Hospital | 5 | 2 | 1:00:04 | - |
| | Queen Elizabeth Hospital | 3 | 2 | 0:48:50 | - |
| | Redlands Hospital | 1 | 1 | 2:48:15 | 3 |
| 12:00 to 12:14 (07/01/2022) | Logan Hospital | 7 | 7 | 1:35:05 | 3 |
| | Mater Adults Hospital | 3 | 2 | 2:02:46 | 2 |
| | Princess Alexandra Hospital | 3 | - | 0:21:18 | 2 |
| | Queen Elizabeth Hospital | 6 | 3 | 1:39:55 | 2 |
| | Redlands Hospital | 2 | 1 | 3:48:21 | 3 |

On 6 January 2022, the QAS Metro South Region experienced 136.66 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes. This lost availability equates to approximately 13 paramedic crews over the period of the day, being unavailable to be dispatched to the community.

This 'Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound as pending incidents continue to accrue as more Triple Zero (000) requests are received; however, ambulance crews are unable to be released from hospitals. The outcome results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

In the days leading up to the time of this incident, significant pressures (hospital delays and ambulance 'ramping') were being experienced throughout southeast Queensland (SEQ) resultant from the COVID-19

Pandemic. South East Queensland Regions were on escalation Extreme from Saturday 1 January 2022 due to the operational pressures.

Metro South Region Staffing
The Metro South Region including Brisbane South and Logan Districts had the following resourcing against approved rosters for the 7 January 2022;

- Day Shift – 17 vacancies
- Afternoon shifts – 13 vacancies

As at Thursday 6 January 2022, Metro South Region had 21 staff confirmed positive to COVID-19 with a further 10 staff isolating as close contacts.

**Outcomes:**

- There was a protracted response to an Irrelevant who had a fall at a Irrelevant and sustained a subsequent injury to hip / leg.
- The patient subsequently passed away the following day in hospital.
- On this day the QAS saw unprecedented demand in the peak of COVID that had an impact of the QAS's ability to send a response to this incident.
- The clinical care of the patient was appropriate and was transported in a stable condition to hospital.

## Review Recommendations:

- Follow up with EMD regarding correct process of handling a second Triple Zero (000) call.

## Appendix:

- Incident Detail Report
- Ambulance Report Form
- Audio Files (including Triple Zero calls)
- Complaint Letter Received

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | | |
| Anthony Hose | Acting District Director South Brisbane | Irrelevant | 07/02/2022 |

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# Significant Incident Review Version 0.3

## Metro South Region

**Authority:**

By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region

**Executive Summary:**

On 11 January 2022 at 17:30rs, a Triple Zero (000) call entered the Queensland Ambulance Servi e call-taking waiting queue. The call was to attend a Irrelevant patien who ad a l i jury, located at Irrelevant , Gailes, QLD, 4300 (Incident 15337677).

The case was initially prioritised in the Advanced Medical Priority Dispatch ystem C as 21B02 requiring a Code 1 response, it was reconfigured to a 2CL at 17 2 h 1C a 17:3 hrs, a 2BL at 17:43 hrs and finally a 1B at 18:03 hrs. There was a significant nguag barrier which made the call taking process challenging, with difficulty obtaining d tails reg ding he inj y.

There was a delay to identify an available paramedic u t to re ond t the case given existing ambulance workload across Metro South Region and Me South Health and Hospital Service (HHS) hospital Emergency Department (ED) del s e exp ienced at some in scope hospitals, affecting paramedic availability. Subsequently, minute elapsed before the first unit was assigned to the incident.

**Terms of Reference:**

This review will review all spects of mbulance response to incident 15337677. The review will examine ambulance operatio prio o, during d following the response. This review will include all requirements outlined in the *rational Incident Review Process*.

**Region Clinica Review:**

Nil clinical oncerns ere identified.

**OpC eview:**

Call Taking P rformance:

cen review fo d that the first Triple Zero (000) was taken by the Rockhampton OpCen, a du licate call received by the Townsville Opcen, and a second duplicate call received by the B sbane OpCen. ProQA was utilised on all Triple Zero Calls. It was noted that there were nication difficulties in the call-taking with language barriers noted. It was first identified that there was a potential amputation at 17:56 hrs during the third Triple Zero (000) call.

Upon review of the WAV files associated with this incident, it was identifed that a more detailed eview of the call taking in the second call should be undertaken.

**Findings:** The call taking review found that the Second Triple Zero (000) call received was coded incorrectly as a Code 1B (MPDS determinant 21B02). It was noted that if the call taker answered question 'KQ2' correctly, the incident would have been coded as a Code 2A (MPDS Determinant 30B01). Furthermore, it was noted that come customer service aspects (compassion, tone, volume, rate of speech) of this call were not at standard.

These errors were not considered to have made a negative impact on the dispatch of an ambula ce unit.

Dispatch

**Findings:** The review found that an appropriate unit was assigned to the incident 7 nutes aft r the Triple Zero (000) entered the QAS call waiting queue. At 17.43 hrs the inci was downgra ed via ProQA triage to a Code 2BL, and the attached crew was subsequently d erted higher priority at 17.45 hrs.

At 18.04 hrs the CDS reviewed the incident which resulted in a manual upgr e to a Code 1B. An ambulance crew and a High Acuity Response Unit (HARU) was ubseq ntly a hed at 18.06 and 18.08 hrs respectively. At 18.16 hrs, 13 minutes following the pgrad to a Code 1B, the first QAS crew arrived on scene.

**Incident Review/Investigation:**

**Scope:** Metro South reviewed the response, cli cal pe orman and operational decision making to ensure the appropriate ambulance respons and management of this case was achieved. It is intended that any operational or clinical perfor anc issue dentified with this case are addressed to ensure lessons are learnt to im rove ture re onses.

**Background:** QAS was c ed to atte d a Irrelevant patient 'CUT LEG – UNK MECH – BROKEN ENGLISH'.

**Timeline:**
17:28 hrs - Triple Zero (000) call ma e.
17:30 hrs - In w ing queue.
17:30 hrs – 1B det minate.
17:32 hrs 2CL dete inate.
17:35 h s - 1C determin e
17:3 hr First unit A606 61 assigned.
17 43 hrs BL determinate
17:45 hrs – A 06861 diverted to higher priority.
18.03 hrs – 1B d erminate (CDS authorised manual upgrade)
1 06 hrs - B50126 assigned.
18 08 hrs - A506111 HARU assigned.
1 :11 hrs - B607696 SOS assigned.
8:1 A506422 assigned.
18:16 hrs – B501264 arrives on scene.
18:30 hrs - A506111 arrives on scene.
18:32 hrs - B607696 SOS arrives on scene.
:22 hrs – A506422 arrives on scene.

**Operational Review:**

Operational dispatch to incident

Response Interval: 46 minutes elapsed from the time the call entered the QAS waiting queue and the time the first unit arrived on scene.

The availability of paramedic units to dispatch to the incident was affected by existing ambulance workload across Metro South Region, as well as delays experienced at Metro South and West Moreton Hospital Emergency Department (ED) delays.

Fifteen-minute snapshots for pending cases within the Southport Operations Centre response area prior to the call, at the time of the call and while the call was pending reveal high numbers of pending cases within the community as follows:

| | Priority | Number of Incidents | Average Wait (h:mm:ss) | Maximum Wait (h:mm:ss) |
|---|---|---|---|---|
| 16:15 to 16:29 11/1/2022 | 1 | 5 | 1:01:02 | 3:53:10 |
| | 2 | 51 | 3:20:59 | 12:40:03 |
| 17:15 to 17:29 (Time of call 17:28) | 1 | 6 | 0:25:11 | 0:42:45 |
| | 2 | 48 | 3:20:11 | 9:57:22 |
| 17:30 to 17:44 (A606861 Assigned 17:37) | 1 | 5 | 0:35:39 | 0:57:38 |
| | 2 | 49 | 2:49:48 | 10:12:25 |
| 17:45 to 17:59 | 1 | 0 | NA | NA |
| | 2 | 51 | 2:45:00 | 10:27:21 |
| 18:00 to 18:14 (B501264 Assigned 18:06) | 1 | 4 | 0:11:58 | 0:34:31 |
| | 2 | 50 | 3:09:08 | 10:42:17 |

Hospital Status

At the time of the call, there were 13 paramedic units at Ipswich General hospital, with 12 'ramped' for 2 hours following arrival at hospital, affecting QAS paramedic availability to respond to emergency cases in the community. The significant hospital delays QAS experienced at West Moreton and Metro South HHS Emergency Departments on this day are demonstrated by the following snapshots which were taken at the following times: prior to the first Triple Zero (000) call, at the time of the Triple Zero (000) call, and while the QAS response to the patient was pending:

| | Hospital | Total no. ambulance units at Hospital (with pts on stretcher) | Total no. ambulance units ramped (>30 mins POST) | Maximum ramped time | Hospital escalation level |
|---|---|---|---|---|---|
| 16:15 to 16:29 11/1/2021 | Logan Community Hospital | 7 | 6 | 1hr 30mins | 3 |
| | Princess Alexandra Hospital | 6 | 4 | 1hr 11mins | 3 |
| | Mater Adults Hospital | 7 | 0 | 28mins | 3 |
| | Ipswich Hospital | 14 | 13 | 4hrs 31mins | 3 |
| | Queen Elizabeth II Hospital | 10 | 5 | 1hr 31mins | 2 |
| 17:15 to 17:29 (Time of call 17:28) | Logan Community Hospital | 9 | 5 | 2hrs 30mins | 3 |
| | Princess Alexandra Hospital | 9 | 3 | 2hrs 11mins | 3 |
| | Mater Adults Hospital | 7 | 7 | 1hr 20mins | 3 |
| | Ipswich Hospital | 13 | 12 | 5hrs 31 mins | 3 |
| | Queen Elizabeth II Hospital | 7 | 6 | 2hrs 31mins | 3 |
| 17:30 to 17:44 (A606861 Assigned 17:37) | Logan Community Hospital | 10 | 6 | 2hrs 45mins | 3 |
| | Princess Alexandra Hospital | 8 | 4 | 2hrs 7mins | 3 |
| | Mater Adults Hospital | 8 | 6 | 1hr 44mins | 3 |
| | Ipswich Hospital | 16 | 11 | 5hrs 46mins | 3 |
| | Queen Elizabeth II Hospital | 7 | 7 | 2hrs 46mins | 3 |
| 17:45 to 17:59 | Logan Community Hospital | 10 | 5 | 2hrs 2mins | 3 |
| | Princess Alexandra Hospital | 6 | 4 | 1hr 8mins | 3 |
| | Mater Adults Hospital | 9 | 6 | 1hr 59mins | 3 |
| | Ipswich Hospital | 14 | 9 | 4hrs 5mins | 3 |
| | Queen Elizabeth II Hospital | 6 | 6 | 2hrs 36mins | 3 |
| 18:00 to 18:14 (B501264 Assigned 18:06) | Logan Community Hospital | 11 | 7 | 2hrs 17mins | 3 |
| | Princess Alexandra Hospital | 7 | 5 | 1hr 23mins | 3 |
| | Mater Adults Hospital | 8 | 7 | 2hrs 5mins | 3 |
| | Ipswich Hospital | 13 | 11 | 4hrs 20mins | 3 |
| | Queen Elizabeth Hospital | 6 | 5 | 2hrs 51mins | 3 |



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On 11 January 2022, the QAS Metro South Region experienced 46:57 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes.

This 'Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound as pending incidents continue to accrue as more Triple Zero (000) reque ts are received; however, ambulance crews are unable to be released from hospitals. The outc me results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

Metro South Region Staffing:

- The Metro South Region, West Moreton District had the following reso rcin again t approved rosters;
    - Day shifts – 10 crews
    - Afternoon shifts – 10 crews.

**Outcomes:**

- 46-minute response interval (QAS receipt of triple ze o (000) all to t unit on scene) resulted from impacts on paramedic availabi ity due to Metro South workload, staffing and hospital delay pressures.
- The incident was reviewed by a CDS 34 minutes ollowin receipt of call, which resulted in the case being upgraded and subsequently given an mmedia response.

## Review Recommendations:

- Continue work with W t Moreto and Me So th Hospital and Health Service regarding hospitals delays and acilitated o oads.
- Continually review s ffing in M th Region to meet demand.
- OpCen to provide feed ck and education to EMD who undertook the second Triple Zero (000) call.

## Appendix of relevant documents/files:

| | |
|---|---|
| Incident Detail Report | IDR 15337677.pdf |
| Ambulance Report Form | DARF_504037586.pdf |
| Clinical Review | ECLIPSE ID: 49009 |
| Incident Notification | WM Incident Notification - delay to case Cn 15337677.msg |
| Audio Files | 220111-1737-1st Triple Zero - IDR 153<br>11-01-2022 Re assign Unit 601637<br>11-01-2022 18.51.42 Clear 607696<br>11-01-2022 18.46.52 re TG.Transport Unit 5012<br>11-01-2022 18.42.49 Clear 506111 re TG.v<br>11-01-2022 18.26.40 SR 607696 re TG.wa<br>11-01-2022 18.18.48 SR 501264 re TG.wa<br>11-01-2022 18.11.28 Dispatch to 607696<br>11-01-2022 18.10.08 Dispatch to 506111<br>11-01-2022 18.09.32 Dispatch to 601617<br>11-01-2022 18.08.33 Dispatch to 501264<br>11-01-2022 17.38.01 Dispatch to 606861<br>11-01-2022 2nd SR 501264 re TG.wav<br>11-01-2022 Case Details to 501264 re<br>11.01.2022 18.08.35 CDS to SOS 153376<br>11.01.2022 17.54.41 Audio 000 15337677<br>INC 15337677 - IDR Gailes 11.01.2022_N<br>20220111 15337677 174032hrs.wma |

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | | |
| Michelle Holsworth | Acting District Director | | |

# Significant Incident Review

Version 1.0 August 2020

## Metro North Region
## Queensland Ambulance Service

**Authority:**
By authority of the Acting Assistant Commissioner, Metro North Region, Queensland Ambulance Service (QAS).

**Executive Summary:**

On 31 January 2022 at 11:30hrs, the QAS received a Triple Zero (000) call for assistance (Incident 15419822) at Irrelevant Mango Hill to attend a Irrelevant patient complaining of chest pain who had self-administered Panadol prior to QAS arrival.

The case was initially prioritised in the Medical Priority Dispatch System (MPDS) as MPDS Determinant 10D05 Heart attack or angina history requiring a Code 1C response at 11:34. A second 000 call was received at 11:49 with the patient reported to have pain in chest, trouble breathing and speaking between breathes. At 11:50 the case was upgraded to MPDS Determinant 10D02 complaining of pain, difficulty speaking between breathes requiring a Code 1B response. A third 000 call was received at 11:59 with the patient continuing to have pain and was now sweating. At 12:08 approximately 38 minutes after the initial 000 call was received with the first QAS resource dispatched on the case. A fourth 000 call was received at 12:09 advising that the patient was enroute to hospital by private means.

The Brisbane OpCen at the time of the first call revealed a high demand for service across the Metro North and South Regions with South East Queensland Escalation of "Extreme Hospital Delays" affecting paramedic availability.

Metro North Region staffing levels for Monday 31 January as per below:-

| DAY SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | BRT | LARU | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | -7 | 6 | | | | | 0 | | 0 | 25 | 3 | 9 | 0 |
| | 82% | 108% | | | | | 100% | | 100% | | | | |

| AFTERNOON SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | BRT | LARU | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | -5 | 2 | -1 | | -4 | | | | | 0 | 1 | 3 | 0 |
| | 50% | 105% | | 100% | 60% | 100% | | | | | | | |

**Terms of Reference:**
This review will investigate all aspects of ambulance response to incident 15419822.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

**Regional Clinical Incident Summary Report:**
This case was cancelled prior to QAS arrival therefore nil clinical review has been completed.

## OpCen ProQA:

Brisbane OpCen reviewed the triple zero call.

11:30 triple zero call received with the EMD not asking clarifying question of "breathing normally", but it is noted the patient is able to complete full sentences. Case coded 1C but potentially could have been a 1B with clarifying the normality of breathing.

11:49 second triple zero call receive with caller advising patient has breathing problems and chest pain with case upgraded to 1B.

11:56 third triple zero call with caller reporting pain and breathing difficulties is getting worse with pain in his arm. EMD failed to document. Private travel was discussed but caller elected to wait for QAS. Call remained 1B.

12:08 fourth triple zero call advising patient was transported via private means.

## Incident Review/Investigation:

### Scope

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

### Background

On 31 January 2022 at 11:30hrs, the QAS received a 000 call for assistance at Irrelevant , Mango Hill to attend a Irrelevant patient with pain in chest.

### Timeline

| | |
|---|---|
| **1st Key Stroke:** | 11:30 |
| **In waiting queue:** | 11:32 |
| **Assigned:** | 12:08 |
| **Case cancelled:** | **12:11 – cancelled by caller** |

### CAD Timeline

| | |
|---|---|
| 11:30 | 1st keystroke |
| 11:32 | Patient had been mowing the lawn, different to previous pain<br>Irrelevant patient conscious, breathing, pain in chest,<br>hx of heart pains and has taken Panadol |
| 11:34 | Irrelevant conscious, breathing<br>hx heart pains where muscular these are different pains |
| 11:49 | Duplicate call |
| 11:50 | Reconfigure to 10D02 (difficulty speaking between breaths)<br>Irrelevant conscious breathing with pain in chest |
| 11:52 | Call back from scene advising pt chest pain and trouble breathing and speaking between breaths – EMD reconfigured accordingly |
| 11:52 | Call from scene requesting QAS hurry up – Req ETA – EMD AVD all crews are on other emergencies and will be with pt as soon as they can – nil ETA given |
| 11:59 | Third call – pain continuing and pt sweating – adv as per previous call QAS busy due to workload and will send appropriate ambulance when available – Caller floated idea of private transport however elected to wait for QAS – advise unable to give ETA but any changes to call back 000 |

12:08 Unit 501154 dispatched on case (located at Prince Charles Hospital)
12:09 Fourth Call – patient already enroute to hospital by private means - QAS SNR
12:10 Called believed response was taking too long – initial call 11:32
12:11 QAS SNR – private transport – CDS of to cancel
12:11 CDS adv verbal auth cx case
14:36 Incident related to 15420145

## Resource Review

### Hospital Status

At 11:30 am on 31 January 2022, the time of the call for incident 15419822, there were 26 QAS units located at Metro North Hospital and Health Service (HHS) hospitals and of these 16 had been 'ramped' for over 30 minutes, with the longest being 2 hours 8 minutes at Redcliffe Hospital. At the time of the call Redcliffe and Caboolture Hospitals were on level 3.

Fifteen-minute snapshots for hospital delays at Metro North HHS hospitals prior to the call, at the time of the call and while the call was pending reveal moderate to extreme delays at hospitals as follows:

| | Hospital | Total no. ambulance units at Hospital (with pts on stretcher) | Total no. ambulance units ramped (>30 mins POST) | Maximum ramped time | Hospital escalation level |
|---|---|---|---|---|---|
| 10:30 to 10:44 | RBWH | 3 | 0 | 28 mins | |
| | Redcliffe Hospital | 4 | 2 | 1 hr 8 mins | 2 |
| | Caboolture Hospital | 5 | 3 | 1 hr 20 mins | 2 |
| 11:30 to 11:44 (TOC 11:30) | RBWH | 4 | 2 | 49 mins | |
| | Redcliffe Hospital | 10 | 8 | 2 hrs 8 mins | 3 |
| | Caboolture Hospital | 6 | 6 | 1 hr 34 mins | 3 |
| | Prince Charles Hospital | 6 | 0 | 29 mins | |
| 12:00 to 12:14 (cancelled 12:09) | RBWH | 6 | 4 | 1 hr 19 mins | 2 |
| | Redcliffe Hospital | 7 | 6 | 2 hrs 28 mins | 3 |
| | Caboolture Hospital | 4 | 4 | 1 hr 49 mins | 3 |
| | Prince Charles Hospital | 7 | 3 | 36 mins | |

## Operational Review

Fifteen-minute snapshots for pending cases within the Brisbane Operations Centre response area prior to the call, at the time of the call and while the call was pending revealed moderate to high numbers of pending cases within the community as follows:

## Queensland Ambulance Service: Operational Incident Reporting

| | Priority | Number of Incidents | Average Wait (h:mm:ss) | Maximum Wait (h:mm:ss) | No. incidents pending > 1hour |
|---|---|---|---|---|---|
| 10:30 to 10:44 | 1 | 2 | 0 03:37 | 0:05 | 4 |
| | 2 | 15 | 0:40:42 | 1:45:33 | |
| 11:30 to 11:44 (TOC 11:30) | 1 | 4 | 0:12:34 | 0:24:13 | 7 |
| | 2 | 20 | 1 00:42 | 2:45:37 | |
| 12:00 to 12:14 (cancelled 12:09) | 1 | 9 | 0:10:29 | 0:32:17 | 8 |
| | 2 | 19 | 1 06:14 | 3:12:44 | |

### System Pressures

On 31 January 2022, the Metro North HHS hospitals experienced 102 hours of 'Lost Time' at Emergency Departments. This Lost Time equates to approximately 10 paramedic crews over the period of a day being unavailable to be dispatched to the community. On 30 January 2022, QAS Metro North HHS hospitals experienced 51 hours of 'Lost Time' at Emergency Departments (approximately 5 paramedics) which was less significant.

Please note - 'Lost Time' data is derived from QAS electronic Ambulance Report Forms (eARFs). All Patient Off Stretcher (POST) performance data, including QAS patient volumes is a point in time and subject to change as eARFs move into completed status and become available for reporting. This report includes Code 1 and 2 incidents that result in a patient transport to a Queensland Health reportable hospital and have a valid at hospital time interval which is greater than 30 minutes for completed eARFs only (approx. 85-90% for prior day)

This 'Lost Time' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound as pending incidents continue to accrue as more Triple Zero (000) requests are received; however, ambulance crews are unable to be released from hospitals. The outcome results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

In the period leading up to the time of this incident, pressures (hospital delays and ambulance 'ramping') were being experienced throughout southeast Queensland (SEQ), leading to SEQ requiring escalation to moderate from 21:30 pm on 30 January 2022, then further escalation to extreme from 16:20pm on 31 January 2022, ending at 08:44 am on 3 February 2022.

At the time of dispatch, the closet available and most appropriate unit was located at Prince Charles Hospital. After further investigation and analysis of AVL data the crew was dispatched at 12:08 and it shows that the unit did not move from its location at Prince Charles Hospital. The case was cleared from the crew a 12:11.

**Commented [RN1]:** What is the reason that this crew did not move from PCH, the IDR indicates they were enroute 7 seconds after being assigned? Reason for this should be added to the SIR.

It has also been noted that nil call backs were performed for this case and nil request for further upgrade or review by CDS completed by EMD.

**Commented [RN2]:** Has the reason the case was not sent to CDS for review been discussed with the EMD ? a comment needs to be added to the SIR.

### Outcomes

- Case cancelled by caller advising due to response taking too long.
- Patient transported by private means to hospital.
- High 000 demand during peak time which resulted in a delayed dispatch time of 36 minutes.
- Request from Redcliffe District Hospital for RED1B transfer of this patient to Prince Charles Hospital – Incident number 15420145 at 12:42.

- SOS attempted to speak with patient and family at TPCH on the 31st of January and the 1st of February with the patient unavailable to do being COVID positive. The SOS passed on a telephone number to hospital staff for contact to SOS for patient or family with no contact made.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- LASN Incident Notification – Dot point report
- Workforce planning reports;

## Regional Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | A/Assistant Commissioner | Endorsed | 01/04/2022 |
| Lisa Dibley | A/District Director | Endorsed | 01/04/2022 |

# Significant Incident Review

Version 1.0 August 2020

## Metro North Region
## Queensland Ambulance Service

### Authority:
By authority of the Acting Assistant Commissioner, Metro North Region, Queensland Ambulance ervice (QAS).

### Executive Summary:

On 7 February 2022 at 03:47hrs, the QAS received a Triple Zero (000) call for assis nce (In d 15447423) at Irrelevant Deception Bay to attend a Irrelevant pat nt who had d ulty in breathing and was Covid-19 Positive. The call went into the Waiting Queue at 03:49hrs (t s is when enough information has been obtained to be able to dispatch a resource).

The case was initially prioritised in the Medical Priority Dispatch Syste (MPDS) s MPDS Determinant 06D4 Breathing Problems, clammy which was a QAS Cod 1C. A sec d 000 all wa received at 04:13 with the patient reported to be unconscious and not breathin The cas wa upgrade to MPDS Determinant 06E01, which requires a response priority code 1 espons At 04:28 8 minutes after the call went into the Waiting Queue and 15 minutes after the case was u raded 1A he first QAS resource arrived on scene.

Upon arrival, QAS paramedics reported locating the atient re iving ine ctive CPR from her partner. QAS resuscitation was commenced however despite be efforts he pa ent was declared deceased at 04:49hrs.

The Brisbane OpCen at the time o he fir all reve a high de and for service across the Metro North and South Regions with South E st Queen nd Escal n of “E treme Hospital Delays” affecting paramedic availability.

### Terms of Reference:
This review will investigate all asp of ambulance response to incident 15447423.
The review will examine ambulance erations prior to, during and following the response.
This review will include all requiremen utlined in the *Operational Incident Review Process*.

### Regional Clin l Incident Summary Report:
A regional clinical re w was undertaken on this case which identified all documentation and clinical practice were performed at the ndard required.

### State OpCen ProQA:
The State Quality Assurance Unit were requested to provide a special review and provide an evaluation of the call performance with the below summary results extracted. There were two 000 calls received.

03:49 1st Triple Zero call received. ProQA utilised. Deemed low compliance with deviation with the caller advising the patient could speak between breaths, but the patient could be heard having difficulty in speaking between breaths.

04:13 2 Triple Zero call received. ProQA utilised. Deemed non-compliant with critical deviation and prohibited behaviours used by the EMD.

The OpCen Director received a copy of the QA with appropriate follow up education provided to the call takers.



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## Incident Review/Investigation:

### Scope

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

### Background

On 07 February 2022 at 03:47hrs, the QAS received a Triple Zero (000) call for assista cident 15447423) at Irrelevant , Deception Bay to attend a Irrelevant patie who h difficulty breathing and was Covid-19 Positive.

### Review

A comprehensive investigation of the incident has been undertaken inclu ng C Taker, spat h, and a resource review as to why the incident occurred, outcomes/findings an actions commend d to ensure that a similar incident does not reoccur.

### Timeline

03:47 000 call received, 1st keystroke
03:49 Call entered the Waiting Queue, Irrelevant th diffic y in breathing
04:05 Delay in dispatch due to workload, common all
04:13 Second 000 call, patient has stopped brea ng
04:15 First unit attached
04:17 CPR in progress
04:28 First unit arrived on sce
04:49 CPR ceased by QAS QPS request d
05:29 MN OS arrived on ene

## Resource Review

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time |
|---|---|---|---|---|
| 03:45 to 03:59 (07/02/2022) | QE11 Hospital | 1 | 0 | 14 mins |
| | Ipswich | 3 | 2 | 6 hrs 20 |
| | Princess Alexandra Hospital | 3 | 0 | 26 minutes |
| | Redlands Hospital | 1 | 0 | 25 minutes |
| | RBWH | 1 | 0 | 2 mins |
| | Redcliffe Hospital | 2 | 1 | 52 mins |
| | Caboolture Hospital | 2 | 0 | 20 mins |
| | Prince Charles Hospital | 1 | 0 | 40 mins |
| 04:00 to 04:14 (07/02/2022) | Ipswich | 4 | 3 | 6 hrs 35mins |
| | Princess Alexandra Hospital | 5 | 2 | 41 mins |
| | Redlands Hospital | 1 | 1 | 40 mins |
| | RBWH | 1 | 0 | 17 mins |
| | Redcliffe Hospital | 1 | 0 | 15 mins |
| | Caboolture Hospital | 3 | 1 | 1hr 28mins |
| 04:15 to 04:29 (07/02/2022) | Ipswich | 4 | 3 | 6hr 50 mins |
| | Princess Alexandra Hospital | 3 | 1 | 56 mins |
| | Redlands Hospital | 2 | 1 | 55 mins |
| | RBWH | 1 | 1 | 32 mins |
| | Redcliffe Hospital | 2 | 1 | 30 mins |
| | Caboolture Hospital | 2 | 1 | 1hr 31 mins |
| | Prince Charles Hospital | 1 | 0 | 2 mins |

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 03:45 to 03:59 (07/02/2022) | 1 | 2 | 00:01:41 | 00:02:29 |
| | 2 | 4 | 00:44:50 | 01:48:59 |
| 04:00 to 04:14 (07/02/2022) | 1 | 3 | 00:09:04 | 00:16:11 |
| | 2 | 5 | 00:49:55 | 02:04:17 |
| 04:15 to 04:29 (07/02/2022) | 1 | 2 | 00:13:39 | 00:24:56 |
| | 2 | 6 | 00:47:43 | 02:18:55 |

## QAS Resourcing

| AFTERNOON SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | BRT | LARU | MH Co-responder | CCP | FCCP | HARU |
| MTN | | 7 | 0 | | -4 | 0 | | | |
| | 100% | 121% | | 100% | 60% | 100% | | | |

| NIGHT SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | Twilight | E.A. | MH Co-responder | CCP | FCCP | HARU |
| MTN | | 2 | 0 | 10 | | | 0 | | 0 |
| | | 105% | | | | | 100% | | 100% |

## Outcomes

- Deterioration of a Irrelevant who suffered a cardiac arrest.
- High Triple Zero (000) demand and delays at HHS facilities
- Resuscitation attempted, time of death 04:49

## Post review actions

- OS attended scene.
- Partner on scene challenging to communicate with, mother of patient appreciative of supervisor and QAS attendance.
- Mother stated multiple recent presentations to ED via QAS and stated patient had discharged against hospital advice.
- Feedback provided to the EMD who took the initial 000 call.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- LASN Incident Notification – Dot point report
- Local level clinical review (Eclipse);
- Audio files;
- AVL tracking of unit positions at time of incident;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active; and

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | A/Assistant Commissioner | Electronically endorsed | 04/04/2022 |
| Lisa Dibley | A/Director Operations | Electronically endorsed | 04/04/2022 |

# Significant Incident Review Version 0.3

## Metro South Region

### Authority:

By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region.

### Executive Summary:

On Friday 25 February 2022 at 8:2pm, QAS received a Triple Zero (000) call for a sistanc inciden mber 15524880) at Irrelevant , Sunnybank Hills QLD 4109 to attend a Irrelevant tient who had been unwell for 3 days with vomiting and abdominal pain.

The case was initially prioritised in the Advanced Medical Priority Di pa Syste (AM DS) as 01A01 (Abdominal pain) requiring a Code 2BL response. A clinical call bac was con ucted by a State Operations Coordination Centre (SOCC) Doctor at 11:40pm which not d the patie t was xperi cing vomiting, abdominal pain and distention. The patient stated the pain in Irrelevan abdom n was w rse hat than hat in Irrelevan knee, following recent total knee replacement. Following the call, a dispatch p n was ered by e SOCC Doctor into CAD to dispatch a vehicle by 00:45am, Saturday 26 February 2022.

A second Triple Zero (000) call was received from the iginal ller at 04am, the patient's condition remained unchanged, but it was noted during the call that the patient's pain had i creased, the incident remained as a 2BL response. A third triple-zero call was received 5:57 m, dur g this call it was noted that the patient was now vomiting blood. The incident w ioritised o MPDS B01M, this resulted in the incident being upgraded to a Code 2A response A fourth d final ple Zer (000) call was received at 6:16am from the patient's daughter requesting an ETA, the EM was apolog c and advised that no ETA could be given at that time.

On the evening of Friday 25 Febr ry 022, the QAS was experiencing a significant increase in demand for service which was compounded b a significant weather event being experienced across Southeast Queensland (SEQ). At the time of the c the Brisbane Operations Centre (BOC) response area had a total of 26 pending case ncluding 1 pending C 1 incident, this rose to a peak at 11:00pm of 45 pending cases including 3 pending de 1 incidents.

The QAS response time s 10 hours and 56 minutes from the time the call entered the 'in waiting queue' to first unit on scene. There w a delay in identifying an available paramedic unit to respond to the case given existing ambulance workload a oss Metro South Region and Metro South Health and Hospital Service (HHS) hospital Emergency Department (ED) delays were experienced at some in scope hospitals, affecting paramedic availability.

T QAS assigned one Advanced Care Paramedic (ACP) crew at 7:15am who arrived on scene at 7:24am. Th ACP crew who responded were a day shift 7:00am start from Sunnybank Station. On arrival the crew fo nd the patient already seated in a car as the family were going to undertake the transport themselves. The assessed by the ACP crew and treatment was provided at scene. The patient was subsequently transported by QAS to Greenslopes Private Hospital at 8:00am, arriving at 8:24am. The patient was triaged and offloaded at 8:51am.

## Terms of Reference:

This review will review all aspects of ambulance response to incident 15524880. The review will examine ambulance operations prior to, during and following the response. This review will include all requiremen outlined in the *Operational Incident Review Process*.

## Region Clinical Review:

**Pertinent information:**

- Appropriate assessment and management documented by transport crew.
- No significant concerns in vital signs recorded (GCS 15, RR20, HR84 SR, BP /52)
- Patient arrived at Greenslopes Private at 8.24am.

**Outcomes:**

- No clinical concerns were identified in the management of the ase fol wing Q S ew arrival.

## OpCen Review:

**Call Taking:**

The correct response was initiated, with the informa on provi ed, at the me of each call.

- 2BL upon the first call
- 2A upon the third call

As part of this review, all Tripl Zero (000) lls were reviewed under the Quality Assurance process and the SOCC Doctor call back review by the M dica The calls were coded and upgraded appropriately. Even though the original Triple Ze (0 0) call was deemed non-compliant as a result of discrepancies in the questions, the coding was found to b correct.

**Dispatch:**

Due to the correct coding f this incident and extreme workload during the evening of 25 February 2022, the delay in dispatch was found be reasonable and appropriate.

## Incident Review/Investigation:

**Scope:**

Metro South Region reviewed the response, clinical performance and operational decision making to ensur the appropriate ambulance response and management of this case was achieved. It is intended that ny operational or clinical performance issues identified with this case are addressed to ensure lessons are l rnt to improve future responses.

**Background:**

QAS was called Irrelevant patient who had been unwell for 3 days with vomiting and bdo al pa

**Timeline:**

**25 February 2022**
20:24 - Triple Zero (000) call received.
20:27 - In waiting queue.
20:41 - Delay in dispatch noted due to workload.
23:40 - Call-back to scene from SOCC Doctor. Plan for dispatch by 0 45.

**26 February 2022**
04:04 - Second Triple Zero (000) call received – Requesting E A
05:57 - Third Triple Zero (000) call received.
05:59 - AMPDS reclassified to 21B01 - 2A Response – Patient now omiting blood.
06:16 - Fourth Triple Zero (000) call received – Daugh er req sting E A.
07:15 - B501122 - Assigned.
07:16 - B501122 - EnRoute.
07:24 - B501122 - On Scene.
08:00 - B501122 - Depart for Gree slopes P ate Ho tal.
08:24 - B501122 - At Destinatio
08:51 - B501122 - Offloaded
09:18 - B501122 - Partially Ava ble.
09:20 - B501122 - Clear.

**Operational Review:**

Operational dispatch incident:
There was a delay of hours and 56 minutes to respond an available paramedic unit to the incident (from when the incident entered e waiting queue to when they were on scene) due to existing ambulance workload across Metro South Regio and Metro South Health and Hospital Service (HHS). Hospital Emergency Department (ED) delays were perienced at some in scope hospitals, affecting paramedic availability.

There were significant wait times for code 1 and 2 incidents throughout the night of 25 - 26 February 2022. ifteen-minute snapshots for pending cases within the Brisbane Operations Centre (BOC) response area at th time of the call and hourly until dispatch, reveal high numbers of pending cases within the community as fo ws:

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 19:15 to 19:29 (25/02/2022) | 1 | 3 | 0:05:31 | 0:12:46 |
| | 2 | 21 | 0:51:15 | 3:31:01 |
| 19:30 to 19:44 | 1 | 1 | 0:10:28 | 0:10:28 |
| | 2 | 16 | 1:02:42 | 3:45:18 |
| 19:45 to 20:00 | 1 | 1 | 0:11:47 | 0:11:47 |
| | 2 | 20 | 1:06:47 | 4:00:10 |
| 20:00 to 20:14 | 1 | 3 | 0:10:33 | 0:25:05 |
| | 2 | 19 | 1:18:58 | 4:15:17 |
| 20:15 to 20:29 | 1 | 1 | 0:12:54 | 0:12:54 |
| | 2 | 25 | 1:18:19 | 4:30:26 |
| 20:30 to 20:44 | 1 | 4 | 0:15:41 | 0 30:39 |
| | 2 | 27 | 1:24:56 | 4:4 3 |
| 20:45 to 20:59 | 1 | 4 | 0:15:41 | 0:3 39 |
| | 2 | 27 | 1:24:56 | 4 5:23 |
| 21:00 to 21:14 | 1 | 6 | 0:10:02 | :21:42 |
| | 2 | 29 | 1 2:23 | 57:2 |
| 22:00 to 22:14 | 1 | 5 | 0:10:22 | 0:27:09 |
| | 2 | 37 | :24:3 | 4:01:55 |
| 23:00 to 23:14 | 1 | 3 | :36 | 0:42:31 |
| | 2 | 42 | 1:4 | 5:01:26 |
| 00:00 to 00:14 (26/02/2022) | 1 | 3 | 1:11:28 | 3:13:01 |
| | 2 | 39 | 55:53 | 6:01:01 |
| 01:00 to 01:14 | 1 | 3 | 0:17:13 | 0:21:46 |
| | | 4 | 2:25:35 | 7:00:50 |
| 02:00 to 02:14 | 1 | 4 | 0:35:55 | 0:59:25 |
| | 2 | | 2:37:23 | 7:37:20 |
| 03:00 to 03:14 | 1 | 3 | 0:37:29 | 1:24:34 |
| | | 4 | 3:04:27 | 7:25:37 |
| 04:00 to 04:14 | 1 | 2 | 0:25:57 | 0:31:42 |
| | 2 | 38 | 3:48:44 | 7:34:05 |
| 0 0 to 05:14 | | 6 | 0:23:21 | 0:47:22 |
| | 2 | 34 | 3:45:14 | 7:52:12 |
| 06:00 to 14 | 1 | 3 | 0:14:20 | 0:23:25 |
| | 2 | 32 | 3:40:55 | 7:54:16 |
| 07:00 to 07:14 | 1 | 5 | 0:48:09 | 1:40:00 |
| | 2 | 30 | 3:14:20 | 7:39:11 |

**spital Status**

Th iROAM 15-minute analysis for the time period 20:15-20:29 reveals there were 22 paramedic units at h spital, with 15 'ramped' for over 30 minutes following arrival at hospital, with the longest delayed for 3 hours tes, affecting QAS paramedic availability to respond to emergency cases in the community.

At the time of the call, the following hospitals within the Metro South Health and Hospital Service (HHS) were on level 3 escalation:

- Queen Elizabeth II Jubilee Hospital
- Logan Community Hospital
- Princess Alexandra Hospital

- Mater Adults Public Hospital

The significant hospital delays QAS experienced at Metro South HHS Emergency Departments on this day are demonstrated by the following snapshots which were taken at the following times: Prior to the first Triple Zero (000) call and while the QAS response to the patient was pending:

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins | Maximum Time at Destination | Escalation level |
|---|---|---|---|---|---|
| 20:00 to 20:14 (25/02/2022) | QE11 Hospital | 2 | 0 | 24 minutes | Nil |
| | Logan Hospital | 6 | 3 | 2 hours 25 minutes | 3 |
| | Princess Alexandra Hospital | 5 | 5 | 2 hours 6 minutes | 3 |
| | Redlands Hospital | 4 | 3 | 1 hour 34 minutes | Nil |
| | Mater Adults Hospital | 5 | 5 | 3 hours 30 minutes | 3 |
| 20:15 to 20:29 | QE11 Hospital | 3 | 1 | 39 minutes | Nil |
| | Logan Hospital | 5 | 4 | 2 hours 2 minutes | 3 |
| | Princess Alexandra Hospital | 7 | 5 | 2 hours 21 minutes | 3 |
| | Redlands Hospital | 5 | 3 | 1 hour 51 minutes | Nil |
| | Mater Adults Hospital | 2 | 2 | 3 hours 45 minutes | 3 |
| 20:30 to 20:44 | QE11 Hospital | 4 | 2 | 54 minutes | 3 |
| | Logan Hospital | 2 | 2 | 1 hour 46 minutes | 3 |
| | Princess Alexandra Hospital | 7 | 4 | 2 hours 36 minutes | 3 |
| | Redlands Hospital | 5 | 4 | 2 hours 5 minutes | 2 |
| | Mater Adults Hospital | 4 | 3 | 2 hours 37 minutes | 3 |
| 21:00 to 21:14 | QE11 Hospital | 2 | 2 | 1 hour 24 minutes | 3 |
| | Logan Hospital | 2 | 1 | 1 hour 19 minutes | 3 |
| | Princess Alexandra Hospital | 8 | 4 | 3 hours 6 minutes | 3 |
| | Redlands Hospital | 3 | 3 | 2 hours 35 minutes | 2 |
| | Mater Adults Hospital | 6 | 3 | 3 hours 4 minutes | 3 |
| 22:00 to 22:14 | QE11 Hospital | 4 | 0 | 22 minutes | 3 |
| | Logan Hospital | 2 | 1 | 39 minutes | 3 |
| | Princess Alexandra Hospital | 4 | 2 | 1 hour 14 minutes | 3 |
| | Redlands Hospital | 2 | 1 | 57 minutes | 2 |
| | Mater Adults Hospital | 4 | 4 | 1 hour 26 minutes | 3 |
| 23:00 to 23:14 | QE11 Hospital | 1 | 0 | 15 minutes | 3 |
| | Logan Hospital | 2 | 0 | 29 minutes | Nil |
| | Princess Alexandra Hospital | 3 | 2 | 1 hour 4 minutes | 3 |
| | Redlands Hospital | 0 | 0 | Nil | 2 |
| | Mater Adults Hospital | 4 | 3 | 2 hours 16 minutes | 3 |
| 00:00 to 00:14 | QE11 Hospital | 0 | 0 | Nil | Nil |
| | Logan Hospital | 5 | 2 | 58 minutes | Nil |
| | Princess Alexandra Hospital | 4 | 3 | 57 minutes | 3 |
| | Redlands Hospital | 3 | 2 | 49 minutes | Nil |
| | Mater Adults Hospital | 0 | 0 | Nil | Nil |

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins | Maximum Time at Destination | Escalation level |
|---|---|---|---|---|---|
| 01:00 to 01:14 | QE11 Hospital | 1 | 0 | 3 minutes | Nil |
| | Logan Hospital | 1 | 1 | 22 minutes | 3 |
| | Princess Alexandra Hospital | 2 | 2 | 54 minutes | Nil |
| | Redlands Hospital | 0 | 0 | Nil | Nil |
| | Mater Adults Hospital | 1 | 1 | 50 minutes | Nil |
| 02:00 to 02:14 | QE11 Hospital | 1 | 0 | 17 minutes | Nil |
| | Logan Hospital | 1 | 0 | 12 minutes | 3 |
| | Princess Alexandra Hospital | 3 | 2 | 48 minutes | Nil |
| | Redlands Hospital | 1 | 1 | 33 minutes | Nil |
| | Mater Adults Hospital | 1 | 1 | 56 minutes | Nil |
| 03:00 to 03:14 | QE11 Hospital | 1 | 1 | 34 minutes | Nil |
| | Logan Hospital | 2 | 0 | 24 minutes | Nil |
| | Princess Alexandra Hospital | 1 | 1 | 35 minutes | Nil |
| | Redlands Hospital | 0 | 0 | Nil | Nil |
| | Mater Adults Hospital | 1 | 0 | Nil | Nil |
| 04:00 to 04:14 | QE11 Hospital | 1 | 0 | 13 minutes | Nil |
| | Logan Hospital | 2 | 1 | Nil | Nil |
| | Princess Alexandra Hospital | 1 | 0 | 23 minutes | Nil |
| | Redlands Hospital | 0 | 0 | Nil | Nil |
| | Mater Adults Hospital | 0 | 0 | Nil | Nil |
| 05:00 to 05:14 | QE11 Hospital | 1 | 0 | 15 minutes | Nil |
| | Logan Hospital | 0 | 0 | Nil | Nil |
| | Princess Alexandra Hospital | 1 | 0 | 27 minutes | Nil |
| | Redlands Hospital | 2 | 1 | 38 minutes | Nil |
| | Mater Adults Hospital | 1 | 1 | 32 minutes | Nil |
| 06:00 to 06:14 | QE11 Hospital | 1 | 0 | 20 minutes | Nil |
| | Logan Hospital | 2 | 0 | 24 minutes | Nil |
| | Princess Alexandra Hospital | 1 | 0 | 8 minutes | Nil |
| | Redlands Hospital | 2 | 0 | 24 minutes | Nil |
| | Mater Adults Hospital | 0 | 0 | Nil | Nil |
| 07:00 to 07:14 | QE11 Hospital | 1 | 0 | 3 minutes | Nil |
| | Logan Hospital | 2 | 0 | 10 minutes | Nil |
| | Princess Alexandra Hospital | 3 | 1 | 31 minutes | Nil |
| | Redlands Hospital | 2 | 0 | 24 minutes | Nil |
| | Mater Adults Hospital | 0 | 0 | Nil | Nil |

On 25 February 2022, the QAS Metro South Region experienced 70 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes. This lost availability equates to approximately 14 paramedics over the period of a day, being unavailable to be dispatched to the community.

T 'Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When th occurs, the QAS prioritises responses according to clinical acuity. The effects of lost availability compound a pending incidents continue to accrue as more Triple Zero (000) requests are received; however, ambulance able to be released from hospitals. The outcome results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

On the day of this incident, significant pressures (hospital delays and ambulance 'ramping') were being xperienced throughout southeast Queensland (SEQ) resultant from the significant weather event. SEQ was escalation to Moderate from 10:21am Friday 25 February 2022 with further escalation to Extreme at 9:45pm on the same evening and remaining on Extreme escalation until 5:30am on Tuesday 1 March 2022.



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**Metro South Region Staffing for the night of Friday 25 February 2022:**

The Metro South Region including had the following resourcing against approved rosters.

| AFTERNOON SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | PROJECTED ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | BRT | LARU | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | -12 | -9 | 0 | 0 | -3 | 0 | | | | 0 | 3 | 5 | 3 |
| | 40% | 75% | | 100% | 70% | 100% | | | | | | | |
| MTS | -1 | -10 | -2 | | -5 | -1 | | | | 3 | 1 | 5 | 1 |
| | 95% | 83% | | | 29% | 0% | | | | | | | |
| WMT | -2 | 0 | -1 | | -1 | | | | | 0 | 1 | 2 | 1 |
| | 67% | 100% | | | 50% | | | | | | | | |
| **MWPU Total** | **-15** | **-19** | | **0** | **-9** | **-100%** | | | | **3** | **5** | **12** | **5** |
| | **67%** | **83%** | | **100%** | **53%** | **67%** | | | | | | | |

| NIGHT SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | PROJECTED ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Night shift TOTALS | Rural | Twilight | E.A. | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | 0 | -4 | 0 | 9 | 0 | | 0 | | 0 | 6 | 1 | 6 | 0 |
| | | 91% | | | | | 100% | | 100% | | | | |
| MTS | 0 | -15 | -1 | 8 | 0 | | 0 | 0 | | 0 | 2 | 4 | 0 |
| | 100% | 70% | | | | | 100% | 100% | | | | | |
| WMT | 0 | 4 | -2 | 10 | -1 | | 0 | | | 0 | 0 | 3 | 0 |
| | | 120% | | | | | 100% | | | | | | |
| **MWPU Total** | **0** | **-15** | | | | | | **0** | **0** | **6** | **3** | **13** | **0** |

Brisbane South and Logan Districts had 5 night sh va ancies i luding 8 twilight shifts which commence at 2:00pm or 4:00pm and finish at 2 0am o 4:00am n additio to this the two districts had 10 afternoon vacancies which were advertised ut unable be filled

## Outcomes:

- Metro South Region Actin As tant Commissioner – Matthew Green and QAS Medical Director - Dr Stephen Rashford called th family (Irrelevant Daughter) to discuss the outcomes of the review on Wednesday 9 March 022. A/AC Green and Dr Rashford apologised for the delay, provided some reasons for the delay but t excuses, advised Irrelevant the QAS strive to provide a quicker response and were reviewing the c cumstances of the case. Irrelevant remains dissatisfied with the case but was grateful for the call. Dr Rashford and A/AC Green provided an invitation to discuss the case and apologise to Irrelevant when she feels well enough to participate.

## Review Recommendations:

- Director - Brisbane Operations Centre confirmed that feedback has been provided to the EMD regarding the discrepancies in the call taking process.

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

| | |
|---|---|
| Incident l Report | Incident Report.pdf |
| pCen Special Review | 220225_SR 15524880_Call 20 24_ RE_ Ministerial - Leanne Page - Sunny |

| | |
|---|---|
| Ambulance Report Form | DARF_504157433.pdf |
| Clinical Review | File Note - 15524880 Sunnybank.docx<br>Re_ Clinical Review 15524880 .msg |
| Audio Files | Triple zero calls to Coominyah Street, S.mp3<br>25-02-2022 23.40pm Triple Zero call.mp3<br>26-02-2022 04.03am SOCC Dr call back.m2<br>2nd Triple Zero call.<br>26-02-2022 05.56am 3rd Triple Zero call.r<br>16-02-2022 06.14am 4th Trilpe Zero call.r |

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Email endorsement | 25/03/2022 |
| Ross Hodges | Acting District Director – Logan | R.Hodges | 22/03/2022 |

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# Significant Incident Review Version 0.3

## Metro South Region

### Authority:
By authority of Mr Matthew Green, Acting Assistant Commissioner, Metro South Region.

### Executive Summary:
On Friday 11 March 2022 at 07:49hrs QAS received a Triple Zero (000) call for assistance (in ent numb r 15587811) at Irrelevant Murarrie 4172 to attend a Irrelevant patient w ad a recent fall nd was having difficulty mobilising.

There was a response time of 3 hours and 14 minutes to respond an available p ame c unit he incident (from when the incident entered the waiting queue to when the first unit arrived on sce e).

At the time the call came in there was significant workload across Sou -East Q eenslan (SEQ) with multiple Code 1 and Code 2 cases pending in the community.

The case was initially prioritised in the Advanced Medical Pri ty Disp ch Syste (AMPDS) as 17A03 (Fall =>6hr Injury No Priority Symptoms) requiring a Code 2C respon

The Clinical Hub (CHUB) reviewed the incident and pe orme call b k at 08:37hrs, The CHUB was advised the patient had exacerbation of right hip pain rad ting to ght knee and was unable to get up from bed. Commenced panadeine forte yesterday. Decrease oral in ake a vomiting last night. Slipped and twisted in bath last Wednesday (nil fall). Pain gg ated, a e ed at Q een Elizabeth II Hospital, nil fracture. No bruising, redness, swelling or obvi s deform y.

The first ambulance was as gned at 08 9hrs with subsequent ambulances assigned at 09:05hrs and 09:27hrs. All three ambulances ere div ed to riority incidents.

A fourth ambulance was assigned a 0:25hrs and arrived on scene at 11:04hrs.

A second triple-zero call was received fro the original caller at 10:33hrs advising the patient had numbness in feet and pain in legs. Patient remains in bed.

A third triple-zero call was received from the original caller at 10:50hrs advising the patient is turning purple and unable to talk properly. The case was re-prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as 17D04 (Fall Not Alert) requiring a Code 1B response.

A fourth triple-zero call was received from the original caller at 11:02hrs advising the patient is staring blankly nd purple with laboured breathing.

O QAS arrival patient was in bed unconscious with agonal breathing. The incident priority was changed to a C de 1A and a further Paramedic crew, Critical Care Paramedic and Senior Operation Supervisor attended d anced resuscitation was undertaken; however, the patient was declared deceased at scene.

Compliance issues were noted in the review of the Triple Zero (000) calls which had an effect on the response coding and therefore potentially the response time.

## Terms of Reference:

This review will review all aspects of ambulance response to incident 15587811. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements outlined in the *Operational Incident Review Process*.

## Region Clinical Review:

The Metro South Region Clinical Education Unit have undertaken a clinical review of this incident. The cl cal assessment, treatment and documentation was completed to an appropriate standard. There are no conc s with the clinical management of this case. ECLIPSE ID # 50151.

## OpCen Review:

The Quality Assurance Unit have reviewed the Triple Zero (000) calls received. The initial T l ero (00 call was found to be low compliance. The second, third and fourth Triple Zero (000) call was found to be n - compliant as the Emergency Medical Dispatchers (EMD) did not follow the corre proc s for de li with subsequent Triple Zero (000) calls. If this was followed the incident would have been cha g d to a Code 1B response at 10:29hrs and a Code 1A response at 10:49hrs.

## Incident Review/Investigation:

**Scope:**

Metro South Region reviewed the response, clinical perfor ance an ope ational cision making to ensure the appropriate ambulance response and management of t case s achiev d. It is intended that any operational or clinical performance issues identified with this ca are ad sse to ensure lessons are learnt to improve future responses.

**Background:**

QAS was called to attend a Irrelevant patien who h d a re ent fall and was having difficulty mobilising.

**Timeline:**

07:49 – Triple Zero (000) call re ved
07:51 – In waiting queue
08:37 – Clinical Hub performe all back
08:19 – 1st unit dispatched and d rte o higher priority case at 08:29hrs.
09:05 – 2nd unit dispatched and dive d to higher priority case at 09:27hrs.
09:27 – 3rd unit dispatched and diverte o higher priority case at 09:52hrs.
10:25 – 4th unit dispatched.
10:33 – Second Triple Zero (000) call recei ed updating the patient's condition.
10:50 – Third Triple Zero (000) call received updating the patient's condition.
10:51 – Incident reconfigured to a Code 1B.
11:02 – Fourth Triple Zero (000) call received updating the patient's condition.
11:04 – QAS arrive on scene.

**Operational Review:**

O erational Dispatch to Incident

Th re was a protracted response of 3 hours and 14 minutes to respond an available paramedic unit to the in dent (from when the incident entered the waiting queue to when they arrived on scene) due to existing b ce workload across Metro South Region.

There were significant wait times for code 1 and 2 incidents throughout the day of the 11 March 2022. Fifteen-minute snapshots for pending cases within the Brisbane Operations Centre (BOC) response area prior to the call, at the time of the call and hourly until dispatch reveal high numbers of pending cases within the community follows:

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 06:45 to 06:59 (11/03/2022) | 1 | 3 | 00:42:36 | 02:00:04 |
| | 2 | 19 | 02:28:27 | 07:53:23 |
| 07:45 to 07:59 (11/03/2022) | 1 | 2 | 0:08:44 | 0:12:51 |
| | 2 | 18 | 2:20:28 | 7:44:15 |
| 08:45 to 08:59 (11/03/2022) | 1 | 3 | 0:11:09 | 0:20:31 |
| | 2 | 25 | 1:19:16 | 8:44:15 |
| 09:45 to 09:59 (11/03/2022) | 1 | 3 | 0:06:38 | 0:08:46 |
| | 2 | 29 | 1:09:42 | 5:24:09 |
| 10:45 to 10:59 (11/03/2022) | 1 | 5 | 0:03:42 | 0:05:25 |
| | 2 | 29 | 0:47:23 | 3:57:07 |

Hospital Status

The hospital delays QAS experienced at Metro South HHS Emergency Departments on this day are demonstrated by the following snapshots which were taken prior to the first Triple Zero (000) call and while the QAS response to the patient was pending:

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 06:45 to 06:59 (11/03/2022) | Logan Hospital | 3 | 3 | 1:15:13 | 3 |
| | Mater Adults Hospital | 1 | - | 0:15:46 | - |
| | Princess Alexandra Hospital | - | - | 0:00:00 | - |
| | Queen Elizabeth Hospital | - | - | 0:00:00 | - |
| | Redlands Hospital | - | - | 0:00:00 | - |
| 07:45 to 07:59 (11/03/2022) | Logan Hospital | 1 | 1 | 1:46:59 | 3 |
| | Mater Adults Hospital | - | - | 0:00:00 | - |
| | Princess Alexandra Hospital | 1 | 1 | 0:30:32 | - |
| | Queen Elizabeth Hospital | 1 | - | 0:00:00 | - |
| | Redlands Hospital | - | - | 0:00:00 | - |
| 08:45 to 08:59 (11/03/2022) | Logan Hospital | 1 | - | 0:00:00 | - |
| | Mater Adults Hospital | 1 | - | 0:00:00 | - |
| | Princess Alexandra Hospital | 4 | 1 | 0:32:57 | - |
| | Queen Elizabeth Hospital | - | - | 0:00:00 | - |
| | Redlands Hospital | 2 | - | 0:00:00 | - |
| 09:45 to 09:59 (11/03/2022) | Logan Hospital | 4 | 4 | 0:55:27 | - |
| | Mater Adults Hospital | - | - | 0:00:00 | - |
| | Princess Alexandra Hospital | 2 | - | 0:00:00 | - |
| | Queen Elizabeth Hospital | 3 | 1 | 0:32:52 | - |
| | Redlands Hospital | 2 | - | 0:24:17 | - |
| | Logan Hospital | 2 | 2 | 0:33:48 | - |

| | | | | | |
|---|---|---|---|---|---|
| 10:45 to 10:59 (11/03/2022) | Mater Adults Hospital | - | - | 0:00:00 | - |
| | Princess Alexandra Hospital | 3 | 1 | 0:33:47 | - |
| | Queen Elizabeth Hospital | 4 | 4 | 1:19:43 | - |
| | Redlands Hospital | 1 | - | 0:00:00 | - |

Metro South Region Staffing
The Metro South Region including Brisbane South and Logan Districts had the following resourcing against approved rosters for the 11 March 2022;

- Day Shift – 5 vacancies

**Outcomes:**

- Compliance issues noted with the handling of the Triple Zero (000) calls which may have affected the response time.
- The clinical care of the patient was appropriate.
- The Senior Operation Supervisor attended scene and confirmed the family were understanding stating the patient had wanted to cancel QAS prior to arrival.

## Review Recommendations:

- Follow up with the Emergency Medical Dispatchers regarding compliance issues noted in the review.

## Appendix:

- Incident Detail Report
- Ambulance Report Form
- Audio Files (including Triple Zero calls)
- Quality Assurance Unit Reviews
- Clinical Review

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Irrelevant | 7/04/2022 |
| Anthony Hose | Acting District Director South Brisbane | | 06/04/2022 |