18:23:33 IDR- POL-Q message from OCS Beaumont to QPS advising single QAS officer needed to go over on QPS boat to leave at 18:45 at this stage- might be just after 19:00

18:49:19 Depart 4535 Telstra Tower to Kingfisher

18:50:05 Arrived 4535 Kingfisher

19:11:44 Assigned 4527 1st leg to Hervey Bay Water Police

19:12:19 IDR- Officer Giltrap will go over on the QPS boat

19:13:58 Enroute 4527

19:45:56 Arrived Hervey Bay Water Police

21:08:42 IDR- 4527 Located patient and officer

21:19:55 IDR- 4527 with patient, consulting for sedation

21:37:25 IDR- 4535 Patient now in the back of the ambulance, handcuffed, 2nd dose of Droperidol-spiting and swearing, GCS 08 airway clear-unable to take BP-radial pulse 112, pupils pinned- will go under an EEA, waiting for things to calm prior to loading onto QPS boast. May have to take stretcher from 4535

21:49:51 IDR-RSQ advised by the MOC OCS

21:56:16 IDR- RSQ SZCC will wait for further information

22:02:22 IDR- No CCP available on Fraser Coast-Crew require helo

22:02:27 IDR- CDS Campbell- Crew requested helo due to sedation requirements and TPT. CDS Campbell then conferenced SZCC

22:11:52 IDR- 8511 tasked to land at Kingfisher

22:12:47 Complete 4527 1st leg to Hervey Bay Water Police

22:13:49 Assigned 8511

20:24:44 4527 33618 now on QPS boat heading to Fraser Island? may have jumped off the jetty

20:27:03 IDR- 4535 Patient did jump from the jetty into the water, has been Cap sprayed and been returned to officer- officer safe

22:36:43 IDR- from OS Paul and QPS officer assaulted by the patient- Chris spat at (in face)

22:48:37 Enroute 8511

23:23:23 Arrived 8511 Kingfisher

00:24:22 IDR- 4535 patient now loaded onto police boat-will be doing likewise heading to Eurong to pick up QPS vehicle then back to Happy Valley

00:32:56 IDR- ETA 01:00 hrs water police

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00:44:37 Assigned 4527 2nd leg Hervey Bay Water Police to HBH with medical team

00:45:15 Enroute 4527

01:15:47 Complete 4535 Kingfisher

01:25:29 IDR- 4527 Now loaded with patient flight crew +QPS escort – officer Giltrap travelling in QPS vehicle to HBH

01:25:32 Arrived Hervey Bay Hospital (HBH)

02:15:04 Complete 8511 HBH Helipad.

02:34:34 Complete 4527 HBH

Review

Clinical presentation

This incident presented to QAS as a "In Field Initiate" meaning OIC Clackett received the dispatch information via QPS Sergeant Irrelevant. Sergeant Irrelevant requested OIC Clacket to proceed to Eurong to conduct a search for the patient. This subsequently evolved into a short search with the patient being located at the Telstra Tower near Central Station.

In the lead up to being on scene with the patient, OIC Clackett received the following intelligence –

- Presenting history from the patients three backpacker friends
- Bystanders who waived down OIC Clacket transiting form Happy Valley to Eurong
- Intelligence from the QPWS who were with the patient

The intelligence received describes the following presentation of OIC Clackets patient

- A Irrelevant
- Was last seen by Irrelevant riends after not sleeping all night, drinking beer, smoking marijuana and acting delusional/ paranoid. Patient displayed very concerning behaviour being naked covering Irrelevant own urine and dirt to warn off dingos.
- Bystanders confirm numerous sightings of the patient wandering around naked.
- QPWS found the patient also confirming the above intelligence.

OIC Clackets clinical assessment reveals

- A Irrelevant atient GCS 15 alert, talking very fast, manic, SAT score 0,
- Hypertensive 171/94, Sinus Tachycardia 104 bpm, Skin= NAD, no radial pulses documented
- Respiratory rate= 19 calm, normal respiratory status, SPo2 98% Room Air.
- Blood Glucose Level 4.1mmol temperature 36.1 degrees (tympanic)
- The patient also confirms paranoid/ delusion behaviour, admits to covering himself with his own urine and eating mushrooms/ berries and illicit drug use the previous night.

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- Given the above information there were numerous "Red Flags" noted for this patient.

Issues

This investigation found the following issues

1. The patient's clinical presentation was underestimated with the implementation of an Emergency Examination Authority (EEA) late into the patient's clinical pathway.
2. There is currently a practice of QAS vehicles staging on the Kingfisher jetty which resulted in the patient jumping off the jetty. The lack of operational supervision of the patient whilst urinating off the jetty resulted in him jumping off into the water.
3. Assault of staff- Lack of scene safety, Crew Resource Management (CRM) practices and Workplace Health and Safety (WH&S) principles by entering the water to restrain the patient resulting in injuries.
4. Lack of escalation reporting required of a significant incident to Senior Supervisors and executive Management.

Outcomes

Issue 1

EEA

CPP_BD_EEA_0421 Clinical practice Procedure: Behavioural disturbances/ Emergency Examination Authority

During OIC Clackets Record of Conversation (RoC), OIC Clacket was asked why he did not inform the patient was being placed on an EEA back at the Telstra Tower. OIC Clackets understanding of the policy was not contemporary and his decisions not to implement an EEA were based on the fact the patient volunteered for assessment.

This understanding seems to be based of the retrospective Emergency Examination Order not the current provisions within an EEA. If OIC Clackett had explained to the patient he was under an EEA and the patient escalated the conditions would have been much different being on land, daylight and having four QPWS officers plus the one QPS officer. By implementing an EEA this may have changed their decisions to let the patient stand at the end of a dark jetty unaccompanied.

Issue 2

Currently when staging for watercraft the QAS stage at the end of the jetty. This current practice afforded a mental health patient with bizarre behaviours the ability to jump off the jetty in the dark with no close supervision. Retrospectively had an EEA been placed this may have prompted the officers to accompany the patient to relieve himself.

This could have been avoided if the crew had of waited on land at the jetty entrance and driven out to the boat on its arrival. OIC Clackets joint decision with Sergeant Fitzpatrick

for the utilisation of the Hervey Bay water Police was based around the safety of this unpredictable patient being transported over water.

OIC Clacket and Sergeant Fitzpatrick did not consider the immediate danger of the patient being next to the water. As stated in OIC's RoC there was a public toilet at the Kingfisher entrance.

Issue 3

Ultimately a number of officers were injured during the restraint and sedation of this patient. There were numerous "Red Flags" and disturbing witnessed behaviours that were considered by not taken into context of the potential unpredictability of this patient.

There seems to have been a fundamental lack of CRM between both OIC Clackett/ Sergeant Irrelevant and again repeated when attempting to sedate the patient and placing him into a small Toyota Troop carrier with the water police and ACP Giltrap.

This investigation found that that there were several "pinch points" with in the case that could have avoided the physical injury to service staff.

As discussed, the EEA should have been implemented earlier with the understanding this patient could escalate at any given time.

Entry onto he jetty with a potentially unstable mental health patient could have avoided the assaults.

There was a fundamental lack of CRM or "game plan" between both Officers Clackett/ Irrelevant before entering the water on a dark remote beach. Both officers were aware of the back up coming from Hervey Bay. The decision to enter the water was based on "case pressure" that they personally would be held accountable for the patient if he was injured or drowned. This external pressure was part of the decision-making process. QAS Policy in the Digital Clinical practice Manual (DCPM) Introduction pp 59-60 clearly outlines the individual clinician's safety is paramount. This scene on the beach was unsafe with the patient charging at OIC Clackett on a deserted beach in the dark then following a single QPS officer into the water to arrest a patient.

QAS teachings from Tier 1 training should have been considered in its entirety – Abnormal Behavioural Disturbance Droperidol / Occupational Safety Training Violence Prevention courses all refer to the Person Object and Place (POP) assessments. Retrospectively OIC Clackets aggress they should have observed the patient from the shore until help arrives or he became incapacitated in the water. Had both officers waited for back up and not entered the water this would have prevented the assaults on these two officers. These officers are lucky serious injury did not result from their decisions.

Once the patient was removed from the water two water police officers and ACP Giltrap arrived. The decision to sedate was with in expected clinical parameters under *QAS DCPM Policy- CPG_BD_ABD_0421*. However, the lack of CRM and expected clinical pathway lacked insight.

During the sedation attempt on the beach ACP Giltrap was spat in the face with spittle entering his eyes. This could have been avoided by wearing safety glasses.

to remove the patient off the beach sounds reasonable. The patient was given one dose of Droperidol 10mgs IMI for a "excited delirium" presentation. After the first dose of Droperidol which was ineffective the decision to transfer this patient into a 4x4 ambulance with reduced space and three officers is high risk. Subsequently the water police officer was bitten on the forearm during this incident. Retrospectively OIC Clackett agrees sedation in its entirety (2nd dose Droperidol) and waiting where for behaviour de-escalation would have been a safer option.

Issue 4

There was a lack of notification to QAS Senior Officers during this event as it unfolded. On the 15 July 2021 WB District had two senior officers in an on-call capacity. These officers were-

- Russell Cooke District Director
- Nigel Jones A/EMO/SOS

This incident started at 15:23 when the QAS/QPS began searching for a lost backpacker. At 20:24 the incident escalated with the patient jumping into the water. Notification to the WB LASN's Senior Officers did not occur.

The OpCen notified OS McIntosh at 21:30 advising there had been an incident on Fraser Island. OS McIntosh then engaged by speaking with the crews on scene. Notification to the SOS did not occur until 22:36 when OS McIntosh informed SOS Jones of the situation and staff injuries.

SOP03.3 OpCen Operations- Notification of QAS Senior Officers was not followed. The OpCen notified the OS for tactical engagement however no level one page of notification occurred.

OS McIntosh also escalated the notification to the SOS, late into the incident. In review this was found to be due to lack of experience in the OS role when dealing with incidents that involve staff injuries.

In conclusion there were several opportunities in this incident were staff injuries could have been avoided. It is acknowledged that both QAS/QPS were presented an extremely difficult patient with limited resources in a challenging remote location in the dark. OIC Clackett displayed professionalism and self-reflection during his interview. With education OIC Clackett was able to self-identify the opportunities for risk identification within this incident.

Review Recommendations:

1. A self-reflective review in ECLIPSE be completed by OIC Clackett listing Kylie Cooke as a peer reviewer targeting scene safety and review the role of the EEA.
2. OIC to follow up with ACP Giltrap regarding the utilisation of PPE - eye wear.
3. OpCen Manager to follow up with OpCen staff regarding SOP03.3 Notification of QAS Senior Officers
4. Executive Manager of Operations to provide feedback to A/OS McIntosh regarding the importance and expectations of significant incidents and upward reporting.

5. OIC Clacket to review staging on the jetty and develop an LPG.

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

Appendix A IDR 14552380
Appendix B Unit Snapshot 14552380
Appendix C eARF 503557558
Appendix D eARF 503558347
Appendix E ECLIPSE ID 39829
Appendix F ECLIPSE ID 39850
Appendix G SHE Report Clackett
Appendix H SHE Report Giltrap
Appendix I RoC OIC Clackett
Appendix J Email A/OS McIntosh

LASN Endorsement

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

Role	Name	Position	Signature	Date
Chief Superintendent	Russell Cooke	District Director WB	Irrelevant	22-7-21

Wide Bay District

Authority:

By authority of District Director Russell Cooke, this Significant Incident Review (SIR) has been undertaken by Nigel Jones in relation to case 14562134.

Executive Summary:

This SIR will analyse a case whereby Queensland Ambulance Service (QAS) attended a house fire in Pialba, Hervey Bay involving a total of nine patients. The incident occurred at 2044hrs on Saturday 17 July 2021, with initial notification to QAS received through Inter-agency CAD Electronic Messaging System (ICEMS). At the time of the incident the Fraser Coast Cluster had eight units in operation, either on shift or on call, in addition to an Operations Supervisor on call.

Following the initial advice from ICEMS at 2044hrs, the first QAS unit arrived on scene at 2055hrs, 10 minutes and 17 seconds later. A total of five QAS resources were attached to this incident, including three ACP2 crews, one CCP crew and one Operations Supervisor. While initial information indicated only two patients, this was soon amended when nine persons were identified as needing medical attention. Throughout the course of this incident, QAS treated and transported two adults and seven children with injuries ranging from a 3 year-old-female with 30% burns involving face through to mild smoke inhalation and minor burns.

This review found that the resourcing of the scene was well balanced with business as usual (BAU) requirements, and that the attending crew worked well to treat and transport all nine patients in an ordered and efficient manner. This review did find that there was inadequate use of the SMART triage tags, however sieve triaging was undertaken but not recorded as per IMS21, which has led to a recommendation discussed below.

Overall, this review has found the execution of this incident to be largely in line with community and organisational expectations, further pending a clinical review.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14562134. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process.*

LASN Clinical Incident Summary Report:

The clinical reviews found;

- ECLIPSE ID 40249 – At standard, nil variation.
- ECLIPSE ID 40250 – At standard, basic assessment and documentation only treatment was transport.

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- ECLIPSE ID 40251 – At standard, minor documentation variance.
- ECLIPSE ID 40252 – Variation to Standard, Invasive BP and Respiratory Status Omission.
- ECLIPSE ID 40253 – At standard, nil variation.
- ECLIPSE ID 40254 – At standard, nil variation.
- ECLIPSE ID 40255 – At standard, nil variation.

Incident Review/Investigation:

Scope:

This review investigated the operational and clinical components of the case to determine whether the actions of the QAS was in line with both contemporary public expectations as well as compliance with organisational policies and procedures. The review will examine available documentation including Incident Detail Reports (IDR), patient Digital Ambulance Reports Forms (DARFs) and officer recounts.

Background:

At 2044hrs on 17 July 2021, QAS Maroochydore Operations Centre (OpCen) received an ICEMS from Queensland Fire Emergency Services (QFES) notifying of a reported house fire in Pialba, Hervey Bay. Initial reports via ICEMS indicated all persons were out of the house, however two were badly burnt, including child. At the time of the case, Fraser Coast Cluster (Hervey Bay, Urraween, Maryborough and Howard) had nine operational resources, consisting of: **italics represents status at time of incident*

- B4526 Hervey Bay - *Logging on 2100 start*
- A4525 Hervey Bay - *Transporting 63yof # ankle*
- B4523 Urraween – *Offloading at HBH ED*
- B4528Urraween – *On Return from HBH ED*
- B4541 Maryborough – *On Station*
- B4504 Maryborough Solo – *On Station*
- Maryborough EA Crew – *On EA*
- Howard EA Crew - *On EA*
- Operations Supervisor B4S10 – *On EA*

Initial dispatch was undertaken five minutes 17 seconds after ICEMS receipt and included a Bravo 4528 (on return from Hervey Bay Hospital (HBH) to Hervey Bay Station), and a Bravo crew from Maryborough Station. Two minutes later the Maryborough crew was cancelled, and replaced with B4523 who had just offloaded at HBH ED. The Operations Supervisor was also dispatched at this time, giving an initial response of two Bravo crews and one OS. As more intel was received from the scene via QPS, additional crews were sought, including B4526 who were logging on, and A4525 who were transporting a Irrelevant with fractured ankle, however diverted to scene to drop off CCP. The first unit arrived on scene at 2055hrs, resulting in a response time to scene as five minutes 55 seconds.

Initial sitreps from scene indicated a total of nine patients, including seven children and two adults. The most critical identified as a three year-old-female.

Timeline:

20:44	ICEMS Received
20:48	ICEMS: "HOUSE FIRE? CHILD ON FIRE"
20:49	In Waiting Queue
20:50	B4528 Dispatched

20:51	B4528 Responding
20:51	B4541 Dispatched
20:51	B4541 Responding
20:52	OS Dispatched
20:53	B4523 Dispatched
20:53	B4523 Responding
20:54	B4541 Cancelled
20:55	OS Responding
20:55	B4528 On Scene
20:57	B4523 On Scene
20:57	A4525 Diverted
21:02	OS On Scene
21:03	B4528 Transporting 3yof Hot HBH
21:05	A4525 On Scene
21:05	B4526 Dispatched
21:05	B4526 Responding
21:09	HBH Advised
21:10	B4526 On Scene
21:17	OS Sitrep- 2x adults, 7x children all accounted for.
21:21	B4526 Transporting (will do two trips)
21:36	B4523 Transporting (will do two trips)

Review:

This review found the sitreps to be timely and of a quality which allowed adequate resourcing of the scene while dynamic deployment from Maryborough allowed adequate BAU coverage. Of the nine patients, a three year-old-female was identified as the most critical, having received 30% burns, including facial burns and stridor. The remaining patients had less severe burns and were deemed as stable. This review did find that triage was undertaken on scene, however failed to use the SMART triage system or IMS21, which made it unclear how many patients were red, yellow or green. Despite this, the early identification, treatment and transport of the three year-old-female within seven minutes, and the complete clearing of nine patients from a chaotic scene within 41 minutes is noteworthy. Due to multiple factors, including resource availability, number of patients and proximity to Hervey Bay Hospital (Appendix 1), two of the units returned to scene to facilitate a second transport. This allowed the four remaining operational units on the Fraser Coast to maintain BAU response.

Outcomes:

Pending the outcome of the clinical review, this review found that the case was managed in an efficient manner. Two minor points to note which require improvement were:

a. Use of SMART triage system
b. Timely synchronisation of iPads to ensure availability of DARF.

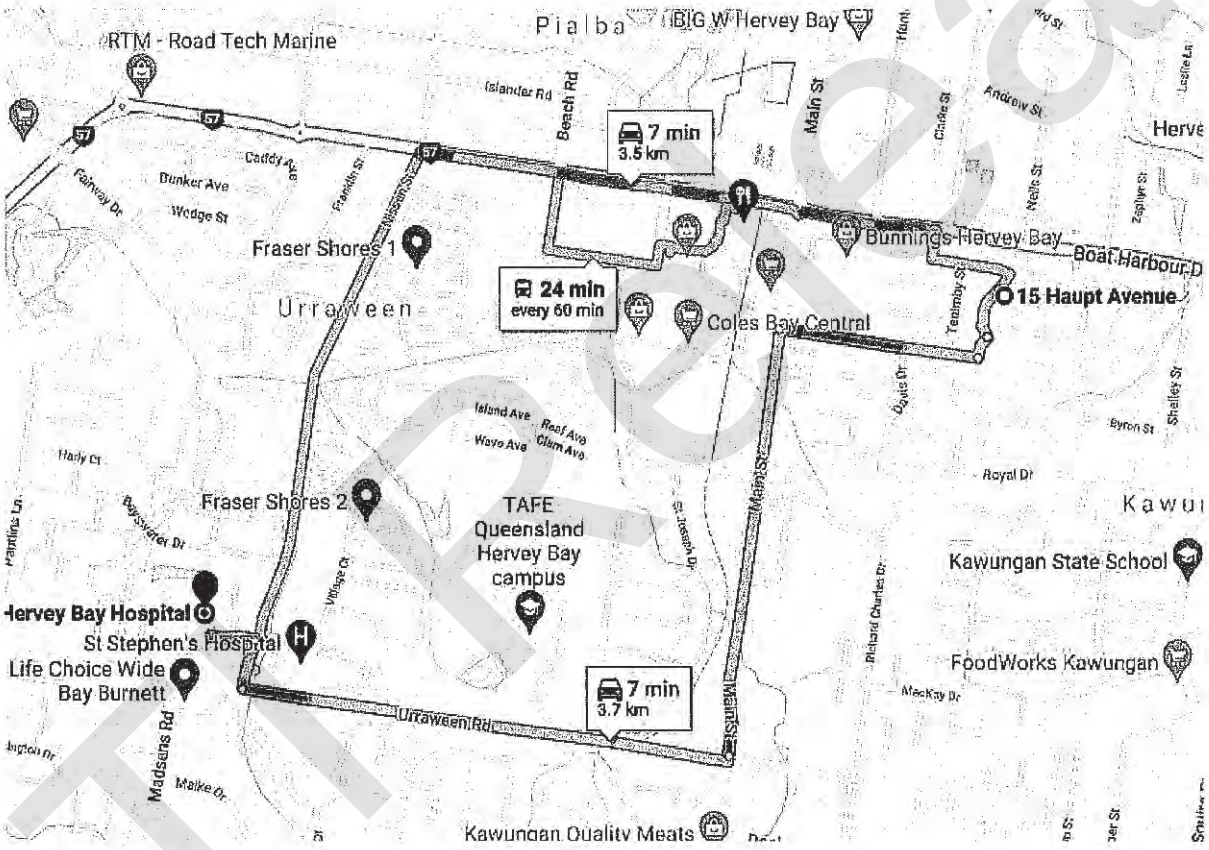
Review Recommendations:

This review finds one recommendation:

1. Feedback provided to the OS, to include areas performed well (efficiency of resources) and need for improvement (use of SMART Tags)

Appendix of relevant documents/files:

Appendix One – Distance from Scene to HBH



Appendix Two - Brief

Date: 17/07/2021

Incident No: 14562134

QAS received a request from Fire Comms for assistance to Fire Multiple Victims. The MPDS determinants were 07D01F, Code 1A response.

Background:

- House fire with multiple victims, Fire started in garage area of a single story 4 bedroom home, garage was- being used a bedroom as house occupied by 2x Adults, 7x Children.
- RED- 3 yof airway burns and 30% to face, neck and arms
- YELLOW- 34 yom smoke inhalation burns to hand face
  33 yof smoke inhalation full thickness burn to L hand

10 yom burns to finger tips and hands

- GREEN- 2 yom smoke inhalation Green
  5 yof smoke inhalation Green
  9 yom Smoke inhalation Green
  11 yof Smoke inhalation Green
  14 yom smoke inhalation Green
- All pt's transported to Hervey Bay Hospital

Staff involved:

- B4528 Officers M.Bubb and S.Hardy
- B4526 Officers M.Black and J.Pattemore
- B4523 Officers K.Dart(Beale) and M.Neeson
- A4525 Officers T.Meacham and R.Grover
- B4S10 OS L.McIntosh

Incident times:

- In Queue: 20:49
- 1st Unit Assigned: 20:50 B4526
- 1st Unit on scene: 20:55
- 2nd Unit Assigned: 20:52 B4S10
- 2nd Unit on scene: 21:02
- 3rd Unit Assigned: 20:53 B4523
- 3rd Unit on scene: 20:57
- 4th Unit Assigned: 20:57 A4525
- 4th Unit on scene: 21:05
- 5th Unit Assigned: 21:05 B4526
- 5th Unit on scene: 21:10
- Response times were within expected timeframes for distances travelled

Actions:

- Initial reports only 2 persons reported injured at scene.
- 3 YOF severe burns was quickly attended to by first arriving unit and departed scene for Hervey Bay Hospital with CCP onboard.
- Hervey Bay Hospital notified via Comms of incident
- Later identified 9 persons involved from the one family living in dwelling.
- First two arriving units were only made aware of three pt's in total
- Multiple children were at neighbouring houses
- Once identified that seven children were involved the remaining children were quickly located and gathered together.
- B4528 and B4526 returned to scene to assist in transporting of additional pt's.
- Priority One notified, Local PSO if possible.

Outcome:

- Total nine pt's transported to Hervey Bay Hospital
- RSQ being notified via CCP early
- Crews attending worked extremely well together
- No notification of Senior Wide Bay office
- Hot Debrief held with all crews at Hervey Bay Hospital
- Priority One made phone contact early and are aware of incident
- Priority One will follow up with crews tomorrow once crews rested

Recommendations:

- May attract media attention

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
District Director	Russell Cooke	General Manager	Irrelevant	3.8.21

Significant Incident Review Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:

By authority of Mr Matthew Green, Acting Assistant Commissioner, LASN Manager, Metro So th LASN.

Executive Summary:

On 18th July, 2021 at 20:08 hrs, QAS received a Triple Zero (000) call for assistan e (incid t numb 14566101) at Irrelevant Yarrabilba, to attend a Irrelevant paediatric pati t who had aken an overdose of Catapres Medication used for Irrelevant Attention Deficit Hyperactivity Diso der (DHD) n approx. 30mins – 2 hours prior to the call to QAS.

The case was initially prioritised in the Advanced Medical Priority Dis atch Sys m (AMP S) as MPDS Determinant 23O01 requiring a Code 2BL response, the c se was u raded o a C de 2A response at 20:29pm.

At 20:45hrs a second Triple Zero (000) call was received, patien was bec i harder to wake when Irrelevant goes to sleep. Further PROQA questions reconfigured the case wit additional information to a MPDS Determinant 23C01, upgraded the case to a 1C resp se wi QAS a ving on scene at 21:35pm.

The QAS response time was 1 hour and 27 minute from ceipt the Triple Zero (000) call. There was a 6 minute delay in the crew responding f the Prin e Alexan a Hospital (Metro South Region, Hospital and Health Service (HHS)).Delays ere bein experie ed at m st scope hospitals across Metro South Region and Metro South HHS E ergency D artments ( ) affecting paramedic availability and ambulance workload.

The VISICAD recommendation fu tio wasn't utilised until 20:48 hrs, 40 mins after initial time of call with none of the recommended units disp ched. The QAS responded Advanced Care Paramedic unit 501323 from Princess Alexandra Hospital at 20 1 hrs which arrived on scene at 21:35 hrs.

QAS paramedics pr ided care and transported the patient to Logan Community Hospital departing at 21:48 hrs, arrivin at facility 22:10 hrs.

Metro th Senior Operati Supervisor was on a case at the time of QAS treating and transporting the pat nt.

Terms of Ref rence:

Th review will review all aspects of ambulance response to incident 14566101. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements tlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

Clinical Review

Review of documentation in relation to a recognised delay in dispatch/response to case.

Summary of Case / DARF

- QAS called to a Irrelevant reported to have taken approx. 6 Clonidine 100mcg tablets.
- Case Received: 20:08, In Waiting Queue: 2011hrs, Dispatched: 2051hrs, On Case: 2057hrs, On Scene: 2135hrs, Depart Scene: 2148hrs, Hospital Notified: 2152hrs, At Destination: 2210hrs
- At 2053hrs crew advised a delay in responding from PAH
- OA Pt laying on bed, responsive, mild pallor, upset, laying in foetal position indicatin levant abdo n was hurting. GCS 14.
- Upon departing scene pt had sudden drop in GCS, eyes open w/ fixed gaze, nil tracking, nil planta or tendon reflexes, nil response to trap squeeze, nil withdrawing or respons VC insertion, maintaining own airway, nil respiratory depression observed, significant g neralis pallor.
- CCP attached at 2138hrs, stood down at 2150hrs due to distance.
- Tx Code 1 to LCH, pre-notified.
- Pt persistently bradycardic, mildly hypertensive, hypothermic, normoglycaem ECG inus Brady.
- QAS consult line contacted during transport – pre-emptive con ult for ids, a rov d to administer 10mL/Kg 0.9% sodium chloride if SBP drops below 90mmH

OpCen Review:

Review undertaken by Southport Operation Centre Quality Assura e Officer found the following;

- The original triple zero call has been reviewed e call w s deemed to be compliant
- The call-back conducted by the Clinical Hub could ha e explor d further clinical questioning given the dose taken, medical history and any o er coll eral i formation
- The call back Clinical Hub Cli could h ve rther qu stioned regarding and priority symptoms including exploring the comment re rding th patients owing breathing slowing down when she is asleep
- Presenting symptom would have b en appropriate to upgrade the case given the delays, an upgrade to 1C would ve been riate
- Concerns regarding CCP an llation and choice of hospital

Incident Review/Investigation:

Scope:

Metro S th reviewed th esponse, clinical performance and operational decision making to ensure the appro e ambulance resp se and management of this case was achieved. It is intended that any op ationa r clinical perform e issues identified with this case are addressed to ensure lessons are le rnt to imp e future responses.

Background:

Q S was called to attend a Irrelevant paediatric patient who had ?taken an overdose of Catapres M dication used for Irrelevant Attention Deficit Hyperactivity Disorder (ADHD).

Timeline:

20:08 - Triple Zero (000) call received.
20:11 - Call taking complete, waiting in queue.
2 :13 – Poisons Information called by QAS
20:25 – Clinical Hub reviewed the incident

20:29 – Priority Change upgrade from 2BL to 2A for acute to dispatch, 4 x 100mg CATAPRES
20:45 – 2nd call back from on scene pt becoming harder to wake when Irrelevant goes to sleep.
20:45 – Reconfigured from 2A to 1C (23C01) due to patient not being alert
20:51 – Crew 501323 dispatched from PAH
20:53 – Crew delayed in responding
21:35 – 501323 arrived on scene
21:41 – Sitrep 1 - Crew request for Critical Care (CCP) backup code 1 – pt bradycardic
21:41 – Crew were advised the CCP had a 40-minute ETA
21:53 – SitRep 2 – Pt bradycardic at 50bpm, BP 120/78, sedated at times, unsure of dose taken ?400-600mg of Catapres. Due to ETA of CCP, crew will load and go to LCH
21:55 – LCH pre notified pt is also hyperthermic shock transporting code 1
22:10 - Arrived at Logan Community Hospital

Clinical Review:

Metro South Clinical Support officer has clinically reviewed the case and made the ollowin notes;

- Nil clinical issues noted
- Thorough consideration for patient's presenting condition, appropriately mana ed.

Operational Review:

Operational dispatch to incident:

The QAS response time was 1 hour and 27 minutes from receipt o he Triple Zero (000) call. There was a 6-minute delay in the responding crew from out of Princ s A andra spital.
The VISICAD recommendation function wasn't utilis d until 2 48 hrs, 4 mins after initial time of call with none of the recommended units dispatched. TheQAS resp nded dvanced Care Paramedic unit 501323 from Princess Alexandra Hospital at 20 rs whic arr ed on s ne at 21:35 hrs.

At the time of the Triple Zero 00) call, the AS had 38 pending cases 2 x Code 1 and 36 x Code 2 pending cases in the Community as we s havin i g paramedic unit impacts due to HHS hospital ED delays:

- Logan Community Hospital – 8 mbulance units at hospital, 4 ambulance units ramped (i.e. >30 minutes) ith the longest delayed r 3 hours and 32 minutes, nil ambulance units enroute, with a level 3 esca tion;
- Qu n Elizab ll Hospital – 2 ambulance units at hospital, 1 ambulance unit ramped (i.e. >30 nutes), with th ongest delayed for 1 hour 10 minutes, 1 ambulance unit enroute with a level 3 calation;
  Pr ess Alexandra H pital – 4 ambulance units at hospital, 2 ambulance unit ramped (i.e. >30 minu s), with the longest delayed for 1 hour 33 minutes, 4 ambulance units enroute with level 2 escalat ;
- Redlands spital - 2 ambulance unit at hospital, 2 ambulance units ramped, with longest delayed for 1 hour 13 inutes, nil ambulance units enroute; and
- Mater Adults Hospital – 3 ambulance units at hospital, nil ambulance unit ramped (i.e. >30 minutes), with the longest delayed for 20 minutes, nil ambulance units enroute with a level 3 escalation.

Metro South Region Staffing:

- The Metro South Region including Brisbane South, Logan and West Moreton Districts was appropriately resourced.

Outcomes:

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- Call taking component compliant
- Second call upgraded to code 1C
- EMD counselled on use of recommend function

Review Recommendations:

- Clinical Hub Clinician reflection regarding thorough history taking and further note taking
- Clinical Hub Clinician reflection regarding time of call and appropriateness of coding and potential for outcome.
- Recommend function to be utilised

Appendix of relevant documents/files:

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

LASN Endorsement

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner		
Peta Thompson	Acting Director Operations		

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Significant Incident Review Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:

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

Executive Summary:

On 20 July 2021 at 23:25hrs, QAS received a Triple Zero (000) call for assistance (incident number 14575583) at Irrelevant ictoria Point Qld 4165, to attend a Irrelevant patient who was complaining of difficulty in breathing. The incident went into the Waiting Queue, ready for dispatch, at 23:27

The case was initially prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as MPDS Determinant 36D02S - ?COVID19 Diff Speak Betw LVL0, requiring a Code 1B response, however the case was upgraded to a Code 1A response at 00:48hrs after the patient went into cardiac arrest.

The QAS response time was 38 minutes from receipt of the Triple Zero (000) call. There was a delay to identify an available paramedic unit to respond to the case given existing ambulance workload across Metro South LASN and Metro South Health and Hospital Service (HHS) hospital Emergency Department (ED) delays were experienced at most scope hospitals, affecting paramedic availability.

At 23:29hrs there was a common call made for four (4) pending Code 1's in the Bayside of Brisbane, there was no response from the common call. At 23:39hrs the Clinical Deployment Supervisor (CDS) performed a call back and spoke to patient's mother, patient collapsed on the ground and is still on the ground with difficulty in breathing. Mother stated 1 year ago patient was in Princess Alexandra Hospital for heart failure due to infection, patient also eventually had a pulmonary embolism. At 23:44hrs the CDS approved for Critical Care Paramedic (CCP) to attend primary to the incident. There are no notes of the Medical Officer in Clinical Hub reviewing the incident.

The CCP was assigned at 23:45hrs from Capalaba Ambulance Station and arrived on scene 00:04hrs.

QAS responded four (4) ambulances who arrived at the scene:

- A Critical Care Paramedic (CCP);
- Two Advanced Care Paramedic (ACP) crews; and
- A Patient Transport Unit (PTS).

The High Acuity Response Unit (HARU) was assigned to the incident however was stood down prior to arrival on scene.

The Queensland Fire and Emergency Service (QFES) was attached to the incident and arrived on scene at 01:07hrs to assist with extrication of the patient.

On arrival of the CCP the patient was GCS 15, however, unstable and progressed into cardiac arrest at 00:42. QAS paramedics provided care including advanced resuscitation, with ROSC achieved at 00:56. The patient was transported to the Princess Alexandra Hospital (PAH), departing at 01:11hrs, arriving at 01:42hrs.

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Terms of Reference:

This review will review all aspects of ambulance response to incident 14575583. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

Clinical Review undertaken and attached.

State ProQA Review:

The Triple Zero (000) call was found to be of Non-Compliant.

The deviation for Chief Complaint Selection, while an incorrect action, has not af cted t e QA oding as the QAS codes were both Code 1B responses.

The reviewers note that the EMDs "Complaint Description" (which is the "word cture" e incident as given by the caller), entered in the initial stages of the ProQA interro tion, w s not reflective of the information provided by the caller. Had the EMD entered a easonab sta ement the context of the nature of the call, it may have influenced the manner in which the Di atcher D or the DS viewed the call.

It is noted in the timeline of the event the considerable attempts to Common Call" for resources were made.

Incident Review/Investigation:

Scope:

Metro South reviewed the res onse, clinica performance and operational decision making to ensure the appropriate ambulance respon and ma ge his case was achieved. It is intended that any operational or clinical performanc ss s identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:

QAS was c ed to att d a Irrelevant patient who was complaining of difficulty in breathing.

Tim line:

23:25 - Triple Z o (000) call received.
23:27 - Call taking omplete, waiting in queue.
2 29 - Common cal ade for pending Code 1's in Bayside of Brisbane.
23 9 - CDS performed a call back to scene and spoke with patient's mother.
2 44 - CDS approved for CCP to attend as primary.
CP dispatched from Capalaba Ambulance Station.
23:46 - Notes in the IDR that the CCP was delayed slightly using the facilities.
00:04 - CCP arrives on scene.
00:05 - ACP crew dispatched from the Princess Alexandra Hospital.
00:17 - SITREP – GCS15 Irrelevant , HR 90 Hypotensive – continue Code 1
0 :28 - ACP crew arrives on scene.
00:42 - SITREP – CPR in progress, second ACP crew requested Code 1.

00:43 - PTS Single Officer dispatched to incident.
00:45 - Common call for back up.
00:48 - Metro South Region Operation Supervisor attached to incident but stood down at 00:56hrs.
00:48 - Case upgraded to Code 1A.
00:49 - HARU assigned to incident.
00:50 - Second ACP crew assigned to incident.
00:55 - QFES requested to assist.
00:58 - SITREP – ROSC achieved and requesting ETA of back up.
01:00 - PTS unit arrives on scene.
01:07 - Second ACP crew arrives on scene.
01:07 - QFES arrives on scene.
01:11 - Patient transported to the PAH with a CCP escort, travelling under emergency conditi ns (lights and sirens).
01:13 - HARU advised spoke with CCP on scene and patient is now GCS 15, will stand down ead towards PAH in case.
01:42 - Arrived at PAH.

Clinical Review:

The Metro South Region Senior Clinical Educator reviewed the case a d made e foll g notes;

- No clinical issues found.
- On arrival patient GCS 15, RR 24, SpO2 98% RA, R 90, B 92/5 .
- Initial Mx oxygen, unable to gain IV access.
- Delay on scene awaiting transport crew.
- On loading patient deterioration in condition worsening resp atory status and hemodynamics.
- Patient experienced a narrow complex PEA a est a 0bpm.
- Resus with CPR, IO and Adrenaline bolus.
- ROSC with return of GCS.
- Transport with Adrenaline in ion mmen
- Pt rearrested just prior to rival at P H, move o ED th CPR in progress.

Operational Review:

Operational dispatch to incident:

There was a delay of 18 minutes to iden fy an available paramedic unit to respond to the case due to existing ambulanc workload across Metr outh LASN and Metro South Health and Hospital Service (HHS). Hospital Em gency Department (ED) delays were experienced at most in scope hospitals, affecting paramedic vailability.

At 23 0 the QAS had 2 ending cases in the community: 3 x Code 1 and 20 x Code 2 incidents, as we as hav g the following pa medic unit impacts due to Metro South HHS hospital ED delays:

- Logan C mmunity Hospital (Level 3 QAS escalation) – 4 ambulance units at hospital, 3 ambulance units ramp (i.e. >30 minutes) with the longest delayed for 2 hours and 32 minutes, nil ambulance units enroute;
- Princess Alexandra Hospital – 4 ambulance units at hospital, 3 ambulance unit ramped (i.e. >30 minutes), with the longest delayed for 1 hours and 48 minutes, 1 ambulance units enroute;
- Adults Hospital – 3 ambulance units at hospital, 2ambulance unit ramped (i.e. >30 minutes), with the longest delayed for 1 hours and 15 minutes, nil ambulance units enroute;
- Queen Elizabeth II Hospital – 2 ambulance units at hospital, 1 ambulance unit ramped (i.e. >30 minutes), with the longest delayed for 1 hour 7 minutes, 2 ambulance units enroute; and
- Redlands Hospital - nil ambulance unit at hospital, nil ambulance units enroute.

Frontline Services Group Review of Recommend of CCP

Frontline Services Group was asked to review why the CCP was not recommended for dispatch and below are the points provided;

- The EMD used recommend which recommended the closest Acute vehicle (507085) and closest Acute Str vehicle (501165) according to the QAS Response Algorithm for a priority code 1B incident.
- 507085 was the Senior Operation Supervisor on shift and appeared to have an ETA of 00:04:09.
- 506084 was the CCP and appears to have an ETA of 00:18:53.
- The vehicle body type for 506084 dictates that it would have been logged on with the capabilities f Acute and Medical, and not Acute -Str and with an ETA of 00:18:53, even if it had a capability of Acute-Str, Unit 501165 would still have been considered closer with an ETA of 00:17:15.
- From the vehicles that appear in the additional recommend which was performed at 23 8:41, one could safely make the assumption that the additional search parameter used was Bra o or Acut Str, which is why 506084 did not appear.
- From the findings above, FSG cannot see any technical issues with the recommendatio for this case.

Closest ACP Unit Not Responded

ACP unit 501165 was recommended at 23:28hrs as the closest ACP unit howeve they were n t spatched on the incident, as they were in an Out of Service EOS Status.

- 501165 had a split crew with one officer on a 12hr shift and the her a 10 shift
- The SOP 2.23 Dispatch – Out of Service Shift End of Operati nal Res urces states Staff who have already worked more than 12 hours will be placed n an 'Out f Serv e En of Shift' status and should not be dispatched past the rostered end of s ft.
- In exceptional circumstances approval to remove a ve le from he out o service end of shift status must be authorised by the OCS and or CDS, Given the v ume of p ng incidents on the Bayside dispatch board at this time it is unreasonable to ect the MD to upwardly manage the OCS/CDS given their primary focus on dispatch.

Senior Operation Supervisor Not Dispatched

- Senior Operation Superviso SOS was dri at the tim of the call being received. It was noted the portable radio was tur ed off at 2 22hrs a d had b en on talk group 107. The vehicle radio was on TG 108; however, th case was TG 107. The vehicle was on Cleveland Redland Bay Road and reported to be tr lling 82km when the portable radio was turned off.
- The SOS did not hear th comm n call ove radio.
- The SOS was not dispatch d y the OpCen or contacted by the OpCen regarding the case.

Metro South Region Staffing:

- The Metro outh Region including isbane South and Logan Districts had the following resources agai st appr ed rosters;
- Th re were an ditional 20 Officers on afternoon shift and were down 15 Officers on night shift gainst approved ters.

O comes

- State Cen Review identified there were compliant issues with the Triple Zero (000) call, however, it is note hat this did not impact the initial coding of the incident.
- The SOS a he closest response was not dispatched by the OpCen or notified of the incident, nor did they hear the common call.
- The closest ACP crew was not dispatched to the incident though would have been appropriate inline with SOP 2.23 Dispatch – Out of Service Shift End of Operational Resources
- Th CCP was not dispatched on the case initially as FSG explained it was not recommended initially as it was the same body type as the SOS.
- Nil clinical concerns noted with the management of the patient.

Review Recommendations:

- Follow up with the EMD regarding the compliant issues noted in the review.
- Follow up with the Dispatcher / OCS regarding the resourcing of the incident.
- Continually review staffing in Metro South Region to meet demand.
- Continually work with Metro South Hospital and Health Service regarding hospitals delays and facilitated offloads.

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- State OpCen Review
- Clinical Review
- SOCC Incident Assurance Review (IAR)
- FSG Review

LASN Endorsement

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner Metro South Region	Irrelevant	
Paul Shaw	Acting Assistant Commissioner Operation Centre		
Anthony Hose	Acting Director Operations Brisbane South District		

Significant Incident Review

Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:

By authority of Assistant Commissioner, Metro South Local Ambulance Service Network.

Executive Summary:

On 21st July, 2021 at 22:22 hrs, QAS received a Triple Zero (000) call for assistance (incident number 14579811) at Irrelevant Shailer Park, to attend a Irrelevant patient who w co laining of pins and needles in in[Irrelevan] legs for 3 days and unable to stand now.

The case was initially prioritised in the Advanced Medical Priority Dispatch System MPD) as M Determinant 36C05 requiring a Code 2A response, the Clinical Hub reviewed the inciden at 22:34 hrs, conducted a call back and ascertained the patient had seen [Irrelevan]GP and w rred for ans w ch were cleared for a ? pinched nerve. The case was then returned to the acute ending q ue for tch.

The Clinical Deployment Supervisor (CDS) performed a ca back at 0 37 (2 July) here was no change in the patient's condition, the patient had been on the floor si 22:00 nable to w ight bare on left leg due to numbness, nil history of the same with nil other acute str e symp ms note

At 01:19 hrs QAS Emergency Medical Dispatch made a r turn phon all to provide follow up to the patient, QAS were advised the patient was now in bed, that [Irr ant] fin ut still n strength in [Irreleva] legs. Caller advised to cancel QAS and will call back when[Irreleva] wakes up n the mo ning.

The patient waited for a period of 2 h nd 57 m s w h no am lance response to scene.

On the 22nd July 2021 at 07:14 s, QAS re ved a Trip (000) call for assistance (incident number 14580693) at 14 Charnley C Shailer Park o attend a 55 year old male patient unconscious.

The case was prioritised in the dvan d Medical P y Dispatch System (AMPDS) as MPDS Determinant 31E01, requiring a code 1A resp

The QAS response time was 17-minu from receipt of the Triple Zero (000) call on the 22nd July, 2021.

The closest mos ppropriate ambulance was dispatched at 07:16 hrs as identified in the Computer Aided Dispatc (CAD) re mend for assignment function with a 9 minute 17 second response time.

Q responded 4 amb nces who arrived at the scene:

- A Critical Care Par edic (CCP);
- vanced Care Paramedic (ACP) crew;
- An perations Supervisor (OS) and;
- A Cri l Care Paramedic (CCP Crew) – Senior Clinical Educator

QAS paramedics p ovided care and transported the patient to Logan Community Hospital departing at 07:57 hrs, arriving at 08:10 hrs.

Terms of Reference:

This review will investigate all aspects of ambulance response to incidents 14579811 & 14580693. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

- Patient called for service the previous night at 22:22 (21/7/2021) with the complaint of pins and needles in Irrelevant legs and unable to stand. The case was coded a 2A – incident no. 1457981
- A paramedic in the clinical hub conducted a call back at 22:28…….
- A call back was made by the CDS at 00:37 with details of patient unable to weight bear e to numbness in left leg and no other acute stroke symptoms. The patient had been lying on th oor unable to move initially but eventually able to get to the bed.
- QAS Emergency Medical Dispatcher called back and the requester cancelle he cas t 01:19 no units attached at any stage and advice given to call 000 if there is any ch nge.
- Second call for service at 07:15 (22/7/2021) to a Irrelevant unconsc us wit agona ineffective breathing. The case was coded 1A – incident no. 14580693.
- The first two QAS units (CCP and ACP crew) arrived at 07:31 with t Rep at 0 40 of u conscious Irrelevant patient responding to pain - ?CVA through the night. Patie has lef ded d it upils equal and reactive and VSS within normal limits.
- It was noted there was a difficult extrication and it s an emo ve sc e with e caller saying “They should have come last night”
- Patient had similar symptoms investigated by Irrelevant GP in e last 3
- Patient was managed with an OP/NP and 8mg IV Ondans on.
- Consultation with Clinical consult line regarding th appropria ness of an RSI and appropriate facility was made. RSI was not undertaken, d it wa ecided t Logan Hospital was the most appropriate facility.

Issues:

- Initial call for service w s not attend d.
- Patient had signs o ymptoms pro essing to now being unable to weight bear.

OpCen Review:

Review undertaken by State Commu ations Development – Quality Assurance Unit with following incident call findings;
Incident 145798 Initial Triple Zero Call 2 :22 hrs (21/07/2021)

- itical De tions – Nil
  2 x Major De ions – Dispatch Life Support Instructions (DLS)
  1 x Moderate D ations – Answer to key questions (KQ) not correctly answered
- Minor Deviations l
- erall Compliance – Low Compliance

Incident 145 93 Initial Triple Zero Call 07:15 hrs (22/07/2021)

- Critical viations – Nil
- 2 x Major eviations – Dispatch Life Support Instructions (DLS) & Protocol Link not followed
- 1 x Moderate Deviations – Answer to key questions (KQ) not correctly answered
- Minor Deviations - Nil
  erall Compliance – Non-Compliant

Incident Review/Investigation:

Scope

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

Background

QAS was called to attend a Irrelevant patient who was complaining of pins and needles in l g or 3 days – can't stand up now. The patient had presented to this General Practitioner (GP) ad completed scans with ?pinched nerve.

Timeline

Incident Number: 14579811
22:22 - Triple Zero (000) call received.
22:24 - Waiting in queue.
22:28 – Clinical Hub Reviewed the incident
22:34 – Clinical hub Review complete – Pins and needles the la few day Now u ble to mobilise due to weakness. HX heart valve replacement – takes blood thinners. Sa GP and referred to scan – all clear ?pinched nerve. Can move all limbs just can't stand.
22:34 – Sent back to acute for dispatch – stretcher
23:30 – Delay in dispatch due to workload
23:48 – Still a delay in dispatch due to workload – de 1 eaude rt pending 32 mins to be resourced first.
00:37 – CDS performed call back. N e in con ti n, pt has en on the floor since 2200 hrs. unable to weight bare on left leg due to nu ness. N istory o e same o other acute stroke symptoms noted. Pt at home with Irrelevant Caller is aw e of delays nd to call ba 0 if changes are noted.
01:19 – EMD called reques back with N fication – Pt now on bed – pt feels find but no strength in legs – Pt will cancel QAS and see w Irreleva feels k when Irrelevan wakes up – QAS SNR.
01:19 QAS cancelled by caller

Incident Number: 14580693
07:14 - Triple Z o (000) call received.
07:15 - Waiting in ueue.
07:16 ispatched 606535 & 601412
07:1 – 606535 Resp ding to case
0 – 601412 Respon g to case
7:19 Advised previous C e from last night (incident no. 14579811) cancelled at 0119
07:19 – ller stating should have come yesterday
07:21 – EM advised the CDS and OCS of previous case
07:26 – Patie history of Metal heart valve replacement a long time ago
07:26 – Caller c feel a faint pulse in patient's arm
07:26 – 602461 pr ceeding code 1, car went into limp mode on way to case – stood down as primary unit
07:31 – 606535 – on scene
07:31 – 601412 – on scene
Pt had recent aortic scan and ? pinched nerve
07:40 – Sitrep – Uncon male resp to pain - ? CVA through night L) side deficit pupils equal and reactive VSS WNL and diff with extrication
07:57 – 601412 Departing with patient on board to Logan Community Hospital
08:04 – 507332 Operations Supervisor will take family member of patient to hospital.

08:10 - Arrived at Logan Community Hospital.

Clinical Review

- No clinical concerns with all clinical management appropriate and consult with the clinical consult line undertaken.

Operational Review:

Operational dispatch to Incident 14579811.

There was a delay of 2 hours and 57 minutes before the caller cancelled the case. There was delay to identify an available paramedic unit to respond to the case due to existing ambulance w d across Metro South Region and Metro South Health and Hospital Service (HHS). Hospital Emerg ncy Dep ment (ED) delays were experienced at most in scope hospitals, affecting paramedic availabilit

At the time of the Triple Zero (000) call, the QAS had 19 pending cases in the community 2 x Cod 1 and 17 x Code 2 incidents, as well as having the following paramedic unit impacts Metro uth HHS hospital ED delays:

- Logan Community Hospital – 6 ambulance units a ospital, 4 mbul nce uni ramped (i.e. >30 minutes) with the longest delayed for 2 hours and 47 inutes, bulance u ts enroute;
- Queen Elizabeth II Hospital – 2 ambulance units at hosp l, nil a ulance nits ramped (i.e. >30 minutes), , nil ambulance units enroute;
- Princess Alexandra Hospital – 1 ambulance unit hospital, l ambulance units ramped (i.e. >30 minutes), 2 ambulance units enroute;
- Redlands Hospital - 1 ambulance unit at ho pital, nil mbulance units ramped and nil enroute; and
- Mater Adults Hospital – 1 ambulance units hos al, nil bulance units ramped and nil enroute.

Metro South Region Staffing:

- The Metro South Region cluding Bris ne South, L g and West Moreton Districts for Wednesday 21st July was appropri ly resourced
- The Metro South Regio cluding B h Logan and West Moreton Districts for Thursday 22nd July was at a reduced cap ty

Outcomes:

- Call f r service was appropria prioritised by the call taker with information provided by the caller
- 2 hour nd 57 min delay to the p ient before the caller cancelled QAS Request for service as the atient h made it into bed
  Closest mo ppropriate ambulance was dispatched for Incident 14580693. A delay of 5 minutes was noted in r onding with Bravo Unit 601412. Delay was discussed with both officers on the 14th October 2021, n er officer recalls any specific delay responding to the incident. OIC advises CCTV from station uld no longer be available.
- A ropriate high standard of clinical care was provided by responding paramedics

Review Recommendations:

th EMDs involved have received feedback and further training on the 18th August 2021.

- Continually review staffing in Metro South Region to meet demand
- Continually meet with Metro South Hospital and Health services regarding hospital delays and facilitating offloads

Appendix of relevant documents/files:

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

LASN Endorsement

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

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner		
Peta Thompson	Acting Director Operations		

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Department of Health
Queensland Ambulance Service

Significant Incident Review Template

Version 1.0 August 2020

West Moreton District - Metro South Region

Authority:

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

Executive Summary:

QAS responded to incidents 14604696 and 14604704 at Irrelevant North Booval QLD 4304 at 1657hrs on 27th of July 2021, where it was reported that a Irrelevant armed with a handgun was shooting in the street and that multiple persons had been injured after being hit by a car. QAS responded with multiple resources including Advanced Care Paramedics, Critical Care Paramedic dical Officer and two Senior Operations Supervisors. On QAS arrival there were found to be a total 4 patien at the scene with one of those patients having multiple gunshot wounds. Two of the patients w e trans rted through to Ipswich Hospital and the remaining two transported through to the incess Al andr Hospit The patient with multiple gunshot wounds went into traumatic cardiac arrest p r to lea cene and as declared deceased on arrival at Ipswich Hospital.
At 1811hrs the QAS responded to incident 14604950 at Irrelevant Tivoli QLD 4305 for two patients related to the earlier incident. QAS responded with Advance Care Paramedics, a Medical Officer and a Senior Operations Supervisor. Both patients w e asse d and nsported from the scene with one patient going to Ipswich Hospital and the other pati t to Prin ss Alexan ra Hospital.

Terms of Reference:

This review will investigate all pects of am ulance resp o incidents 13690416, 14604704 and 14604950. The review will amine ambul ce operations prior to, during and following the response. This review will include all require nts outli *rational Incident Review Process*.

Clinical Incident Summary eport:

- Pend g

Sta OpCen Pro :

- Pending

Incident R view/Investigation:

Scope:

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

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Background:

- QAS responded to incidents 14604696 and 14604704 at Irrelevant , North Booval QLD 4304
- Initial reports were that a Irrelevant armed with a handgun was shooting in the street and that multiple persons had been injured after been struck by a car.
- QAS responded 4 x ACP crews, 2 x CCPs, 2 x SOS's, a Medical Officer and the Medical Director.
- Patient overview:
  - Irrelevant with GSW to the chest and leg. QPS applied chest seal and tourniquet prior to QAS arrival. On QAS arrival patient appeared agitated and shocked, crew rapidly loaded patient into ambulance and departed Code 1 for Princess Alexandra Hospital. Shortly after leaving scene the patient deteriorated into traumatic cardiac arrest. Crew diverted to Ipswich Hospital and patient was declared deceased shortly after arrival.
  - Irrelevant who was struck by a car which was intentionally driven at him. Patient sustained chest/pelvic and leg injuries with multiple abrasions all over his body. Patient transported through to Princess Alexandra Hospital in a serious condition with ?femur # fracture, VSS stable on route.
  - Irrelevant who alleges Irrelevan was struck on the head with the gun causing altered neurology and a 5cm laceration to his head. Patient was transported to Princess Alexandra Hospital Code 1, VSS stable on route.
  - Irrelevant with a head injury from being struck with known object. Transported Code 2 to Ipswich Hospital.
- At 1811hrs the QAS responded to incident 14604950 at Irrelev nt , Tivoli QLD 4305 for two patients related to the earlier incident.
- QAS responded with Advanced Care Paramedics, a dical O and a Se ior Operations Supervisor.
- Patient overview:
  - Irrelevant with right sided facial i s follow blunt force trauma to head. Patient had an expanding subgaleal haema ma and s trans rt Code 1 to Princess Alexandra Hospital with Medical Officer on bo d.
  - Irrelevant with penetrating ury t ight fo arm. Patient was transported to Ipswich Hospital with QPS

Timeline:

Incident: 14604696

Received: 16:58hrs
Dispatched: 16:58hrs
On Case: 16:58hrs
On Scene: 17:05hrs
Depart Scene 17:21hrs / 17:56hrs
At Destination: 32hrs / 18:32hrs
Clear: 20 hrs

I i nt: 14604704

Receive 17:00hrs
Dispatched 17:01hrs
On Case: 17:01hrs
On Scene: 15hrs
Depart Scene: 17 51hrs / 17:58hrs
At Destination: 18:02hrs / 18:31hrs
Clear: 20:25hrs

Incident: 14604950

Received:	18:13hrs
Dispatched:	18:14hrs
On Case:	18:14hrs
On Scene:	18:17hrs
Depart Scene:	19:02hrs
At Destination:	19:29hrs
Clear:	20:29hrs

Review:

Incidents: 14604696/14604704

- 4 x Bravo Units, 2 x CCPs, 2 x SOS, 1 x Medical Officer (HARU) and 1 x Medical Director.
- Response time was 7 minutes with the closest most appropriate resources being dispatched.
- 2 x SOS attended scene once notified of incident and provided management of the complex scene spread over 200m.
- No operational issues identified by the SOS.
- SEQ was on an extreme escalation with Ipswich Hospital being o 3 Escalation with longest at 2 hrs 53 mins.

Incident: 14604950

- 2 x Bravo Units, 1 x SOS, 1 x Medical Officer (HARU)
- Response time was 3 minutes with the closest most appr riate re being dispatched.
- No operational issues identified by the SOS.

Outcomes:

- 6 patients in total were transported from th wo s nes. 3 Princess Alexandra Hospital and 3 x Ipswich Hospital (1 x with Q)
- 31 year-old-male with G W to the est and was dec red deceased shortly after arrival at Ipswich Hospital.
- Confronting inciden or respondin Officers and EMD's with support mechanisms in place.
- Resourcing of the in ent was p

Post OIRR actions:

- Peer Support activated.

Review Rec mmendations:

- ending Cli al Review

Appendix of relevant documents/files:

Incident Detail Report	Incident Report 14604950.pdf; Incident Report 14604704.pdf; Incident Report 14604696.pdf
EARF	Irrelevant
PSDU Notification Email	RE_ Incident Notification -Metro; RE_ Incident Notification -Metro; Incident Notification -Metro
LASN Notification Email West Moreton	WM Incident Notification - North
Clinical Review	
OpCen Brief	270721 DAY SOUTHPORT OPCEN
OpCen QA of Triple 0 Call	
iROAM Time Snapshot	

LASN Endorsement

Name	Position	Signature	Date
Matthew Green	A/Assistant Commissioner – Metro South		
Drew Hebbron	District Director – West Moreton District		
Ross Hodges	A/Executive Manager Operations West Moreton District		

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 30 July 2021 at 17:38hrs, QAS received a Triple Zero (000) call for assistance (incident number 14618831) at Irrelevant Wacol, Qld 4076, to attend a Irrelevant patient who had a fall and complaining of a head knock.

The case was initially prioritised in the Advanced Medical Priority Dispat Sy em (AMPDS) as 31D04 (uncon/faint not alert) requiring a Code 2A response. There was a se nd Trip Zero (000) call received at 18:10hrs requesting ETA and was advised accordingly. A hird Triple ero (0 0) ca was received at 18:23hrs and the case was upgraded to a Code 1C through e ProQ qu stioning At 18:40hrs the Emergency Medical Dispatcher (EMD) requested the Clinical ploym Supervi or (CDS) to review the case for possible upgrade to a Code 1B due to the patient having n ALO DIB post head trauma. The CDS attempted to call back the patient, however, went to voicemai ase was upgraded to a Code 1B at 18:46hrs.

The EMD who took the third Triple Zero (000) call w s still n the hone to the caller at the time of the CDS call back. The EMD disconnected an DS spo t the calle at 18:56hrs. The CDS ascertained the patient was still on the ground, ble ding con lled, th atient w s climbing ladder to pick fruit and felt dizzy, got off ladder and tried to sit dow but fell on concrete a it back of head on concrete, also has small foot injury.

The Operations Centre made 2 co m calls, first at 18:30hrs and the second at 18:46hrs.

The QAS response time was 1 hour an 51 minutes from receipt of the Triple Zero (000) call to first unit on scene (NB. the in dent entered the waitin queue at 17:40 – this means enough information had been obtained to dispatch n ambulance). There was a delay to identify an available paramedic unit to respond to the case gi n existing mbulance workload across Metro South Region and Metro South Health and Hospital ervice (HHS) h pital Emergency Department (ED) delays were experienced at some in scope hospit affecting parame availability.

The QAS res nded one Advanced Care Paramedic (ACP) crew at 19:21hrs which arrived on scene at 19:29hrs. The A P crew that were responded to the incident was a nightshift crew that was rostered to ommence shift a 9:00hrs. The Operations Centre had difficulty contacting the crew and confirmed via s ion phone at 19: they would be logging on shortly.

T e crew found the patient to be GCS 14 (family reports responding normal), laceration to head, C-Spine laceration to toe, unequal pupils, weakness left side. The QAS paramedics provided treatment to the patient and transported him to the Princess Alexandra Hospital at 20:25hrs, arriving at 20:43hrs. The patient was handed over in resus with nil significant change to condition noted.

Terms of Reference:

This review will review all aspects of ambulance response to incident 14618831. 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:

A clinical review was completed by a Clinical Support Officer and below are the salient points;

- Documentation indicates a thorough assessment and appropriate management of this gentleman.
- Documentation is of a high standard.
- IDR does not indicate any sitrep.
- Critical Care Paramedic (CCP) backup could be considered; however, on consultation with a CCP, this patient does not appear to be indicated for any further prehospital interventions.

OpCen Review:

A comprehensive investigation of the incident management has been undertaken that includes, the Call Taker and the CDS performance and resource review as to why the incid d occurred, outcomes/findings and actions recommended to mitigate that a simila ncident oes not reoccur.

Call Taking Performance
Brisbane OpCen local Quality Assurance Unit were requeste o cond a review nd provide an evaluation of the call performance with the below summary results extracte There e 3 riple Zero (000) Calls received and 2 CDS call backs for this incident. ProQA was utilise n 2 of the 3 Triple Zero Calls.

17:38:16 – 1st Triple Zero Call - Received by Brisba e. ProQ utilised. D emed Low Compliance due to minor variations with the correct MPDS Protocol us ge an Corr t final coding.

18:10:24 – 2nd Triple Zero Call – R eived b Brisban No evid nce that ProQA was utilised. Call Taker requested update of the conditio and apolo sed for the .

18:22:24 – 3rd Triple Zero Call Receive T wnsville OpCen. ProQA utilised. During this call the EMD has re triaged the call and u ra d 31D04 (Alert with abnormal breathing) appropriately. Call taker stayed on the line with the caller wit ome language difficulties.

18:46:52 – CDS empted a call back ho ver the call went to straight to voice mail. At this time the CDS upgraded the priori o a 1B response.

18:54.15 Townsville ca aker transfers Triple Zero (000) call to Brisbane CDS. At this point the call drops out.

1 55:59 – C S call back – Performed by Brisbane CDS with a clinical assessment of the patient undertaken.

Fi dings: In summary the 1st Triple Zero (000) call (17:38hrs) received low compliance with the correct re ponse code 2A applied. The 2nd call (18:10hrs) did not use ProQA which is outside of the required d with missed potential opportunities to gain an update on the patient's condition. The 3rd call (18:22hrs) was triaged through ProQA with an appropriate upgrade. At this juncture the call taker remained on the line before transferring to a Brisbane Clinical Deployment Supervisor.

Dispatch
17:40 - Incident in Waiting Incident Queue coded 2A with no CAD recommendations carried out as a 2A.
18:23 - Incident upgraded to a 1C and CAD recommendations utilised at 18:25 with the EMD stating delay due to workload at 1837.
18:46 - Incident upgraded 1B by CDS
19:16 - Dispatcher contacts Centenary Station requesting Logon ETA for Code 1 Wacol.
19:20 - Unit Logged on post delay.
19:21 - Unit 501324 assigned.
19:22 - Unit 501324 responded from Centenary Station.
19:52 - Unit 501324 on scene (corrected time- see note below)

Findings: Nil recommendation utilised when incident received as a Code 2A. Multiple CAD recommendations utilised after upgrade with multiple Single Officers close to 12hr finish time identified but not utilised. The EMD carried out the 1st CAD recommendation 4 minutes after the upgrade to 1C. 1st unit assigned 1 hr 41 mins after the incident entered the in waiting queue. The 19:00hrs log on unit did not log on until 19:20:35 after the dispatcher called the station, the officer stated they had just finished vehicle checks & were about to log on however they logged on 3 mins 19 seconds after that call.

Incident Review/Investigation:

Scope:

Metro South reviewed the response, clinical performance and peratio decision making to ensure the appropriate ambulance response and management of this case as achi d l s intended that any operational or clinical performance issues identified with this case addressed to ensure lessons are learnt to improve future responses.

Background:

QAS was called to attend a 92-yea old mal atient o had a ll and complaining of a head knock.

Timeline:

17:38 - Triple Zero (000) call rece d
17:40 - In waiting queue.
18:10 - Second Triple Zero (000) call r eived requesting ETA and was advised accordingly.
18:23 - Third Trip Zero (000) call receiv and case was reprioritised through ProQA to Code 1C.
18:25 - Initial Assig ent completed – 501338 (4 mins)
18:27 - Visi AD Reco mendation completed – 501147 (7 mins) , 501137 (10 mins), 601476 (17 mins), 6 1458 (17 mins 601421 (18 mins).
18:30 rst Common Call de.
18:3 - In l Assignment com eted – 506422 (8 mins), 501137 (10mins).
18 36 - VisiC D Recommendation completed – 501338 (10mins), 601637 (13 mins), 601675 (13 mins), 601476 16 mins), 601421 (18 mins).
18:38 - Initial Ass ment completed – 506422 (8 mins),501321 (9 mins).
1 38 - VisiCAD Rec mmendation completed – 601675 (12 mins), 601637 (13 mins), 601476 (16 mins), 601421 (18 mins), 501304 (28 mins).
1 40 - EMD requested CDS to review for possible upgrade.
CDS attempted to call back, no answer and upgraded case to Code 1B.
18:46 - Second Common Call made.
18:56 - CDS called back and spoke to the caller and noted updated clinical information.
19:21 - ACP unit 501324 dispatched to incident.
19:29 - Unit 501324 arrives on scene (corrected time- see note below).
2 25 - Patient transported to Princess Alexandra Hospital.
20:43 - Patient arrived at Princess Alexandra Hospital.

Operational Review:

Operational dispatch to incident:
There was a delay of 1 hour and 41 minutes to respond an available paramedic unit to the incident (from when the incident entered the waiting queue to when they were dispatched) due to existing ambulance workload across 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.

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 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)	No. incidents pending > 1hour
16:30 to 16:44	1	2	0:01:32	0:02:04	7
	2	16	1:23:39	4:09:02	
17:30 to 17:44 (TOC 17:38)	1	0	N/A	N/A	2
	2	20	0:27	1:56:46	
18:30 to 18:44	1	3	0:21:	0:55	2
	2	15	34:53	1 :17	
19:15 to 19:29 (dispatched 19:21)	1	6	0:2 9	1:40:03	6
	2	1	0:45:00	1:53:31	

Hospital Status
At the time of the call, there were 3 param c units hospital with 24 'ramped' for over 30 minutes following arrival at hospital, with e longest layed for ree hours, affecting QAS paramedic availability to respond to eme ency cases i the community.

At the time of the call, the follow g hosp als within Metro South Health and Hospital Service (HHS) were on level 3 escalation:

- Logan Community Hospital
- Mater A ts Public Hospital
- Queen Eliz eth II Hospital
- P cess Alex dra Hospital
- edlands Hospit

The gni nt hospital delay QAS experienced at Metro South HHS Emergency Departments on this day a demons ted by the following snapshots which were taken at the following times: prior to the first Triple Zero (000) call t 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
16:30 to 16:44	QE11 Hospital	5	4	2 hrs 58 mins	3
	Logan Hospital	11	7	3 hrs	3
	Princess Alexandra Hospital	5	1	2 hrs 32 mins	3
	QLD Children's Hospital	2	1	37 mins	
	Mater Adults Hospital	6	4	2 hrs 28 mins	3
	Redlands Hospital	6	5	3 hrs 14 mins	3
17:30 to 17:44 (TOC 17:38)	QE11 Hospital	6	3	1 hr 32 mins	3
	Logan Hospital	11	9	4 hrs	3
	Princess Alexandra Hospital	7	5	1 hr 16 mins	3
	Mater Adults Hospital	9	6	3 hrs 28 mins	3
	Redlands Hospital	1	1	1 hr 18 mins	3
18:30 to 18:44	QE11 Hospital	9	5	1 hr 37 mins	3
	Logan Hospital	7	5	2 hrs 48 mins	3
	Princess Alexandra Hospital	4	1	53 mins	3
	Mater Adults Hospital	12	10	4 hrs 28 mins	3
	Redlands Hospital	3	2	mins	
19:15 to 19:29 (dispatched 19:21)	QE11 Hospital	7	3	rs 10 mins	3
	Logan Hospital	13	7	2 hrs 15 ins	3
	Princess Alexandra Hospital	5	4	43 m s	3
	QLD Children's Hospital	1	0	2 mins	
	Mater Adults Hospital	11		3 hrs 57 mins	3
	Redlands Hospital	3	2	59 mins	

On 30 July 2021, the QAS Metro Sout ion exp e ed 194 ours of 'Lost Availability' at Emergency Departments. Lost ava ability is lculate s the time elapsed between the At Destination timestamp and the P rtially Avai ble timesta ess 30 minutes. This lost availability equates to approxi ately 38 par medics over the period of a day, being unavailable to be dispatched to the commu y. On 29 y QAS Metro South Region experienced 152 hours of 'Lost Availability' at Eme nc Departments which was also significant.

This 'Lost Availability' reduces the num r of ambulances available to deploy to pending incidences. Whe his occurs, the QAS p ritises responses according to clinical acuity. The effects of lost availa ity compound as pending incidents continue to accrue as more Triple Zero (000) reque s are rec ed; however, ambulance crews are unable to be released from hospitals he outcome r ults in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and si).

In he perio ading up to the time of this incident, significant pressures (hospital delays and ambulance 'ramping') wer eing experienced throughout southeast Queensland (SEQ), leading to SEQ requiring escalation to extr e from 1035hrs on the 28/07/2021.

O Scene Time

- It was noted the on scene time was completed by the EMD at 19:51hrs.
- On review of the AVL the crew arrived on scene at approximately 19:29hrs.
- st set of vital signs was recorded in the patient record at 19:35hrs.
- As a result of the above information the on scene time has been amended to be recorded as 19:29hrs.

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Metro South Region Staffing:

- The Metro South Region including Brisbane South and Logan Districts had the following resourcing against approved rosters;
  - Day Shift – down 7 crews (14 officers)
  - Afternoon shifts – down 4 crews (8 officers)

Outcomes:

- 1 hour and 51 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.
- Incorrect on scene time documented initially.
- External complaint received.
- Coroner requested patient documentation and the Incident Detail Report which was provided by QAS Professional Standards.
- The most appropriate unit was not attached in accordance with the recommendations.

Review Recommendations:

- Update the on scene time to 19:29hrs in the Incident Detail Report - on scene time has since been amended to the correct time.
- Continue work with Metro South Hospital and Health Service regarding hospitals delays and facilitated offloads.
- Continually review staffing in Metro South Region to meet demand.
- Follow up with the night shift crew at Centenary Station has occurred reminding the Officers of the correct start of shift process, including logging on first.
- Follow up with EMD's regarding the call taking and dispatch occurred on the 2nd September 2021 and educational support was provided at that time.

Appendix of relevant documents/files:

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

Region Endorsement

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner	Irrelevant	16/09/2021
Anthony Hose	Acting Director Operations		15/09/2021

Sunshine Coast District Significant Incident Review

1. Authority

This Significant Incident Review (SIR) has been completed under the authority of the Assistant Commissioner Mr Stephen Gough, Sunshine Coast & Wide Bay Region.

2. SIR Incident Description

On the 27th August 2021, Queensland Ambulance Service received a request to attend a Irrelevant Irrelevant who was unconscious. The case resulted in a refusal against advice. A second 000 request was received 25 minutes later to attend the same patient who was in cardiac arrest.

3. Executive Summary

On the 27th of August 2021 the QAS received two requests for service to address located at Irrelevant Irrelevant Glenwood and attended this address on two separate occasions.

The first request for service at this address was received at 11:50 to a Irrelevant unconscious. This incident was categorised Medical Priority Dispatch System (MPDS) as a 31C01; 1C response. Incident Detail Report (IDR) 14736345.

The outcome was patient remained at address against QAS advise.

25 minutes after leaving the address at 13:14, a second call was received to attend the same patient who was describes as unresponsive with agonal ineffective breathing. This case was categorised Medical Priority Dispatch System (MPDS) as a 31D01; 1A response. Incident Detail Report (IDR) 14736713.

Outcome: Patient was in a PEA arrest and the patient was deceased after resuscitative efforts were exhausted.

4. Terms of Reference

This review will:

- investigate all aspects of ambulance response to incidents 14736345 & 14736713;
- examine ambulance operations prior to, during and following the response; and
- included all requirements outlined in the Operational Incident Review Process.

5. District Clinical Incident Review - Summary Report

An Eclipse review has been completed. Upon Clinical Incident review identified the following findings:

1. Officers Walker and Langridge undertook a comprehensive conversation with the patient to advocate for his transport to hospital. They invested time and used different strategies to attempt to change the patient's valid refusal of transport, to no avail. The VIRCA documentation supported the detail of the paramedic patient conversations and the validity of the patient's refusal.

2. The acquisition of a 12 Lead ECG was indicated and should have occurred in this case. No significant findings were evident on the 4 Lead ECG acquired on the patient, however the

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consideration of possible cardiac aetiologies requires integrative assessments, including 12 Lead ECG.

3. The administration of ondansetron to this patient is not well supported by the QAS Drug Therapy Protocol Indications and administered with the knowledge the patient was not, or potentially not, being transported. Ondansetron should not have been administered in this case.

6. State OpCen ProQA Assessment

State OpCen ProQA assessment was not requested

7. Incident Review/Investigation

a) Scope

- There were no response issues noted. Glenwood is located 38 km North of Gympie. On receipt of both cases the crew was dispatched immediately from the local Gympie area. Distance was the only factor in the 27-minute response time for the first case. The second response was quicker as the crew were on return from this address.
- This review therefore investigates the QAS ambulance management and decision making involved with IDR 14736345 and the decision not to transport.
- The response and management with IDR 14736713 after a second call to the same patient who was identified as not breathing and CPR in progress during the call. The patient was deceased at scene after unsuccessful resuscitative efforts.

b) Background

Queensland Ambulance Service received a request for service to attend Irrelevant Irrelevant reportedly unconscious at Irrelevant Glenwood.

QAS resources attending this incident included:

Irrelevant

The 000 call was from Irrelevant who reported the patient's condition as alert with abnormal breathing at 11:52.

401918 was dispatched according to Standard Operating Procedure SOP02 as the closest, most appropriate unit.

401918 were on scene with the patient for 27 minutes prior to clearing from scene with no transport. A comprehensive DARF was completed with the crew advising transport but the patient refused against advice. The DARF cites multiple attempts at suggesting transport to hospital and completion of a VIRCA when patient had refused.

25 minutes after clearing another 000 call was received to this same location for Irrelevant unresponsive. During the call it was established that the patient was not breathing and CPR instructions were commenced.

QAS resources included:

Irrelevant

On arrival at scene CPR (ineffective due to being on a soft bed) was in progress and the patient was noted to be in a PEA arrest.

Resuscitation attempts continued for approximately 40 minutes prior to termination after clinical consult with Dan and Steve Rashford for discontinuation.

Life extinct declared at 14:13 pm.

c) Timeline

- The first incident, IDR 14736345 was categorised as a 31C01, code 1C response

A Code 1C response requires an immediate response, lights and sirens, of the closest most appropriate Paramedic unit

- CAD recommendations:
- Incident 14736345
  - 11:53 CAD recommendation - 401918 (24:54 minutes); 401926 (24:45 minutes); 406793 (28:53 minutes); 4541 (36:13 minutes) & 936343 (37:41 minutes)
  - 11:53 B401918 closest, most appropriate unit dispatched from QAS Gympie
  - 12:22 B401918 arrived on scene.
  - 12:44 Situation Report (SR) was provided querying the patient had a sleep apnoea episode and was refusing transport at present.
  - 12:49 SR patient refusing transport against QAS advice, completed VIRCA
  - 12:49 case complete

Audio records from Operations Centres indicate:

- 11:50 "000" call received by Southport Operation Centre
- 11:55 dispatch of unit 401918
- 12:43 SR received from 401918
- 12:49 401918 advising clear of incident patient refusing against QAS advice, completed VIRCA

The second incident IDR 14736713 was categorised as a 31D01, code 1A response
A code 1A response requires an immediate response, lights and sirens, of the closest most appropriate Paramedic unit and CCP if available. Closest CCP eta 1hr 15 minutes and therefore a second (much closer) ACP unit was dispatched instead.

- CAD recommendation:
- Incident 14736713
  - 13:16 CAD recommendation – 401727 (9:24 minutes); 401918 (20:30 minutes); 401902 (24:54 minutes); 4506 (34:38 minutes); 4541 (36:13 minutes) 936343 (37:41 minutes)
  - 13:17 401727 closest unit reassigned from Bauple and unit 401918 assigned from Chatsworth
  - 13:31 401727 on scene and 401918 on scene 13:38

- 13:36 SR patient in PEA arrest continue backup code 1
- 14:13 Life extinct declared
- 14:15 SR resuscitation ceased patient deceased QPS required

Audio records from Operations Centres indicate:

- 13:14 "000" call received by Southport Operation Centre
- 13:17 dispatch of unit 401727 and 401918
- 13:21 "000" third call received by Rockhampton Operation Centre for same incident
- 13:35 SR from 401727 – PEA arrest, continue backup code 1
- 14:15 SR from 401727 resuscitation ceased patient deceased QPS required
- 14:51 SR from 401918 clearing scene on return to restock, 727 remaining waiting QPS arrival & waiting for return call from CSO
- 15:16 SR 401727 now clear of scene patient in care of QPS

The Digital Ambulance Report Form (DARF) has been synchronised and a clinical review of both cases has been completed (see findings in section 5 of this report).

d) Outcomes

Patient deceased after QAS resuscitation attempts

e) Post review actions

- Audio files requested from Maroochydore Operations Centre received and reviewed
- ECLIPSE audit completed
- Notification to Acting Emergency Manager Alexis Hughes & Operation District Director Robert Cornthwaite
- Priority One notification and is providing support to officers
- Follow up by Clinical Education Supervisor Simon Mitchell who conducted hot debrief and dot point supplied

8. Recommendations

There has been CSO follow up with both officers since the case to offer support and discuss the case in detail. Discussions have centred around the findings and it was apparent to the CSO that the officers have undertaken deep self- reflection of the case and the areas identified in these findings.

9. Appendix of relevant documents/files

A. Incident Detail Report (IDR)
B. Electronic Ambulance Report Form (eARF)
C. Clinical Incident Review
D. AVL tracking location of unit positions at time of incident
E. Details of active incidents from 1 hour prior to the SIR and while SIR was active
F. Audio WAVE Files

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10. Prepared by

Name	Position	Signature	Date
Shane Kropp	Senior Operations Supervisor	Irrelevant	27/08/2021

11. District/Regional Endorsement

Name	Position	Signature	Date
Alexis Hughes	Executive Manager Operations	Irrelevant	5/09/2021
Robert Cornthwaite	District Director		5/09/2021

12. Lodgement

- SIR Report must be endorsed by SOS, District Director and Assistant Commissioner
- Converted to PDF and
  - email to Irrelevant @Ambulance.qld.gov.au with a CC to Irrelevant @Ambulance.qld.gov.au

Sunshine Coast District
Significant Incident Review

SCWBR Version 2 Nov 2021

SIR Incident Description

1. External complaint - Incident Detailed Report (IDR) 14807213.
2. A complaint was received from Irrelevant regarding the delay in response to Irrelevant mother Irrelevant following a 000 call, who was diagnose post-hospitalisation as having had a stroke.
3. Irrelevant states QAS took 1 ½ hours to arrive at her Irrelevant mother who died in hospital 4 days later at the Sunshine Coast University Hospital (SCUH).
4. Irrelevant makes comment in her complaint about understaffing in QAS and high workload, as well as making comment on her conversation with the EMD in relation to the continuing need for an ambulance attendance at her mother.

Authority

5. This Significant Incident Review (SIR) has been complete under the authority of the Assistant Commissioner Sunshine Coast Wide B y R gion.

Terms of Reference

6. This review:
   - investigated all aspects of ambula ce r ponse o incident 14807213;
   - examined ambulance operations prior t during and following the response; and
   - included all requirements outline in the Op rational Incident Review Process.

Executive Summary

7. At 03:36 on the 3th September 2021 Queensland Ambulance Service (QAS) received a '000' re est to ttend elevant at a private residence in Buderim.
8. The incident was categor d through the Medical Priority Dispatch System (MPDS) as a 18A 1; headache, brea ing normally; code 2CL response, Immediate response of the clos t most appropriate Paramedic unit to a patient that has a low acuity injury o llness tha equires paramedic assessment or intervention.
9. 401752 were d patched in accordance with State Operations Centre Standard Op ating Procedu e (SOP) SOP02, however, there was a delay in their response from e Sunshine Coast University Hospital (SCUH).
10. During th response B401752 the crew were diverted to higher priority incident.
11. A total of 3 crews were dispatched to Irrelevant, with the first two being stood down due to either being diverted to a higher priority or identifying a closer crew.
12. At 04:27 the case was re-prioritised to a 2A after a second 000 call was received, and additional information was obtained.
13. B401853 were dispatched at 04:33 and arrived on scene at 04:56. There was a delay of 1 hour 20 minutes from the initial request for QAS attendance until arrival of the first QAS on scene
14. Irrelevant was transported to SCUH at code 2 status where according to the information provided by Irrelevant died 4 days later as a result of her condition.

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District Clinical Incident Review Summary

15. A Clinical Incident Review (CIR) of the case documentation was undertaken by the Clinical Education Unit (CEU).

16. The Digital Ambulance Report Form (DARF) is attached to this report. The CIR completed by Clinical Support Officer (CSO) Lucinda Clarke on the attending crew, confirmed the Irrelevant was transported Code 2 to the most appropriate facility.

17. CSO Clarke identified that the clinical documentation completion, did not comply full with the QAS clinical documentation policy. CSO Clarke highlighted a paucity of comprehensive vital sign data, limited examination/assessments being conduc d, and patient disposition not being documented.

18. The CIR also noted that a Clinical Frailty Score had not been being undertaken.

19. CIR is attached to this report.

State OpCen ProQA Assessment

20. The Quality Assurance (QA) officer who reviewed this case noted an incorrect recording of an answer of the initial call which resulted in a 2CL coding instead of 2A coding.

21. Call audio files have been compiled for this incid nt and all recordings have been reviewed. A full transcript of the calls and orrelat n to he da a entry into CAD has been compiled (attached).

22. The key points of the QA review were examinat n of the initial and subsequent 000 calls made to the OpCen, as well as th co ments attitude of the EMD which could be identified during the call.

23 Irrelevant comment i r comp int *unbel vably, I was asked by the call centre operator if we did in fa still n ed an mbulanc - and it was suggested I could drive* Irrelevant *to the hospital yself if th need wa rgent*", was also considered in the call audio file review.

24. SOP01.1 Call Taking MP S s4.2: Caller compliance and customer service outlines: "*a caller's cooperation c n be influenced by the quality of engagement on the part of the EMD. In each instan e the EMD must listen to what the caller is saying, acknowl dging key informat n when provided, not asking questions where the inf mation as been clearly and unambiguously provided. EMDs must keep the ller informe at the earliest appropriate opportunity, the caller should always be dvised that help is being arranged.*"

25. SO 03.22 Communication Techniques and Telephone Etiquette s3 and S4 Respo sibilities outlines: *"that professional communication in all situations can have a profou d impact on the progress and outcomes of an incident. Interaction and engagement with a caller on the part of the EMD can largely influence the quality and amount of information obtained, the provision of effective pre-arrival advice and the overall reputation of the QAS. OpCen staff must maintain a level of professionalism and a customer service focus when engaging with callers requesting QAS assistance. EMDs should always be polite, empathetic and non-judgemental, maintaining a high level of operational awareness and QAS representation when communicating with all callers".*

26. The initial call was at 03:36 (by the patients' grandchild). The address and phone number were verified correctly. The complaint description was *"We've got an elderly* Irrelevant *complaining of pain in* Irrelevant *head.* Irrelevant *can't sleep.* Irrelevant *restless.* Irrelevant *had a few falls".*

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27. The EMD confirmed that the patient was awake and breathing, and selected Protocol 18 (Headache). NOTE: As the caller did not report "stroke" or the sudden onset of symptoms, Protocol 18 was appropriate. "Is Irrelevant completely alert?" could have been considered obvious, due to the caller volunteering the patient was disoriented and agitated. However, it was asked as scripted. The caller said "No Irrelevant can't focus her vision". The EMD used the scripted clarifier "Does Irrelevant respond appropriately when you talk to Irrelevant?" The caller said "Yes". This was recorded correctly as "Yes".

28. "Has Irrelevant had a recent change in behaviour?" was asked correctly. The caller s d "Irrelevant ust this night Irrelevant been very Irrelevant been having trouble sleeping, and v ry restless". This was recorded incorrectly as "No".

29. This affected the final coding and resulting QAS response (Code 2CL). Had this been recorded correctly, there would have been a Code 2A response. The Stroke Diagnostic Tool would also subsequently have been triggered.

30. The second 000 call was received at 04:25 (by the patients' Irrelevant) and was taken by the same EMD. The call stated Irrelevant thought Irrelevant mother was having a stroke. The EMD reconfirmed that the patient was awake and breathing, used the Stroke Diagnostic Tool correctly and reconfigured the case.

31. The caller stated that the symptoms started "probably out 10pm", which was outside the Medical Director approved Stroke treatment ti e window of 3 hours.

32. This upgraded it from a QAS Code 2CL to Code A An opportunity to update the key questions about "completely alert" and "re nt ch ge in behaviour" was missed.

33. During this call the callers tone appeared worried nd asked why the ambulance had not arrived after nearly an hour.

34. There were some additional convers tion abou this including the caller asking if Irrelevant should try and take Irrelevant oth to ho al Irreleva t

35. The responses by th EMD ap eared ters , lacking compassion, and not in the spirit of 'good custome ervice', a outline in SOP03.22.

36. The case was reconf ur d at this time to 28C07 (sudden vision problems), suffix k Clear evidence of strok >= T hours) with a response code now of 2A, Immediate response of the closest mo t appropriate Paramedic unit to a patient has an injury or illness th requires immedia assessment or treatment by paramedics.

37. Th s case w not reviewed by a CDS until almost 40 minutes into the case. There re two factors at would have impacted on the time taken to review the case.

8. Th first unit was d patched at 03:41 and showing enroute (showing only 3 minutes in th queue) so would not have been highlighted in the pending queue.

39. Shortly a er that first unit was diverted to a higher priority case, the CDS reviewed the case and attempted a call back (04:18) but the call was unanswered.

EMD workload

13 September 2021, the Maroochydore Operations Centre (OpCen) experienced very high call demand receiving 492 calls for ambulance assistance.

41. The Maroochydore OpCen was experiencing reduced staffing capacity. On the night of the incident, the EMD was the only call taker on duty after 2300 on the night 12th September 2021.

42. The EMD received sixty seven (67) triple zero calls during their shift and was the only OpCen team member available to cover dispatcher breaks, input hospital RAFTs and ICEMS requests throughout the shift.

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Incident Review

43. Queensland Ambulance Service received a '000' request for service to attend Irene MILLER at 2/10 Henderson Street in Buderim.
44. QAS resources dispatched to this incident included:
    B401752
    B401853
    B401955
45. At 03:41 B401752 was dispatched and have utilised their MDT to notify the OpCen they were proceeding on case.
46. The crew have then advised the OpCen via radio communication at 03:42 that th required fuel with CAD notation by EMD at 03:46.
47. The closest fuel station being located less than 1km from SCUH, however the AVL did not show B401752 moving from SCUH where they were located when dispatched, until 04:00.
48. A fuel docket confirms unit B401752 receipting a fuel purchase at 04:04 at Ampol Kawana Way Birtinya.
49. The next AVL tracker shows B401752 travelling on K wan Way at 04:07 going past the Birtinya shops approx.1km distance from the fu l stati n.
50. B401752 were however, diverted to a high priorit in dent in Minyama at 04:15.
51. The CDS attempted to contact the caller at 04: 9 but s u able to make contact.
52. At 04:25 a duplicate call was received e OpC n and this call was appended to IDR 14807213.
53. The incident is reconfigured to 28C 7K CVA isual problems with evidence of a stroke) and the case w s upg ded to code 2A response.
54. The closest availab e unit (B4 1955) was dispatched at 04:29 from Noosaville but subsequently stoo down a 0 33 when a closer unit becomes available in the Caloundra area.
55. B401853 were dispatche at 04:33 and arrived on scene at 04:56. There was a delay of 1 ho r 20 minutes from e initial request for QAS attendance until arrival of the first QAS n scene.
56. T e patient w transported code 2 to SCUH arriving at hospital at 05:50. The patient ied four days fter being admitted to hospital. QAS have received a Ministerial co plaint regardin the delayed response to this incident.

Irrelevant

<u>Timeline</u>

1st Key S oke	03:36
In waiting queue	03:38
401752 assigned and enroute from (SCUH) at same time	03:41
CAD notation – fuel required on the way to the case	03:46
AVL tracking confirms 401752 proceeding now from SCUH	04:00
401752 cleared from case and diverted to higher priority incident (IDR 14807334)	04:15
CDS performed call back, Nil answer, Unable to contact (UTC)	04:19
Duplicate call received; call appended	04:25
Incident reconfigured 28C07; vision problems; code 2A response	04:27
Call ended. EMD unsure if caller wanted to cancel case. EMD attempted call back. UTC. 401955 assigned from Noosaville area	04:29
Caller confirmed QAS still required	04:32
401955 enroute	

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401955 cancelled from case (Closer unit available)	04:33
401853 assigned and enroute from Caloundra area	
401853 arrived at scene	04:56
401853 departed code 2 with patient for SCUH	05:27
401853 arrived at SCUH	05:50
401853 case completed	06:36

Review

57. SOS conducted a review of all available documentation and records post inciden

58. Sunshine Coast District workload and resource availability have been reviewed s part of this incident review.

59. On the day of the incident between the hours of 03:00 – 04:59, the Sunshine Coast District was responding to 9 cases (4 Units Code 1 responses and 5 Units code 2 responses) requiring 11 responses (6 units code 1 responses and 5 units code 2 responses).

60. At 03:30 – 03:44 1 code 2 incident was in the pending queue and was coded a Red 2c with a wait time of 1:07 mins. At 04:15 – 04:29 5 code 2 incidents were in the pending queue with the longest wait time 1:52 mins

61. Sunshine Coast District full complement of nights ft staf ng comprised twelve (12) night shift crews, one (1) solo Critical Care arame c (CP) re ponse, one (1) Flight Critical Care Paramedic (FCCP) and (1) perati s Sup visor (OS). Five (5) stations have officer(s) on emergency avai bility (A), and One (1) Senior Operations Supervisor was rostered duty u il midnight and on emergency availability until 06:00.

62. At the time of the incident availab st fing was well below these levels despite intensive efforts to fill acan shifts, many of which occurred with limited notice. Staffing/crewing imp cts are d tailed bel

Shift Vacancies

63. From 1800 - 0600 on t 2th September Sunshine Coast district had significant staff shortages with 50% of n ht shift crews not able to be filled. The details of the shift vacanci s are provided bel w:

Aft rnoon hift vacancies:
1 20 Beerwa (-1 officer)
2-22 Kawana (officer)

Nig t shift vacanc es:
18-06 Caloundra (-2 officers)
18-06 N mbour (-2 officers)
18-06 Coo m (-2 officers)
18-06 Maroochydore (-1 officers)
19-07 Kawana (-2 officers)
18 6 Tewantin (-2 officer)

64. Sunshine Coast District WPU contacted all available officers on RDO's via calls, SMS broadcasts to SCD and neighbouring districts, shifts were uploaded onto the e-shift tool for casuals and manipulated shifts for better coverage

65. The A/District Director was contacted at 0956 for overtime and AT leave authorisation to cover vacancies and unscheduled leave.

66. All officers available on RDO's or on AT leave contacted in the Sunshine Coast, Wide Bay, Metro North and Darling Downs districts. Unable to allocate any casual officers to night shift through eSHIFT.

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67. SOS notified SOCC and A/EMO of the significantly reduced operational capability on the Sunshine Coast as a result of unscheduled leave.

68. SOS then sought approval from A/EMO to consult with the day shift OS to undertake EA. SOS liaised with OS Grant Williams and he agreed to perform EA until 0600 on the 13th September 2021.

69. SOS liaised with the PSDU and Metro North (MN) SOS to request resource assistance due to workload demand. Unable to assist.

70. SEQ were unable to provide resource assistance due to SEQ workload (pend ng queue / nil resources available in Brisbane)

71. SOS notified PACH of very limited ability to complete inter-facility transfers (IFT) overnight due to staffing shortages.

B401752 Workload

72. SOS has reviewed the workload of B401752 for their shift (attached).

73. Officers Eberhard / Fraser were rostered to 1800 – 0600 shift at QAS Beerwah on QAS Unit B401752 completed 6 cases overnight.

74. B401752 were dispatched continuously with nil brea s f the duration of their 12-hour shift due to demand and available staffing.

75. Allocated meal breaks for the crew betwee 2100 00 0 and 130 – 0500 were not achieved.

Response Delay

76. SOS reviewed B401752 response o incid nt 148 7213. There was a delayed response of 19 minutes from time o dispa ch u il vehicle movement to Mrs Miller.

77. SOS discussed the de ayed spons with Of cer Brendon Fraser however, he is unable to provide an insight to the re for this delay apart from a recollection of his attendance duties.

78. Officer Fraser had n rec llection if the vehicle was refuelled between 04:00 and 04:07 at Birtinya Ampo

79. A/EMO lso discussed the elayed response with Officer Andrew Eberhardt. Officer Eberhard was unable to reca the case, however recalled working with Officer Fraser as his was e first time they had been crewed together.

80 Officer Eberhar was able to recall the case immediately prior to the case in question d to the nature o the case and the patient attended. Officer Eberhardt cannot recall the asons for the delay but believes he may have finished the paperwork prior to respon ng on case 14807213.

81. A review o the previous case attended shows the crew arrived at SCUH at 03:10 (IDR 14807003). There was a CAD entry at 03:24 stating ‘technically ramped, may have a bed, will try and get on to the team leader’.

82. At 03:36 the crew updated their status to ‘off stretcher’ using their portable radio. They were then marked as partially available and then available at 03:41 by the EMD and dispatched on the case being reviewed.

83. This may have contributed in part to some of the 19-minute delay in responding to the next case as they were likely still getting their unit ready.

84. The DARF for IDR 14807003 shows it was printed at 03:52.

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85. The B401752 response to Ms Miller was diverted to incident 14807334 assigned at 04:15. The case was received at 04:13 and in queue at 04:15. It was at 1B priority located at Minyama.

86. The coding assigned to incident 140807213 and decision to divert the crew was appropriate.

87. All actions from this point were considered appropriate however were being impacted by the staff shortages detailed previous. This includes attempt by CDS to call th scene to review.

88. Dispatch efforts continue with allocation of the next available crew at Noosavill to Ms Miller and then a further reassignment of a closer crew who became available the Caloundra area.

89. The distance from SCUH to the Ms Miller's address is approximately 15km with an estimated travel time of 18 minutes.

Recommendations

90. EMD follow-up.

a) Based on initial caller information, although the response was could have been coded as a 2A instead of a code 2CL, the initial espo se parameters remained the same requiring an immediate response the losest most appropriate Paramedic Unit available.

b) An audit of the case has been undertak n and educati nal follow up will be required by the OpCen PDO with the EMD oncerned in relation to call taking process and questioning.

c) Discussion of the EMD's perceive lack f empathy to occur with the OpCen PDO in line with SOPs. SOP01.1 Ca T king MPDS s 4.2 Caller compliance and customer service and SO 03.22 ommun cation Techniques and Telephone Etiquette s3 and 4 should so be revi ed.

91. Crew follow-up (de yed Re Unit B401752)

d) The 2CL coding ma ave impacted on the delay of the crew responding from the hospital. It appears e crew continued to complete the paperwork from the previ us case prior to r ponding, even though they have shown themselves respon ng using the MDT.

e Further foll w up should occur with the crew on the need to respond to every case immediately w en they are dispatched unless they have received permission for a elay in respons by the CDS.

f) Th CDS role is best placed to determine if it is safe to delay a response. The crew d request permission to refuel prior to attending the case but there is no evidence they requested permission to complete previous cases eARF prior to responding.

Relevant SOPs. - SOP02.1 Dispatch QAS response Priorities focusing on QAS Response Priority Summary should be reviewed with their OIC.

92. Crew follow-up (attending Unit B401853)

h) Attending crew should be counselled on the requirements for clinical documentation to be created to meet the QAS Clinical Documentation Policy standards.

i) CEU should undertake a random review of Officer Keith Taylors Clinical Documentation over past 3 months with follow up discussion and management of any relevant findings to improve performance in this area.

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93. Other

j) Email reminder to all Sunshine Coast District staff outlining requirements for immediate responses as outlined in SOP02.1 Section QAS Response Priorities.

Appendix of relevant documents/files

a) Incident Detail Report (IDR); 14807213 and 14807003 (prior case)
b) Digital Ambulance Report Form (DARF) 1480713 and 503714707 (prior case)
c) Senior Operations Supervisor end of shift report 12/09/2021 (1800 - 0600)
d) Operations Centre end of shift brief 12/09/2021 (1800 - 0600)
e) Copy of all active incidents 1 hour prior to the incident occurring & whilst the incident was active
f) Local level clinical review (Eclipse)
g) AVL tracking B401752
h) Case workload B401752
i) Emails
j) Audio files
k) Transcript and CAD entry of call logs
l) Ministerial complaint by Irrelevant
m) File note interview with Officer Andrew Eberhardt

2021_09_13 SIR 14807213.Ministerial Complaint.zip

1. District/Regional Endorsement

Name	Position	Signature	Date
Alex Hughes	A/EMO	Irrelevant	10/11/21
Tony Hucker	A/District Director		10/11/21
Stephen Gough	Assistant Commissioner		10/11/21

2. Lodgement

SIR Report must be endorsed by SOS, District Director and Assistant Commissioner.
Converted to PDF email to Irrelevant @Ambulance.qld.gov.au
cc to Irrelevant @Ambulance.qld.gov.au

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Significant Incident Assurance Review Version 1.0 August 2020

South East Operations Centre Region

Authority:

By authority of Assistant Commissioner South East Operations Centre Paul Shaw

Executive Summary:

On 23 September 2021 at 16:40hrs, QAS received a Triple Zero (000) call for assistance (Incident number 14854720) at Unit 508 9 Regina Street, Stones Corner Qld, to attend a Irrelevant female patient who had early signs of labour with a possible high risk birth due to possible cord prolapse.

On initial review of the Triple Zero (000) call performance by the A/Director, Brisbane OpCen indicates that the response to this patient should have been a Code 1 therefore negating a delay of 32 minutes under a Code 2 response.

The case was initially prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as 24O01 (Waters broken (no contractions or presenting parts) requiring a Code 2BL response. The EMD requested a CDS review of the incident during the call at 16:48hrs noting "? U/G, Unknown High-Risk complications but states cord presentation which can lead to cord prolapse"

There was a second Triple Zero (000) call received at 17:11hrs during which the caller advised that she had not felt the baby move in the previous 30 minutes which was unusual. The call was upgraded to a Code 1B, 24D05 at 17:11hrs., with a unit arriving on scene at 17:18hrs.

The QAS response time was 38 minutes from receipt of the Triple Zero (000) call. There was a delay to identify an available paramedic unit to respond to the case given existing ambulance workload across Metro South Region and Metro South Health and Hospital Service (HHS) Emergency Department (ED) delays were experienced at some in scope hospitals, affecting paramedic availability.

The QAS responded one Advanced Care Paramedic (ACP) two officer crew at 17:12hrs and arrived on scene at 17:18hrs. The patient was transported to the Royal Brisbane Hospital in a stable condition arriving at 17:42hrs.

Incident Review/Investigation:

Scope:

Brisbane Operations Centre reviewed the response, call performance and operational decision making to ensure the appropriate ambulance response and management of this case was achieved. It is intended that any operational issues identified with this case are addressed to ensure lessons are learnt to improve future responses.

Background:

QAS was called to attend a Irrelevant female patient who had early signs of labour with a possible high-risk birth due to possible cord prolapse.

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Timeline:

16:40 - Triple Zero (000) call received.
16:42 - In waiting queue.
16:48- EMD requested CDS to review for possible upgrade
17:11 Second Triple Zero (000) call received and case was upgraded to Code 1B by the OCS.
17:12 - Initial Assignment completed – 501251
17:13 – Unit 501251 enroute
17:18 – Unit 501251 on Scene
17:32– Unit 501251 departed scene for Royal Brisbane Hospital
17:42 - Unit 501251 arrived at Royal Brisbane Hospital
18:13 – Case closed

Operational Review:

Operational dispatch to incident:

There was a delay of 32 minutes to this incident due to the incorrect coding of the case as a 2BL instead of a 1B response. This was identified through a State QA of the call which det ined the EMD selected the Omega determinant level incorrectly. Based on the information provid d by the aller during case entry and non-utilisation of sub-chief complaint a determinant level of Delta wa approp ate. This would have generated a Code 1 response.

Dispatch response time frames were appropriate for each respo e cod r the ncident.

The attending ACP crew found the patient to be anxio a n a sta condition with nil contractions or urges to push. There was no evidence of cord prese tation o mminen irth. Due to the high-risk diagnosis of Vasa Previa and potential cord prolapse the pati t was ansp rted Code 1 to hospital

Outcomes:

- 32-minute response dela due to inc rect codin cident through Pro QA that resulted in a Code 2BL initial response in tead of a Co e 1B response.
  - Feedback has een provi EMD by the PDO in line with the State QA feedback.
- EMD requested CDS rev w of he incident for possible upgrade during the call at 16:48hrs.
  - CDS read the comm t at 16:57hrs and did not upgrade the incident.
- OCS upgraded Incident at 17: hrs to a Code 1B response due to patient's condition following a second t le zero call.
- Director Bri ane OpCen provided eedback to CDS Riddington on the 10th November 2021. CDS Rid ngton did ot specifically recall the incident but indicated that due to the volume of notifications eived that it m y have inadvertently been clicked on and cleared prior to any action being taken.
- DS Riddington ac owledge the importance of being aware of notifications and incident review and w receptive to the f dback.

Review Rec mmendations:

e workflow and w kload of the Clinical Deployment Supervisors across all Operations Centres should be re ewed to determine if there are any actions that can be taken to mitigate future risk of missing a no fication as identified in this incident.

Region Endorsement

Role	Name	Signature	Date
A/Assistant Commissioner	Paul Shaw	Irrelevant	10/11/2021
Deputy Commissioner Statewide Operations South	Dee Taylor-Dutton		

Department of Health

Queensland Ambulance Service

Sunshine Coast District
Significant Incident Review

1. Authority

This Significant Incident Review (SIR) has been completed under the authority of the Assistant Commissioner Sunshine Coast & Wide Bay Region.

2. SIR Incident Description

Delayed response and delay to treatment for Irrelevant with chest pain. Patient arrested in the ambulance unit but achieved ROSC with a GCS of 15 after 1 DCCS.

3. Executive Summary

On September 30, 2021, at 12:05pm QAS received a 000 call at tc Irrelevant Tin Can Bay. The case IDR14883347 was coded 1C for a 10D04 (Chest Pain, clammy).

The closest crew was dispatched, this was a crew on fatigue at Tin Can Bay. Although the address is only approximately 1 km from the ambulance station there was a response time of 21.4 minutes from assign to scene. This was attributed to EA/fatigue issues. Further, there was a delay to definitive treatment (lysis) identified due to the crew not carrying the medications required and relying on meeting back-up enroute to hospital.

The patient, Irrelevant was identified as suffering a STEMI and suffered a VT arrest during transport but ROSC was achieved with a GCS15 post 1 DCCS. The patient was transported to SCUH by R8511.

4. Terms of Reference

This review:

- investigated all aspects of ambulance response to incident 14883347;
- examined ambulance operations prior to, during and following the response; and
- included all requirements outlined in the Operational Incident Review Process.

5. District Clinical Incident Review - Summary Report

An Eclipse review was conducted which identified some documentation issues as well as some other concerns, some of which have now been addressed.

There was a significant delay to lysis administration due to multiple factors including one officer (ACPII Thornton) not yet trained in lysis at that time. The other key issue was vehicle and lysis kit availability. One vehicle was being serviced and as such the EA officer (ACPII Douglas) was at home without a car (1.4km from station) and needing to be collected by the partner (ACPII Thornton) from the station. As ACPII Thornton was not lysis trained he did not have one in his unit. Also, the available lysis kit was left for the day shift crew due to it being 'change over day' at the station.

The main documentation issue was that there was no documented clarification in the clinical notes as to why there was a significant delay (50 minutes) from time of STEMI recognition to Lysis treatment.

6. State OpCen ProQA Assessment

ProQA evaluation has not been requested at this time. Audio files have not been requested at this time but there are comprehensive entries into the IDR regarding the actions and dispatch decisions.

Given the location of the incident the closest crews – EA officers on fatigue – were dispatched. The recommend function was used and showed the closest alternative response was 31 minutes. There was a high workload in the area with Rainbow Beach on a case, the Tin Can Bay day crew on a case and Gympie crews also on active incidents.

Information in the case suggests early attempts to identify available backup to allow crew to resume their fatigue break, and within 4 minutes of arrival on scene crew advised an obviously unstable patient and requested any available CCP support. They were just starting the ECG at that time and quickly relayed ST Elevation. CDS conferenced with RSQ immediately to get additional support and transport to a cath lab. There were several messages about the best and safest landing site and then also some discussion about no having any access to lysis and meeting the backup ACPII crew enroute to helicopter rendezvous site.

There were no obvious issues noted in the was the OpCen managed this case in trying to support the crew and provide best options for definitive care for the patient.

7. Incident Review/Investigation

a) Scope

This review considered the response time to scene – 21 minutes for a distance of 1km, the clinical management, including critical thinking involved with the case. This involves the delay to lysis administration, the decision making by the attending crew and the OpCen, and the clinical documentation.

b) Background

The Tin Can Bay locality is approximately 55km from Gympie township. The QAS station is a day/EA station with an 8 on 6 off roster rotation with changeover day on Thursdays (so two crew operating on these days).

On Thursday 30 September 2021, OpCen received a 000 from an address in Tin Can Bay for a Irrelevant with severe chest pain. The call was received at 12:05 pm and the day shift crew were already on a case the EA crew from the night before were on fatigue but were by far the closest available crew.

Although there are generally enough units at Tin Can Bay for the oncoming day crew and both Officers on EA to have a unit, one was away for a service leaving them one short. For this reason, arrangements had been made for one officer (who lives 1.4km from station) to be without an ambulance and be collected by his partner (who states on station for ea) for any cases. This arrangement and the fact that the crew were still on fatigue from a busy night, caused a extended response time of 21.4 minutes to the address that was only 1 km from the station. This issue could be prevented by ensuring car servicing does not occur on Thursdays when there is always an additional crew at the station.

Once the crew arrived on scene they quickly identified a very unwell looking Irrelevant and quickly called back-up. They provided timely sitreps and quickly identified the patient as suffering a

STEMI (ST elevation identified). They also notified OpCen during the sitrep that this did not have access to lysis. A back-up crew was dispatched immediately and CDS liaised with RSQ for helicopter assistance and R8511 was tasked. There were several entries in the case about the quickest and safety rendezvous point and with safety at the forefront the decision was made to land at Archery Park in Gympie, rather than on a road somewhere closer.

The sitrep stated the patient condition including inferior STEMI and 'nil lysis on board will meet 401924 who are lysis trained'. Further investigations revealed that one Officer (ACPII Thornton) was not lysis trained and there was no lysis in his unit. His partner who he collected enroute, ACPII Douglas was lysis trained but did not have a unit and so no lysis drugs on him. There was also a comment about the lysis drugs being left for the day crew to use when investigated by the CSO. There should still have been another lysis kit at Tin Can Bay Station as there are 2 kits assigned to the station. It appears to have been an oversight in not having that kit on the unit.

The patient, Irrelevant suffered a VF arrest during Code 1 transport, approximately 21 minutes after departing scene. ROSC was achieved with a GCS15 after 1 DCCS. The crew administered their lysis protocol approximately 5 minutes after ROSC and in accordance with instructions from the QAS Consult line.

The patient was transported to Archery Park to meet with R8511 where he received further cares and transport via helicopter to SCUH.

c) Timeline

12:05:16 **1st Key Stroke**
12:07:19 **In waiting queue**
12:08:11 **Assigned** B401851
12:11:59 **IDR entry:** Discussion with crew regarding potential halfway meet with Gympie if required – to allow return to ea.
12:18:02 **Enroute**
12:29:51 **At scene**
12:33:00 **SR:** 401851 ??ICP availability presenting grey / sweating / centralised chest pain – just starting ECG
12:33:21 **SR:** Some elevation
12:36:16 401924 dispatched; enroute at 12:36:19
12:36:25 **SR:** INFERIOR STEMI ELEVATION II, III AND aVF 4MM AND HR52, BP 129/73 . ACTIVE CHEST PAIN. NIL LYSIS ON BOARD WILL MEET 401924 WHO ARE LYSIS TRAINED.
12:37:10 Conf with RSQ SZCC > 8511 tasking authorised
12:44:12 R8511 accepted tasking eta to Tom Steele Park Tin Can Bay 1320. Assigned at 12:44:40 and enroute at 13:00:36
12:44:42 SR 401851 meeting other crew at Rainbow Beach turnoff
12:47:55 401924 – just approaching turnoff
12:48:13 401924 arrived rendezvous point. 12:49:04 crew suggesting helo landing site at intersection of Maryborough/Cooloola Rd. > RSQ notified.
12:53:31 401851 **Departed scene.** Advised with ETA of 1320 will meet at Archery Park crew. ETA will be the same, safe landing spot and if anything changes close to GGH. RSQ updated with new LZ or Archery Park.
13:14:07 401851 – Pt in cardiac arrest
13:15:00 401851 One shock delivered, have ROSC > GCS 15
13:16:28 CDS entry – 401918 attached to case to transport flight team to pt in case 401851 have to pull over again.

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13:19:37 401851 SR Pt not lysed yet was about to when pt arrested. Consult line has directed crew to go to GGH direct.
13:21:05 401918 has retrieval team on board and will meet 851 enroute to GGH
13:27:22 FCCP and Dr with pt now at Victory Hotel. Decision made again to go direct to helo
13:34:07 401851 arrived Archery Park.
13:46:50 R511 departed for SCUH
14:23:19 R511 **At hospital SCUH**

d) Review

All documentation was reviewed. Initial concerns were based around time to scene as DARF was not available for clinical review. The delay in responding was clearly related to the crew being on fatigue but the iROAM avl track away from the scene required clarification.

OIC ACPII Douglas who was one of the Officers on the case was contacted to understand the route taken to scene. This was clarified citing the vehicle issues and his location 1.4km from station and needing to be collected enroute to scenes. This can be prevented by ensuring future servicing on vehicles does not occur around Thursdays when there is the double up crew for changeover day.

It was also later recognised the significant delay in getting lysis to the patient post STEMI recognition.

An Eclipse review has been conducted by CEU as well as some other relevant investigation regarding the delay to lysis. There are 2 lysis kits available at Tin Can Bay but it appears there was an oversight that one Officer (ACPII Thornton) was NOT trained in lysis and therefore not carrying a kit. The other Officer (ACPII Douglas) was trained in lysis but did not have an ambulance and needed to be collected by his partner – this oversight meant there was no lysis kit when attending this case. Although there was potentially one still at the station it may have been seen as quicker to be met by a crew with a lysis kit as the quickest option. The review also revealed some documentation issues in terms of not explaining the delay to lysis.

e) Outcomes

Irrelevant maintained a GCS 15 post defibrillation, with stable vital sign recordings, which were maintained throughout transport to SCUH.

f) Post review actions

Officer Thornton has now been trained in lysis.
OIC Douglas is putting structures in place to try to reduce the risk of re-occurrence such as managing vehicle servicing.

8. Recommendations

That this review be noted. Follow-up has already been completed with Officer Thornton completing his lysis training and additional measures introduced around vehicle and equipment availability.

9. Appendix of relevant documents/files

A. Incident Detail Report (IDR); 14883347
B. Electronic Ambulance Report Form (eARF); 503764307 & 503764481

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C. Local level clinical review (Eclipse); ID 44809
D. Email trails x 3
E. AVL tracking of unit positions at time of incident; - attached to email trail

10. Prepared by

Name	Position	Signature	Date
Dianne Rigby	Senior Operations Supervisor	Irrelevant	21/10/2021

11. District/Regional Endorsement

Name	Position	Signature	Date
Alexis Hughes	Executive Manager of Operations	Irrelevant	22 October 2021
Tony Hucker	District Director		27/10/21
Stephen Gough	Assistant Commissioner		21 October 2021

12. Lodgement

- SIR Report must be endorsed by SOS, District Director and Assistant Commissioner
- Converted to PDF and
  - email to Irrelevant @Ambulance.qld.gov.au with a CC to Irrelevant @Ambulance.qld.gov.au

Significant Incident Review 096-2021

Version 1.0 August 2020

Wide Bay District

Authority:

By authority of Hayley Salethorne Acting District Director, this SIR was completed in relation to case 14906390, 14910864 and 14912387.

Executive Summary:

On 7 October 2021, Maroochydore Operations Centre (MOC) received a 000 call. It was coded as a 1A with an AMPDS code of 9E01, Nil Breathing.

On arrival at the address the crew confirmed that the patient was deceased, resuscitation was not commenced. The crew attempted to obtain a death certificate from the GP, however this was declined, necessiting QPS attendance. The patient's daughter arrived on scene and whilst scrolling through the deceased's phone alerted the crew to triple-zero calls made the previous evening.

On reviewing the previous evening's IDR, it was noted that the call had dropped out and QPS were requested to do a welfare check on the premises. A QAS crew arrived at the scene and allege they were informed by QPS that the person involved was in hospital and this is where the call originated from, QAS services were not required and the crew cleared the scene.

This review found two recommendations, and was able to provide information to QPS for their review.

Terms of Reference:

This review will investigate all aspects of ambulance response to incidents 14906390, 14910864 and 14912387.

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

LASN Clinical Incident Summary Report:

A Clinical Education Unit Review found:
Case 14910864 (eARF 5037827869 ECLIPSE 44369)

- Nil issues, documentation to standard (no patient assessment/management).

Case 14912387 (eARF 503781913 ECLIPSE 44370)

- Nil issues with assessment of patient. Documentation does not contain signatures from all officers in attendance. Documentation includes 'quoted' comments made by GP that are irrelevant to the clinical care of the patient; further the GP is not identified nor is there information regarding whether or not the GP is willing to complete a death certificate which is relevant information in this case.

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State OpCen ProQA:

Of the three incidents reviewed, two calls for service were received via Triple Zero (000) and in one incident the call for service was received via ICEMS request. All calls were reviewable utilising AQUA.

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

Critical Deviations
- Nil

Major Deviations
- 1 x Incorrect descriptor in Final coding

Moderate Deviations
- 3 x Key Questions not recorded correctly.
- 2 x Key Questions omitted
- 1 x minor Customer Service deviations were noted.

The QAS priority was deemed to be correct the time of the call entering the Waiting Incident Queue. It was created as a QAS Code 2CL

The second incident was a call for service via ICEMS and call was found to be of **Partial Compliance**

Critical Deviations
- Nil

Major Deviations
- Nil

Moderate Deviations
- 3 x Cases Entry not recorded correctly

The QAS priority (QAS Code 2AL) was deemed to be correct the time of the call entering the Waiting Incident Queue.

In this call, the EMD has made some assumption in the details provided via ICEMS. An assumption, by the EMD that the caller to QPS was male (not female as described in the details form Telstra Triple Zero), and about the conscious state of the patient was made.

In this call, QPS called QAS off the incident, believing that the patient was in hospital.

The third incident was received via Triple Zero (000) call and was found to be **Non-Compliant**.

Critical Deviations
- 1 x Incorrect Determinant Level
- 1 x PDI's not delivered

Major Deviations
- 1 x Protocol link not used correctly
- 1 x Echo Fast Track not used correctly

Moderate Deviations

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- 1 x Case Entry question not asked correctly
- 1 x Freelance Question in Case Entry
- 1 x Key Question not asked correctly
- 1 x EIDS tool not used.

The QAS priority was deemed to be incorrect the time of the call entering the Waiting Incident Queue. It was created as a QAS Code 1A and should have been processed as an Obvious Death utilising the "Delay/Send" pathway with a QAS response Code 2AL.

Incident Review/Investigation:

Scope:

This review will consider all aspects of QAS attendance in relation to incidents 14906390, 14910864 and 14912387. It will critique crew decision making and operational and clinical compliance.

Background:

On 5 October 2021, QAS attended Irrelevant at Irrelevant an independent living unit at Irrelevant Bundaberg, case 14906390. Irrelevant had suffered a mechanical fall, and was subsequently transported to Bundaberg Base Hospital by QAS. Irrelevant who lives at this address was an inpatient at Bundaberg Base Hospital at the time. Irrelevant was subsequently discharged from Bundaberg Base Hospital and returned home via private means on the afternoon of Wednesday 6 Octobe Irrelevant daughter settled Irrelevant and left at approximately 1700hrs the same day.

At 2253hrs the same day, MOC received an ICEM request to attend a welfare check. Intelligence provided by QPS indicated that the Telstra operator had taken a call from a distressed Irrelevant and was unclear of their requirements. The caller hung up and a call back by Telstra was iniated with no answer. Telstra data indicated that the phone number was registered to a Irrelevant person at the address. QAS also attempted multiple call-backs, again with no answer.

QPS initiated a welfare check on the property and on arrival they found the unit secure with no indication of an occupant. QPS made contact with the facility manager who informed them that the occupant Irrelevant Irrelevant was in hospital. It is unclear if QPS were made aware that there was a couple living in the residence, and that Irrelevant was possibly at home. Following a discussion with the facility manager, QPS made a phone call to Bundaberg Base Hospital, who confirmed that Irrelevant was an inpatient. Based on the information provided by both the facility manager and Bundaberg Base Hospital, QPS believed that the residence was vacant and subsequently notified QAS that services were not required.

Shortly after 1000hrs on Thursday 7 October, Irrelevant daughter attended the unit to check on her Irrelevant at which time Irrelevant was found to be deceased within the unit. QAS was called to attend, with the attending crew arriving at 1026hrs. The crew identified Irrelevant to be obviously deceased with no resuscitation commenced. Whilst on scene, the crew were advised by Irrelevant laughter that two triple-zero calls were made on Irrelevant phone the previous eventing. This information was relayed to the Operations Centre Supervisor and Senior Operations Supervisor, who prepared a brief and notified senior officers.

Timeline:

Wednesday
06/10/2021

2253	ICEMS from QPS- "*Telstra op reports it sounded like a distressed* Irrelevant *caller – unclear on req – after tfr only breathing & eventually hung up called number back – no answer, left msg to txt* Irrelevant *listed at address*" (IDR - Appendix 1)
2256	Case dispatched to B4403, 2A response 32B01 Unknown Problem
2258	B4403 diverted to a higher priority
2300	B4406 attached to case from EA
2301	OCS attempted call back to both the mobile and landline associated with case from previous day, no answer, message left.
2305	B4406 Enroute
2308	QPS on Scene
2326	B4406 on Scene
2327	QAS cleared by QPS
Thursday 07/10/2021	
1018	QAS received call from Irrelevant daughter reporting that Irrelevant had found her mother deceased.
1019	B4413 attached to case, 1A response 09E01.
1020	B4413 Enroute
1026	B4413 on Scene
1032	B4413 report patient code zero
1039	B4413 unable to access Doctor to issue death certificate, QPS requested. Doctor later contacted, however not prepared to issue certificate.

Review:

In review of this incident, the operational response by QAS was found to be in line with expectations with no concerns in the operational response noted. The crew of 4406 had no reason to question QPS advice that there was no one present at the address. Based on QPS enquiries and direction the crew cleared.

Despite some errors noted in the ProQA review, it is evidenced through audio retrieved that MOC followed the relevant SOP in regard to call drop-outs (SOP01 v5.5.0 s4), undertaking multiple call backs. Further, the OCS searched address history to ascertain alternate contact details and utilised both mobile and terrestrial numbers associated with the address. It is recommended by the District that the non-compliance noted in the ProQA be referred to Maroochydore OpCen Manager for management.

Outcomes:

As an outcome of this review, QPS Officer in Charge Michael McGarry has been notified of the incident in order to trigger a QPS review into the case.

Review Recommendations:

This review finds two recommendations:

1. That the Operations Centre Manager be provided with a copy of the SIR in relation to findings from the ProQA Reivew.
2. That Mrs SLATER's daughter and husband be contacted to be notified of the review.

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

- Consultation with LASN OpCen. Audio tapes of call in file.
- A chronology/ timeline of events from receipt of Triple Zero (000) call for the OIRR;
- Incident Detail Report (IDR);
- ProQA Review
- ECLIPSE Review

LASN Endorsement

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

Role	Name	Signature	Date
Acting Director	Hayley Salethorne	Irrelevant	20/11/21
Assistant Commissioner	Stephen Gough		20/11/21
Deputy Commissioner (South)	Dee Taylor-Dutton		

Significant Incident Review

Version 0.5

Metro North Region

Executive Summary:

QAS received a Triple Zero (000) call for assistance (incident number 14950172), on 15 October 2021 at 11:40pm, at Irrelevant Zillmere to attend Irrelevant patient who was dizzy with fever, incontinent and history of urinary tract infection.

The request was initially prioritised in the Medical Priority Dispatch System (MPDS) as a 36C05S (?COVID19 high risk level 0) requiring a Code 2A response (no lights and sirens).

QAS paramedics arrived on scene at 7:33am and during treatment provided a sitrep at 7:40am of commencing CPR, requesting another Bravo back up code 1.
At 7:42am a CCP was attached code 1 and arrived on scene at 7:55am
At 7:42am paramedics on scene provided a sitrep that the patient had a dial p e and to continue back up code 1.

At 7:55am CCP arrived on scene. At approx. 7:55am CCP p ned OS dvi ng patie was conscious and breathing with normal vital signs, nil CPR commenced and pa nt suffe a possibl vasovagal episode after going to the bathroom.

At 8:09am the patient was transported to The Prince C Hospital PCH), arriving at 8:26am

OpCen ProQA:

The request for service was received AS line 00) t 11:47p and coded as a 36C05S (?COVID19 high risk level 0) requiring a Code A resp e.

The caller called a second ti at 1:52am w h nil change in the patient conditions reported.

Incident Review/Investiga :

Background

QAS received a uest for service for inci ent number 14950172, at 11:47am on the 15th October 2021 for a Irrelev nt tient who was dizzy with fever, incontinent and history of urinary tract infection. The incid t was coded a 2A, with QAS attending and transporting the patient to TPCH code 2, arriving at 8: m on the 16th Octo r 2021. The crew offloaded the patient at TPCH and cleared from the incident at 03

The incide was coded in line with SOP 2.1 Dispatch – QAS Response Priorities as a 36C05S (?COVID19 high risk leve (2A) where the patient is deemed as immediate response, with an injury or illness that requires immed e assessment or treatment.

The caller called back at 1:52am with nil change to the patient's condition reported. QAS Clinical Deployment Supervisor (CDS) performed call backs at 2:31am, 4:26am and 6:37am reviewing the patient condition, t d as unchanged and responding normally and advising of delays.

The first ambulance was dispatched at 5:22am (501155). This ambulance was diverted at 5:25am to a higher priority case. The second ambulance was dispatched at 7:03am (501154). This ambulance was diverted at 7:04am to a higher priority case. The third ambulance was dispatched at 7:05am (501355), arriving on scene at 7:33am.

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This crew, at 7:40am reported commencing CPR and requesting code 1 back up.
At 7:42am a CCP was attached code 1 and arrived on scene at 7:55am
At 7:42am paramedics on scene provided a sitrep that the patient had a radial pulse and to continue back up code 1.

At 8:09am the patient was transported to The Prince Charles Hospital (TPCH), arriving at 8:26am

Timeline

Incident no. 14950172 – 15/10/2021

Phone Pickup:	23:40
In Waiting Queue:	23:43
1st Unit Assigned:	05:22
1st Unit Cancelled:	05:23 (diverted to higher priority)
2nd Unit Assigned:	07:03
2nd Unit Enroute:	07:04
2nd Unit Cancelled:	07:04 (diverted to higher priority)
3rd Unit Assigned:	07:05
3rd Unit Enroute:	07:06
3rd Unit Arrived:	07:33
Depart for Hosp:	08:09
Arrive Hospital:	08:26
Incident Closed:	09:03

Review

- The total time from receipt of the Triple Zero (0 0) call fo nitial incid t 14950172 (15/10/2021) to the first QAS unit on scene was 7 hours and 53 m utes.
- Paramedic nightshift resourcing s Brisba M opolitan egion was - 22 officers. According to current vacancy modelling thi s con ered a s ficant sho fall in staffing.
- Where a shortfall in staffin exists, a se es of stra s implemented to manage this demand including identifying an otifying all av lable staff and sending text messages offering overtime by way of shift extension to th xisting work ce and also by the dynamic deployment of existing ambulance resources to the demand the tim .
- Metro North Operational Inc Notification described the Operational Supervisor (OS) receiving a call at 7:55am from CCP at the sc Patient was GCS 15 with normal vital signs, nil CPR commenced and possible vaso-vagal episode ing to the bathroom.

Clinical Revie

N/A

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 (23:40) and every hour while the call was pending (incident no. 14950172) reveal a moderate to high number of pending incidents within the community as follows:

	Priority	Number of Incidents	Average Wait (h:mm:ss)	Maximum Wait (h:mm:ss)	No. incidents pending > 1hour
23:30 to 23:44 15/10/2021 (TOC 23:40)	1	6	00:38:23	03:24:19	26
	2	40	01:51:45	05:47:34	
00:30 to 00:44	1	4	00:19:26	00:31:42	32
	2	46	02:20:30	06:47:26	
01:30 to 01:44	1	8	00:42:07	02:08:31	33
	2	47	02:59:46	07:47:25	
02:30 to 02:44	1	4	00:45:57	01:29:04	33
	2	40	03:39:43	06:55:47	
03:30 to 03:44	1	4	00:50:17	02:29:06	25
	2	29	04:17:42	07:38:44	
04:30 to 04:44	1	1	00:09:53	00:09:53	20
	2	29	03:56:38	07:55:24	
05:30 to 05:44	1	0	-	-	15
	2	5	03:12:31	07:36:01	
06:30 to 06:44	1	1	00:00:33	00:00:33	14
	2	19	03:03:28	07:30:07	
07:00 to 07:14 (Time dispatched 07:04)	1	2	00:08:07	00:15:20	14
	2	18	02:47:00	07:10:01	

Pending incid s in the community are u ssessed patients and prioritised according to the response code derived from MP and further clinical interrogation.

Hosp al Status

A 40pm on the 15th O ber 2021, time of call for incident 14950172, there were 10 QAS ambulances cate t Metro North HHS spitals and of these 9 had been 'ramped' for over 30 minutes, with the longest being 1 r 52 minutes at TPCH.

At the time o e call TPCH was on level 2 escalation.

Fifteen-minute s shots for hospital delays at Metro North HHS hospitals prior to the call, at the time of the call (11:40pm) and every hour while the call was pending, reveal low to moderate 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
23:30 to 23:44 15/10/2021 (TOC 23:40)	RBWH	1	1	00:33	
	Redcliffe Hospital	0	0	-	
	Caboolture Hospital	2	1	00:31	
	Prince Charles Hospital	7	7	01:52	2
00:30 to 00:44	RBWH	3	0	00:29	
	Redcliffe Hospital	3	2	00:48	
	Caboolture Hospital	1	1	00:45	
	Prince Charles Hospital	5	4	02:52	3
01:30 to 01:44	RBWH	4	1	00:36	
	Redcliffe Hospital	0	0	-	
	Caboolture Hospital	0	0	-	
	Prince Charles Hospital	3	3	03:33	3
02:30 to 02:44	RBWH	2	1	01:06	
	Redcliffe Hospital	3	2	00:54	
	Caboolture Hospital	1	0	00:15	
	Prince Charles Hospital	1	0	00:25	3
03:30 to 03:44	RBWH	2	0	00:23	
	Redcliffe Hospital	0	0	-	
	Caboolture Hospital	3	2	01:15	2
	Prince Charles Hospital	2	1	00:55	
04:30 to 04:44	RBWH	0	0	-	
	Redcliffe Hospital	0	0	-	
	Caboolture Hospital	1	0	00:26	
	Prince Charles Hospital	1	1	00:34	
05:30 to 05:44	RBWH	0	0	-	
	Redcliffe Hospital	0	0	-	
	Caboolture Hospital	1	0	00:12	
	Prince Charles Hospital	0	0	-	
06:30 to 06:44	RBWH	0	0	-	
	Redcliffe Hospital	1	1	00:36	
	Caboolture Hospital	0	0	-	
	Prince Charles Hospital	1	0	00:07	
07:00 to 07:14 (Time dispatched 07:04)	RBWH	3	0	00:14	
	Redcliffe Hospital	1	0	00:18	
	Caboolture Hospital	0	0	-	
	Prince Charles Hospital	1	0	00:25	

System Pre ures

On 15th October 2 21, the Metro North and South HHS hospitals experienced 174 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. t availability equates to approximately 34.8 paramedics over the period of a day, being unavailable to be dispatched to the community.

In the period leading up to the time of these incidents, pressures (hospital delays and ambulance 'ramping') were being experienced throughout southeast Queensland (SEQ), leading to SEQ requiring escalation to

moderate from 6:40pm and then to extreme at 8:15pm on the 15th October 2021, remaining in place throughout the 16th October 2021.

Recommendations

Outcomes

- The QAS delayed response to incident 14950172, was impacted by increased workload demand and hospital ramping at the time of call and subsequent period.
- The closest most appropriate unit was dispatched to incident 14950172.
- The incident coding was appropriate and at no time during call backs, was a pt condition change detected or reported for upgraded response.
- Brisbane OpCen Clinical Deployment Supervisors (CDS) have undergone documented case reflection and feedback session with Clinical Hub team leader.

LASN Endorsement

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

Role	Name	Signature	Date
A/Assistant Commissioner	David Hartley		
A/Director North Brisbane	Warren Painting		
Deputy Commissioner Statewide Operations South	Dee Taylor-Dutton		

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Region

Authority:

By authority of Chris Draper, A/AC Gold Coast Region

Executive Summary:

On 26 October 2021 at 19:31hrs a call was received by QAS, (via vital call), requestin service at relevant Irrelevant Upper Coomera. For a Irrelevant pt complaining of shor ess breath che pain, clammy and vomiting blood.

Bravo 601594 Irrelevant (36429) and Irrelevant (34518 were d atched 2 minutes later on a 1C (21DO5), the crew were immediately available and the 'call to arr l time w 10 minutes.

The crew were presented with a frail geriatric Irrelevant (ant also n scene with a history of recent hospitalisation (orthopaedic hip issues) and chronic medi l histo (including QAS presentations) of ACS. Irrelevant was self-caring had been feeling well, g up afte nap, drank a beer, vomited and possibly aspirated fluid – QAS called.

After a relatively uncomplicated x and load, an mily and pt request he was taken to Gold Coast Private Hospital (GCPH), recent dis rge from there three weeks ago.

Accepted over th hone, the crew arrive t Nursing handover between evening and night shift. This extended tri e time t this point the night shift Tirage Nurse / Supervisor advised the crew that due to limited n sing capacity, p tient acuity (needed isolation and O2) they could no longer accept the patient. (ED cto was present at thi oint). The crew advised this was communicated in a non-urgent and casual m nner, sug sted he be taken across the road to Gold Coast University Hospital.

he crew reloaded e patient and had a discussion with the Irrelevant (phone call) and patient (who was in active) . They advised the 'under no circumstances was Irrelevant go to GCUH' and requested Pindara P vate Hospital (PPH).

The crew risk managed the decision between patient urgency, triage and potential ramp time at Uni, (10-minute drive to PPH).

A cepted at the PPH over the phone the crew drove (12mins) to PPH. On arrival the patient vomited (minimal external vomit only) – subsequently **the patient acutely developed significant respiratory**

distress at tirage. Irrelevant was treated in acute and then moved to resus for BiPAP. However, after several hours' Rx in the emergency department Irrelevan subsequently died.

PPH staff, were reported as angry at the actions of GCPH and noted that they were not directing this at the QAS crew.

- The crew were faced with the difficult risk decision surrounding disposition of the patient after be g physically turned away from GCPH.
- The crew did weigh up and risk manage, patient advocacy, pt acuity , immediacy of ca on arrival (versus ramping) and the requests of the patient and family.
- Clinically the case was reviewed by the MCE GC , the care was provided was reasonable and justifiable. As was the clinical risk decision to transport to PPH. Deteriorati n (like further aspiration) was unforeseen and potentially have occurred regardless of stinati n.
- The crew were proactive in their actions and decision making, they notified in al time he SOS, followed up with the OS after they were advised of the patient ath (00hrs pro .). Including via email and being open to providing further details.
- However, the DARF documentation was scant on d ils of th e ents at t age, and this was inadequately described – which needs the QAS crew to dersta th onsequence of this.
- Conversations had with MCE Foote with the SO rong, O O'Neil and both of the crew provided a consistent narrative, open communication a d was r lective in ature.
- In conclusion the care provided by the QAS was mely, a propriate and logistical challenges posed by delayed patient disposit n were anaged th the p ient's best interest first.
- MCE Foote has passe condolence to the family and the QAS was thanked for their care.
- GCP and PPH have be conta d and ovided responses to inform this SIR.

Terms of Reference:

This review will in stigate all aspects of a bulance response to incident 14996690. The review will examine am ulance rations prior to, during and following the response.
This rev w will include al quirements outlined in the *Operational Incident Review Process*.

R gion C ical Incident Summary Report:

This case was re ewed by MCE Foote in line with the completion of this SIR.
T patient was a Irr evant who made a call for service via vital call. Irrelevant has previously made several other si lar calls for service , generally secondary to frailty or chest pain. On this occasion the call was triaged pp l and response initiated in timely fashion. Resources were available and response undelayed. The crew arrived in 8 minutes from, despatch via a direct route (iROAM) and initiated care. The time on scene was consistent with standard prehospital care times to arrive, asses, treat and extricate a frail and ed patient. The crew described a steep driveway which slightly extended the safe extrication.

The crew discussed the patient destination with the patient's Irrelevant and Irrelevant on scene, and at Irrelevant request, in line with QAS practice, called ahead and had the patient accepted by the Gold Coast Private Hospital (GCPH). The patient had recently (3 weeks ago) been discharged from there post orthopaedic treatment the patient was duly transported there. Oxygen was provided to the patient, in line with QAS guidelines maintaining a relatively low SPo2 (hx of COPD). But cognisant that the patient had a working Dx of Acute aspiration. The crew noted in conversation with the MCE that this intervention and patient status was communicated to the Hospital (GCPH).

The crew did provide low dose fentanyl as the patient had 3/10 pain (poorly described in the DARF as underpinning reasoning for narcotics in aspiration case), however on questioning the crew no d t the patient had central chest pain but was more epigastric in nature (ACS could not be rul ut) . Reviewing similar cases where the patient presents with chest pain and SOB and thus the ri k of resp ory depression versus relief of chest pain must be considered, this was acknowledged in discuss n wit the t ing paramedics. In this case small aquilots of fentanyl were appropriate in the opinion of t e MCE

Vistal signs were taken and recorded regularly, demonstrated a rela vely fra older person, but were not deranged significantly. The Corpuls data provided post the ent by t e O C are at ched. Neurologically the patient was described as interacting and communicating well – mons ing re sonable end organ perfusion, acutely. There was some respiratory embarrassment bu o immediate or acute haemodynamic compromise.

This patient disposition to a private h l was re on ble and onsistent with his previous admissions to the same within the same month

On arrival (GCPH) the crew (en discus g ith the MCE) independently and consistently described bringing the patient in at hospital/ ening nursing handover. This entailed a delay in triage, described as up to twenty minutes, the Evening Nu briefly reviewed the patient and then handover occurred with the night nursing sta The Night Triage nurs isualised the patient and the second RN and doctor was present. They advise that du o only having two nurses on and that this patient was oxygen dependent and would require a ingle room an ignificant nursing resources they would not be able to manage him. That the crew shou ta him on to the GC H. The Doctor is present at this conversation. The crew individually describe th s as a rela ely casual conversation and were surprised when it was later described as a directive by the doctor – that ass ion was contrary to their recollection.

Th triage notes and comments provided to the MCE via the Clinical Manager of the GCPH (Irrelevant I levant suggest the patient was non communicative and would likely require resuscitation, that the presentation differed from that presented in the accepting phone call. That the doctor had directed the crew to take the pt to GCUH and the QAS had refused. The QAS OS on that night Bradley O'Neil who received a all from the GCPH ED staff after the patient had died at 0400hrs approx, (PPH had rung and requested their notes post the death). The phone to the OS suggested that the crew had refused an order from the

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doctor and that responsibility lay with the crew. There had been no follow up in the previous >4 hr window where their concerns were escalated. GCPH had also refused a second patient on after arrival the same night (IDR14996713) with that patient being transported to GCUH. There was no follow up on this (2nd) case by GCPH.

Faced with a refusal at the ED, the crew had to make a clinical decision surrounding further transport and patient impact. In this case the patient was not acutely deteriorating but needed intervention in reasonab time frame. The decision a described below is clinically appropriate and safe, with the choice of p ntial ramping at GCUH and 10 mins to accepting private ED with no wait.

The crew noted verbally that the patient did slowly have escalating oxygen demands as the journey progressed. That the patient was interactive and awake throughout the journey but ad ga ric fluid in small amounts on unloading at PPH. This appeared to be a vomit, mostly interna it did n t re ire suctioning, but was consistent with the patient's acute presentation and Irrelevan likely aspir ed furt er at this point. Irrelevant was noted to deteriorate at this point and **as they walked int he ge** it s re gnised that Irreleva would need immediate intervention and care.

A discussion by between the Emergency Medical Director Be Walter PPH for his report and his review of the triage notes at PPH notes that the patient was described a eing o ded, GCS 3, pinpoint pupils, agonal resps' and in need of immediate resuscitation hes otes w e made after the patient had immediate cares in the ED.

This is consistent with the story prov ed by e QAS icers in t at they advised that the patient had been interactive and relatively stable ght up until e point tha y had unloaded at Pindara , where the patient was witnessed to have vomite further. Th sistent with the Corpuls data of the case where no acute deterioration is shown during tran ort hat the patient had almost immediately deteriorated and that they had to present the patient to triage in ute distress. This can be seen as the sentinel event in the patient journey but at the ame time is not an un mmon situation faced by paramedics transporting dynamic and evolving cas . This often hard to foresee and would likely have occurred wherever he presented. The MCE an Dr Walters agr d that this can and does occur, but that the narrative of this event is poorly docu en d in the QAS DAR which leads to documentation gap in the patient journey.

The crew freely nd openly discussed this situation, again consistently and independently, approximately 16 ours after the eve (both on the phone after waking up post night shift). They advised that they apologised to e Pindara staff, i.e., walking in with a patient who now differed acutely from the original presentation. T e crew advised that the hospital staff stated they understood and that they were not happy with the decision t n by GCPH to refuse care. That they may be contacting them later, a sentiment echoed by the Pindara medical director Dr Ben Walters in the later conversation with the MCE.

he crew stated they completed the DARF and continued with their shift, they contacted the SOS to advise of the events and later discussed with the OS after he had been advised of the painet death.

This review gives rise to the questions that need to be considered for assurance:

Did the QAS present accurate information to the initial hospital to allow them to accept? – this is unknown, but there are no reports of the same for this crew or other cases that are taken here. The crew anecdotally enjoy a reputation for professionalism and do not flag clinically. The GCPH were changing their resourcing dynamically during the case and this may have impacted acceptance. Phone triage in inherently difficult a d the patient did not need immediate hospital intervention in the 20 mins tha[Irrelevan] waited for triage to be completed. The patient acuity may have been undersold by QAS and the initial GCPH Triage but i ot outside the normal variation that may occur .

Why was there a delay at GCPH at triage over handover? This both delayed care and final patient acceptance, with a longer delay than normal or if there was a redirection transport p or to rrival. Th c w described advocating for their patient at triage but recognising that they have to w it for the N ing staff to be ready (this is consistent with the MCEs recent on road experiences). Whilst problematic, be ause after the delay the patient wasn't accepted for admission to the ED, it is not tsid f the perie ce of the QAS when the patient is being admitted into the department.

There are is a variation of recollection around the GCPH staf essag in regard o the redirection, which is differently described by themselves versus the QAS recollectio The G redirected another patient the same night after arrival of QAS, believed to be for sim resou ng issue. They are noted to have proactively rung the QAS (OS) only after becoming ware o he patient death and not for the second case. Regardless of the how this was stated GCPH ha di charged heir duty of care at this point (recognising through their actions that the pati t did not quire im diate suscitation- or that they were refusing to the same??) and the QAS had pri ary care of t e patient in the immediate disposition and destination choice – this was duly attended by the Q S at thi point.

The question is on how and why the S then decided to transport the patient beyond the relatively close location of the G H. The crew had to m e a redirection patient disposition decision on being moved on from the prim ry hosp al, I believe the crew made a patient advocacy decision balanced against clinical stability i ormed by loca gistics knowledge, that was sound. The crew described reviewing the patient acuit , t transport logistic nd considerations of the family. They did not describe making a decision to di regard a d ctive by the Doctor at GCPH, rather that they had an independent decision to make.

he Med Director Walters (PPH) provided a retrospective narrative view that, on paper, the patient was re sed at one hospital with inconsistent patient status described, arrived at the second immediately needing r uscitation with the variation being the QAS. The QAS DARF describes a patient who was relatively stable, the crew s d he was awake and interactive (relative for condition) during transport to PPH. The doctor understandably suggests there is a gap in the narrative. On examination of these event in sequence and retrospectively, the gap is in the DARF. There was also very limited description of the sentinel event and the immediate deterioration upon arrival at PPH. This is an error on the part of the QAS and presents a gap in the patient journey narrative. To confirm the narrative provided by the QAS a review of the quantitative data

on the Corpuls was undertaken. Provided by the OIC Helensvale, the data (attachment) shows a consistent and relatively stable haemodynamic state with relative hypoxia. The hypoxia was managed (per DARF and by the crew with increasing supplemental O2). The patient had BP measurements recorded throughout the QAS care. Clearly oxygen dependent the patient maintained SPO2 and BP throughout QAS care without acute deterioration. This is consistent with the story provided by the crew.

In conclusion

This review notes that the decision taken around the patient care by the QAS crew appear sou d and reasonable in the face of this patient presentation. The crew were unduly delayed at GPH tri e, whe refusal of care could have provided earlier, the secondary transport could have been effected without undu delay. The information provided by the GCPH, were after denial of care and the dut rema ed with QAS or the ongoing care decisions. The way the GCPH describe the messaging around e case cou also be taken to say they refused to resuscitate a critically ill patient, which they had accepted upon a val, sending the patient away to be resuscitated elsewhere. This is unlikely and thus upp s the nside ation that there was a clinical appreciation that there was time for a secondary trans rt.

The secondary destination decision is also sound and reason le (th me logis cal decision taken by the second crew refused at GCPH that night). And this was demonst ed in th minute transport time to PPH. The sentential event had the potential to have o curr at any oint in the patient therapeutic journey. Delays in pt drop off, resulted in it occurring with Q S. The AS crew poorly documented the significant events (which were made more impo with hind gh and thi ead to QAS care being questioned and complex to defend.

The description of a sentinel d erioration i l at PPH is backed up by Corpuls data and separate and independent QAS crew descriptio T e crew proactively contacted and discussed the case in real time with the SOS and OS on the shift and ave been open and reflective subsequently. I am satisfied based on data and discuss directly with the crew at the events occurred as described. This crew would benefit from a furthe discus n with the MCE to both review the documentation and for them to gain an understa ding of its impo nce, especially in this type of case.

S ate Op n ProQA:

No issues noted the IR for the ProQA or dispatch of this case.

In ident Review/ nvestigation:

This case s reviewed to consider the dispatch, response, treatment and transport decisions of the QAS on a call for service on 26 Oct 2021 for patientIrrelevant

It further considered the interactions of the QAS with patient disposition to the private hospitals Gold Coast rivate and Pindara Private Hospital and the impact that had on the care provided.

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Timeline Case ID 14996690

- B601594 dispatched: 19:32:24
- Enroute to Scene: 19:34:24
- Arrived Scene: 19:42:46
- Depart Scene: 20:23:01
- Arrived GCP: 20:43:33
- Depart GCP: 21:10:24
- Arrived PPH: 21:22:35
- Complete PPH: 22:07:22

Review Recommendati ns:

The outcomes and learnings incl e

1. That the CPH resourcing impac should be considered when they are accepting patients, prov ding inc sed rigor to their telephone triage. This should be considered a conversation b tween relevan enior clinical and operational peers between QAS and GCPH.

2. That e QAS care while satisfactory could have included a 12 led ECG and the DARF completion could be proved to describe events more fully. Which is likely to be a systemic issue for the QAS.

3 Recognition that sentinel events occur and that as in this case crews and operational supervisors are proactive in obtaining information and initial statements of events from crews.

4. The family were contacted by MCE Foote, condolences provided to the patient's Irrelevant an open-ended general conversation had where the patient's Irrelevant thanked the QAS and did not wish to converse further.

Appendix of relevant documents/files:

Appendix 1: DARF 503833823

Appendix 1 DARF 503833823.pdf

Appendix 2: IDR 14996690

Appendix 2 IDR 14996690.pdf

Appendix 3: Email notification and email from Kelly Ward to OS O'Ne

Appendix 3 Email notification and em

Appendix 4: MCE emailed Pindara Hosp and subse uently s oke with D Ben Walters

Appendix 4 MCE emailed Pindara Hos

Appendix 5: MCE emailed Gold C st ivate and received email reply.

Appendix 5 email from GCPH Re ith

Appen 6: IDR Second C e

Appendix 6 IDR econd Case.pdf

A endix 7 Corpuls data 14996690

Appendix 7 Corpuls data 14996690.pdf

Conversations on the 27 October 2021 with:

- Irrelevant

MCE Spoke with family expressed condolences

- Nil further concerns .
- QAS offered further contact if required.

Region Endorsement

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

Role	Name	Position	Signature	Date
A/Assistant Commissioner	Chris Draper	General Manager	Irrelevant	12/11/21
A/District Director	Rachel Latimer	Chief Superintendent		

Incident Detail Report

Data Source: QACIR
Incident Status: Closed
Incident number: 14996690
ProQA number: 17899879
Console name: QA529
Incident Date: 26/10/2021 19:30:10
Last Updated:

Incident Information

Incident Type:	ACUTE	Alarm Level:	
Priority:	1C	Problem:	HAEM/LAC ABNOR BREATH MEDICAL
Determinant:	21D05M	Agency:	QAS
Base Response#:	121459	Jurisdiction:	6 Southport Gold Coast
Confirmation#:	01162837	Division:	6 Coomera
Taken By:	Corry, Briana	Battalion:	6 Coomera
Response Area:	6 Coomera	Response Plan:	Acute
Disposition:	A Case Completed	Command Ch:	
Cancel Reason:		Primary TAC:	TLK GRP 111/UHF Ch 103
Incident Status:	Closed	Secondary TAC:	
Certification:	ACUTE	Delay Reason (if any):	
Longitude:	26701574	Latitude:	62141474
Patient Name:	Irrelevant	Patient DOB:	Irrelevant

Incident Location

Location Name:		County:	GOLD COAST
Address:	Irrelevant	Location Type:	
Apartment:		Cross Street:	Irrelevant
Building:		Map Reference:	GBR4
City, State, Zip:	UPPER COOMERA QLD 4209		

Call Receipt

Caller Name:	Irrelevant	Original CLI Phone	Irrelev nt
Method Received:		Call Back Phone:	
Caller Type:		Caller Location:	

Time Stamps

Description	Date	Time	User
Phone Pickup	26/10/2021	19:30:10	
1st Key Stroke	26/10/2021	19:30:10	
In Waiting Queue	26/10/2021	19:31:52	
Call Taking Complete	26/10/2021	19:36:39	Corry, Briana
1st Unit Assigned	26/10/2021	19:32:24	
1st Unit Enroute	26/10/2021	19:34:24	
1st Unit Arrived	26/10/2021	19:42:46	
Closed	26/10/2021	22:07:22	Graham, Genine

Elapsed Times

Description	me
Received to In Queue	00:01:42
Call Taking	00:06:29
In Queue to 1st Assign	00:00:32
Call Received to 1st Assign	00:02:14
Assigned to 1st Enroute	00:02:00
Enroute to 1st Arrived	00:08:22
Incident Duration	02:37:12

Resources Assigned

Unit	Assigned	Disposition	Enroute	Staged	Arrived	At Patient	Delay Avail	Comple	Odm. Enroute	Odm. Arrived	Cancel Reason
B601594	19:32:24	A Case Completed	19:34:24		19:42:46		21:5 :26	22:07:2			

Personnel Assigned

Unit	Name
601594	Irrelevant

Pre-Scheduled Information

No Pre-Scheduled Information

Transports

Unit	Location/Address	Patient	Mode	Protocol	Mile Start/E	otal	Depart	Arrived	Complete
601594	Irrelevant		Cold	Pre Hosp atient conditi	0.0//		20:25:01	20:43:33	21:10:24

Transport Legs

Unit	Location/Address	Patient	Mode	rotocol	Mileage Start/End/Total	Depart	Arrived	Complete
601594	Irrelevant		d	re Hosp - pati ition	//	21:10:24	21:22:35	22:07:22

Comments

Date	Time	User	Type	Comments
26/10/2021	19:31:52	5BRICOR	Response	[ProQA Dispatch] Dispatch Level: 21D05 (Abnormal breathing) Suffix: M (MEDICAL) Response Text: 1C Irrelevant cious, Breathing. Problem Description: SOB - CHEST PAIN - CLAMMY - VOMITING BLOOD
26/10/2021	19:31:52	5BRICOR	Response	t ey Questions] 1. The cause of the bleeding is non-traumatic. 2. Irrele is coughing up blood: 3. It's not known if irrel is completely alert (responding appropriately). 4 Irrele is not breathing normally.
26/10/2021	19:32:04	5BRICOR	Response	[ProQA: Key Questions] 5. It's not known if there is SERIOUS bleeding. 6. It's not known if irrel has a bleeding disorder or normally takes blood thinners.
26/10/2021	19:32:20	5BRICOR	Response	[Private] 0466 013 923
26/10/2021	19:32:24	PS	Response	[Page] Dispatch page sent to Unit:601594, Sent From: KEDCADQASPIS01
26/10/2021	19:32:36	PS	Response	[Page] Dispatch page to Unit:601594 complete to Irrelevant Message sent successfully to Whispir
26/10/2021	19:33:21	5BRICO	Response	Irrelevant ON SCENE BUT IF NEEDED - KEYSAFE RHS FACING FRONT DOOR - CODE 9125
26/10/2021	19:34:22	601594	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
26/10/2021	19:34:46	5BRICOR	Response	PT WAS ON ASPIRIN UNTIL LAST WEDNESDAY
26/10/2021	19:34:54	ICOR	Response	[ProQA: Key Questions] 5. There is no SERIOUS bleeding.
26/10/2021	19:35:27	594	sponse	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
26/10/2021	19:35:41	5BRICOR	onse	PT HAS CHESTY COUGH
26/10/2021	19:36:15	5BRICOR	R se	DOOR OPEN
26/10/2021	19:36:3	601594	Res	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
26/10/2021	19:36	601594	Respo	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
26/10/2021	19 2	601594	Respons	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
26/10/2021	:27	15ZAYBOU	Response	[Page] Units: 601594, Sent From: PC919032, Hi crew, if you're transporting to public hosp may you please transport to Robina if clinically appropriate. Thanks PACH
26/10/2021	21:10:58	GRA	Response	601594 GCP NOT HAPPY TO ACCEPT TX TO PINDPH
26/10/2021	21:53:06	6J A	Response	[Page] Units: 601594, Sent From: PA605, You have been at hospital for 30 minutes. Your Unit will be made Partially Available, unless advised of delays via radio.

Pr ger
nges

Call Activities

Date	me	Radio	Activity	Location	Comments	User
26/10/2021	9:30:10		No AML Data Received		No AML data received with this call	SDSIAML
26/10/2021	19:31:52		Incident in Waiting Queue			
26/10/2021	19:31:52		Waiting Pending Incident Time Warning		Waiting Pending Incident Time Warning timer expired	
26/10/202			ANI/ALI Statistics		INT Insert:Oct 26 2021 19:30:06 / INT SendNP:Oct 26 2021 19:30:06 / WS RecvNP:Oct 26 2021 19:30:06 / WS Process:Oct 26 2021 19:31:53	5BRICOR
26/1 1	19:31:53		Read Comment		Comment for Incident 879 was Marked as Read.	5BRICOR
6 021	19:31:53		ProQA	Irrelevant	ProQA determinant sent	5BRICOR
/2021	19:32:01		Read Incident		Incident 879 was Marked as Read.	6GENGRA
/2021	19:32:02		Remove Waiting Pending Incident Warning		Removing Waiting Pending Incident Time Warning timer expired	
26/1	19:32:03		Incident in Waiting Queue Timer Clear			
26/10/2	19:32:04		Read Comment		Comment for Incident 879 was Marked as Read.	6JACCHA
26/10/202	19:32:11		UserAction		User clicked Exit/Save	6JACCHA
26/10/2021	19:32:24	601594	Dispatched	Irrelevant	Response Number (121459)	6GENGRA
26/10/2021	19:32:26		UserAction		User clicked Exit/Save	6GENGRA
26/10/2021	19:33:24		Incident Late		Active incident marked as late	
26/10/2021	19:34:24	601594	Resp	Irrelevant	Responding From = Irrelevant	VisiNET
26/10/2021	19:35:18		Read Comment		Comment for Incident 879 was Marked as Read.	5BRICOR
26/10/2021	19:36:37		Read Comment		Comment for Incident 879 was Marked as Read.	5BRICOR
26/10/2021	19:36:39		UserAction		User clicked Exit/Save	5BRICOR
26/10/2021	19:42:46	601594	At Scene	Irrelevant		VisiNET
26/10/2021	19:44:20		UserAction		User clicked Exit/Save	215ZAYBOU
26/10/2021	19:54:17		Read Comment		Comment for Incident 879 was Marked as Read.	215ZAYBOU
26/10/2021	19:54:22		UserAction		User clicked Exit/Save	215ZAYBOU
26/10/2021	20:13:21		UserAction		User clicked Exit/Save	215ZAYBOU
26/10/2021	20:25:01	601594	Dep	GOLD COAST PRIVATE HOSPITAL		VisiNET
26/10/2021	20:43:33	601594	Dest	14 HILL ST [GOLD COAST PRIVATE HOSPITAL]		VisiNET
26/10/2021	20:43:34	601594	Transport Time		Depart Scene Time: 20:25:01, Arrive Destination Time: 20:43:33	VisiNET
26/10/2021	21:10:24	601594	Dep	PINDPH (A&E)		6JACCHA

26/10/2021	21:22:35	601594	Dest	Allchurch Ave [PINDPH (A&E)]		VisiNET
26/10/2021	21:22:36	601594	Transport Time		Depart Scene Time: 20:25:01, Arrive Destination Time: 20:43:33	VisiNET
26/10/2021	21:50:00	601594	Status Update Received	Allchurch Ave [PINDPH (A&E)]	Status update Off Stretcher received from Radio 601594P1	GWNKED
26/10/2021	21:52:35		Incident Late		Active incident marked as late	
26/10/2021	21:52:54		Read Comment		Comment for Incident 879 was Marked as Read.	6JACCHA
26/10/2021	21:53:16	601594	Reset System Timer		Days Warn before expiration Passwords	6JACCHA
26/10/2021	21:53:24		UserAction		User clicked Exit/Save	6JACCHA
26/10/2021	21:58:16		Incident Late		Active incident marked as late	
26/10/2021	21:59:07		Read Comment		Comment for Incident 879 was Marked as Read.	6JACCHA
26/10/2021	21:59:26	601594	Partially Av	Allchurch Ave [PINDPH (A&E)]		6JACCHA
26/10/2021	22:04:29		UserAction		User clicked Exit/Save	6JACCHA
26/10/2021	22:07:22	601594	Available	49 Eggersdorf Rd [INSIDE COLES - ORMEAU VILLAGE]		6GENGRA
26/10/2021	22:07:22	601594	Disposition	Irrelevant	A Case Completed	6GENGRA
26/10/2021	22:07:22	601594	Response Closed		Response Disposition: A Case Completed	6GENGRA
27/10/2021	00:57:13		UserAction		User clicked Exit/Save	6JADWIL

Edit Log

Date	Time	Field	Changed From	Changed To	Reason	Table	Workstation	User
26/10/2021	19:30:10	Call_Back_Phone		(07)37228657	(Response Viewer)	Response_Master_Incident	QA529	5BRICOR
26/10/2021	19:30:15	City	SALISBURY	UPPER COOMERA	Updated City	Response_Master_Incident	QA529	5BRICO
26/10/2021	19:30:15	City	SALISBURY	UPPER COOMERA	(Response Viewer)	Response_Master_Incident	QA529	5B
26/10/2021	19:30:20	Address	(Blank)	Irrelevant	New Entry	Response_Master_Incident	QA529	ICOR
26/10/2021	19:30:23	Address	Irrelevant		Entry Selected/Returned from GeoLocator	Response_Master_Incident	QA529	BRICOR
26/10/2021	19:30:23	Latitude	0	62141474	Entry Selected/Returned from GeoLocator	Response_Master_Incident	QA529	BRICOR
26/10/2021	19:30:23	Longitude	0	26701574	Entry Selected/Returned from GeoLocator	Response_Master_Incident	QA529	BRIC
26/10/2021	19:30:24	Jurisdiction		6 Southport Gold Coast	(Response Viewer)	Response_Master_Incident	QA529	OR
26/10/2021	19:30:24	Division		6 Coomera	(Response Viewer)	Response_Master_Incident	Q	5B R
26/10/2021	19:30:24	Battalion		6 Coomera	(Response Viewer)	Response_Master_Incident	29	5BRI
26/10/2021	19:30:24	Response_Area		6 Coomera	(Response Viewer)	Response_Master_Incident	A529	5BRICOR
26/10/2021	19:30:24	ResponsePlanType	0	0	(Response Viewer)	Response_Master_Incident	QA529	BRICOR
26/10/2021	19:30:24	Primary_TAC_Channel		TLK GRP 111/UHF Ch 103	(Response Viewer)	Response_Master_Incident	QA529	ICOR
26/10/2021	19:30:32	Location_Name	CHUBB		(Response Viewer)	Response_Master_Incident	QA529	COR
26/10/2021	19:30:45	ProQaCaseNumber		17899879	(Response Viewer)	Incident		5 COR
26/10/2021	19:31:52	Problem		HAEM/LAC ABNOR BREATH MEDICAL	(Response Viewer)	Response_Master_Incident	Q 9	5 COR
26/10/2021	19:31:52	Response_Plan		Acute	(Response Viewer)	Response nt	QA529	BRICOR
26/10/2021	19:31:52	DispatchLevel		Normal	(Response Viewer)	Respons aster_In	QA529	5BRICOR
26/10/2021	19:31:52	ResponsePlanType	0	1	(Response Viewer)	Respo _Master_Inc	QA529	5BRICOR
26/10/2021	19:31:52	Incident_Type		ACUTE	(Response Viewer)	Resp e_Master_In n	QA529	5BRICOR
26/10/2021	19:31:53	Read Comment	False	True	(Response Viewer)	Resp e_Master_I ent	529	5BRICOR
26/10/2021	19:31:53	Priority_Number	0	3	Updated by ProQA	Resp e_Master ident	9	5BRICOR
26/10/2021	19:31:53	Determinant		21D05M	(Response Viewer)	Resp e_Mast ncident		5BRICOR
26/10/2021	19:31:53	EMD_Used	0	1	(Response Viewer)	Response_Ma _Incident	A529	5BRICOR
26/10/2021	19:31:53	CIS_Used	0	null	(Response Viewer)	Response_M _Incident	A529	5BRICOR
26/10/2021	19:31:53	Pickup_Map_Info	(Blank)	G6K4		Response_Tr orts	KEDCADQASCXA04	5BRICOR
26/10/2021	19:31:53	Map_Info		G6K4		onse_Ma Inciden	KEDCADQASCXA04	5BRICOR
26/10/2021	19:32:01	Read Call	False	True	(Respons ewer)	R se_Mas	PA606	6GENGRA
26/10/2021	19:32:04	Read Comment	False	True	(Respon iewer)	R onse_Master_ dent	PA605	6JACCHA
26/10/2021	19:32:28	Field_Data		Irrelevant	Patient me:	sponse User_Data_Fields	QA529	5BRICOR
26/10/2021	19:32:37	Field_Data			Patient B:	Respon ser_Data_Fields	QA529	5BRICOR
26/10/2021	19:34:28	Current_UnitRespPriorityDesc	601594: 1C	HOT1C	Field R nse	Respons ehicles_Assigned	KEDCADQASMDI01	
26/10/2021	19:35:18	Read Comment	False	True	(Respon ew	Respons aster_Incident	QA529	5BRICOR
26/10/2021	19:36:34	CIS_Used	0	null	(Respons)	Respon Master_Incident	QA529	5BRICOR
26/10/2021	19:36:34	ProQATerminationStateCode		C	Response r)	Incide	QA529	5BRICOR
26/10/2021	19:36:37	Read Comment	False	True	sponse Vi	Re e_Master_Incident	QA529	5BRICOR
26/10/2021	19:54:17	Read Comment	False	True	onse Viewe	onse_Master_Incident	PC919032	215ZAYBOU
26/10/2021	20:25:02	Current_UnitRespPriorityDesc	601594: HOT1C	COLD1C	Fi sponse	Response_Vehicles_Assigned	KEDCADQASMDI01	
26/10/2021	20:25:02	Map_Info	(Blank)	G28M10		Response_Transports	KEDCADQASMDI01	VisiNET
26/10/2021	21:10:37	Map_Info	(Blank)	G38P9		Response_Transports	KEDCADQASCXA32	6JACCHA
26/10/2021	21:52:54	Read Comment	False	True	(Respons wer)	Response_Master_Incident	PA605	6JACCHA
26/10/2021	21:59:07	Read Comment	False	True	(Response r)	Response_Master_Incident	PA605	6JACCHA

Significant Incident Review

Metro North Region

Authority:
By authority of David Hartley A/Assistant Commissioner, Metro North Region

Executive Summary:

QAS responded to a call for assistance for an Irrelevant patient bleeding from an existing wound on the foot. The patient was reportedly on anti-coagulants and the bleeding was unable to be controlled. A Triple Zero (000) call was made by the patient's son, who had advised the Emergency Medical Dispatcher (EMD) that he was unable to follow haemorrhage control instructions as he did not have any medical training. The patient elected to remain in the shower with an actively bleeding foot and wait for the arrival of QAS.

The closest available resource was attached from Lakeside Park, Kurwongbah. Upon the crew's arrival, the patient was found to be unconscious, not breathing with approximately 3L of blood loss noted in shower. CPR was immediately commenced, and additional resources appropriately requested by crew.

The patient was resuscitated for a total of 35 minutes prior to achieving a Return Of Spontaneous Circulation (ROSC). The patient maintained ROSC throughout the transport to Caboolture Hospital, however remained GCS3 and intubated. A poor prognosis was expected for the patient given the amount of time in cardiac arrest secondary to exsanguination. Caboolture Hospital confirmed to QAS that the patient was declared deceased a short time after arriving in ED.

Terms of Reference:
This review will investigate all aspects of ambulance response to incident 15042758. 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 ***(excerpt from dARF)***

> **Presenting Complaint:** CT 87 YOM C/O laceration to foot.
>
> **Hx of Presenting Complaint:** OA QAS met by the pts son who led QAS through the house to the pt- stating that the pt has stopped talking about 10mins ago, I think Irrelevant passed out . OA the pt was sitting upright on a chair with legs in the shower- Irrelevant appeared, unconscious, pale, not breathing, with approx 3 L blood loss in the base of shower- nil obvious active bleeding from wound in R foot. The pt was peripherally cold but felt centrally warm- the pt was lifted from the chair and moved to the centre of the adjacent room- the pts son was asked to assist with CPR but he refused. Son could not relay any Hx for the pt and could not specify if the pt had an AHD. Appropriate time of unconsciousness 10 mins prior to QAS arrival bleeding for approximately 30 mins prior to that. CCP and back up crew requested code 1.
>
> **Examination:** OE pt GCS 3, not breathing, intact airway- nil obstructions or vomitus, nil active bleeding from wound large skin tear to L arm (injury was there on QAS arrival), ECG (defibrillator pads) indicated narrow complex PEA @ 30BPM- CPR was started. Large pool of blood in shower approximately 3-5L estimation with flexibility for amount that may have drained.
>
> **Disposition:** CPR was commenced, Red OP airway inserted, IV access gained with total of 2 L fluid administered during arrest- CCP and back up crew arrived- LMA initially attempted with nil C02 readings- changes to IGel with same result. (Equipment was checked and rechecked with plan to change monitors post intubation if problem persisted). Intubated size 8.0mm Tube with grade 1 view on second attempt due to difficulty in passing epiglottis with tube over introducer. Total 3mg IV adrenaline administered during

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resuscitation. Consultation with Dr Steve Rashford conducted authorising termination of CPR however ROSC achieved after 35mins of resuscitation. ?Low output state requiring Adrenaline infusion of 50mcg/min to maintain haemodynamics. Capnography suggestive of cuff leakage and unable to be rectified however decent rise and fall of chest and positive C02 readings. Nil additional complications encountered with active warming. Post handover CAH Lactate 10mmoL, hB 60, pH 6.8mmoL.

Incident Review/Investigation:

Scope:

43-minute response to a 1C response – anti-coagulated patient bleeding from wound on foot. Nil first aid provided to patient prior to QAS arrival.

Background

At 2:41pm on Saturday 6 November 2021, QAS received a call for assistance for an Irrelevant patient bleeding from an existing wound on foot. The patient was currently on blood thinning medication. The call was made by the patient's son who was unable to comply with haemorrhage control instructions from the EMD during the Triple Zero (000) call. The ambulance arrived on scene 43 minutes after the call was received, finding the patient in cardiac arrest secondary to exsanguination.

Timeline

1st Key Stroke:	2:41pm
In waiting queue:	2:43pm
Assigned:	2:54pm
Enroute:	2:55pm
At scene:	3:24pm
Departed scene:	4:35pm
At hospital:	4:46pm
Partially available:	5:14pm

Sequence of Events

- 2:41pm – QAS received a request for assistance via Triple Zero (000) call.
- 2:47pm – note from call taker advising that patient was refusing to control bleeding and wants to keep in the water in bath.
- 2:49pm – CDS reviewed case and requested next available ambulance attend and incident to remain Code 1 until haemorrhage could be controlled.
- 2:54pm – first ambulance attached to case from Kurwongbah area, with an ETA of approximately 27 minutes away from scene.
- 3:24pm – first ambulance arrived on scene to find the patient in cardiac arrest secondary to exsanguination.
- 3:27pm – Caboolture CCP Pod attached to the incident with a Code 1 response from the Caboolture hospital area.
- 3:30pm – delayed SITREP entry "*patient is asystole cold but essentially warm slow PEA not talking CPR in progress*".
- 4:16pm – ROSC achieved, patient extricated and loaded into ambulance for transport.
- 4:35pm – 501223 departed to Caboolture Hospital with CCPs on board.
- 4:46pm – Arrived Caboolture hospital and handed over care.

Review

Operational

- 11minute and 25 second delay in dispatch for Code 1C.
- 43-minute delay from call received time to the first ambulance arriving on scene.

- Ambulance unit 501223 was attached as closest available resource from Kurwongbah area.
- Ambulance unit 501223 proceeded to the scene without delay.
- No haemorrhage control was applied to the patient's foot prior to QAS arrival.
- CAH and RDH both operating at BAU with no ramping delays at time of case.
- SEQ escalated to moderate pressure at 10:01am.

OpCen

- The initial Triple Zero (000) call was found to be of Partial-Compliance.
  - Review attached.
- OpCen review of case findings;
  - No recommendations carried out by Dispatcher for any of the units assigned
  - In queue 1C to the first unit assigned 11 mins 25 secs
  - Unit 501223 advised dispatcher delayed waiting for someone to let them out of the racetrack
  - Unit 501223 from responding to on scene - 29 mins 16 secs
  - Unit 501223 1st sitrep requested CCP code 1 - a unit was assigned in 18 secs
  - Dispatcher requested the sitrep repeated to provide to CCP, the Dispatcher hasn't entered the sitrep as exactly stated however 5 mins later it was re-entered by EMD on console 11.

Clinical Review by Regional CEU

- Case managed at standard. Good outcome given the events leading to presentation on scene. Nil clinical concerns or recommendations.

Regional Resourcing

- Metro North resourcing was reduced on this day. The table provided outlines the number of day and afternoon shifts that were unable to be filled. All attempts were made to fill these shifts using casuals, overtime and staff on accrued time.

Outcomes

- Patient transported to Caboolture hospital and was declared deceased a short time later by ED staff.

Post review actions

- SOS attended scene to meet with patient's family to apologise for the response delay.
- Patients' family appreciative of treating crews' efforts and real-time follow up.
- Patients' son voluntarily disclosed to SOS that he felt increasingly anxious throughout the Triple Zero (000) call and stated he did not have any medical training, therefore felt he could not provide any assistance with haemorrhage control.
- SOCC, District Director and Assistant Commissioner notified of case.
- Welfare check of attending crews at Caboolture Hospital.
- Incident notification generated.
- Significant Incident Review completed.

Review Recommendations

- Region will continue to make all efforts to fill unscheduled absences to ensure response times meet current QAS KPIs.

Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Incident notification to Region Executive team.
- WPU Staffing snapshot for days and afternoon shifts.
- Metro North PACH Summary – showing nil hospital escalations for RDH or CAH throughout day.
- 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


#15042758 - IDR.pdf


#15042758 -dARF.pdf


#15042758 - Beachmere_- Delaye

WPU Staffing Staffing

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	BRT	LARU	MH Co-responder	CCP	FCCP	HARU			
MTN	-9	-12				0		0	5	2	
	31%	85%				100%		100%			
MTS	-3	-12				0	0		3	3	
	73%	88%				100%	100%				
WMT	0	-1				0			3	1	
	100%	96%				100%					
MWPU Total	-12	-25				0	0	0	11	6	0
	56%	88%				100%	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	BRT	LARU	MH Co-responder	CCP	FCCP	HARU			
MTN	-3	-12		-5					2	4	
	50%	65%	100%	50%	100%						
MTS	-1	-5		-4					0	2	
	86%	91%		43%	100%						
WMT	-1	-2		0					0	1	
	50%	88%		100%							
MWPU Total	-5	-19	0	-9	0				2	7	0
	67%	82%	100%	53%	100%						

Metro North PACH Executive Summary for CAH & RDH for 6th November 2021

MNHHS Facility	Predicted Acute Bed Capacity up to 12MN	Emergency Department	"Never Events"	Comments
Caboolture	5	[redacted]	Nil	QAS Level 0 Nil Escalations Internal Level BAU 1 Medical bed flexed down
Redcliffe	4	[redacted]	Nil	QAS Level 0 Nil escalations Internal Level BAU

Details of active incidents and Hospital delays 1 hour prior and while incident was active

Queensland Ambulance Service: Operational Incident Reporting

	Hospital	Total no. ambulances at Hospital (with pts on stretcher)	Total no. ambulances ramped (>30 mins POST)	Maximum ramped time	Escalation level
13:30 to 13:44 (6/11/2021) 1 hour prior to Case	Prince Charles Hospital	2	0	N/A	
	RBWH	3	0	N/A	
	Redcliffe Hospital	1	0	N/A	
	Caboolture Hospital	1	0	N/A	
14:30 to 14:44 (6/11/2021)	Prince Charles Hospital	1	0	N/A	
	RBWH	2	0	N/A	
	Redcliffe Hospital	4	0	N/A	
	Caboolture Hospital	1	0	N/A	
15:30 to 15:44 (6/11/2021)	Caboolture Hospital	3	0	N/A	
	RBWH	3	0	N/A	
	Redcliffe Hospital	1	0	N/A	
	Prince Charles Hospital	4	0	0:52:46	

	Priority	Number of Incidents	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)
13:30 to 13:44 (6/11/2021) 1 hour prior to case	1	0	N/A	N/A
	2	4	0:11:16	0:29:18
14:30 to 14:44 (6/11/2021)	1	0	N/A	N/A
	2	8	0:15:28	0:35:52
15:30 to 15:44 (6/11/2021)	1	0	N/A	N/A
	2	10	0:39:05	1:11:31

Regional Endorsement

(Document must be signed by Regional Assistant Commissioner and converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Name	Position	Signature	Date
David Hartley	Acting Assistant Commissioner	Irrelevant	3/12/21
Lisa Dibley	District Director		2/12/21

Department of Health

Queensland Ambulance Service

Metro North Region

Authority:

By authority David Hartley, Assistant Commissioner, Metro North Region.

Executive Summary:

On 7 November 2021 at 3:28am the Queensland Ambulance Service (QAS) received a Triple Zero (000) call for assistance (Incident number 15044842) at Irrelevant Rothwell, to attend a Irrelevant patient with difficulty in breathing.

The incident was initially prioritised in the Medical Priority Dispatch System (MPDS) as MPDS Determinant 06D02 Difficulty speaking between breaths, requiring a code 1B response. An ambulance was unable to be dispatched after this Triple Zero (000)-call due to high demand in workload. At 3:44am, 16 minutes after the initial call, a second Triple Zero (000) call was received with the caller stating that the patient was not breathing. At 3:46am two ACP crews were attached to the incident arriving on scene at 3:52am. The Operations Supervisor and a Critical Care Paramedic were attached to support the primary response.

Upon arrival to the scene, the patient was located in the entrance way to the toilet, with ineffective bystander CPR in progress. QAS commenced resuscitative efforts for 16 minutes., The Clinical Consult line was consulted with the advice to continue resuscitation to 20 minutes prior to discontinuing resuscitation attempt was provided. Recognition of Life Extinct was declared at 4:16am with Queensland Police Service (QPS) requested to attend the scene.

The Brisbane OpCen pending queue at the receipt of the first Triple Zero (000) call revealed there were one Code 1 and 18 Code 2s incidents waiting to be dispatched. During the night of 6 and 7 November 2021 there was very high demand for service across the Metro North and Metro South response areas with South East Queensland escalation of "Extreme Hospital Delays" affecting paramedic availability.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 15044842. The review will examine ambulance operations prior to, during and following the response.

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

LASN Clinical Incident Summary Report:

Case managed at standard. There were no clinical concerns or recommendations.

State OpCen ProQA:

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

Critical Deviations
1 x Did not meet the Minimum Standard of Practice
1 x Did not follow appropriate DLS links
1 x Determinant Level incorrect
1 X Critical deviation (Multiple) PDI's omitted

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Major Deviations
1 x KQ omitted

Moderate Deviations
1 x Key Question answer recorded incorrectly
1 x Case Entry Question answer recorded incorrectly
1 x KQ asked incorrectly
1 x EIDS tool not utilised correctly
1 x Freelance Question

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 was created as a QAS Code 1B response whereas the reviewers identified that a QAS Code 1A was appropriate.

The reviewers felt that by not selecting the appropriate ECHO response, by not offering airway management instructions as part of DLS, and by not staying on the line, the EMD has not met the minimum standard of care expected on this call.

The second Triple Zero (000) call was found to be **Non-Compliant**.

Critical Deviations
1 x Chief Complaint Selection incorrect
1 x PDIs omitted (Numerous)
1 x Did not follow appropriate DLS Links

Major Deviations
Nil

Moderate Deviations
1 x CE Question asked incorrectly.
1 x Fast Track not utilised
1 x Calming Techniques not used
1 x Compression tool used incorrectly.

The QAS priority (QAS Code 1A) was deemed to be correct the time when the call was reconfigured.

While this call has been evaluated as Non-Complaint, the deviations are technical in nature and while particular pathways have been followed by the EMD, and technically incorrect, there was not any significant delay in getting the resuscitation effort commenced by the EMD.

Incident Review/Investigation:

Scope

- Resources dispatched
- Timeliness of dispatch
- Appropriateness of resources dispatched
- Overview of clinical management

Background

- On 7 November 2021 at 3:28am triple zero was called for a Irrelevant who was experiencing difficulty in breathing.

- The call was disconnected as the OpCen was under emergency disconnect rule. This involves the EMD having to terminate the Triple Zero (000) call to answer pending Triple Zero (000) calls.
- An ambulance was unable to be immediately dispatched due to workload with the EMD performing a common call. This involves the dispatcher utilising a general broadcast across the talkgroup announcing the pending incident. This may prompt an ambulance crew to reprioritise their current taks to become available to respond.
- At 3:44am the caller phoned back reporting that the patient was not breathing.
- At 3:46am unit 501127 was dispatched from Brighton and 501376 (Out of Service from shift finish) dispatched from Deception Bay.
- At 3:52am unit 501376 arrived on scene 23 minutes after the initial call.
- At 3:54am Metro North Operations Supervisor arrived on scene.
- At 3:56am unit 501127 arrived on scene.
- At 4:16am the patient was declared deceased.
- At 4:17am the Critical Care Paramedic arrived on scene.

Timeline

1st Key Stroke: **03:27am**
In waiting queue: **03:28am**
Assigned: **03:45am**
EnRoute: **03:46am**
At scene: **03:52am**
Departed scene: **NA**
At hospital: **NA**
Partially available: **05:30am**

Review

Lost Time

On 6 November 2021, the QAS Metro North Region experienced 48 hrs of 'Lost Availability' at Emergency Departments. On 7 November 2021, the QAS Metro North Region experienced 94 hrs of 'Lost availability' at Emergency Departments. This "Lost Availability' reduces the number of ambulances available to deploy to pending incidences. When this occurs, the QAS prioritise responses according to clinical acuity.

Workforce Planning:

NIGHT 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	Twilight	LARU	MH Co-responder	CCP	FCCP	HARU			
MTN		-1	14			-1			0	2	
		[redacted]				[redacted]		[redacted]			
MTS		-14	6			0			0	1	
		[redacted]				[redacted]	[redacted]				
WMT		1	10						0	0	
		[redacted]				[redacted]					
MWPU Total		-14				-1	0	0	0	3	0
		88%				86%	[redacted]	[redacted]			

There were no issues with resourcing in Metro North region.

Resource Review

	Priority	Number of Incidents	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)
02:45 to 02:59 (07/11/2021)	1	2	0:15:03	0:23:51
	2	23	1:51:05	6:40:45
03:00 to 03:14 (07/11/2021)	1	2	0:33:34	0:39:24
	2	18	2:11:51	6:56:18
03:15 to 03:29 (07/11/2021	1	1	0:03:45	0:03:45
	2	18	2:04:58	7:10:48
03:30 to 03:44 (07/11/2021)	1	3	0:13:26	0:18:42
	2	21	2:01:29	7:22:16

	Hospital	Total no. ambulances at Hospital (with pts on stretcher)	Total no. ambulances ramped (>30 mins POST)	Maximum ramped time	Escalation level
02:45 to 02:59 (07/11/2021)	Ipswich Hospital	6	2	2 hr 12	3
	Royal Brisbane Hospital	3	1	34 mins	
	Redcliffe Hospital	2	0	22 mins	
	Caboolture Hospital	1	0	22 mins	
	Princess Alexandra Hospital	1	1	1hr 34	
03:00 to 03:14 (07/11/2021)	Ipswich Hospital	4	3	2 hr 28	3
	Logan Hospital	2	2	52 mins	2
	Royal Brisbane Hospital	3	1	50 mins	
	Prince Charles Hospital	2	0	32 mins	
	Redlands Hospital	1	0	25 mins	
	Redcliffe Hospital	1	0	1 mins	
03:15 to 03:29 (07/11/2021	Ipswich Hospital	3	3	2 hr 42	
	Royal Brisbane Hospital	1	1	01hr 05	
	Redcliffe Hospital	1	0	16 mins	
03:30 to 03:44 (07/11/2021)	Ipswich Hospital	4	3	2 hrs 57	3
	Redcliffe Hospital	2	2	31 mins	
	Prince Charles Hospital	1	0	12 mins	
	Princess Alexandra Hospital	2	0	8 mins	
	Caboolture Hospital	1	0	1 mins	
	Redcliffe Hospital	3	3	48 mins	2
	Caboolture Hospital	2	1	35 mins	

Outcomes

- Irrelevant pronounced deceased on scene post unsuccessful resuscitation.
- Matter referred to QPS.

- Debrief conducted by OS with officers involved in case.
- Metro North Senior Operations Supervisor phoned the spouse of the deceased to offer condolences for the passing and to advise that the case was being reviewed with an outcome to be provided.
- Region reviewing the standard of clinical care provided by the attending paramedics.

Post review actions

- Clinical review of case undertaken. – completed and no further action required.
- Follow up and further education provided to the EMD. – this has been completed as advised by the Director Brisbane OpCen.

Review Recommendations:

- Family contacted by region representative to provide outcome of the review.

Appendix of relevant documents/files:

- Incident Detail Report 15044842
- Electronic Ambulance Report Form 503863970
- Workforce planning snapshot
- 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.

Regional Endorsement

(Document must be signed by Regional Assistant Commissioner and converted to PDF and sent to Irrelevant @ambulance.qld.gov.au)

Name	Position	Signature	Date
David Hartley	Assistant Commissioner	Irrelevant	26.11.21
Lisa Dibley	District Director		26/11/21

Wide Bay District IR109-2021

Authority:

By authority of Russell Cooke, Director Wide Bay District

Executive Summary:

On Thursday 25th November 2021 at 01:22 Queensland Ambulance Service (QAS) Maroochydore Operations Centre (OpCen) received a 000 call for a welfare check by Irrelevant (Patient) at his address Irrelevant Apple Tree Creek. ProQA coded this incident as a 2A 25B03 with Bravo Unit 4509 from Childers being responded.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 15122944.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process.*

LASN Clinical Incident Summary Report:

The WB District Clinical Education Unit completed an ECLIPSE clinical review on the 26/11/2021.

ECLIPSE ID 46229

- Documentation and management to required standards.

Incident Review/Investigation:

Scope:

This review will critically analyse the delayed response of the Queensland Police Service (QPS) to support QAS paramedics in executing their duties in a safe manner. The review considered all aspects of this case including the following-

- Paramedics decision to delay entering the dwelling and request for QPS assistance
- QPS decision to initially deny assistance before requesting the Childers QPS officers to attend.
- The time delay for this patient before receiving definitive clinical management.

This investigation reviewed the following information-

- Incident Detailed Report (IDR)
- electronic Ambulance Report Form (eARF)

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- Wave Files (OpCen) audible communications between OpCen and the attending crew and a conversation between the QAS OpCen Centre Supervisor (OCS) Sheryl Beaumont and QPS OpCen Sergeant Chris Mcloughlin.

Background:

QAS received a call from Irrelevant regarding the patient who was calling Irrelevant friends with suicidal thoughts/ tendencies. No contact had been made with the patient for two hours. A history was noted on the Mental Health (MH) database for a long Hx of depression, alcoholism, and a recent Emergency Examination Order (EEA) having been completed. Further to this, social issues regarding the loss of Irrelevant were believed to be compounding Irrelevant emotional state.

QAS dispatched two Advanced Care Paramedics Level 2 (ACP²) from Childers Station who were on Emergency Availability. Officers Isabella Gibson (401788) and Jesse Gleeson (36198) attended the residence.

On arrival, the house was found to be locked up, with a large dog barking behind the closed door in retaliation to their knocking. Further exploration revealed a person in a bedroom snoring, which was audible from the outside. As the crew could not gain access due to the dog, they knocked loudly on the bedroom window to try and rouse the person. Despite this, the crew were unable to gain a response from the individual.

A review of the information reveals the crew maintained constant contact with the OpCen, with information being updated pertaining to PMHx, attempted actions and the inability of the patient to be roused. ACP² Gleeson stated he thought the risks of self-harm/ overdose verses the patient just being asleep throughout constant banging and the dog barking warranted execution of entering the building for an urgent welfare check. Both ACP" s made a reasonable decision for their safety in not to entering the residence due to the large dog that was displaying aggression.

The crew were unable to visualise the dog or patient whilst waiting outside. ACP² Gleeson did open the door to see what the dog was doing. As this occurred a large German Shepard raced towards the door aggressively. ACP² Gleeson shut the door immediately and awaited Queensland Police Service (QPS). OpCen requested QPS to allow QAS safe passage into the residence to assess the observed individual.

OpCen requested QPS attendance at 01:47 to assist via ICEMS. During what was an extended period whilst QAS and QPS OpCen discussed the case, QPS attended the scene at 03:36, one hour and forty-nine minutes since the initial request for assistance.

After QPS arrival, both agencies entered the dwelling with the dog staying on the lounge growling. QAS quickly located the patient and found a Irrelevant lying supine on the bed with a Glasgow Coma Score (GCS) of 03, establishing the patient was unconscious. The patient was noted to have a positional airway occlusion, hypotensive due to a possible alcohol/ drug OD. Retrospectively the patient was found to have suffered a polypharmacy overdose.

Queensland Fire and Rescue were quickly requested, and transport subsequently initiated to Bundaberg Base Hospital in 4509.

Timeline:

01:22 Call Received

01:28 IDR- Pt was threatening self-harm when speaking with a friend Irrelevant last heard from > 2hrs ago

01:34 MAR OpCen tried residential landline- nil success

01:36 MHLC contacted- Irrelevant on database

01:40 Assigned (Both 4422/4509)

01:47 Enroute (4509)

01:47 IDR- Mar OCS contacted QPS explaining situation and requesting QPS attendance

01:50 IDR- MHLC added information last seen this month/ PMHx alcohol dependence/ depression. Recent EEA for drug OD. Comments also regarding a change in social situation.

01:52 IDR- "Request for attendance" has not been actioned by POL-Q

01:55 IDR- POL-Q state no flags for violence and suggest the sister as a contact for Irrelevant mental health- Irrelevant

02:01 Arrived (4509)

02:09 IDR- to POL-Q by MAR OCS someone in the house, snoring loudly, large dog barking inside. Hx of previous pt OD and QAS need to confirm pt sleeping or OD. Can QPS attend please

02:17 IDR- POL-Q to QAS Childers are not currently rostered on. Can QAS crew make more enquiries before requesting QPS

02:23 IDR- MAR Dispatcher to POL-Q? pt OD Unconscious unable to confirm until QAS get access to the property, large dog barking. QAS have safety concerns due to the animal.

02:33 IDR- POL-Q sent a large text regarding the QAS/QPS Interagency Agreement 2019 and how the officers must access a risk relating to an individual not just a barking dog. QPS are asking for what danger is the dog presenting to QAS on scene

02:35 IDR- QPS are attempting to ring the occupant

02:42 IDR- Mar OCS to POL-Q advising QAS knocking loudly, dog inside and upset (risk to crew) Pt has PMHx of OD and crew need to confirm an OD or sleeping pt

02:43 IDR- POL-Q QPS on phone with supervisor to review availability and capacity to attend

02:50 IDR- ICEMS POL-Q Have staff to attend if required

02:53 IDR- Mar OCS requesting an ETA for QPS

02:55 IDR- ICEMS POL-Q QPS have a Bundaberg crew to attend ETA 30minutes

03:02 IDR- ICEMS POL-Q QPS state Bundaberg not available/ Childers finished at 22:00 hrs and can QAS confirm if QPS still needed, is the dog inside, what risk is it to QAS and advise why QPS is needed

03:20 IDR- ICEMS POL-Q QPS recalled to duty for QAS officer safety and to gain access to the house for a welfare check.

03:31 IDR- ICEMS POL-Q QPS responding

03:36 IDR- ICEMS POL-Q QPS now on scene

03:46 IDR- 4509 requesting QFES for extrication due to pt being GCS 03

03:58 IDR- ICEMS FIRE-Q QFES on route

04:06 IDR- ICEMS FIRE-Q QFES on scene

04:22 Depart (BBH)

04:57 Arrived Destination (BBH)

05:55 Complete (BBH)