arriving on scene at 23:51hrs. The QAS also dispatched the single officer OS unit at 23:44hrs to respond, arriving as the first officer on scene at 23:49hrs, 45 minutes after the initial Triple Zero (000) call.

At 23:52hrs, CDS approved the upgrade of the incident from a Code 1B incident to a Code 1A incident, with CCP/Officer in Charge to respond to Code 1A.

At 23:53hrs after being on scene for four minutes, the OS provided a situation report via radio that the pati nt was now unconscious and CPR was about to commence, which was later confirmed in progress at 23:56 rs. At 00:45hrs the paramedics advised the patient was deceased and requested Queensland Police Servic (QPS) attend. QPS was dispatched at 01:49hrs and arrived on scene at 01:57hrs.

The QAS response time to this incident was 45 minutes from receipt of the Triple Zero (000) ll, however this included a 34 minute delay between the time of the CCP unit was “recommended” to att d the e which was not accepted by the EMD and when the CCP was dispatched to attend the inciden :41hrs.

At the time of the Triple Zero (000) call, the Brisbane Operations Centre experienc d a nu ber of p es affecting paramedic availability to respond to emergency cases in the community This inc ud d a high demand for ambulance services in the community; a number of unscheduled sta vacan ies in e Brisbane area which were unable to be backfilled, despite all usual attempts being made; and QAS expe iencing delays offloading patients at Metro North and Metro South Hospital and H h Servic (HHS) public hospital Emergency Departments (ED’s). Consequently, these pressures resul ed in a h h dem or ambulance services for several hours before and after the Triple Zero (000) call roducing a high demand for service and activity in the Operations Centres across South Easte Queens nd th call acks being regularly performed, multiple “common calls” on dispatch boards, and tive ma gement o a significant pending queue existed.

Terms of Reference:

This review will review all aspects of ambulance re onse t ncident 14221322. The review will examine ambulance operations prior to, during and following he r ponse This review will include all requirements outlined in the *Operational Incident R view rocess*

LASN Clinical Incident S mmary R port:

A Clinical Review was underta n and is

No clinical issues identified

Synopsis:

- Irr evant who is reported by support worker to be dyspnoeic with episodes of apnoea, aphoretic, cold d not alert.
- n arrival of single ficer, patient was in cardiac arrest. Family member assisted relocating patient to e floor.
- Pres ting rhythm was Pulseless Electrical Activity (PEA) - 20bpm, and the patient was unconscious – Glasc w Coma Score 3.
- CPR was mmenced.
- Intra Osseou (IO) access was obtained and patient was administered six Adrenaline boluses and a Laryngeal Mask Airway (LMA) was utilised in a timely manner.
- Mechanical chest compression device was utilised.
  se in PEA rate to 40 bpm queried to result from Adrenaline administration.
- Consideration was given by responding paramedics to intra-arrest lysis, however this was withheld due to lack of supporting information and the patient’s history of Alteplase allergy.
- Decision to continue resuscitation was made on scene in the interest of crew safety as it was deemed to require a difficult extrication from loft.
- The patient’s clinical presentation was deteriorated, with PEA decreased to 18bpm, no spontaneous respirations, pupils fixed and dilated.

- Total resuscitation time was approximately 55 minutes.

Pertinent information:

- Contraindicated for intra-arrest lysis.

Clinical Education Unit Recommendations:

- Emotive scene noted. Welfare check with clinicians / EMDs involved.

Well managed by all, of particular note initial single officer.

State OpCen ProQA:

A state Quality Assurance (QA) review of the Triple Zero (000) calls indicates the fir thr calls were managed appropriately, with deviations to practice recorded on the fourth call, ho ever, th deviations would have no impact on the final outcome of the response.

Review of Dispatch:

A review of EMD actions was undertaken in relation to use of the CAD recommend" fun on:

- At 23:07hrs, the EMD appropriately enacted the CAD recom end fu ction o identify recommendable units for dispatch as per protocol.
- At that time, several units appeared in a recommenda statu ut were ot available, with the exception of A506083 (CCP Metro North). These recomm ndatio e not accepted by the EMD, including the Critical Care Paramedic unit (A506083) who w s three minutes from the incident scene, located at Fortitude Valley.
- This unit was later dispatched at 11:41pm, en loca ed at Kedron Park.

At this time, the EMD alerted the CD ha ere we resourc s available to send, initiating a "Common Call" at 22:07hrs and again at 23:2 hrs to al nits on South de.

The QAS EMD requested the DS review e case at 23:29hrs, however there were no notes in the Incident Detail Report to indicate if this o urred

The QAS response time to this incid was 45 minutes from receipt of the Triple Zero (000) call, however this included a 34 minute delay betwee he time of the CCP unit was "recommended" to attend the case which was not ac ted by the EMD and en the CCP was dispatched to attend the incident at 23:41hrs. The EMD sh uld ha dispatched the closest available unit, being the CCP (A506083) unit to the incident, which wou have resu d in a response time 11 minutes earlier than occurred.

A rev f activity in the Op ations Centre during the timeframe of this case and for several hours before an after in cating a high leve f demand for service and activity in the Brisbane Operations Centre. Call backs were b g regularly performed, multiple "common calls" on dispatch boards and a significant pending queue existed.

In ident Review nvestigation:

S ope:

State Oper ons Centre and Metro South LASNs 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 by the patient's carer to attend a Irrelevant patient at Woolloongabba, initially being not alert, suffering from shortness of breath and fatigue.

Timeline:

23:04 Triple Zero (000) call received.
23:06 Call taking complete, waiting in queue.
23:07 EMD utilised "Recommend" function in InformCAD and identifies CCP unit A506083 as being available and three minutes from incident scene, however, does not dispatch unit. EMD advises CDS there are no available units to respond to incident.
Common call for any units to make themselves available to respond to a Code 1 inci nt.
23:21 Common call for any units to make themselves available to respond to a Code 1 incide
23:21 Second Triple Zero (000) call received - unknown if any changes to patient c on as the caller was outside waiting for QAS to arrive. Advised caller that EMD will call an check patien condition now.
23:24 Call back conducted by EMD - QAS attempted to call back on scene – ni espo se. V message left advising to call back on Triple Zero (000) if patient condition changes.
23:29 Third Triple Zero (000) call received - patient is struggling to bre EMD re ains n the telephone with the caller who was with the patient until paramedics arriv). EMD r quested DS review the call given the patient's changing condition.
EMD can hear extreme SOB on the phone, patient ing col
23:30 Call disconnected when caller entered a lift. EMD cal d back emain o ine. Carer asked to return to the patient to keep QAS updated about patient ndition
23:31 Fourth Triple Zero (000) call received – caller advised the p ient was sweating profusely, sometimes stopping breathing and caller really concerne abou e patie 's difficulty in breathing.
23:37 EMD requested permission from CDS to dis atch CC – patien sweating profusely and he does sometimes stop breathing. The caller was ncern d for e patient.
23:39 EMD noted they can hear ext hortnes of reath.
23:41 Pt is extremely exhausted
CCP unit (A506083) dis atched to in dent.
23:42 ACP crew (B501296) spatched to ncident.
CDS contacted the Op tions S erv) at the Princess Alexandra Hospital (PAH) to release a crew to respond to the i id t and if unable to, the OS was asked to proceed.
23:44 ACP unit (B507316) dispatc d.
23:49 ACP unit (B507316) arrived on ene.
Caller ad ed the patient is now g sping for air.
23:51 ACP crew (01296) arrived on scene.
23:52 EM changed sponse priority from QAS Code 1B to Code 1A response after CDS approved C P/OIC respon to Code 1A incident.
23:53 tuation report rec ed from on scene paramedic, advising patient is unconscious (GCS 3) with C about to be in pr ress.
23 54 CCP nit (A506083) arrived on scene.
23:56 Situatio eport received from on scene paramedic, advising CPR is now in progress.
00:45 Situation r ort received form on scene paramedic, advising patient is deceased and requested QPS attendance.
01 9 QPS was dispatched.
0 57 QPS arrived on scene.

Operational Review:

At the time of the Triple Zero (000) call at 23:04hrs on 29 April 2021, the Brisbane Operations Centre was xperiencing a number of pressures affecting paramedic availability to respond to emergency cases in the community. This included a high demand for ambulance services across South Eastern Queensland; a high number of unscheduled staff vacancies in the Brisbane area which were unable to be backfilled, despite all

usual attempts being made; and was experiencing delays offloading patients at Metro North and Metro South HHS public hospital EDs.

High demand for ambulance services across South Eastern Queensland:

At the time of the Triple Zero (000) call at 23:04hrs on 29 April 2021, the Brisbane Operations Centre was managing 44 pending incidents in the community who were waiting for an ambulance to attend:

- 2 x Code 1 incidents – longest had been pending for 1 hour and 15 mins.
- 42 x Code 2 incidents – longest had been pending for 7 hours and 42 mins.

Additionally, the Southport Operations Centre was managing three pending incidents in the com un ty in the Beenleigh area who were waiting for an ambulance to attend:

- 1 x Code 1C incident – longest had been pending for 57 mins.
- 2 x Code 2A incidents – longest had been pending for 19 mins.

Brisbane (Metro North, Metro South and West Moreton LASNs) on 29-30 April 202 :

The State Workforce Management Unit confirmed the QAS workforce resourcing cros Brisba on 29-30 April 2021, confirming QAS experienced high unscheduled staff leave (affecting Metro North, Metro South and West Moreton LASNs) which was unable to be backfilled:

- Metro North
  - Afternoon shift – two paramedic shift vacancies hree Lo al A ea Res nse Unit (LARU) shift vacancies
  - Night shift – three paramedic shift vacancies, one C cal Car medic (CCP) pod shift vacancy
- Metro South
  - Afternoon shift – 11 additional paramed c shifts
  - Night shift – 18 paramedic shift vacanc s
- West Moreton
  - Afternoon shift – thre paramed shift vac cies
  - Night shift – six pa medic shift acancies

QAS attempted to cover these s s usi g the deployment of rostered officers, offering shifts to operational casual officers, and through the util on of overtime to off duty staff, however this was unsuccessful.

Delays offloading atients at Metro North nd Metro South HHS hospital EDs:

There was v y high mand for service across the Metro South LASN and Metro South Health and Hospital Service (HHS) hospital E ergency Department (ED), delays were experienced at most scope hospitals, affectin paramedic availab ty.

H pital ED lays were experienced at most hospitals across South Eastern Queensland, particularly affecting Metro orth and Metro South HHS hospital EDs, reducing paramedic availability:

A he time of the fir Triple Zero (000) call at 23:04hrs, there were 17 ambulance vehicles at these hospital E , with nine of them were ramped (>30 minutes), with the longest ramped at the Logan Community H spital (2 hours and 26 minutes) and on level 3 escalation (6 at hospital and 3 ramped); Queen Elizabeth II s it l (1 hour 56 minutes) and on level 2 escalation (5 at hospital and 3 ramped); Mater Adults Hospital (1 hour 52 m es) and on level 3 escalation (4 at hospital and 3 ramped); Redlands Hospital (1 hour and 7 minutes) (2 at hospital and 1 ramped); and Royal Brisbane and Women's Hospital (1 hour and 28 minutes) and on level 2 escalation (4 at hospital and 4 ramped).

QAS requires ambulances to be returned into a state of readiness within 30 minutes of arrival to hospital. The time elapsed past the 30 minutes reduces ambulance response capacity to the community.

Hospital Times

	Location	Currently At Dest	Enroute To Hospital	Average At Dest (hh:mm:ss)	Maximum At Dest (hh:mm:ss)	
View	QH CAIRNS BASE HOSPITAL	7	3	00:23:05	01:00:51	
View	QH IPSWICH HOSPITAL	7	0	00:47:19	01:49:33	
View	QH LOGAN COMMUNITY HOSPITAL	6	2	00:37:17	02:26:50	
View	QH QUEEN ELIZABETH HOSPITAL	5	3	01:02:01	01:59:05	
View	QH MATER ADULTS HOSPITAL	4	1	00:46:47	01:52:42	
View	QH ROYAL BRISBANE HOSPITAL	4	2	01:07:56	01:31:32	
View	QH ROCKHAMPTON BASE HOSPITAL	4	1	00:24:36	00:40:01	
View	QH MACKAY BASE HOSPITAL	3	0	00:18:19	00:28:30	
View	QH REDLANDS HOSPITAL	2	0	00:42:41	01:07:56	
View	QH CABOOLTURE HOSPITAL	2	2	00:28:13	00:31:07	
View	QH GOLD COAST UNIVERSITY HOSPITAL	2	1	01:07:05	01:18:01	
View	QH SUNSHINE COAST UNIVERSITY HOSPITAL	2	0	01:20:37	02:07:14	
View	QH BUNDABERG BASE HOSPITAL	2	1	00:28:32	00:39:12	
View	QH MAREEBA HOSPITAL	1	0	00:33:47	00:33:47	
View	QH PRINCE CHARLES HOSPITAL	1	1	00:49:11	00:49:11	
View	QH HERVEY BAY HOSPITAL	1	0	00:05:52	00:05:52	
View	QH INNISFAIL HOSPITAL	1	0	00:00:14	00:00:14	
View	QH NAMBOUR HOSP (A & E)	1	2	00:18:40	00:18:40	
View	QH ATHERTON HOSPITAL	1	0	00:02:39	00:02:39	
View	QH TOWNSVILLE UNIVERSITY HOSPITAL	1	1	00:00:34	00:00:34	
View	QH GYMPIE HOSP (A & E)	1	0	00:26:10	00:26:10	
View	QH TOOWOOMBA BASE HOSPITAL	1	0	00:05:56	00:05:56	
View	PINDARA PVH	1	0	00:07:22	00:07:22	
View	QH WARWICK BASE HOSPITAL	1	0	00:22:51	00:22:51	
View	QH MITCHELL GENERAL HOSPITAL	1	0	00:54:23	00:54:23	
View	QH PROSERPINE HOSPITAL (A&E)	0	1	00:00:00	00:00:00	
View	QH NOOSA DISTRICT HOSPITAL	0	1	00:00:00	00:00:00	
View	QH DALBY HEALTH SERVICE	0	1	00:00:00	00:00:00	
View	QH PRINCESS ALEXANDRA HOSPITAL	0	1	00:00:00	00:00:00	
View	QH GOLD COAST HOSPITAL ROBINA CAMPUS	0	1	00:00:00	00:00:00	

1 - 30

Findings:

- Th QAS resp se to this Code 1 incident involved a response time of 45 mins from the time of the i ial Triple Zero 000) call.
- e initial Triple Ze (000) call for service was appropriately prioritised by the call taker with in mation provided.
- The EMD should have dispatched the closest available ambulance unit to the Code 1B (immediate respons with lights and/or siren), being the CCP unit which was subsequently dispatched at 23:41hrs, t could have been dispatched at 23:07hrs, having a three minute response time to the incident scen
- The EMD utilised the “Recommend” function in InformCAD, identifying the closest, most appropriate paramedic, however the EMD did not accept this recommendation, resulting in a 34 minute response to a time critical incident.
- An appropriate high standard of clinical care was provided by the responding paramedics.
- The QAS response delay to attend the patient arose due to:
  - the EMD not dispatching the closest, most appropriate paramedic response, resulting in a response delay of 34 minutes had the EMD accepted the InformCAD recommended vehicle at 23:07hrs.

- a number of pressures affected paramedic availability to respond to emergency cases in the community, including a high demand for ambulance services across South Eastern Queensland; a high number of unscheduled staff vacancies in the Brisbane area which were unable to be backfilled, despite all usual attempts being made; and QAS was experiencing delays offloading patients at Metro South and Metro North HHS public hospital ED's.

- The QAS EMD requested the CDS review the case at 23:29hrs, however there were no notes in the Incident Detail Report to indicate if this occurred.

Review Recommendations:

- The EMD to receive remedial retraining regarding the utilisation of the recommend button and utilising as closest most appropriate resource at all times when dispatching paramedics to emergency cases.
- QAS to work collaboratively with the executives of the Metro South and Metro North HHS's to release paramedics from hospital ED's to improve paramedic availability to respond to emergency ambulance cases in the community.
- The QAS Medical Director, in accordance with standard QAS practices, to provide the State Coroner with detailed submissions outlining the circumstances of this review, including areas for systemic improvement.

Appendix of relevant documents/files:

- Incident Detail Report (IDR)
- Electronic Ambulance Report Form (eARF)
- State OpCen ProQA Wave Files – Triple Zero (000) calls
- Quality Assurance Summary Report
- iROAM snapshots
- Frontline Services Group (FSG)CAD Activity Report

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
AC State OpCens	Peter Warrener	General Manager		30/4/2021
A/AC Metro South	Anthony Hose	LASN Manager		12/05/2021

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

By authority of Acting Assistant Commissioner Chris Draper, Gold Coast Local Ambulance Service Network.

Executive Summary:

At 10:40pm on Saturday 1 May 2021, the Queensland Ambulance Service received a request for service for a Irrelevant with reported abdominal pain.

The 000 call was received in OPCEN 2, the case was coded as a 01C06, 2A response. The case was placed in the pending queue due to increased workload within the Gold Coast Local Ambulance Service Network.

At 11:14pm the clinical dispatch supervisor called back to the residence and obtained further clinical information about the patient. Information supplied indicated the patient had a history of kidney issues and a renal stent which was recently removed, the patients pain was on the left hand side, not in the back and has a history of bleeding from the bowel, past a clot yesterday and has had bowel issues in the last week.

At 11:23pm a 000 call was received at OPCEN 6, from the residence, the caller requested an ETA as the patient's pain was getting more severe, the call taker apologised for the delays and advised the local crew was on a case, the next available will be sent out from the Gold Coast area.

At 01:04am, Sunday 2 May 2021, a further 000 call was received at OPCEN 6, this call was from the residence in which the caller stated the patient was still in pain, notation on the IDR indicated the patient was still lucid, the call taker apologised for the for delays due to workload.

The Southport OPCEN on 4 separate occasions attempted to dispatch crews to the case, these units were sent on higher priority cases over the 2.5hrs the case was pending.

At 01:17am, Sunday 2 May 2021, A Southport crew (B 601508) arrived on scene, identified the patient was severely septic and requested a CCP code 1 to assist.

The patient was transported to the Gold Coast University Hospital code 1.

At 06:30am, ACP Nicol approached the GCLASN SOS, requested a review of the case due to the potential delay in response. Due to this conversation, the GCLASN SOS initiated a review and completed a notifiable incident notification to GCLASN Executive.

At 07:00am advice received is the patient died in the emergency department soon after arrival.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident CN 14229906
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

LASN Clinical Incident Summary Report:

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

State OpCen ProQA:

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

Incident Review/Investigation:

Scope:

The review considered the QAS resource allocation and response. Although the espond g units dispatched to higher acuity cases an OPCEN review should identify if the call back t 11:14pm the 1 May 2021 should have been upgraded in light of updated clinical information or if the ca shou have entially been re processed through a MPDS as a 21 Medical haemorrhage.

The response however based on dispatch matrix was appropriate cons ering er ca we of a higher acuity and MPDS response.

The initial response at 11:50pm was a single CCP (A 6015) this un was erted a ay from this case to a number of higher priority cases, CN 14229968 Hope Islan CN 14 34 Corn ia and CN 14230157 Coombabah.

The second unit dispatched to this case at 12:10am, this crew w diverted to a higher priority case at Oxenford CN 14230170.

The third unit dispatched (B 601505) to this cas at 12: am were diverted to a higher priority case at Coombabah CN 1423015.

The fourth unit dispatched (B 60 08) was 12:38am his crew rrived on scene at 01:17am.

The patient received care 2h 37mins from equest for service,

The patient arrived at hospita hrs 25m s from for service.

Background:

The Gold Coast SN and South East Que nsland were experiencing high demand throughout the afternoon, evening nd into th early hours of 2 May 2021.

The gh community d and resulted in available ambulance resources being diverted from low to high acuity c increasing delays low acuity pending cases, infrequent surges into hospitals within the Gold Coast Hospi and Health Service These surges saw some delays in off loading patients at facilities however did not resul hospital escalations.

Queensland Ambulance Service: Operational Incident Reporting

15-minute interval review.

10:45pm to 11:00pm

Pending Incidents

	OpCen	Priority	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)	Number of Incidents	
View	1	1	00:00:32	00:00:32	1	
		2	00:16:20	00:30:08	4	
View	2	2	00:03:09	00:03:09	1	
View	4	2	00:28:20	01:37:32	9	
View	5	1	00:04:10	00:07:49	2	
		2	01:29:08	03:27:45	31	
View	6	1	00:05:54	00:05:54	1	
		2	00:18:35	00:59:06	11	
View	7	1	00:07:55	00:07:55	1	
		2	00:58:10	02:04:08	4	
View	State	1	00:04:32	00:07:55	5	
		2	00:58:44	03:27:45	60	

QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 01/05/2021 Timeslot 22:45 - 22:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	01D01	14229670	1B	Cold	6594	21:48:25	21:56:26	21:56:36	22:14:23	22:28:39					00:01:30
View	19D04	14229682	1C	Cold	6504	21:50:23	21:51:11	21:51:51	22:02:35	22:24:56					00:00:37
View	12D02	14229612	1B	Cold	6561	21:29:58	21:33:26	21:33:36	21:59:02	22:17:58	22:38:14	-	-	00:12:00	-
View	17B01	14229529	2A	Cold	6543	21:07:07	21:09:26	21:10:23	21:30:22	22:03:30	22:34:29	-	-	00:15:45	-
View	25B03	14229550	2A	Cold	6316	21:15:37	21:49:44	21:49:51	21:49:52	22:01:59	22:21:40	-	-	00:28:34	-
View	36C03S	14229573	1C	Cold	6553	21:19:46	21:20:35	21:21:23	21:38:09	22:02:26	22:19:40	-	-	00:30:34	-
View	06C01	14229562	1C	Cold	6556	21:16:36	21:33:26	21:33:35	21:36:56	21:53:50	22:09:59	22:49:29	-	00:39:30	-
View	19D04	14229441	1C	Off	9228	20:32:07	20:32:50	20:34:06	21:01:01	21:14:09	21:44:59	22:13:53	22:13:53	00:29:03	

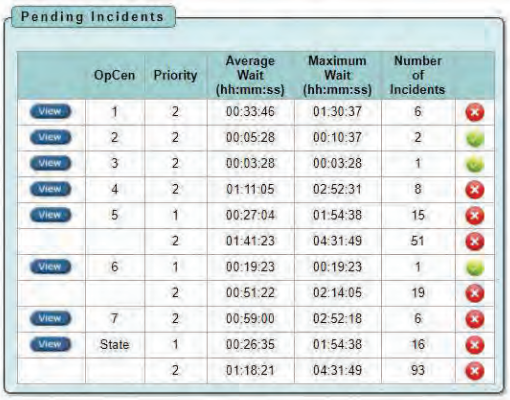
QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

Return Refresh

Date Created 01/05/2021 Timeslot 22:45 - 22:59

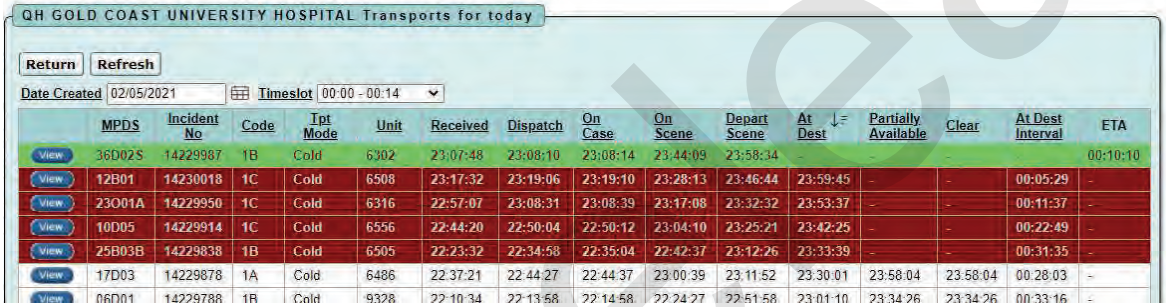
	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	01C03	14229784	1C	Cold	6586	22:08:43	22:11:31	22:11:40	22:28:07	22:45:58					00:03:16
View	17B01G	14229628	2A	Cold	6303	21:34:04	21:34:21	21:35:50	22:09:52	22:20:34	22:41:56	-	-	00:08:18	-
View	17B01P	14229609	2A	Cold	6562	21:29:02	21:35:15	21:35:23	21:46:11	22:14:58	22:38:45	-	-	00:11:29	-
View	MATA3	14229536	2A	Cold	6523	21:08:47	21:09:54	21:09:57	21:27:14	22:00:02	22:15:59	-	-	00:34:15	-
View	06D01A	14229544	1B	Cold	6505	21:12:15	21:12:35	21:12:43	21:17:36	21:33:23	21:55:09	22:24:20	22:25:03	00:29:11	-

12:00am to 12:15am



Pending Incidents

	OpCen	Priority	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)	Number of Incidents	
View	1	2	00:33:46	01:30:37	6	
View	2	2	00:05:28	00:10:37	2	
View	3	2	00:03:28	00:03:28	1	
View	4	2	01:11:05	02:52:31	8	
View	5	1	00:27:04	01:54:38	15	
		2	01:41:23	04:31:49	51	
View	6	1	00:19:23	00:19:23	1	
		2	00:51:22	02:14:05	19	
View	7	2	00:59:00	02:52:18	6	
View	State	1	00:26:35	01:54:38	16	
		2	01:18:21	04:31:49	93	

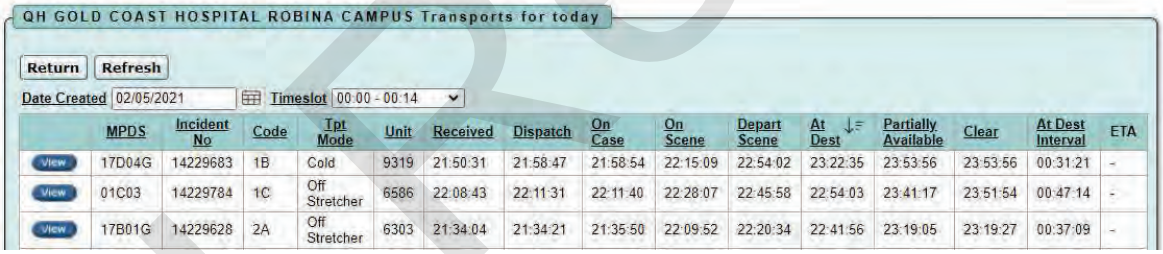


QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 00:00 - 00:14

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	36D02S	14229987	1B	Cold	6302	23:07:48	23:08:10	23:08:14	23:44:09	23:58:34	-	-	-	-	00:10:10
View	12B01	14230018	1C	Cold	6508	23:17:32	23:19:06	23:19:10	23:28:13	23:46:44	23:59:45	-	-	00:05:29	-
View	23O01A	14229950	1C	Cold	6316	22:57:07	23:08:31	23:08:39	23:17:08	23:32:32	23:53:37	-	-	00:11:37	-
View	10D05	14229914	1C	Cold	6556	22:44:20	22:50:04	22:50:12	23:04:10	23:25:21	23:42:25	-	-	00:22:49	-
View	25B03B	14229838	1B	Cold	6505	22:23:32	22:34:58	22:35:04	22:42:37	23:12:26	23:33:39	-	-	00:31:35	-
View	17D03	14229878	1A	Cold	6486	22:37:21	22:44:27	22:44:37	23:00:39	23:11:52	23:30:01	23:58:04	23:58:04	00:28:03	-
View	06D01	14229788	1B	Cold	9328	22:10:34	22:13:58	22:14:58	22:24:27	22:51:58	23:01:10	23:34:26	23:34:26	00:33:16	-



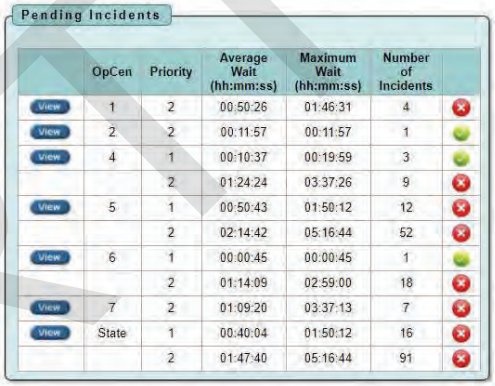
QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 00:00 - 00:14

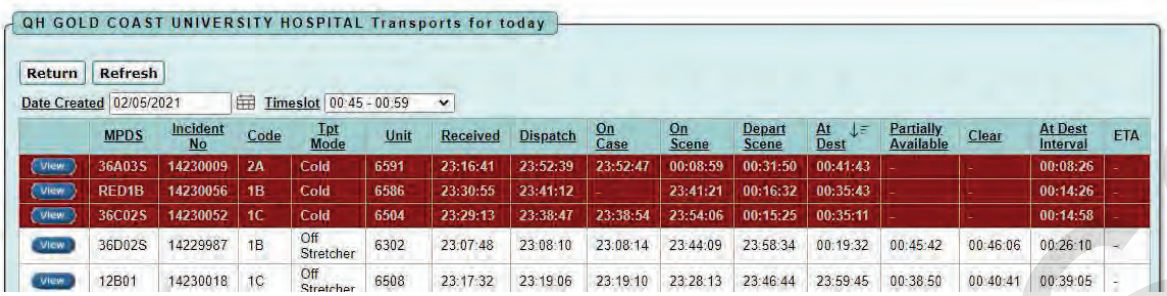
	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	17D04G	14229683	1B	Cold	9319	21:50:31	21:58:47	21:58:54	22:15:09	22:54:02	23:22:35	23:53:56	23:53:56	00:31:21	-
View	01C03	14229784	1C	Off Stretcher	6586	22:08:43	22:11:31	22:11:40	22:28:07	22:45:58	22:54:03	23:41:17	23:51:54	00:47:14	-
View	17B01G	14229628	2A	Off Stretcher	6303	21:34:04	21:34:21	21:35:50	22:09:52	22:20:34	22:41:56	23:19:05	23:19:27	00:37:09	-

12:45am o 1:00am



Pending Incidents

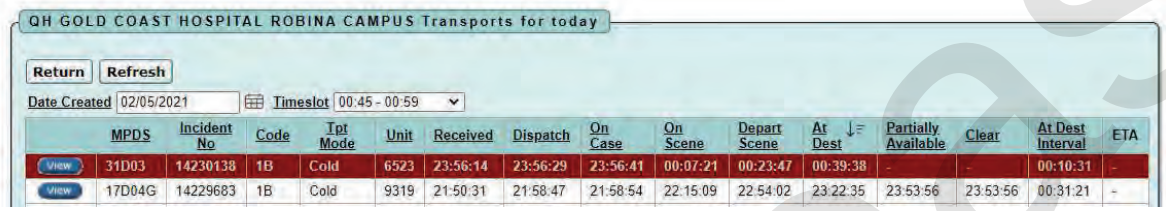
	OpCen	Priority	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)	Number of Incidents	
View	1	2	00:50:26	01:46:31	4	
View	2	2	00:11:57	00:11:57	1	
View	4	1	00:10:37	00:19:59	3	
		2	01:24:24	03:37:26	9	
View	5	1	00:50:43	01:50:12	12	
		2	02:14:42	05:16:44	52	
View	6	1	00:00:45	00:00:45	1	
		2	01:14:09	02:59:00	18	
View	7	2	01:09:20	03:37:13	7	
View	State	1	00:40:04	01:50:12	16	
		2	01:47:40	05:16:44	91	


QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 00:45 - 00:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	36A03S	14230009	2A	Cold	6591	23:16:41	23:52:39	23:52:47	00:08:59	00:31:50	00:41:43	-	-	00:08:26	-
View	RED1B	14230056	1B	Cold	6586	23:30:55	23:41:12	-	23:41:21	00:16:32	00:35:43	-	-	00:14:26	-
View	36C02S	14230052	1C	Cold	6504	23:29:13	23:38:47	23:38:54	23:54:06	00:15:25	00:35:11	-	-	00:14:58	-
View	36D02S	14229987	1B	Off Stretcher	6302	23:07:48	23:08:10	23:08:14	23:44:09	23:58:34	00:19:32	00:45:42	00:46:06	00:26:10	-
View	12B01	14230018	1C	Off Stretcher	6508	23:17:32	23:19:06	23:19:10	23:28:13	23:46:44	23:59:45	00:38:50	00:40:41	00:39:05	-

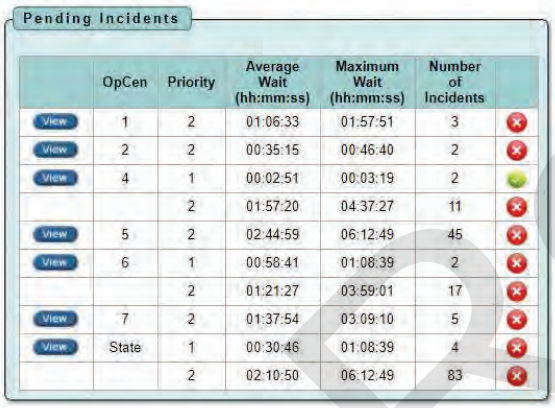

QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

Return Refresh

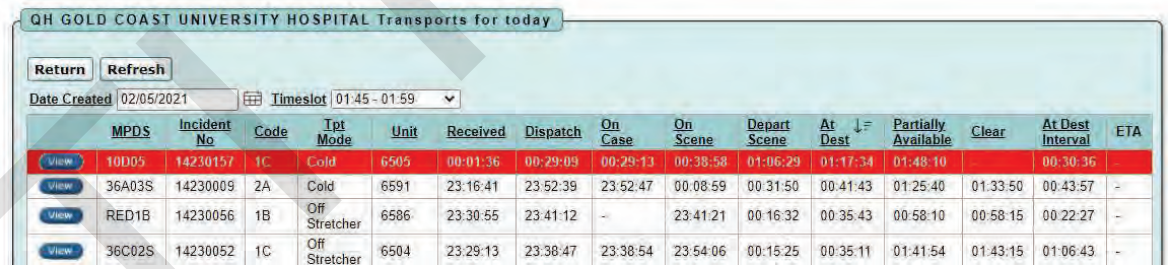
Date Created 02/05/2021 Timeslot 00:45 - 00:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	31D03	14230138	1B	Cold	6523	23:56:14	23:56:29	23:56:41	00:07:21	00:23:47	00:39:38	-	-	00:10:31	-
View	17D04G	14229683	1B	Cold	9319	21:50:31	21:58:47	21:58:54	22:15:09	22:54:02	23:22:35	23:53:56	23:53:56	00:31:21	-

1:45am to 2:00am


Pending Incidents

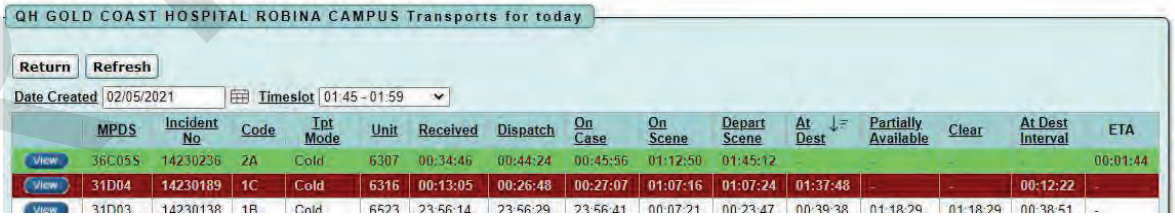
	OpCen	Priority	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)	Number of Incidents	
View	1	2	01:06:33	01:57:51	3	
View	2	2	00:35:15	00:46:40	2	
View	4	1	00:02:51	00:03:19	2	
		2	01:57:20	04:37:27	11	
View	5	2	02:44:59	06:12:49	45	
View	6	1	00:58:41	01:08:39	2	
		2	01:21:27	03:59:01	17	
View	7	2	01:37:54	03:09:10	5	
View	State	1	00:30:46	01:08:39	4	
		2	02:10:50	06:12:49	83	


QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 01:45 - 01:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	10D05	14230157	1C	Cold	6505	00:01:36	00:29:09	00:29:13	00:38:58	01:06:29	01:17:34	01:48:10	-	00:30:36	-
View	36A03S	14230009	2A	Cold	6591	23:16:41	23:52:39	23:52:47	00:08:59	00:31:50	00:41:43	01:25:40	01:33:50	00:43:57	-
View	RED1B	14230056	1B	Off Stretcher	6586	23:30:55	23:41:12	-	23:41:21	00:16:32	00:35:43	00:58:10	00:58:15	00:22:27	-
View	36C02S	14230052	1C	Off Stretcher	6504	23:29:13	23:38:47	23:38:54	23:54:06	00:15:25	00:35:11	01:41:54	01:43:15	01:06:43	-

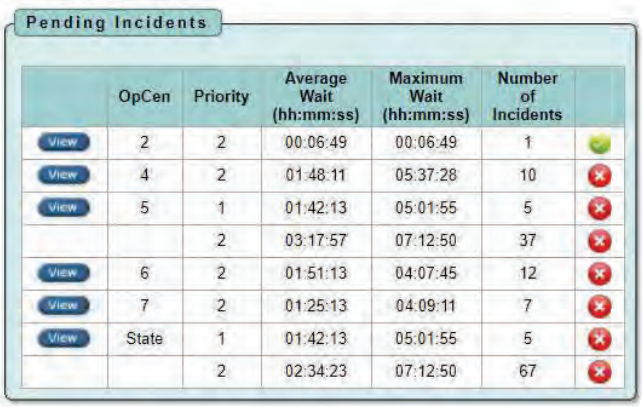

QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 01:45 - 01:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	36C05S	14230236	2A	Cold	6307	00:34:46	00:44:24	00:45:56	01:12:50	01:45:12	-	-	-	-	00:01:44
View	31D04	14230189	1C	Cold	6316	00:13:05	00:26:48	00:27:07	01:07:16	01:07:24	01:37:48	-	-	00:12:22	-
View	31D03	14230138	1B	Cold	6523	23:56:14	23:56:29	23:56:41	00:07:21	00:23:47	00:39:38	01:18:29	01:18:29	00:38:51	-

2:45am to 3:00am



Pending Incidents

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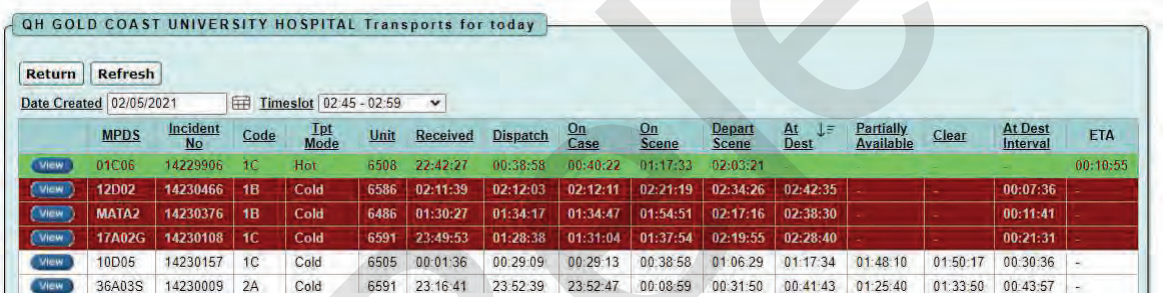
View	2	2	00:06:49	00:06:49	1	
View	4	2	01:48:11	05:37:28	10	
View	5	1	01:42:13	05:01:55	5	
		2	03:17:57	07:12:50	37	
View	6	2	01:51:13	04:07:45	12	
View	7	2	01:25:13	04:09:11	7	
View	State	1	01:42:13	05:01:55	5	
		2	02:34:23	07:12:50	67	

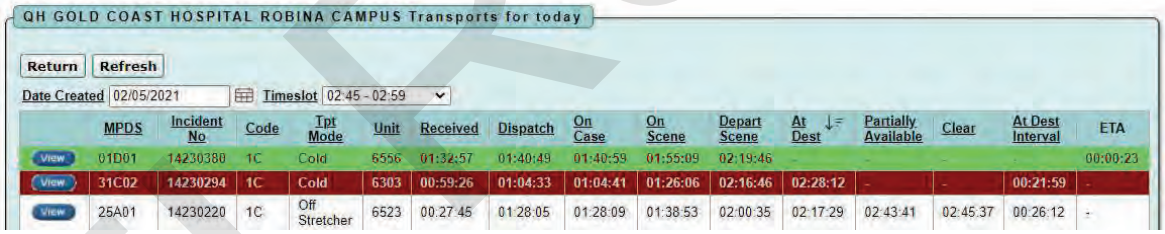


QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 02:45 - 02:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	01C06	14229906	1C	Hot	6508	22:42:27	00:38:58	00:40:22	01:17:33	02:03:21					00:10:55
View	12D02	14230466	1B	Cold	6586	02:11:39	02:12:03	02:12:11	02:21:19	02:34:26	02:42:35	-	-	00:07:36	-
View	MATA2	14230376	1B	Cold	6486	01:30:27	01:34:17	01:34:47	01:54:51	02:17:16	02:38:30	-	-	00:11:41	-
View	17A02G	14230108	1C	Cold	6591	23:49:53	01:28:38	01:31:04	01:37:54	02:19:55	02:28:40	-	-	00:21:31	-
View	10D05	14230157	1C	Cold	6505	00:01:36	00:29:09	00:29:13	00:38:58	01:06:29	01:17:34	01:48:10	01:50:17	00:30:36	-
View	36A03S	14230009	2A	Cold	6591	23:16:41	23:52:39	23:52:47	00:08:59	00:31:50	00:41:43	01:25:40	01:33:50	00:43:57	-



QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

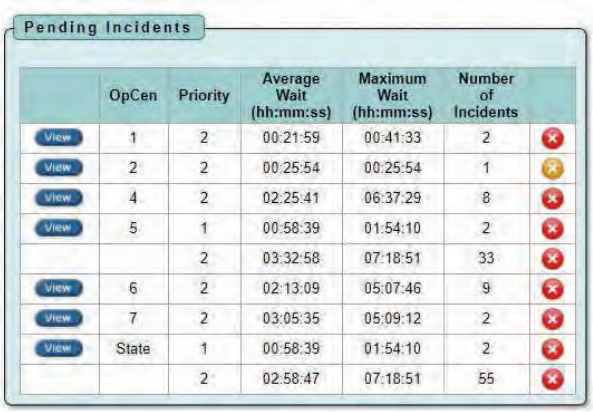
Return Refresh

Date Created 02/05/2021 Timeslot 02:45 - 02:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	01D01	14230380	1C	Cold	6556	01:32:57	01:40:49	01:40:59	01:55:09	02:19:46					00:00:23
View	31C02	14230294	1C	Cold	6303	00:59:26	01:04:33	01:04:41	01:26:06	02:16:46	02:28:12	-	-	00:21:59	-
View	25A01	14230220	1C	Off Stretcher	6523	00:27:45	01:28:05	01:28:09	01:38:53	02:00:35	02:17:29	02:43:41	02:45:37	00:26:12	-

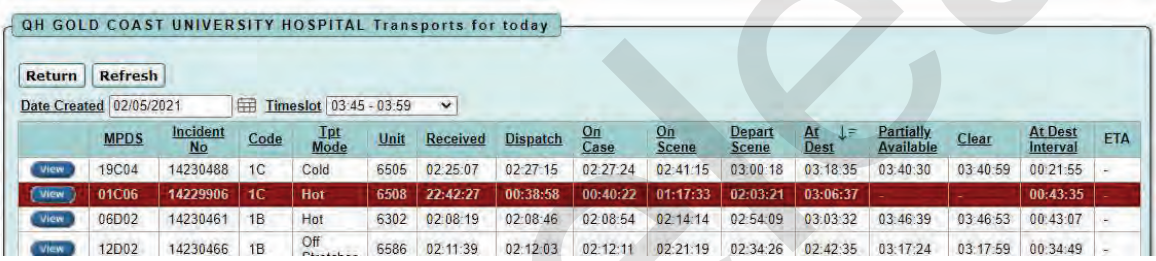
RTI 3320/22
Page 212 of 535

3:45am to 4:00am



Pending Incidents

	OpCen	Priority	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)	Number of Incidents	
View	1	2	00:21:59	00:41:33	2	
View	2	2	00:25:54	00:25:54	1	
View	4	2	02:25:41	06:37:29	8	
View	5	1	00:58:39	01:54:10	2	
		2	03:32:58	07:18:51	33	
View	6	2	02:13:09	05:07:46	9	
View	7	2	03:05:35	05:09:12	2	
View	State	1	00:58:39	01:54:10	2	
		2	02:58:47	07:18:51	55	

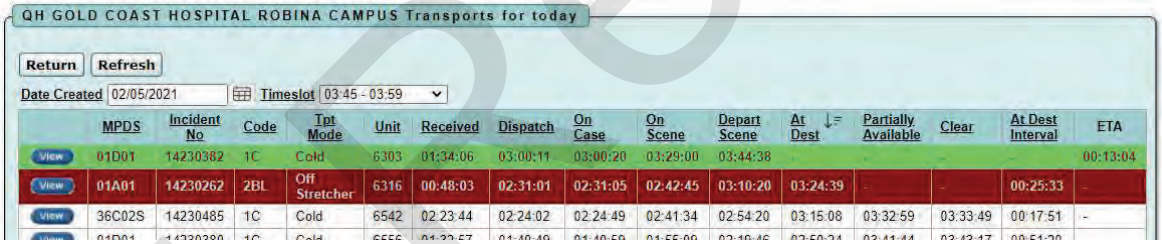


QH GOLD COAST UNIVERSITY HOSPITAL Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 03:45 - 03:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	19C04	14230488	1C	Cold	6505	02:25:07	02:27:15	02:27:24	02:41:15	03:00:18	03:18:35	03:40:30	03:40:59	00:21:55	-
View	01C06	14229906	1C	Hot	6508	22:42:27	00:38:58	00:40:22	01:17:33	02:03:21	03:06:37	-	-	00:43:35	-
View	06D02	14230461	1B	Hot	6302	02:08:19	02:08:46	02:08:54	02:14:14	02:54:09	03:03:32	03:46:39	03:46:53	00:43:07	-
View	12D02	14230466	1B	Off	6586	02:11:39	02:12:03	02:12:11	02:21:19	02:34:26	02:42:35	03:17:24	03:17:59	00:34:49	-



QH GOLD COAST HOSPITAL ROBINA CAMPUS Transports for today

Return Refresh

Date Created 02/05/2021 Timeslot 03:45 - 03:59

	MPDS	Incident No	Code	Tpt Mode	Unit	Received	Dispatch	On Case	On Scene	Depart Scene	At Dest	Partially Available	Clear	At Dest Interval	ETA
View	01D01	14230382	1C	Cold	6303	01:34:06	03:00:11	03:00:20	03:29:00	03:44:38	-	-	-	-	00:13:04
View	01A01	14230262	2BL	Off Stretcher	6316	00:48:03	02:31:01	02:31:05	02:42:45	03:10:20	03:24:39	-	-	00:25:33	-
View	36C02S	14230485	1C	Cold	6542	02:23:44	02:24:02	02:24:49	02:41:34	02:54:20	03:15:08	03:32:59	03:33:49	00:17:51	-

Timeli :

10 pm – Request for vice received OPCEN 2 via 000

10:42p – *CASE NOTE – 9 ear-old female, C/O sharp abdo pain -? kidney related.*

11:14pm – *ASE NOTE – CDS Call bac – Hx of kidney issues and a renal stent removed recently. Pain however LHS do, not in back. Pt has a hx of bleeding from the bowel yesterday passed a clot, ? has had bowel issues in t last week.*

11:40pm – A 601507 dispatched.

1 47pm – *CASE NOTE – duplicate call appended – 000 call back to check ETA, Pt advised pan getting more re apologised for delays, advised local crew on a case and that next available will be sent out from Gold Coast area.*

11:51pm – A 601507 on case

12:02am – A 601507 case complete diverted to a higher priority case.

12:10am – B 601556 dispatched.

12:11am – B 601556 on case

12:11am – B 601556 – case complete diverted to a higher priority case.

12:11am – B 601303 – dispatched.

12:11am – B 601303 – on case.

12:21am – B 601303 – case complete diverted to a higher priority case.

12:28am – B 601505 – dispatched.

12:28am – B 601505 – on case.

12:29am – B 601505 – case complete diverted to a higher priority case.

12:30am – B 601508 – dispatched.

12:40am – B 601508 – on case.

1:04am – *CASE NOTE – 3rd call pt C/O constant pain still lucid, apolo sed for lays due to workload.*

1:17am – B 601508 – on scene.

1:18am – B 601508 – at patient.

1:31am – A 606515 – dispatched.

1:32am – A 606515 – on case.

1:33am – ***Sitrep B 601508 – Severely eptic and ype ensive here CCP code 1.***

1:54am – ***Sitrep B 601508 –*** Irrel nt***, GCS 5, prese ing as a rosepsis, temp 34.8, tachypnoeic 30 resps, poor room air sats, 1 /60***

2:03am – B 601508 – transp ting to GC

2:32am – A 606515 – on scene

2:34am – ***Sitrep B 601508 – CCP o board pt infusion, destination GCUH. ACP driving behind in pod, talked to con ult line as well.***

3:06am – B 601 – arrived destination GCUH.

3:39a – B 601508 ***t off Str – extensive paperwork, if we can pls have some time.***

3 m – A 606515 – cas omplete.

4:10am B 601508 – case complete.

6:30am – *CA E NOTE –* Irrelevant *approached GCLASN SOS discussing case and requesting review.*

7:00am – *CASE TE – GCLASN SOS contacted GCUH PACH advised patient outcome died in emergency department.*

Review

The following are the findings of this review.

1. Concerns arise after the initial call back from the CDS, did the case at this point require an upgrade in response. The patient's residence has called back to QAS on two other occasions, further exploration regarding the patient's current clinical presentation would have provided a clearer picture to determine if case up grade was required. This information hopefully would provide further insight around the rationale, this is a critical point as would have changed the response and time to patient if the case was to be upgraded.

Outcomes: describe outcomes and impacts of the OIRR;

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

Review Recommendations:

All applicable

Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Briefing notes identifying operational issues;
- Consultation with State OpCen Assistant Commissioner (for "State ProQA Special Review" if relevant);
- Briefing notes identifying pertinent incident information;
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- State level clinical audits (should be requested from the Medical Directors Office for complex clinical incidents or incidents with deviations from clinical policy and procedure);
- Relevant audio (wav) files;
- AVL tracking of unit positions at time of incident;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active;
- Workforce planning reports; and
- Any reports or documents received from the Queensland Police Service (QPrime Number).

LASN Endorsement

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

Role	Name	Position	Signature	Date
		General Manager		

Significant Incident Review

Version 1.0 August 2020

Metro South Local Ambulance Service Network

Authority:

By authority of Mr Peter Warrener, Assistant Commissioner, State Operation Centres and Mr nthony Hose, Acting Assistant Commissioner, Metro South Local Ambulance Service Network (LASN) Man ger.

Executive Summary:

On 4 May 2021 at 21:05hrs, the Queensland Ambulance Service (QAS) received a Triple Zer (000) call in the Brisbane Operations Centre from a second party caller on scene to attend a l elevant atient who was not behaving normally, stated to have been punching himself in the head, m ntal hea th episode, sweating and ?intoxicated (incident number 14241737) at Irrelevant Sun bank Hills, Qld 4109.

The case was initially prioritised in the Advanced Medical Priority Dis atch S stem AMPDS) as MPDS Determinant 25D03 – Psychiatric/Abnormal Behaviour/Suic e Attem – Near han ng, strangulation, or suffocation (alert with difficulty breathing) requiring a Code 1B spons mmedia response with lights and/or siren).

A common call was performed at 21:12hrs for any uni to m e them lves available to respond to a Code 1 incident, however no resources were identified to espond

At 21:19hrs, due to the delay identifyi vailabl r w to resp nd to the case given the ambulance workload and resourcing pressure at the tim a Clin l Deployment Supervisor (CDS) in the Brisbane Operations Centre reviewed the ase and do ngraded it quire a Code 2A response, requiring a Code 2A undelayed response witho lights and s en

Whilst waiting for paramedics to a ve he QAS remained in contact with the caller who was with the patient, with call-backs being undertaken on other four occasions to confirm the patient's condition.

At 21:41hrs, the ntal Health Liaison Cl ian in the Brisbane Operations Centre reviewed the case and called the scene at 48hrs, being advised the patient was sleeping, with concerns surrounding his behaviour

Anoth ree call-backs to scene were undertaken by the Clinical Deployment Supervisor (CDS) in the Bri ane erations Centre a 0:27hrs (advised the patient was snoring loudly and had consumed two bottles of win hat night), 2:53hrs (Neighbour still on scene. Patient still asleep. Neighbour remaining on scene and will it for QAS, advised of delays) and 05:16hrs (Nil change, patient still asleep, neighbour equested ETA an advised accordingly, apologised for delays), with the caller advising the patient's c dition remained u hanged so there was no alteration was made to the QAS response priority to attend th case.

l sest available ambulance was dispatched at 04:52hrs, however this ambulance was diverted to a higher priority incident, prior to arriving on scene at Sunnybank Hills.

The next ambulance was dispatched at 05:29hrs from the Princess Alexandra Hospital and arrived on scene t 05:47hrs. Upon arrival, QAS paramedics advised there were extensive delays waiting for the front door to b opened and while the wife and roommate of the patient explained what had happened. The wife reported the patient had fallen beside the bed ten minutes prior to QAS arriving. QAS dispatched available paramedic

units to attend the incident however the “recommend closest” function was not utilised by the Emergency Medical Dispatcher in this instance.

On initial examination the patient was found to be in cardiac arrest and the paramedics requested further paramedic assistance. QAS responded a further three ambulances who arrived at the scene:

- A second Advanced Care Paramedic (ACP) responded to provide assistance and arrived on scene at 06:16hrs.
- A Critical Care Paramedic (CCP) arrived on scene at 06:24hrs, and
- An Operations Supervisor arrived on scene at 07:16hrs.

Paramedics performed advanced resuscitation for approximately 49 minutes, before the patie was declared deceased. The QAS Medical Director was consulted prior to ceasing resuscitation.

The Queensland Police Service (QPS) was requested to attend the scene at 06:41hrs arriving at 07:02hrs

At 07:35hrs, the responding Operations Supervisor advised the patient’s wife had ecome otionally upset, requesting a transporting paramedic crew be dispatched to assist. At 07:52hrs, t Oper ions upervisor advised the patient’s wife had been removed from the scene by the QPS, so a transpo ng pa medic unit could be cancelled.

The QAS response time to this incident was 8 hours and 42 minutes om rec pt of the Triple Zero (000) call.

During the night of 4 May 2021, there was very high demand fo service cross th Metro South LASN and Metro South Health and Hospital Service (HHS) hospital Emergen y Depart nt (ED) delays were experienced at most scope hospitals, affecting paramedi ailability o respond to the community.

Terms of Reference:

This review will review all aspects ambula e resp se to inci ent 14241737. The review will examine ambulance operations prior to, d ing and fo wing the r se. This review will include all requirements outlined in the *Operational In ent Review rocess*.

LASN Clinical Incident Summ ry Report:

Clinical Review was undertaken and is ached.

State OpC n Pro A:

The ov ll result of the Sp ial Quality Assurance review was that the call was found to be compliant. There were o ical, major or mo ate deviations found during the review of the Triple Zero (000) Call. The final M DS Dete inant of 25D3, requiring a Code 1B QAS lights and/or siren response was deemed to be correct based the information provided by the caller.

e Special Quality ssurance review noted that the CDS downgrade of the case to a Code 2A occurred w out a call back to scene and was based on the CDS’s judgement when reviewing the initial information pr ided in the Triple Zero (000) call. As per the State Operations Centre Standard Operations Procedures OP) the mandatory ‘call back’ and assessment of incidents by the CDS prior to the downgrading of any respons ities is required. However in the SOP, it also provides: *exceptions or specific situations where an incident ‘call back’ is not advisable or possible and in such circumstances all relevant information must be documented in the incident.*

the CDS did not perform a call back to confirm the patient’s clinical presentation and did not provide the relevant information in CAD that they relied upon when making the decision to downgrade the call, the CDS

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is not compliant with this QAS State Operations Centre SOP, which will need to be remedial into the near future.

Incident Review/Investigation:

Scope:

State Operations Centre and Metro South LASNs reviewed the response, clinical performance and operational decision making to ensure the appropriate ambulance response and management of this cas 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 at Sunnybank Hills who was initi ot behaving normally, punching Irrelevant in the head, sweating and restless.

Timeline:

21:05 - Triple Zero (000) call received.
21:10 - Call taking complete, waiting in queue.
21:12 - Common call for any units to make themselves av ilable to r pond t a Code 1 incident.
21:19 - QAS response downgraded by the CDS to a Code A respon e.
21:41 - First call back conducted by Mental Health Clinician.
00:27 - First call back conducted by CDS.
02:53 - Second call back conducted by CDS.
04:52 - ACP unit dispatched and proceeding howeve was erted t higher priority case at 04:55hrs.
05:16 - Third call back conducted by CDS.
05:29 - ACP unit dispatched and proceeding from e Prin ess A xandra Hospital, arriving on scene at 05:47hrs.
05:47 - First QAS paramedic crew rives on cene.
06:02 - Radio communication fr m the scene advising th ent is in cardiac arrest requesting further assistance.
06:03 - ACP unit dispatched an arrived 06:16hrs.
06:05 - CCP unit dispatched and ive on scene at 06:24hrs.
06:47 - Operations Supervisor dispa ed and arrived on scene at 07:16hrs.
06:50 - Patient declared deceased.

Clinical Review:

Paramed s report exper cing a delay to reach and assess the patient as they had to wait for the door at the re nce to be answer Irrelevant to find a key to unlock the door, and while the Irrelevant explained to QAS why the ad b n called. It was a noted there was a language barrier which further complicated the di cussions.

The clinical care p vided was deemed appropriate, with responding paramedics consulting with the QAS M dical Director prio o ceasing resuscitation.

D cumentation overall was found to be of a high standard.

Operational Review:

At the time of the Triple Zero (000) call at 21:05hrs on 4 May 2021, the Brisbane Operations Centre was xperiencing a number of pressures affecting paramedic availability to respond to emergency cases in the c mmunity. This included a high demand for ambulance services across South Eastern Queensland; a high number of unscheduled staff vacancies in the Brisbane area which were unable to be backfilled, despite all

usual attempts being made; and was experiencing delays offloading patients at Metro North and Metro South HHS public hospital EDs.

High demand for ambulance services across South Eastern Queensland:

At 21:05hrs, QAS Brisbane Operations Centre were managing 45 pending incidents in the community who were waiting for an ambulance to attend:

- 3 x Code 1Cs – longest had been pending for 21mins
- 42 x Code 2s – longest had been pending for 6hrs 28mins

Unscheduled staff vacancies across Brisbane on 4-5 May 2021:

The State Workforce Management Unit confirmed the QAS workforce resourcing across Brisbane on 4-5 May 2021, confirming QAS experienced high unscheduled staff leave (affecting Metr h, Metro South and West Moreton LASNs) which was unable to be backfilled:

- Metro North
  - Afternoon shift – ten additional paramedic shifts
  - Night shift – three paramedic shift vacancies
- Metro South
  - Afternoon shift – two additional paramedic sh two Lo l Are Resp se Unit (LARU) shift vacancies
  - Night shift – 15 paramedic shift vacancies and one ritical e Par medic (CCP) pod shift vacancy
- West Moreton
  - Afternoon shift – three additional param dics
  - Night shift – four paramedic shift vacan es

QAS attempted to cover these shift using t deploy ent of ros ered officers, offering shifts to operational casual officers, and through the lisation of vertime to y staff, however this was unsuccessful.

Delays offloading patients at M ro North South HHS hospital EDs:

There was a delay of 7 hours and 4 inutes between the time of the first Triple Zero (000) call and the time the first available crew was dispatched t 04:52hrs to attend the case before they were cancelled off the case at 04:55hrs hen the crew was req ed to respond to a higher priority case.

There was y high d mand for service across the Metro South LASN and Metro South Health and Hospital Service (HS) hospital E ergency Department (ED), delays were experienced at most scope hospitals, affecti paramedic availab y.

T re was a tal delay of 8 hours and 24 minutes from the first Triple Zero (000) call and the dispatch of the responding par medic crew at 05:29hrs and a final QAS response time of 8 hours and 42 minutes, arising due to existing am ulance workload across Metro North and Metro South LASNs and HHS'.

H pital ED delays were experienced at most in scope hospitals across South Eastern Queensland, p ticularly affecting Metro North and Metro South HHS hospital EDs, reducing paramedic availability:

- At time of the first Triple Zero (000) call at 21:05hrs, there were 60 ambulance vehicles at these hospital EDs, with 43 of them ramped for >30 minutes, with the longest ramped at the QE2 Hospital (3 hours and 2 minutes) and on level 3 escalation, Princess Alexandra Hospital (3 hours and 1 minute) and on level 3 escalation, Prince Charles Hospital (3 hours) and on level 3 escalation, Logan Community Hospital (2 hours and 51 minutes) and on level 3 escalation, Redcliffe Hospital (2 hours and 47 minutes), Redlands Hospital (1 hour and 54 minutes) and on level 3 escalation, Royal Brisbane Hospital (2 hours and 33 minutes) and on level 3 escalation.

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Hospital Times

	Location	Currently At Dest	Enroute To Hospital	Average At Dest (hh:mm:ss)	Maximum At Dest (hh:mm:ss)	
View	QH IPSWICH HOSPITAL	11	2	01:37:46	06:03:43	
View	QH ROCKHAMPTON BASE HOSPITAL	7	0	01:14:41	03:03:41	
View	QH GOLD COAST UNIVERSITY HOSPITAL	7	4	01:01:18	02:24:56	
View	QH ROYAL BRISBANE HOSPITAL	13	0	00:58:33	02:03:15	
View	QH LOGAN COMMUNITY HOSPITAL	13	3	00:43:40	01:56:03	
View	QH REDCLIFFE HOSPITAL	5	2	00:54:20	01:46:34	
View	QH PRINCE CHARLES HOSPITAL	5	1	00:50:23	01:36:54	
View	QH QUEEN ELIZABETH HOSPITAL	6	0	01:09:49	01:36:18	
View	QH CAIRNS BASE HOSPITAL	4	2	00:32:49	01:08:52	
View	QH PRINCESS ALEXANDRA HOSPITAL	10	1	00:39:32	01:07:44	
View	QH TOWNSVILLE UNIVERSITY HOSPITAL	2	1	00:39:57	00:57:05	
View	QH MACKAY BASE HOSPITAL	9	2	00:33:14	00:50:56	
View	QH CABOOLTURE HOSPITAL	4	0	00:34:05	00:47:43	
View	QH TOOWOOMBA BASE HOSPITAL	4	2	00:33:01	00:46:52	
View	QH SUNSHINE COAST UNIVERSITY HOSPITAL	5	0	00:24:09	00:45:39	
View	QH GOLD COAST HOSPITAL ROBINA CAMPUS	4	2	00:27:47	00:41:45	
View	MATER PRIVATE HOSPITAL	1	1	00:39:18	00:39:18	
View	QH BUNDABERG BASE HOSPITAL	3	1	00:21:53	00:37:55	
View	QH PROSERPINE HOSPITAL (A&E)	2	0	00:30:59	00:35:55	
View	QH MATER ADULTS HOSPITAL	4	1	00:26:57	00:34:37	
View	QH REDLANDS HOSPITAL	4	2	00:19:16	00:33:11	

When call backs were completed by the Mental Health Clinician a d the QAS Clinical Deployment Supervisors whilst awaiting paramedic arrival at 05:47h 5 May 2 21, QAS paramedics were still experiencing long delays at public hospital EDs, with many fa ities on hospital escalation level 2 or 3:

- 21:41hrs:
  - o 2 hours and 33 minute Loga Commu y Hospita
  - o 1 hour and 52 minut s - QE2 H pital
  - o 1 hour 23 minute at Redcliffe Hospital
  - o 53 minutes at Roy l Brisban en's' Hospital
- 00:27hrs:
  - o 2 hours and 33 minute Logan Community Hospital
  - o 1 hour and 52 minutes - E2 Hospital
  - o 1 ho 23 minutes at Redcli Hospital
  - o 53 min es at Royal Brisbane nd Women's' Hospital
- 02:5 hrs:
  - 2 hours and 3 minutes - Logan Community Hospital
  - o 1 hour and 52 inutes - QE2 Hospital
  - 1 hour 23 minute at Redcliffe Hospital
  - o 3 minutes at Royal Brisbane and Women's' Hospital
- 05:16h
  - o 2 ho and 33 minutes - Logan Community Hospital
  - o 1 hour d 52 minutes - QE2 Hospital
  - o 1 hour 23 minutes at Redcliffe Hospital
  - o 53 minutes at Royal Brisbane and Women's' Hospital

QAS requir ambulances to be returned into a state of readiness within 30 minutes of arrival to hospital. The time elapsed past the 30 minutes reduces ambulance response capacity to the community.

Operational dispatch to incident:

QAS dispatched five ambulance units to the incident, with four arriving on scene. The first unit dispatched on this incident was cancelled prior to responding when they were required to attend a higher priority incident that they were identified as being the closest, most appropriate vehicle.

QAS dispatched available paramedic units to attend the incident however the "recommend closest" functio was not utilised by the Emergency Medical Dispatcher in this instance. On follow-up with the EMD involv , she stated she was overwhelmed with the volume of dispatch decisions and the constant inability to have available resources throughout the shift. This EMD normally utilises CAD recommend and accepts availab units.

A common call was made at 21:12hrs to request paramedics clear to attend this case if poss le, how er o available crews were able to be freed up to respond from hospital ED's. No further common ca ere performed due to the case being downgraded to a 2A. However common calls are nor lly performed for code 1 incidents.

Outcomes:

- The QAS response to this Code 1 incident involved a response ti f 8 hou and 4 minutes from the time of the initial Triple Zero (000) call.
- The Triple Zero (000) call for service was appropriately prior sed by he Ca l Taker given the information provided during the call.
- The closest available ambulance vehicles were respo ded to nd.
- An appropriate high standard of clinical care was provid by the ding paramedics.
- The QAS response delay to attend the patient arose due to number of pressures affecting paramedic availability to respond to emergen y cas in the mmunity. This included a high demand for ambulance services across So h Easte Queensl nd; a high number of unscheduled staff vacancies in the Brisbane area which ere u able t be backfilled, despite all usual attempts being made; and was experie delays o lo ding pati nts at Metro North and Metro South HHS public hospital ED's.
- Paramedics reported th there was delay in as sing the patient while they awaited access to the residence from th patient's Irreleva

Review Recommendations:

- After furth r consultation with the Medical Director, consideration will be explored of the first Clinical Deploymen Supervisor to undertak supervised practice and remedial training in regards to the dec on to do ngrade this case to address the concerns outlined in the State QA Summary with a gnment to the ate Operation Centre SOP 1.25.
- mergency Medica Dispatcher to reinforce utilisation of the recommend button through education to e ble the closest m appropriate resource be utilised.
- QAS continue working collaboratively with the executives of the Metro North and Metro South HHS' t elease paramedics from hospital EDs to improve paramedic availability to respond to emergen ambulance cases in the community.
- The QAS M ical Director, in accordance with standard QAS practices, to provide the State Coroner with detailed submissions outlining the circumstances of this Review, including areas for systemic improvement.

Appendix of relevant documents:

- Incident Detail Report (IDR);
  Electronic Ambulance Report Form (eARF);
- State OpCen ProQA;
- Clinical timeline.

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LASN Endorsement:

Name	Position	Signature	Date
Peter Warrener	Assistant Commissioner State Operations Centre	P. Warrener (Electronically Endorsed)	12.05.2021
Anthony Hose	Acting Assistant Commissioner Metro South LASN	A.Hose (Electronically Endorsed)	12.05.2021

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Region

Authority:

By authority of Director, Gold Coast Region

Executive Summary:

IDR 14296672 – At 0835hrs on Monday 17 May 2021 the Queensland Ambulan Servic (AS) received a request for service from Irrelevant for a patient located at Irrelev nt Mermaid Waters. This request was for a Irrelevant fitting, unconscious and not breathing, rep ted to e the caller's Irrelevant

Information received from the caller was haphazard. Initially it was stat d seizu activity had occurred however this was rescinded shortly after. The caller was reported to e extrem y hy erical oughout her call to QAS, did not appear to be listening and was non- compliant w direc from Q S. The caller refused to commence CPR on the patient.

QPS were subsequently attached to this incident and upg aded to a ghts and sirens response.

This case was coded 1A determinant 17D02 in r sponse the info mation provide. An ambulance was dispatch to the address at 08:36hrs including a Cri al Ca para edic, a High Acuity Response unit and an Operations Supervisor. The patient w orted t ha e receiv trauma Irrelevant head and confirmed to be Signal 4 upon QAS arrival. The are was co oned o nd decla ed a potential crime scene.

Terms of Reference:

This review will investigate all as cts o ambulance ponse to incident 14296672. The review will examine ambulance operations pri , during and following the response.
This review will include all requiremen outlined in the *Operational Incident Review Process*.

Region Cl nical I ident Summary Report:

The Go Coast Manager Clinical Education allocated the clinical review to CSO Irrelevant .

Fro a cli al aspect, the rev w found:

> *"Reas ble decision to withhold CPR due to rigidity and at least 26min down time with no CPR*
>
> *At Standar No further action required"*

State n ProQA:

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

- *Nil required for this incident*

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Incident Review/Investigation:

Scope:

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

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

Background:

Alleged events as described by mother on scene:

Approximately 0800hrs this morning mother and patient having coffee on top floor of two story h use. Moth went downstairs followed by patient shortly after.

Mother heard bangs and noises consistent with a fall downstairs. Unwitnessed in dent.

Mother stated patient was unconscious and not breathing +/- seizure activity.

Timeline:

- 1st key stroke: 08:34:10
- In waiting queue: 08:35:36
- Assigned 1st unit: 08:36:15
- Enroute 1st unit: 08:36:34
- At scene 1st Unit: 08:47:21

- 08:35:31 12D02 Irrelevant Breathing tatus u ertain.
- 08:36:43 Patient not ten to EM nd will no answer questions
- 08:38:29 Irrelev Conscious not breathing.
- 08:39:06 Fall w down airs
- 08:39:16 Patient con med not breathing
- 08 1:09 Caller is hysteric she is not listening to EMD
- 08:41:2 Caller initially said seizure but she then changed her mind advised nil seizure occurred.

  08:41:30 EMD s struggling to get caller to listen to commence CPR
- 0 42:59 Caller does not want to listen to EMD. She is not commencing CPR
- 08:43 601525 ? Attach QPS Due to Unknown
- 08:45:24 QPS requested
- 08:46:41 SOS advised of case. OS to be attached.
- 08:47:20 601525 Patient Signal 4 QPS required.
- 08:47:35 Police advised patient was Signal 4.

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- 08:47:58 601525 Obvious death
- 08:54:08 QPS on scene

- **Review:**

The review considered available documentation, including IDR and the EARF. Patient care records were assessed by a clinical support officer. It is noted there is discrepancy between the story presented to the EMD and the findings by the units on scene. This is what prompted the officers to recommend QP investigation surrounding the death.

- **Outcomes:**

Clinical interventions considered appropriate based on presenting history – potenti l rigou nd prol ged down time.

Review Recommendations:

- Peer support to be provided to attending crews.
- Nil clinical concerns identified

Appendix of relevant documents/files:

- Incident detail report (IDR)

IDR 14296672.html

- Electronic Ambulance Report Form eARF);

DARF_503402421.p
d

- O en Brief

170 1 DAY
SOUTHPO OPCEN

- PSDU Resp se

Incident
Noti cation - Gold (

Incident
Notification - Gold (

- Local level clinical review (Eclipse);

QAS GOL CEU
Clinical Review CIM

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
Assistant Commissioner	Peter Warrener	General Manager	Irrelevant	14/07/2021

s47(3)(b)

s47(3)(b)

s47(3)(b)

Significant Incident Review Template Version 1.0 July 2020

Gold Coast Local Ambulance Service Network

Authority:

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

Executive Summary:

Wednesday 9th June 2021 at 15:40hrs a Queensland Ambulance Service (QAS) received a call to attended Case #14399133 at Irrelevant Gold Coast (COVID Quarantine Facility). The incident was related to a Irrelevant who Type 1 Diabetic having a low run of medications – Patient erratic. A case was generated and coded as a 1C Diabetic not Alert.

QAS had dispatched the closest unit to the case as per response protocols. The following issues arouse from this and further dispatches, officers experienced sickness and where unable to respond, officers have not been vaccinated or past safety mask fit test.

Advice from Clinical Hub and SOCC Medical when responding to a Code One no requirement for safety mask fitting or commencement/completion of vaccination regime is required. When responding to a code two It is mandatory:

- COVID 19 vaccination regime commenced; and
- Passed fit test (>100 fit factor); and
- Surveillance testing to commence or continue.

Supervisor (SOS) was made aware of case and assigned a supervisor.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14399133. The review will examine ambulance operations during and following the response.

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

LASN Clinical Incident Summary Report:

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

State OpCen ProQA:

Nil required

Incident Review/Investigation:

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Scope:

Gold Coast LASN reviewed the response and resourcing of QAS to this case to ensure appropriate service delivery.

Background:

- Irrelevant Type 1 Diabetic having a low run of medications – Patient reported to be erratic.
- Case was responded to with QAS Officers assessing the patient and no transport requir
- Various QAS crews dispatched with officers advising they are feeling sick or are not v ccinated or safety mask fitting compliant.
- Clinical hub and SOCC Medical advised the SOS the most appropriate response uni respond there are no mandatories for code ones. He was advised that's what the medical Director and Infection Control Nurse signed off with the CHO (Chief Health ffic

Timeline:

- Phone Pick up 09/06/2021 15;40:03
- 1st Key Stroke 09/06/2021 15:40:03
- In Waiting Queue 09/06/2021 15:41:57
- Call Taking Complete 09/06/2021 15:45:23
- 1st Unit Assigned 09/06/2021 1 48:02
- 1st Unit Enroute 09/06/2021 15:4 49
- 1st Unit Arrived 09/06/2021 16:28:
- Closed 09/06/2021

Elapsed times:

- Delays with response from QAS officers.
  - Assigned: 15:48
  - Enroute: 1 8:02 First Uni 6:14:55 – nit that ar d on cene
  - Arrived: 16:28:06

Unit Name

First crew Dispatched:

601521 - Irrelevant

Officer evant Called OpCen at 1 0hrs as case was being dispatched to advised he is sick

First S ervisor Dis tched:

606598 - Irrelev

fficer advised OpC he is sick and has a headache once assigned at 16:44hrs

Second Cr Dispatched:

601583 rrelevant

Crew advised that 1 officer has 1 Vaccination – 1 officer has not passed safety mask or has any vaccinations – Crew removed

Thir w considered for dispatch:

Irrelevant ramped unable to respond

Designated COVID crew at hospital undertaking a COVID clean post previous case

Crew and Supervisor who attended case:

- 601501 - Irrelevant
- 607312 - Irrelevant

Unit	Assigned	Disposition	Enroute	Arrived	At Patient	Complete	Cancel Reason
B601521	15:48:02	Cancel En Route	15:48:49			15:50:53	.Diverted To Higher Priority
A606598	15:49:07	Cancel En Route	15:50:35			15:59:39	.Diverted To Higher Priority
601583	15:51:28	Cancel En Route				15:56:28	.Diverted To Higher Priority
A606598	16:02:07	Cancel En Route	16:02:19			16:11:13	Unit Swap Recommended
601537	16:12:34	Cancel En Route				16:12:51	.Diverted To Higher Priority
601501	16:13:19		16:14:55	16:28:06	16:43:14		
B607312	16:13:54	Cancel En Route				16:15:29	.D erted To H er Prio y
B607312	16:16:35		16:20:37	16:32:12			

- Comment Diverted to Higher Priority not correct ther opti for EMD to explain Cancel reason

Incident Detail Report:

Date	Time	User	Type	Comments
09/06/2021	15:40:21	Autom c by Syste	Response	[Address: 2807 GOLD COAST HWY Irrelevant GOLD COAST]] [High] [QAS Operational Notification] Designated 14 day quarantine location with possible COVID pts. Notify SOCC Medical Services and attach supervisor. Crews to call adn advise triage with ETA and on arrival. (Exp: 07/07/2021)
0 /2021	15:40:21	utomatic by ystem	Response	[Premise: 2807 GOLD COAST HWY Irrelevant Irrelevant GOLD COAST]] [High] [QAS Operational Notification] Designated 14 day quarantine location with possible COVID pts. Notify SOCC Medical Services and attach supervisor. Crews to call adn advise triage with ETA and on arrival. (Exp: 07/07/2021)
09/06/2021	15:41:57	6CHRHOW	Response	[ProQA Dispatch] Dispatch Level: 13C01 (Not alert) Response Text: 1C Irrelevant , Conscious, Breathing. Problem Description: TYPE 1 DIABETIC HAVING A LOW RUN OUT OF MEDICATIONS - PT ERRATIC
09/06/2021	15:41:57	6CHRHOW	Response	[ProQA: Key Questions] 1 Irrelevan is not completely alert (not responding appropriately). 2. Irrelevan is not behaving normally now. 3. It's not known if Irrelevant is breathing normally.

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09/06/2021	15:42:32	6CHRHOW	Response	PT A HOTEL Irrelevant
09/06/2021	15:42:53	6CHRHOW	Response	[ProQA: COVID-19] Is the patient in quarantine or isolation? Yes:, Has the patient travelled interstate or overseas in the past month? Yes: Irrelevant
09/06/2021	15:43:15	6CHRHOW	Response	Irrelevant
09/06/2021	15:44:35	6RACCOL	Response	[Private] OCS AWARE OF CASE - REVIEWING WITH CHUB
09/06/2021	15:48:03	PS	Response	[Page] Dispatch page sent to Unit:6 1521, Sent From: KEDCADQASPIS01
09/06/2021	15:48:04	601521	Response	[PRIVATE] ACKNOWLEDGEMENT INCIDENT RECEIVED BY MDT
09/06/2021	15:48:15	PS	Response	[Page] Dispatch page to nit:60 21 complete to Irrelevant Message sent succes ully.
09/06/2021	15:49:08	PS	Response	[Page] Dispatch page sent t Unit:60 598, Sent From: KEDCADQASP 01
09/06/2021	15:49:10	606598	Response	[PRIVATE] CKNOW EDGE OF INCIDENT ECEIVED BY MDT.
09/06/2021	15:51:29	PS	Response	age] Dis atch age se to Unit:601583, S From: DCADQA PIS01
09/06/2021	15:51:31	601583	Response	[PRI TE] AC OWLEDGEMENT OF INCIDE RECEIVED BY MDT.
09/06/2021	15:51:42	PS	Response	[ge] Disp tch page to Unit:601583 complete to I levant essa e sent successfully.
09/06/2021	15:52:15	6CIAGIL	Resp se	601583 ONE OFFICER HAS FAILED MASK TEST OTHER OFFICER NOT HAD ANY ID VACCINES
09/06/2021	15:52:17	60 98	Res onse	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
09/06/2021	15:58:33	6RACCOL	Response	[Private] OCS AWARE OF CREW COMMENTS - DISP AWAITING FURTHER INSTRUCTION FOR CREW ATTACHMENT - 601545 PAGED AT HOSP
09/06/2021	16:0 07	PS	Response	[Page] Dispatch page sent to Unit:606598, Sent From: KEDCADQASPIS01
09 /2021	16:02:09	6598	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
09/06/2	16:02:21	PS	Response	[Page] Dispatch page to Unit:606598 complete to Irrelevant Message sent successfully.
09/06/2021	1 4:05	36JESPAT	Response	[Private] Clinical Hub reviewing incident.
09/06/2021	16:0 4	6STESTR	Response	CDS reviewing
09/06/2021	16:07:06	606598	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
09/06/2021	16:09:18	36JESPAT	Response	[Private] DISCUSSED WITH Q6 OCS DISPATCH PLAN. CLINICAL HUB WILL CONTACT SOS TO ADVISE DISPATCH MATRIX PROTOCOL ACCORDINGLY

09/06/2021	16:12:09	6STESTR	Response	CDS performed call back (CDS to document) RN ON SCENE STATES QPS WITH PT NOW REPORTS PT SEEMS "OFF" HAS DRY MOUTH AND ANXIETY. PT HAS RAN OUT OF MEDS. DOES NOT HAVE A BSL MONITOR. UNKNOWN BSL ?GCS14 AS PER RN CODING APPROPRIATE
09/06/2021	16:12:34	PS	Response	[Page] Dispatch page sent to Unit:601537 Sent From: KEDCADQASPIS01
09/06/2021	16:12:36	601537	Response	[PRIVATE] ACKNOWLEDGEMENT F INCIDENT RECEIVED BY MDT.
09/06/2021	16:12:56	PS	Response	[Page] Dispatch page to Unit:601537 complete to Irrelevant Message sent successf ly.
09/06/2021	16:13:20	PS	Response	[Page] Dispatch page ent to U it: 1501, Sent From: KEDCADQ SPIS
09/06/2021	16:13:21	601501	Response	[PRIVATE] ACKNOWLEDG MENT O INCIDENT RE D BY M T.
09/06/2021	16:13:41	PS	Response	[Page] Dis atch pag to Unit:6 1501 complete rrelev nt ssage s nt ccessfu y.
09/06/2021	16:13:41	PS	Response	[Pa] Disp h page t Unit:601501 comp e to Irre Messag ent successfully.
09/06/2021	16:13:55	PS	Response	[P e] Disp ch page sent to Unit:607312, S nt From: KEDCADQASPIS01
09/06/2021	16:13:57	607312	ponse	[PRIVA E] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
09/06/2021	16:14:07	PS	Resp se	[Pag] Dispatch page to Unit:607312 omplete to Irrelevant Message sent successfully.
09/06/2021	16:16:36	PS	esponse	[Page] Dispatch page sent to Unit:607312, Sent From: KEDCADQASPIS01
09/06/2021	16:16:37	607312	esponse	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
09/06/2021	16:1 54	PS	Response	[Page] Dispatch page to Unit:607312 complete to Irrelevant Message sent successfully.
09 /2021	16:29:33	CIAGIL	Response	601501 OS ETA ?

Southp t OpCen brief 09.0 .2021

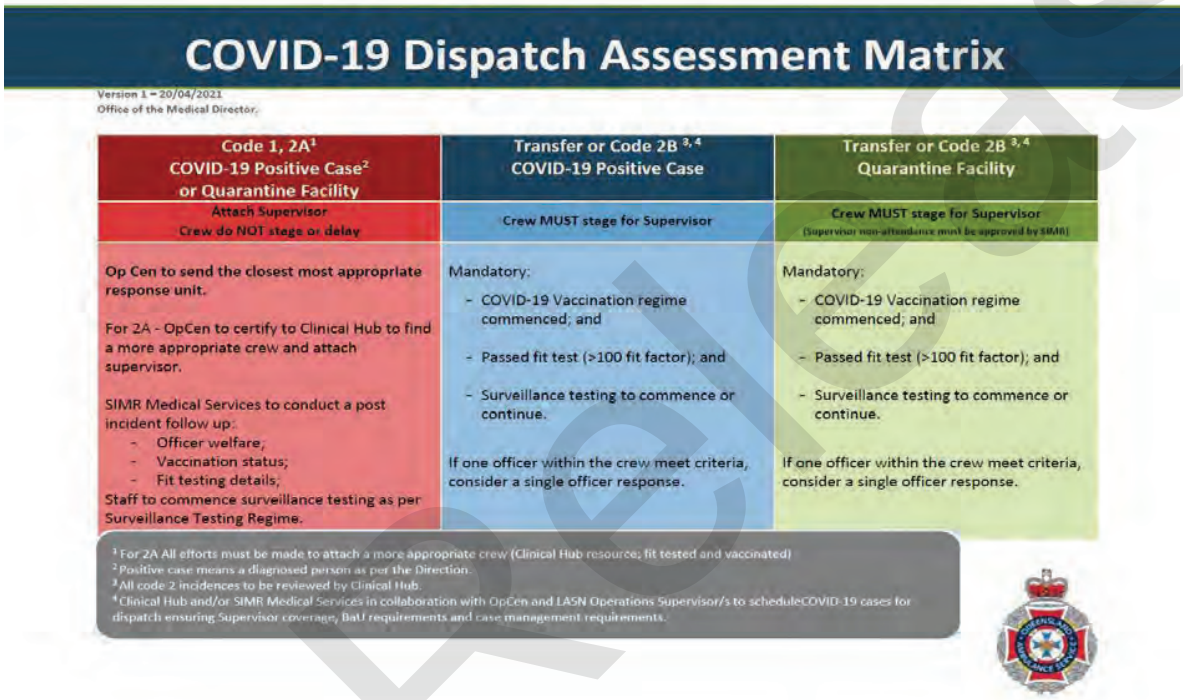
Shift Report (Any issues/items of interest for noting that do not fit into another category or require further elaboration)									
Entry	Time	Acute/PTS	Issue	Action/Case Information	Entered By	Incident	Unit	LASN	Station/ OpCen
1	06:00		BCP Printer	Operational	OCS			OPCENS	SOC
2	16:00	ACUTE	**GOL LASN** : 40min Delay responding to code 1 case # 14399133 multiply crew attached.	SOS / Clinical hub (hotel quarantine) aware of delays.	OCS			GOL	
3									

Issues associated with the case:

- Sickness of various Officer

- Officer not having the mandatory vaccination regime or passing the fit test
- When SOS questioned Clinical hub and SOCC Medical as to what the most appropriate response unit is and why are officers' mandatories to be managed for code 2 A, B but not for code ones. He was advised that's what the medical Director and Infection Control Nurse signed off with the CHO (Chief Health Officer)
- The below Dispatch Assessment matrix was emailed as the reference to the above question
- OpCen was unaware of the matrix but have followed the below Operational Communiques

Reference for COVID-19 Dispatch Assessment Matrix.



COVID-19 Dispatch Assessment Matrix

Version 1 – 20/04/2021
Office of the Medical Director.

Code 1, 2A[1] COVID-19 Positive Case[2] or Quarantine Facility	Transfer or Code 2B [3,4] COVID-19 Positive Case	Transfer or Code 2B [3,4] Quarantine Facility
Attach Supervisor Crew do NOT stage or delay	Crew MUST stage for Supervisor	Crew MUST stage for Supervisor (Supervisor non-attendance must be approved by SIMR)
Op Cen to send the closest most appropriate response unit. For 2A - OpCen to certify to Clinical Hub to find a more appropriate crew and attach supervisor. SIMR Medical Services to conduct a post incident follow up: - Officer welfare; - Vaccination status; - Fit testing details; Staff to commence surveillance testing as per Surveillance Testing Regime.	Mandatory: - COVID-19 Vaccination regime commenced; and - Passed fit test (>100 fit factor); and - Surveillance testing to commence or continue. If one officer within the crew meet criteria, consider a single officer response.	Mandatory: - COVID-19 Vaccination regime commenced; and - Passed fit test (>100 fit factor); and - Surveillance testing to commence or continue. If one officer within the crew meet criteria, consider a single officer response.

[1] For 2A All efforts must be made to attach a more appropriate crew (Clinical Hub resource, fit tested and vaccinated)
[2] Positive case means a diagnosed person as per the Direction.
[3] All code 2 incidences to be reviewed by Clinical Hub.
[4] Clinical Hub and/or SIMR Medical Services in collaboration with OpCen and LASN Operations Supervisor/s to scheduleCOVID-19 cases for dispatch ensuring Supervisor coverage, BaU requirements and case management requirements.

State Operati s Centre – Operational mmunique – No 01 – 21

SO Operational
C nique 01-21

State Op ations Centre – Operational Communique – No 03 – 21

SOC_Operational
Communique 03-21

Review:

- **Dispatching of resources**: - Initial crew was dispatched to case with various other crews dispatched then cancelled from case.

Outcomes:

- Patient was Assessed by QAS Crew, No transport required.
- Appropriate resources dispatched to incident in a timely manner.
- Confusion as to what crews are required to have commenced or completed with vaccinations or Safety mask fit tests

Post OIRR actions:

- Priority One access

Review Recommendations:

- Operations Centre Review in regards dispatching of case.
- All QAS staff to be informed as to their requirements with vaccinations and safety mask fitting that they are not required when responding to code one cases.

Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Briefing notes identifying operational issues;
- Briefing notes identifying pertinent incident information;
- A clear timeline of events from receipt of Triple Zero (000) call for the OIRR;
- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- State level clinical audits (should be requested from the Medical Directors Office for complex clinical incidents or incidents with deviations from clinical policy and procedure);

LASN Endorsement

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

Role	Name	Position	Signature	Date
		General Manager		

s47(3)(b)

s47(3)(b)

Department of Health

Queensland Ambulance Service

Significant Incident Review Version 1.0 August 2020

State Operation Centres Local Ambulance Service Network

Authority:

By authority of Mr Peter Warrener, Assistant Commissioner, State Operation Centres and Mr David Harley, A/Assistant Commissioner, Local Ambulance Service Network (LASN) Manager, Metro North LASN.

Executive Summary:

On 12 June 2021 at 02:02hrs, the Queensland Ambulance Service (QAS) received a Triple Zero (000) call for assistance (Incident number 14409932) at Irrelevant Mitchelton, to attend a Irrelevant patient with severe abdominal pain, vomiting, weakness with a history of a recent 11-day hospital admission for urinary retention.

The case was initially prioritised in the Medical Priority Dispatch System (MPDS) as MPDS Determinant 01A01 Abdominal Pain requiring a Code 2B response. A second Triple Zero (000) call was received at 0235 hrs with patient complaining of more pain, sweating, feeling cold and vomiting. At 07:13hrs, approximately 5 hours and 10 minutes after the initial Triple Zero (000) call was received, the day shift Clinical Deployment Supervisor (CDS) made a call back to review the patient's condition. From this consult there was no change to the QAS response to the patient, with the CDS advising the caller there was a high demand in workload and delays with the intent of sending a day crew ambulance. A further four Triple Zero (000) calls were received at 07.15hrs, 08:56hrs, 10:21hrs and 10:40hrs. At the request of the EMD (Dispatcher) to the CDS the incident was upgraded at 09:45hrs from a 2B to a 2A response. It was on the last Triple Zero (000) call received that the EMD Call Taker changed the MPDS Determinant 28C02 (Stroke Abnormal Breathing) to a Code 1C response.

The first ambulance was dispatched at 10:47hrs, however this ambulance was diverted to a higher priority incident 1B prior to arriving on scene. The next ambulance was dispatched at 11:06hrs from the Princess Alexandra Hospital, a non-divert notification enacted at 11:12hrs by the CDS, with Unit 501073 subsequently arriving on scene at 11:21hrs.

Upon arrival, QAS paramedics reported the patient be unresponsive, pale, mottled skin, lividity well set in, not breathing and cool to touch. At 11:29hrs the attending paramedics advised that the patient was deceased and requested QPS to attend the scene.

The Brisbane OpCen pending queue at the receipt of the 1st Triple Zero (000) call revealed there were 4 Code 1s and 55 Code 2s incidents waiting to be dispatched. During the night of 12 June 2021 there was very high demand for service across the Metro South LASN and Metro South response areas that continued into the day with SEQ Escalation of "Extreme Hospital Delays" affecting paramedic availability.

Against a background of high demand workload, in summary a total of six Triple Zero (000) calls were received, only one call back conducted by the day shift CDS with several missed opportunities identified in this review that contributed to an unacceptable response timeframe of 9 hours and 16 minutes.

Terms of Reference:

This review will assess all aspects of ambulance response to incident 14409932 and examine ambulance operations in accordance with the *Operational Incident Review Process*.

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LASN Clinical Incident Summary Report *(excerpt from eARF)*

Presenting Complaint: CT Irrelevant CO urinary retention/UTI/sepsis.

Hx of Presenting Complaint: OA patient located at home in care of sister and niece. Upon QAS Arrival QAS officer 025135 has buzzed the apartment. The patient's sister has answered and commented to the effect of Irrelevant QAS officers have proceeded to level two and was granted entry to unit 202 by the patient's niece. QAS officers have been led to the patient's bedroom, upon entry patient observed to by lying in bed. The patient was unresponsive, with pale, mottled skin. Lividity was well set in, and the patient was not breathing and was cool to touch. Nil signs of battery/assault; Nil bleeding/bruising; and Nil evidence of drooling. Nil vomitus on scene

Other Hx = patient admission to PCH for 11 Days for the management of urinary retention and UTI as stated by sister. Sister has referred patient for QAS treatment and transport to hospital on the recommendation of patients Doctor due to recent blood test results indicating infection/sepsis.

Examination: Patient GCS 3, unresponsive to central stimulus, Nil breathing, Nil pulse, Nil heart sounds, pupils dilated, fixed and unresponsive to light.
H2T =
1. skin mottled and lividity well set in; 2. Patient cool to touch. QAS Officer 025135 - did not attempt resuscitation due to patient presentation.

Disposition: I 025135 declare life extinct at 1129hrs. QAS COMMs advised and QPS services requested. ROLE form given to QPS officer. SOS contacted and advised of situation. Officer 025135 called patients GP Irrelevant - Doctor did not want to produce a death certificate stating he wanted to talk to the coroner first.

State OpCen Call Taking Performance ProQA:

State Quality Assurance Unit were requested to provide a special review and provide an evaluation of the call performance with the below summary results extracted. There were 6 Triple Zero (000) Calls received and 1 CDS call back for this incident. ProQA was utilised on 4 of the 6 Triple Zero Calls.

02:02:11- **1st** Triple Zero Call -Received by Southport. ProQA utilised. Deemed *Compliant* with the correct MPDS Protocol usage and Correct final coding. EMD changed the QAS Priority from a 2BL to 2B which was appropriate, due to the patient being unable to walk.

03:36:22 - **2nd** Triple Zero Call – Received by Maroochydore. ProQA utilised. Deemed *High Compliant*. QAS Response Priority 2B.

07:07:18 - **CDS call back** – Performed by Brisbane. CDS made a clinical assessment of the patient with no changes made to the QAS Response Priority 2B.

07:14:20 - **3rd** Triple Zero Call – Received by Brisbane. No evidence that ProQA was utilised. Medication advice sought which was out of EMD scope of practice.

08:56:10 – **4th** Triple Zero Call -Received by Brisbane. No evidence that ProQA was utilised. Caller advised GP pathology received with provisional diagnosis of sepsis and acute kidney injury and an ambulance is required, "as fast as possible."

09:06:58 – EMD ID 5CARLAN requested CDS to Review Priority and Upgrade
09:45:25 – CDS ID 5PAUVEN1 changed QAS Priority from 2B to 2A

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10:20:21 – 5th Triple Zero Call - Received by Brisbane. ProQA utilised. Deemed Non-Compliant with missed opportunity to change the QAS priority to a 1A response

10:40:29 – 6th Triple Zero Call- Received by Maroochydore. ProQA utilised. *Deemed Non-Complaint however, Protocol* appropriately changed to Protocol 28 Stroke (CVA) and Correct Final Coding of 28-C-02 Suffix J which is a 1C response. Case Entry Awake and Breathing Questions were not asked (both Critical deviations) 3 of 6 DLS Instructions omitted (Critical Deviation).

Incident Review/Investigation:

Scope

State Operations Centre and Metro North have reviewed the response, clinical performance and the 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

On 12 June 2021 at 02:02hrs, the Queensland Ambulance Service (QAS) received a Triple Zero (000) call for assistance (incident number 14409932) at Irrelevant Mitchelton, to attend a Irrelevant patient with severe abdominal pain, vomiting, weak with a history of a recent 11 day hospital admission for urinary retention.

CAD Timeline:

02:05	Triple Zero (000) call received for a 69yof severe abdominal pain, vomiting, weak, coded as 2b
02:35	Notification Delay in dispatch due to workload
03:41	2nd Triple Zero (000) call received (MOC 4DANPIL) advising "PT C/O MORE PAIN – SWEATING - FEELING COLD - VOMITING - NIL FURTHER CHANGES PER PROQA"
07:13	CDS (5PAUVEN) call back "SPOKE WITH Irrelevant PT IS ALERT, NO RELIEF FROM ABDO PAIN, UNABLE TO PASS URINE, NOT EATING, FEELS WEAK, FEVER NAUSEA / VOMITING, RECENT HX UTI AND KIDNEY DAMAGE AS A RESULT. HX AT PCH. ADVISED OF HIGH DEMAND / DELAYS"
07:15	3rd Triple Zero (000) call received "Requesting eta – adv accordingly"
08:56	4th Triple Zero (000) call received "REC CB FROM INF WHO JUST REC CALL FROM GP - PT HAS CRP 120 - WHITE CELL COUNT OF 35 - ?SEPSIS"
09:06	Notification to CDS "Review priority – EMD requested CDS to review ?UG"
09:45	Notification CDS approved upgrade/downgrade priority - Upgraded timeframe from 2b to 2a
09:45	Notification Delay in Dispatch due to workload
10:21	5th Triple Zero (000) call received
10:26	Notification Review priority "EMD requested CDS to review CB REQ ETA - ADV ACC - CALLER SHE IS WORRIED ABOUT SEPSIS AND PT IS VERY WEAK AND FRAIL - PT IS HAVING SOB AND DRY MOUTH - CALLER INITIALLY SAID PT 85% ALERT THEN STATED RESPONDING APPROPRIATELY BUT VERY QUIETLY"
10:40	6th Triple Zero (000) call received "CALL BACK ADVISED NOW NOT MAKING SENSE"
10:44hrs	Case reconfigured and changed to stroke, altering response priority from 2a to a 1C MPDS 28C02 (Stroke Abnormal Breathing)
10:49hrs	Entered note into case Irrelevant

Irrelevant

10:47hrs	1st Unit assigned B501197
10:52hrs	B501197 diverted to code 1b
10:53hrs	Notification "MH TO CHECK THIS CASE PLEASE ?MH ISSUE"
10:54hrs	Notification "The unit responding to this incident has been diverted. The case requires immediate review and a response plan formulated. 501197 DIVERTED 1b ASHGROVE 2YOM ALOC&DIB
11:06hrs	2nd Unit assigned B501073
11:09hrs	Maroochydore OCS called Brisbane OCS regarding case to request CDS call back as call taker concerned that pt definitely had slurred speech
11:12hrs	CDS Pattle noted in case "CDS NOT CALLING BACK CREW EN ROUTE" & "NON DIVERT IN PLACE"
11:13hrs	CDS Pattle noted in case "NIL VALUE FOR CDS CALL BACK CREW APPROX 3 MINUTES FROM SCENE"
11:21hrs	B501073 arrived scene
11:29hrs	SITREP "ON SCENE WITH A SIGNAL 4 QPS REQUIRED"

Review:

A comprehensive investigation of the incident management has been undertaken including, Call Taker and the CDS performance and resource review as to why the incident had occurred, outcomes/findings and actions recommended to ensure that a similar incident does not reoccur.

Call Taking Performance

The review of the six Triple Zero (000) calls evaluated the call taking performance with outcomes including what was done to standard and issues of concern. The below has been drawn from the State QA Unit evaluation summary.

1st Triple Zero Call received 02:02hrs by the Southport OpCen was deemed compliant, ProQA utilised with the correct MPDS Protocol usage and Correct final coding. The EMD changed the QAS Priority from a 2BL to 2B which was appropriate, due to the patient being unable to walk.

2nd Triple Zero Call received 03:41hrs by the Maroochydore OpCen was deemed to be highly compliant, ProQA utilised and was deemed Highly Compliant. Incident located, ProQA reopened and all appropriate questions asked. Protocol and Final Coding remained unchanged as the patient condition had not changed. QAS Response Priority 2B.

3rd Triple Zero Call received 07:14hrs by the Brisbane OpCen with no evidence that ProQA was utilised. Caller asked for advice as to if the patient can be given their morning tablets. EMD correctly located the incident. The EMD advised the caller that it was "fine" for the patient to take their medication. This advice is out of scope of EMD practice and advice contained within the MPDS. EMD incorrectly recorded in the incident that the caller requested ETA and not information about caller request about patient medication.

4th Triple Zero Call received 08:56hrs by the Brisbane OpCen with no evidence that ProQA was utilised. Caller advised that they had received a phone call from the patients GP and the caller provided the EMD results of the patient pathology and the GP's provisional diagnosis of sepsis and acute kidney injury and an ambulance is required, "as fast as possible." The EMD advised the caller, the updated information has been added to the incident and that an upgrade can hopefully occur.

5th Triple Zero Call received 10:20hrs by Brisbane OpCen with ProQA utilised however deemed non-compliant. This call has been verbally confirmed that the EMD was undergoing a call taking assessment at the time of the call with several missed opportunities to upgrade the incident as detailed below.

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- *Missed opportunity* for the EMD to have selected Ineffective / Agonal Breathing at CEQ6 in case entry, as the Caller has provided a description of the patients breathing that is equivalent to Ineffective Breathing.
- *Missed Opportunity* to have manually changed to Protocol 36 to address the Ineffective breathing based upon new and updated information. If the EMD had manually moved to Protocol 36, a patient with ineffective / agonal breathing would have received a QAS priority 1A response.
- *Missed opportunity* to have reconfigured the incident from a Final coding of 1-A-1 (2B) upgraded earlier by CDS to a (2A) to a 1-D-1 (1C) as the patient is now reportedly not alert.

6th Triple Zero Call received 10:40hrs by Maroochydore OpCen with ProQA utilised, however was deemed non-complaint. The Protocol was appropriately changed to Protocol 28 Stroke (CVA) and correct final coding of 28-C-02 (Abnormal Breathing) Suffix: J determined which is a (1C) response. Nevertheless, there was a missed opportunity by not asking Case Entry Awake and Breathing Questions (both critical deviations) with 3 of 6 DLS Instructions omitted (Critical Deviation). At 10:49:02 the EMD has entered a notification comment that the caller will be going to the local member due to the government taking money from health to buy a farm.

At 10:53hrs Brisbane OpCen EMD 5CARLAN has entered a private notification "MH to check this case please ?MH issue." This request may have been triggered by the EMD comment entered into the incident at 10:49hrs. This comment was also allayed by the Maroochydore EMD at 11:09hrs entering a clarification comment calling Q5 to speak to CDS re case that incident is not a Mental Health case.

Findings: In summary the 1st (02:02hrs) and 2nd calls (03:41hrs) received compliance with the correct response code 2B applied. The 3rd (07:14) and 4th (08:56hrs) the call takers did not use ProQA that is outside of the required standards with missed potential opportunities to gain an update on patient's condition. The 5th call (10:20hrs) management could have been upgraded to a Code 1A if the correct pathway was undertaken. At this juncture the deployment of a resource would have been at the highest priority. The 6th call (10:40hrs) whilst the change of protocol was appropriate to a 1C, there was also a missed opportunity by not asking case entry Awake and Breathing Questions.

CDS Clinical Performance

There was no call back to the patient conducted or touch point by the night shift CDS from 02:02 to end of shift at 06:00. This is considered to be below standard expectations. During this timeframe, considering the volume of cases presenting, and the incident remained coded appropriately as a Code 2B response, the dispatch of an ambulance sooner without a follow up call back clinical assessment being done, may have compromised the safety of higher acuity patients also requiring ambulance services.

It wasn't until 07:07 where the day shift CDS made a call back for a clinical assessment of the patient, apologised for the delays and advised the caller of the plan to send a day crew to the patient. The CDS documented his call back in the CAD incident. No changes were made to the QAS Response Priority 2B which is considered to be a missed clinical opportunity to upgrade the incident.

At 09:06 EMD ID 5CARLAN requested CDS to Review Priority and Upgrade, it wasn't until 09:45 that the CDS changed the QAS Priority from a 2B to 2A. On review this response priority level was not adequate.

Whilst the 6th Triple Zero (000) call received at 10:40hrs enacted an upgrade to a 1C by an EMD. The first unit to be deployed was diverted to a 1B with the next available unit arriving on scene, the CDS could have considered a "Do not divert" and an EMD upgraded through the use of ProQA.

Findings:
There were numerous missed opportunities during the timeframe of this incident that could have resulted in an improved response time by QAS. These include the numerous call backs from scene and receipt of additional pertinent clinical information.

Resource Review

For the purpose of the review, three key timings for the response to this incident were evaluated:

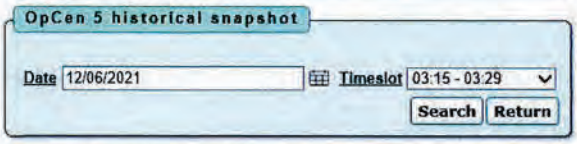
- 17:00hrs 11th June (start of night)
- 02:00hrs 12th June (time of Triple Zero call)
- 09:00hrs 12th June (call from GP and request to upgrade incident)

Pending Incidents:

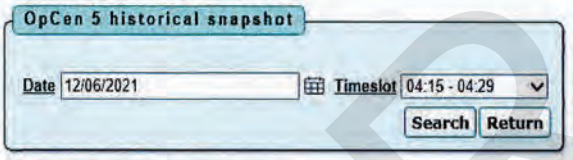
	1700hrs 11th June	0200hrs 12th June	0900hrs 12th June
Brisbane OpCen Pending Incidents (Code 1 and 2)	58	59	23
State Pending Incidents (Code 1 and 2)	89	85	33

The following demonstrates ongoing pending incidents following the initial Triple Zero (000) call:

Code 1s	Code 2s	
4	55	Incidents
22.85	184.08	Avg Wait (mins)
46.75	475.62	Max Wait (mins)



Code 1s	Code 2s	
4	41	Incidents
134.8	179.14	Avg Wait (mins)
473.7	450.22	Max Wait (mins)



Code 1s	Code 2s	
1	39	Incidents
2.55	199.55	Avg Wait (mins)
2.55	800.03	Max Wait (mins)

Code 1s	Code 2s	
0	34	Incidents
0	241.44	Avg Wait (mins)
0	860.05	Max Wait (mins)

Code 1s	Code 2s	
3	27	Incidents
5.42	155.77	Avg Wait (mins)
6.83	441.93	Max Wait (mins)

Code 1s	Code 2s	
1	21	Incidents
.58	218.39	Avg Wait (mins)
.58	979.98	Max Wait (mins)

Code 1s	Code 2s	
1	21	Incidents
1.22	125.71	Avg Wait (mins)
1.22	453.42	Max Wait (mins)

Code 1s	Code 2s	
1	23	Incidents
1.15	55.94	Avg Wait (mins)
1.15	435	Max Wait (mins)

Code 1s	Code 2s	
7	33	Incidents
18.45	84.31	Avg Wait (mins)
51.92	494.95	Max Wait (mins)

Code 1s	Code 2s	
2	37	Incidents
270.1	93.67	Avg Wait (mins)
539.97	437.37	Max Wait (mins)

There was very high demand for service across the Metro North and Metro South Health response areas. State Operations Coordination Centre (SOCC) Operations Day and Night Shift Reports indicate SEQ Escalation began the day on an "Extreme Hospital Delays" commencing at 10:25 (10/06/2021) and continuing, subsequently affecting paramedic availability. There was also an increase in the number of Triple Zero (000) calls into Brisbane OpCen during the night.

Hospital Status:

	1700hrs 11th June	0200hrs 12th June	0900hrs 12th June
Caboolture (QAS escalation)	Stage 3	Nil escalation	Nil escalation
Number of vehicles over POST	2	1	0
longest time	1:26hrs	49min	29min
Total Vehicles	3	3	1

Redcliffe (QAS escalation)	Nil escalation	Nil escalation	Nil escalation
Number of vehicles over POST	0	0	0
longest time	14min	26min	0
Total Vehicles	1	1	0

Prince Charles (QAS escalation)	Stage 3	Nil escalation	Nil escalation
Number of vehicles over POST	1	3	1
longest time	1:07hrs	1:10hrs	46min
Total Vehicles	6	6	3

Royal Brisbane (QAS escalation)	Stage 2	Nil escalation	Nil escalation
Number of vehicles over POST	6	1	0
longest time	1:13hrs	31min	0
Total Vehicles	11	1	0

Princess Alexandra (QAS escalation)	Stage 3	Nil escalation	Nil escalation
Number of vehicles over POST	7	1	0
longest time	3:40hrs	21min	0
Total Vehicles	8	1	0

Mater (QAS escalation)	Nil escalation	Nil escalation	Nil escalation
Number of vehicles over POST	1	0	0
longest time	32min	0	30min
Total Vehicles	4	0	3

QEII (QAS escalation)	Stage 3	Nil escalation	Nil escalation
Number of vehicles over POST	2	0	1
longest time	1:47hrs	0	43min
Total Vehicles	2	0	1

Redlands (QAS escalation)	Stage 3	Nil escalation	Nil escalation
Number of vehicles over POST	1	3	1
longest time	1:03hrs	56min	1:03hrs
Total Vehicles	1	4	1

Logan (QAS escalation)	Stage 3	Stage 3	Stage 3
Number of vehicles over POST	3	2	3
longest time	58min	1:29hrs	1:28hrs
Total Vehicles	6	2	4

Staff Resourcing

The resourcing across Brisbane was not affected by unscheduled staff absenteeism. However key staff vacancies were noted in the CDS role in the Brisbane OpCen, with only one CDS being present in the room after 11.00 pm where two are usually rostered. This did place the CDS under high pressure given the size of the pending queue throughout the shift after 11pm, requiring regular call backs. Despite this, the paramedic nightshift resourcing shortfall was not considered significant given the hospital delays experienced by QAS as the pending cases commenced at 49 at 6pm and reduced to 30 at 6am.

Actions Taken and Outcomes:

- Assistant Commissioner, State OpCens notified the On-Duty Executive on date of incident.
- Delayed response contributory factors include Call taking concerns during the day shift with several missed opportunities identified including the CDS clinical assessment, with workload demand placing impacts on paramedic availability.
- State QA evaluation requested and received that identifies the 6 call taker performance with standards met and areas of concern that need to be addressed.

- Medical Director notified that he contacted the CDS involved. The CDS confirmed he had missed the clinical presentation involved.
- LASN has been requested to confirm/review the standard of clinical care provided by the attending paramedics.

Review Recommendations:

- Further follow up required with the CDS by the Director Brisbane OpCen with input by the Medical Director to ensure learnings are met.
- EMDs involved who have not followed call performance protocols are to receive QA evaluation feedback in detail for learning and development.
- Family contact by LASN representatives to be identified considering the long delay and the patient outcome.
- SEQ Waiting Incident Management > 90 minutes process implemented and evolving.

Appendix of relevant documents/files:

- Incident Detail Report (IDR).
- Electronic Ambulance Report Form (eARF)
- State QAU Evaluation Summary

LASN Endorsement

Name	Position	Signature	Date
Peter Warrener	Assistant Commissioner State Operations Centre	Irrelevant	
David Hartley	Acting Assistant Commissioner Metro North LASN		26.7.21.

Significant Incident Review Template Version 1.0 July 2020

Sunshine Coast Local Ambulance Service Network

Authority:

By authority of Sunshine Coast Assistant Commissioner (AC), Mr Stephen Gou h in compliance with LASN directive 08-15, this review was completed by Senior Operations Su ervis (SOS) K i t McAlister.

Executive Summary:

At 03:43 on the 12 h June 2021 Queensland Ambulance Servic (QAS) eceived a request to Irrelevant Irrelevant Caloundra for an Irrelevant , with xace bation chronic obstructive pulmonary disease (COPD).

The incident was categorised through the Medical Priority D atch System (MPDS) as a MATA3; 2A response; Incident Detailed Report (IDR) 144 062

Two further calls were received prior to QAS arrival at sc e advising of deterioration in patient condition. The incident was reco ed and gr ded to code 1B (MATA2) at 04:09 and then upgraded to a code 1A (MAT) at 04 0. B40 85 and B 01774 were dispatched and a Critical Care Paramedic (CCP) wa also attac ed to the t at 04:12. As B401785 was arriving on scene another call was r ceived at 04 8 requesting cancellation of QAS response as the patient was now deceased and th patients being contacted.

There was a delay in dispatch 7 minutes before the first units with a solo officer were assigned. The case was requested as a M ically Authorised Ambulance Transport (MAAT) from a Health Care Profes nal (HCP). The initial ding was MATA3 which in this instance can be defined as an urgent non-life reatening illness requ ring an undelayed ambulance attendance for assessment and tra port. T delayed response of 27 minutes was avoidable; B401785 was located at QAS Birti a and B40177 was partially available at Sunshine Coast University Hospital (SCUH) at 03:40.

Terms f Reference:

This review ill investigate all aspects of the ambulance response to incident 14410062 to examine the appropria ess of the QAS response and identify (if any) operational or clinical issues.

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

LASN Clinical Incident Summary Report:

At the time of writing this report a primary review of case documentation has not been completed as the Digital Ambulance Report Form (DARF) has not been synchronised.

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

The patients' doctor was contacted to provide a Recognition of Life Extinct (ROLE) form.

Incident Review/Investigation:

SOS conducted a review of available documentation and records post incident. The IDR DARF, LASN workload and resource availability have been reviewed as part of this incident rep t.

- Sunshine Coast LASN were situated with -1 officer on night shift at Buderim S on
- SEQ was on EXTREME escalation

- The incident was categorised at a MATA3, code 2A response
- The call was ended as the request for service originated from a Hea Car Profe al
  - Audio records pertaining to this incident have been requ te rough e Ma oochydore Operations Centre Manager (OCM), Richard Raymon to dete mine if th nitial call was categorised correctly
- There was a 27-minute delay in dispatching a uni n this e
  - There is no evidence the CDS performed a call bac to advise of a delay in response
  - The CDS did not read or conduct a r iew of is incid nt until 04:12
  - There is no notification in IDR to su ervisors f 'no resources available'
- A code 2A response re es imme e respon e, no lights and sirens, of the closest most appropriate Par medic un
  - On review it uld appear ultiple units were available for response including:
    B401785 (solo icer) a ilable at Birtinya;
    B401774 (solo offi r) ffloaded and partially available at SCUH at 03:40;
    B401809 cleared SC H and available at 03:31;
    B401954 cleared Namb r General Hospital (NGH) and available at 03:33;
    In ddition, B401815 offlo ed and became partially available at SCUH at 03:49
  - A Critic Care Paramedic was dispatched at 04:12 after the incident was upgraded to a 1A respon
- 401785 arrived o scene at 04:28, after responding from QAS Birtinya
- A 4:31 a Situation Report was provided confirming the patient was deceased
- The gital Ambulance Report Form (DARF) has not been synchronised at the time of writing this rev w.

- Maroochydore Operations Centre had two (2) CDS rostered on duty (1800 – 0600)
  - CDS workload may have impacted on the capacity of the CDS to make a call back to this case prior to it being upgraded
  - SOS has requested OpCen review of CDS case workload for pending cases and evidence that call backs were being made during this time.

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- This incident has not been recorded in the Operations Centre End of Shift Brief 11/06/2021, (1800 – 0600)

Background

Queensland Ambulance Service received a request for service to attend Colin McCilric at Blue Care Aminya, Caloundra.

QAS resources attending this incident included:

Irrelevant	Irrelevant
Irrelevant	Irrelevant
Irrelevant	Irrelevant

The patient was experiencing exacerbation of COPD with oxygen being admini ered when QAS was called at 03:43.

At 04:07 a second call to QAS was received advising the patie t had l boured breathing and low oxygen saturations.

A third call back to QAS was received at 04:16 stating t patien was d teriorating further with oxygen saturations now unreadable.

QAS received a final call at 04:28 to cancel the QAS res onse as e patient was deceased.

On arrival at scene attending QAS ers con m the pat nt was deceased.

Chronology

03:43 QAS request for se ce rec ed, M ode 2A response

03:45 Incident 'In Waiting Que

04:07 Dupli e call received an app ded

04:09 ncident re nfigured MATA2 and upgraded code 1B response

0 Incident reconfig ed MATA1 and upgraded code 1A response

B 1774 dispatched and responding from SCUH at same time

B4017 dispatched and responding from QAS Birtinya at same time

04:12 A406801 dispatched from Sunshine Coast Airport Base

Solo officers rendezvous at SCUH and continued to incident as a crew in B401785

04:16 Duplicate call received an appended

04:28 B401785 arrived on scene

Duplicate call received and appended. Patient deceased; QAS cancelled. Dr being contacted

04:31 SR B401785 confirming patient deceased

A406801 cleared from case

04:39 B401785 cleared from case

Incident Outcomes:

Patient deceased prior to QAS arrival

Irrelevant contacted the patients' Doctor to provide ROLE form

Review Recommendations:

As part of a proactive review, audio files have requested through Maroochydore OCM
A review has been requested regarding the OpCen management of this incident.

That this Significant Incident Review be noted and filed.

Appendix of relevant documents/files:

- Incident Detail Report 14410062
- Digital Ambulance Report Form (DARF) has not yet been synchronised
- Senior Operations Supervisor end of shift report 11/06/2021 (1800 - 0600)
- Operations Centre end of shift brief 11/06/2021 (1800 - 0600)
- Dot point brief

LASN Endorsement

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

Role	Name	Position	Signature	D6te
Assistant Commissioner	Stephen Gough	General Manager	Irrelevant	12/02/2021

Significant Incident Review

Version 1.0 August 2020

Metro North Region

Authority:

By authority of Mr David Hartley, A/Assistant Commissioner, Metro North Region.

Executive Summary:

On the 21 June 2021, QAS received a call for service at 1507hrs (CN: 14452258) for a Irrelevant w o was febrile. The case was coded as a 2A and an Advanced Care Paramedic (ACP) g officer was attached at 1541hrs, with a Kilcoy First Responder being attached at 1543hrs. Th patien as asse ed and treated on scene and was transported to Kilcoy Hospital at 1613hrs, arriving t hospi al a 618hrs.

A subsequent transfer from Kilcoy Hospital through to Caboolture Hospital on the 21 ne 202 at 2013hrs (CN: 14453287). This case was booked by the requesting clinician as RED with e pro sional diagnosis as a Pulmonary Embolism/Urosepsis. An ACP crew was in ally disp tched to the case at 0304hrs (22 June 2021), however was diverted to a higher priority ase. A su sequ t cre was dispatched from Burpengary at 0310hrs, arriving on scene at Kilcoy Hospita t 0416h The crew eparted Kilcoy Hospital at 0458hrs and during transport continued to take clinical obse ations the patie t and arrived at Caboolture Hospital at 05:31hrs on the 22 June 2021, 9hrs and minute the case was booked.

The Brisbane OpCen pending queue at the receipt of he RE 2A call vealed there was 15 cases pending with delays being experienced across the Metro No h HHS cilities. There was high demand for service across the Metro North Region.

On 21 June 2021, the QAS Metro orth LAS experie ed 227 hours of 'Lost Availability' at Emergency Departments. On 22 June 2021 QAS exper nced 209 hou s of 'Lost Availability' at Emergency Departments. This 'Lost Avai ility' reduce the number of ambulances available to deploy to pending incidences. When this occurs, t QAS p oritise es according to clinical acuity.

QAS Professional Standards receive orrespondence from the Coroner with the delay to Caboolture hospital of greater than 8.5 hrs did not ect diagnosis or outcome but more broadly a highlighted systemic issue. With the d and experienced with the OpCen, the CDS missed opportunities to review the case and speak with clini ns at Kilcoy hospital and review alternative dispatch plans.

Term of Reference:

Th review ll investigate all a pects of ambulance response to incident 14452258 & 14453287. The review will examine a ulance operations prior to, during and following the response.

L SN Clinical In ident Summary Report:

A nical review was undertaken by the Metro North Clinical Education Unit through ECLIPSE (39369 and 3 349) with no clinical issues noted within these cases.

State OpCen ProQA:

- The 000 call has been deemed High Compliant
- The first of the non-acute calls from Kilcoy hospital is processed correctly
- The second call from Kilcoy hospital (1st call back), the EMD advises of delays and checks the status of the patient.

- The third call from Kilcoy hospital (2nd call back), the EMD advises of delays but does not checks the status of the patient.

Incident Review/Investigation:

Scope

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

Background

Initial Incident CN: 14452258

- On the 21 June 2021 at 1507hrs triple zero was called for a Irrelevant who w s fe ile.
- At 1522hrs the case was reviewed by the clinician in the Clinical Hub located withi the B sbane Operations Centre.
- At 1522hrs the case was changed from the initial coding of a 2C a d upg ded to 2A ue to patient condition.
- At 1541hrs unit 504392 was assigned and they mark d respond g in e sam moment, responding from Kilcoy Ambulance Station.
- At 1541hrs the Kilcoy First Responder was also assigned, nd they arked sponding two minutes later at 1543hrs, responding from the Kilcoy area.
- At 1547hrs unit 504392 arrived on-scene.
- At 1558hrs the Kilcoy First Responder arrived o -scene
- At 1613hrs unit 504392 marked transporting fo Kilcoy Hospital.
- At 1618hrs unit 504392 marked at pital.
- At 1644hrs unit 504392 was cl ared fro the ca

Timeline (CN: 14452258)

1st Key Stroke:	**1507hrs**
In waiting queue:	**1509hrs**
Assigned:	**1541hrs**
Enroute:	**1541hrs**
At sce :	**1547hrs**
Dep ed scene:	**613hrs**
A hos tal:	**1 8hrs**
artially vailable:	**1644hrs**
Incident dura n:	**1hr 44minutes**

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ec Incident CN: 14453287

- On the 21 June 2021 at 2013hrs a call was made to the Queensland Ambulance Service to book the transfer of patient Leslie Harrison through to Caboolture Hospital – this case was booked as a RED2A. At 2312hrs Kilcoy Hospital contacted the Brisbane Operations Centre to enquire for a ETA – "KILCOY HOSP CALLED FOR ETA – ADV ACC – NIL CHANGES"

- At 0143hrs the EMD placed a note in the case advising "DELAY IN DISPATCH DUE TO WOKRLOAD"
- At 0303hrs the initial unit 501383 was assigned to the case and was responding from Kippa-Ring.
- At 0307hrs unit 501383 was diverted to a higher priority case in Caboolture.
- At 0310hrs unit 501374 was attached and responded from Burpengary.
- At 0416hrs unit 501374 arrived on scene at Kilcoy Hospital.
- At 0458hrs unit 501374 marked transporting code 2 to Caboolture Hospital.
- At 0500hrs & 0526hrs unit 501374
- At 0531hrs unit 501374 arrived at Caboolture Hospital.

Timeline (CN: 14453287 – IHT)

1st Key Stroke:	**2013hrs**
In waiting queue:	**2014hrs**
Assigned:	**0303hrs**
Enroute:	**0304hrs**
1st unit cleared	**0307hrs**
2nd unit assigned	**0310hrs**
2nd unit enroute	**0310hrs**
At scene:	**0416hrs**
Departed scene:	**0458hrs**
At hospital:	**0531hrs**
Partially available:	**0603hrs**
Incident Duration	**9hrs 49minutes**

On 21 June 2021, the QAS Metro North LASN experienced 227 hours of 'Lost Availability' at Emergency Departments. On 22 June 2021, QAS experienced 209 hours 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:

Variance - ACUTE						Variance - PTS		
D	A	N	LARU	CCP	STRU	D	A	N
-5	10	-7	-3	-2	0	-7	-2	0

Review Initial Incident - 14452258

- A timely dispatch of the initial incident (14452258) occurred, the case was referred from the acute pending queue through to the Clinical Hub due to the incident meeting the criteria for the Clinical Hub to review the case for a call-back/dedicated Clinical Hub resource to attend.
- The case was reviewed by the clinician and placed back into the acute pending queue and consequently dispatched to the closest most appropriate resource (Kilcoy Unit 504392).

Review Second Incident – 14453287

- When Kilcoy Hospital contacted QAS to book the case at 2013hrs (21 June 2021) they booked the case as a RED2A and advised the EMD that the patient was "READY NOW"
- Kilcoy Hospital contacted QAS again at 2312hrs (21 June 2021) to obtain an estimated time of arrival and the call was advised accordingly.
- There were no further call-backs from the facility to obtain further updates.
- Apart from the two units dispatched to the incident at 0304hrs & 0310hrs respectively there was no other units assigned to this incident.
- There is no sign of any review from the Clinical Deployment Supervisor or Operations Centre Supervisor within the IDR.

- Notations made within the Metro North Operations Report from the 21 June 2021 indicated that the Royal Brisbane Hospital & Caboolture Hospital were escalated to level 3 since the early afternoon on the 21 June 2021.

Outcomes

- Assistant Commissioner, Metro North Region notified after receiving feedback from QAS Profession Standards.
- Ambulances delayed at Emergency Departments impacted on availability resulting in higher acuity responses being prioritised.
- LASN has reviewed standard of clinical care provided by the attending paramedics.

Post review actions

- SEQ waiting Incident Management >90 minutes process has since been implem nt
- Metro North Region has deployed further spare stretchers to emergency dep tments assist in facilitated transfer of care.

Appendix of relevant documents/files:

Incident Detail Report	IDR 14452258.pdf IDR 53287.pd
Ambulance Report Form	ARF 144 258.pdf F 1445328 pdf
iROAM snapshots	Pe ng cases.pdf
Clinical Review	ECLIPSE audits.pdf
W rkforc lanning	NIGHT WORKSHEETS - 1. M
O Cen Audio	01.36.12 Ph Kilcoy ED to QAS 22 June 2 23.11.22 Ph Kilcoy ED to QAS 21 June 2 20.13.51 Ph Kilcoy ED to QAS 21 June 2 210621_SR17316354_14452258_WINYA [5
OpCen Review	OpCen Review .pdf OpCen timeline.pdf 210621_SR17316354_14452258_WINYA [5 210621_SR17316354_14452258_WINYA [5

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LASN Endorsement

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

Name	Position	Signature	Date
David Hartley	Assistant Commissioner		19/7/21
Warren Painting	Director Operations		19/7/21
Lisa Dibley	Director Operations		19/7/21

Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **14452258**
ProQA number: **17316354**
Console name: **QA523**
Incident Date: **21/06/2021 15:07:43**
Last Updated:

Incident Information

Incident Type:	ACUTE-STR	**Alarm Level:**	
Priority:	2A	**Problem:**	?COVID19 FLU SYMPTOM ONL LVL0
Determinant:	36A03S	**Agency:**	QAS
Base Response#:	099210	**Jurisdiction:**	5 Brisbane North
Confirmation#:	00669821	**Division:**	5 Kilcoy
Taken By:	Irrelevant	**Battalion:**	5 Kilcoy
Response Area:	5 Kilcoy	**Response Plan:**	Acute-Str
Disposition:	A Case Completed	**Command Ch:**	
Cancel Reason:		**Primary TAC:**	TLK GRP 105 24 KILCOY
Incident Status:	Closed	**Secondary TAC:**	
Certification:	ACUTE	**Delay Reason (if any):**	
Longitude:	27419135	**Latitude:**	63061449
Patient Name:	Irrelevant	**Patient DOB:**	12/

Incident Location

Location Name:		**County:**	OMERSE
Address:	Irrelevant	**Location Type:**	
Apartment:		**Cross Street:**	NEURU RD/SAL A D RD
Building:		**Map Reference:**	DL9E
City, State, Zip:	Irrelevant		

Call Receipt

Caller Name:	Irrelevant	**Original CLI Phone**	Irrelevant
Method Received:		**Call ck Phone:**	
Caller Type:		**Caller ation:**	Ir evant

Time Stamps

Description	Date	Time	User	Elapsed Ti Descriptio	Time
Phone Pickup	21/06/2021	15:07:42			
1st Key Stroke	21/06/2021	15:07:43		**ived to In eue**	00 01:50
In Waiting Queue	21/06/2021	15:09:33		**Call ng**	00 03:25
Call Taking Complete	21/06/2021	15:11:08	Pratt, Jasmine	**In Qu e to 1st As**	00:31:27
1st Unit Assigned	21/06/2021	15:41:00		**Cal eceiv d to 1st Assign**	00:33:18
1st Unit Enroute	21/06/2021	15:41:51		**A igned t st Enroute**	00 00:51
1st Unit Arrived	21/06/2021	15:47:22		**nroute to t Arrived**	00 05:31
Closed	21/06/2021	16:52	M Debra	**Incident D ation**	01:44:53

Resources Assigned

Unit	Assigned	Disposition	En te	Staged	ived	At Patient	Delay Avail	Complete	Odm. Enroute	Odm. Arrived	Cancel Reason
504392	15:41:00	A Case Completed	15:4				16:26:33	16:44:43			
F599200	15:41:16	A Case Completed	15:43:15		15:58:35			16:52:35			

Personnel Assigned

Unit	Name
504392	Irrelevant

Pre-Scheduled rmation

No Pre-Sche ed Information

Transpo

Uni	Loca /Address	ent	Mode	Protocol	Mileage Start/End/Total	Depart	Arrived	Complete
50 92	QH KIL HOSPITAL 12 KROPP S		Off Stretcher	Pre Hosp - patient condition	0.0//	16:13:28	16:18:53	16:44:43

ments

Da	Time	Us	Type	Comments
21/ 2021	15:09:33	5JASPRA	Response	[ProQA Dispatch] Dispatch Level: 36A03 (Flu-like symptoms only (cough, fever, chills, sweats, sore throat, vomiting, diarrhoea, muscle/body aches, fatigue/weakness, headache, etc.)) Suffix: S (Level 0 (COVID-19 surveillance only)) Response Text: 2C Irrelevant , Conscious, Breathing. Problem Description: HIGH FEVERS - PARAPLEGIC AND IS BED RIDDEN
21/06/2021	15:09:33	5JASPRA	Response	[ProQA: Key Questions] 1. This is a coronavirus (COVID-19) outbreak. 2. The locally designated Triage Level is 0 (surveillance only). 3. The most prominent complaint is having a fever. 4. Irrelevant is completely alert (responding appropriately). 5 Irrelevant not changing colour. 6. Irrelev has chills. 7 Irrelev is not a HIGH RISK patient.
6/2021	15:10:42	5JASPRA	Response	EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS
21/06/2021	15:10:51	5JASPRA	Response	LAST TEMP 39.3
21/06/2021	15:22:38	36JESPAT	Response	[Private] Clinical Hub unable to review, to be managed by OpCen.
21/06/2021	15:41:02	PS	Response	[Page] Dispatch page sent to Unit:504392, Sent From: KEDCADQASPIS01
21/06/2021	15:41:02	504392	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
21/06/2021	15:41:16	PS	Response	[Page] Dispatch page sent to Unit:599200, Sent From: KEDCADQASPIS01
21/06/2021	15:41:17	PS	Response	[Page] Dispatch page to Unit:504392 complete to Irrelevant Message sent successfully.
21/06/2021	15:41:42	PS	Response	[Page] Dispatch page to Unit:599200 complete to Irrelevant Message sent successfully.

21/06/2021	15:41:43	PS	Response	[Page] Dispatch page to Unit:599200 complete to Irrelevant Message sent successfully.
21/06/2021	15:41:46	PS	Response	[Page] Dispatch page to Unit:599200 complete to Irrelevant Message sent successfully.

Priority Changes

Date	Time	Changed from Priority	Reason	User
21/06/2021	15:22:38	2C	Patient Condition	Schimpf, Cai lin

Call Activities

Date	Time	Radio	Activity	Location	Comments	User
21/06/2021	15:07:43		AML Data Received		Center of caller area HELI: -26 56.418600, 152 34.597800 ESCAD: #-26 94031/152.57663	SDSIAML
21/06/2021	15:09:33		Incident in Waiting Queue			
21/06/2021	15:09:33		Incident in Waiting Queue			
21/06/2021	15:09:33		Waiting Pending Incident Time Warning		Waiting Pending Incident Time Warning timer expired	
21/06/2021	15:09:34		ANI/ALI Statistics		INT Insert:Jun 21 2021 15:07:42 / INT SendNP:Jun 21 2021 15:07:41 / WS RecvNP:Jun 21 2021 15:07:42 / WS Process:Jun 21 2021 15 09:34	ASPRA
21/06/2021	15:09:35		Read Comment		Comment for Incident 354 was Marke Read.	JASPRA
21/06/2021	15:09:35		ProQA	5001 Daguilar Hwy	ProQA determinant sent	5JASPR
21/06/2021	15:09:43		Remove Waiting Pending Incident Warning		Removing Waiting Pen g Inci Time Warning imer expire	
21/06/2021	15:09:43		Incident in Waiting Queue Timer Clear			
21/06/2021	15:09:45		Read Incident		Incident 354 was Ma ked as ead.	5PATLAF1
21/06/2021	15:10:03		UserAction		User clicked Exit/Save	5PATLAF1
21/06/2021	15:11:08		UserAction		User click it/Save	5JASPRA
21/06/2021	15:13:24		Read Comment		Comm t for I nt 354 Mark as Re	5CAISCH
21/06/2021	15:21:33		UserAction		U clicked E Save	5CAISCH
21/06/2021	15:22:22		UserAction		U clicked xit/Save	36JASMER
21/06/2021	15:22:38		Incident Priority Change		In nt p ity chang rom 2C to 2A due to Pat ondition	5CAISCH
21/06/2021	15:22:38		Waiting Pending Incident Time Warning		Waiti ending Inci nt Time Warning timer expired	
21/06/2021	15:22:40		Priority Upgrade/Downgrade Prompt		hange From 2C to 2A? - User clicked OK	5CAISCH
21/06/2021	15:22:49		Remove Waiting Pending Incident Warning		Re ing Waiting Pending Incident Time Warn imer expired	
21/06/2021	15:22:49		Incident in Waiting Queue Timer Clear			
21/06/2021	15:25:57		UserAction		User clicked Exit/Save	5CAISCH
21/06/2021	15:28:25		Read Comme		Comment for Incident 354 was Marked as Read.	36JESPAT
21/06/2021	15:38:49		UserActi		User clicked Exit/Save	5PATLAF1
21/06/2021	15:39:33		Inciden ate			
21/06/2021	15:39:33		Pen Incident Time Warn		Pending Incident Time Warning timer expired	
21/06/2021	15:40:47		UserAct		User clicked Initial Assign	5DEBMOS
21/06/2021	15:40:48		Initial Assig en		The following unit(s) is (are) recommended for assignment: 504392 (00:02:05)	5DEBMOS
21/06/2021	15:41:00	504392	Dispatched	5001 Daguilar Hwy	Response Number (099210)	5DEBMOS
21/06/2021	15:41:01		Incident Timer Cle		Incident Timer Cleared	
21/06/2021	15:41:16	599200	Dispatched	5001 Daguilar Hwy	Response Number: 099213;	5DEBMOS
21/06/2021	15:41:20		UserAction		User clicked Exit/Save	5DEBMOS
21/06/2021	15:4 :51	5 92	Resp	5001 Daguilar Hwy	Responding From = 5(11) KILCOY	VisiNET
21/06/2021	15 16		Incident Late		Active incident marked as late	
21/06/2021	42:39		Read Comment		Comment for Incident 354 was Marked as Read.	5DEBMOS
21/06/20	15:43:07		U Action		User clicked Exit/Save	5DEBMOS
21/06/2	43:15	599200	Re	5001 Daguilar Hwy	Responding From = 268 Rasmussen Rd [NEURUM CREEK BUSH RETREAT]	5DEBMOS
21 2021	15: 2	504392	At Scene	5001 Daguilar Hwy		VisiNET
21/06/2021	15:54		UserAction		User clicked Exit/Save	36JESPAT
21/06/2021	15:58:35	599200	At Scene	5001 Daguilar Hwy		5BELSEI
1/06/2021	16:13:28	4392	Dep	QH KILCOY HOSPITAL		VisiNET
6/2021	16:18:53	92	Dest	12 KROPP ST [QH KILCOY HOSPITAL]		VisiNET
21/ 2021	16:18:53	504392	Transport Time		Depart Scene Time: 16:13:28, Arrive Destination Time: 16:18:53	VisiNET
2 6/2021	16:26:17	504392	Status Update Received	12 KROPP ST [QH KILCOY HOSPITAL]	Status update Off Stretcher received from Radio 504392P1	GWNPOL
21/06/202	17	504392	Off Stretcher	12 KROPP ST [QH KILCOY HOSPITAL]		GWNPOL
21/06/2021	16:26:33	504392	Status Update Received	12 KROPP ST [QH KILCOY HOSPITAL]	Status update Partially Available received from Radio 504392P1	GWNPOL
21/06/2021	16:26:33	504392	Partially Av	12 KROPP ST [QH KILCOY HOSPITAL]		GWNPOL
6/2021	16:26:45		UserAction		User clicked Exit/Save	5PATLAF1
21 06/2021	16:44:43	504392	Available	12 KROPP ST [QH KILCOY HOSPITAL]		5DEBMOS
21/06/2021	16:44:43	504392	Disposition	5001 Daguilar Hwy	A Case Completed	5DEBMOS
21/06/2021	16:52:35	599200	Available	5001 Daguilar Hwy		5DEBMOS
21/06/2021	16:52:35	599200	Disposition	5001 Daguilar Hwy	A Case Completed	5DEBMOS
21/06/2021	16:52:35	599200	Response Closed	5001 Daguilar Hwy	Response Disposition: A Case Completed	5DEBMOS

Edit Log

	Changed	Changed

Date	Time	Field	From	To	Reason	Table	Workstation	User
21/06/2021	15:07:43	Call_Back_Phone		0414106540	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:07:52	City	LAWNTON	KILCOY	Updated City	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:07:52	City	LAWNTON	KILCOY	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:07:56	Address	(Blank)	5001 DA*	New Entry	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:08:08	Jurisdiction		5 Brisbane North	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:08:08	Division		5 Kilcoy	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:08:08	Battalion		5 Kilcoy	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:08:08	Response_Area		5 Kilcoy	(Response Viewer)	Response_Master_Incident	QA523	5JAS A
21/06/2021	15:08:08	ResponsePlanType	0	0	(Response Viewer)	Response_Master_Incident	QA523	5JA RA
21/06/2021	15:08:08	Primary_TAC_Channel		TLK GRP 105/U 24 KILCOY	(Response Viewer)	Response_Master_Incident	QA523	5JAS A
21/06/2021	15:08:08	Address	5001 DA*	Irrelevant	Entry Selected/Returned from GeoLocator	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:08:08	City	KILCOY	Irrelevant	Updated City	Response Master Incident	QA523	5JASP
21/06/2021	15:08:08	Latitude	0	63061449	Entry Selected/Returned from GeoLocator	Response_Master_Incident	QA523	5JASP
21/06/2021	15:08:08	Longitude	0	27419135	Entry Selected/Returned from GeoLocator	Response_Master_Inci nt	QA52	ASPRA
21/06/2021	15:08:13	Building	1		(Response Viewer)	Response_Master_Inc ent	A523	5JASPRA
21/06/2021	15:08:22	Call_Back_Phone	Irrelevant	349	(Response Viewer)	Response M r Incident	QA523	5JASPRA
21/06/2021	15:08:35	ProQaCaseNumber		17316354	(Response Viewer)	Incide	Q	5JASPRA
21/06/2021	15:08:40	Caller_Name		Irrelevant t	(Respo Viewer)	Res se_Ma r_Incid	QA523	5JASPRA
21/06/2021	15:09:33	Problem		?COVID19 FLU SYMPTOM ONLY LVL0	(Response Viewer)	Respon Master_Inci nt	QA523	5JASPRA
21/06/2021	15:09:33	Response_Plan		Acute-Str	(R ponse ewer)	Resp Master_Incident	QA523	5JASPRA
21/06/2021	15:09:33	DispatchLevel		Normal	Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:33	ResponsePlanType	0	1	Resp se r)	sponse_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:33	Incident_Type		A TE-S	(R onse View	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:34	Field_Data		Ir vant	Patient Name:	Response_User_Data_Fields	QA523	5JASPRA
21/06/2021	15:09:34	Pickup_Map_Info	(Blank)			Response_Transports	POLCADQASCXA22	5JASPRA
21/06/2021	15:09:34	Map_Info		DL9E1		Response_Master_Incident	POLCADQASCXA22	5JASPRA
21/06/2021	15:09:35	Read Comment	ls	True	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:35	Priority_Number	0	6	Updated by ProQA	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:35	Det nant		36A03S	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15:09:35	EMD_U	0		(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/2021	15 35	CIS_Used	0	null	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/06/20	09:45	Read Call	False	True	(Response Viewer)	Response_Master_Incident	QA503	5PATLAF1
21/0	02115: 2	Field_Data		Irrelevan FEBRILE BED BOUND	Pt Comments	Response_User_Data_Fields	QA503	5PATLAF1
1/06/2021	15:10:39	Field_ a		Irrelevant	Patient DOB:	Response_User_Data_Fields	QA523	5JASPRA
6/2021	15:11:03	CIS_Us	0	null	(Response Viewer)	Response_Master_Incident	QA523	5JASPRA
21/	2021	15:11:03 ProQATerminationStateCode		C	(Response Viewer)	Incident	QA523	5JASPRA
2 6/2021	15:13:24	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	QA548	5CAISCH
21/06/202		riority_Description	2C	2A	Patient Condition	Response_Master_Incident	QA548	5CAISCH
21/06/2021	15:22:38	Priority_Number	6	4	Patient Condition	Response_Master_Incident	QA548	5CAISCH
21/06/2021	15:22:39	Priority_Description	2C	2A	Priority Change Accepted	Response_Master_Incident	QA548	5CAISCH
21/06/2021	15:22:41	Certification_Level	Clinical Hub	ACUTE	(Response Viewer)	Response_Master_Incident	QA548	5CAISCH
6/2021	15:28:25	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	PC901212	36JESPAT
21/06/2021	15:41:51	Current_UnitRespPriorityDesc	504392: 2A	COLD2A	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
21/06/2021	15:42:39	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	QA507	5DEBMOS
21/06/2021	16:13:29	Map_Info	(Blank)	KCY1F7		Response_Transports	KEDCADQASMDI01	VisiNET
21/06/2021	16:26:17	Transport_Mode	(Blank)	Off Stretcher	Additional Information	Response_Transports	POLCADQASGWN01	GWNPOL

Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **14453287**
ProQA number:
Console name:
Incident Date: **22/06/2021 03:10:43**
Last Updated:

Incident Information

Incident Type:	ACUTE-STR	**Alarm Level:**	
Priority:	2A	**Problem:**	RED2A
Determinant:		**Agency:**	QAS
Base Response#:	101152	**Jurisdiction:**	5 Brisbane North
Confirmation#:	00670818	**Division:**	5 Kilcoy
Taken By:	Meredith, Zachary	**Battalion:**	5 Kilcoy
Response Area:	5 Kilcoy	**Response Plan:**	Acute-Str
Disposition:	A Case Completed	**Command Ch:**	
Cancel Reason:		**Primary TAC:**	TLK GRP 10 U 24 KILC
Incident Status:	Closed	**Secondary TAC:**	TLK GRP 105 24 OY
Certification:	MATI	**Delay Reason (if any):**	
Longitude:	27439066	**Latitude:**	630 8
Patient Name:		**Patient DOB:**	

Incident Location

Location Name:	QH KILCOY HOSPITAL	**County:**	
Address:	Irrelevant	**Location Type:**	QHea Facility
Apartment:		**Cross Street:**	ROW T/TAYLOR ST
Building:		**Map Reference:**	KCY 7
City, State, Zip:	Irrelevant		

Call Receipt

Caller Name:	Irrelevant	**Orig l CLI Phon**	
Method Received:		**Call Ba Phone:**	I evant
Caller Type:	Irrelevant	**Caller Lo on:**	elevant

Time Stamps

Description	Date	Time	User
Phone Pickup	21/06/2021	20:13:57	
1st Key Stroke	21/06/2021	20:14:24	
In Waiting Queue	21/06/2021	20:19:18	
Call Taking Complete	21/06/2021	20:19:06	Meredith, Za ary
1st Unit Assigned	22/06/2021	03:03:0	
1st Unit Enroute	22/06/2021	03:0 7	
1st Unit Arrived	22/06/2021	0 6:08	
Closed	22/06/2021	:03:43	Lan haw, Cara

Elapsed Time

scription	Time
Rec ed to In Q ue	
C Takin	
Queue 1st Assign	06:43:47.7
Call Rece ed to 1st Assign	06:49:08.7
Assigne o 1st Enroute	00:01:02
Enrou to 1st Arrived	01:12:01
ent Duration	09:49:46

Resources Assigned

Unit	Assigned	Disposition	Enrout	St d	Arrived	Patient	Delay Avail	Complete	Odm. Enroute	Odm. Arrived	Cancel Reason
B501383	03:03:05	Cancel En Route	03:04:07					03:07:59			.Diverted To Higher Priority
B501374	03:10:43	A Case pleted	03:10:46		04:16:08		06:01:40	06:03:43			

Personnel Assig ed

Unit	ame
501374	Irrelevant
501383	Irrelevant

Pre edul nformation

P nt	Call Tak n	Pickup Requested	Pickup Promised	Appointment
Irrelevant	21/06/2021 20:19:17	21/06/2021 20:14:00	21/06/2021 20:14:00	21/06/2021 20:14:00

Transports

Un	Location/Address	Patient	Mode	Protocol	Mileage Start/End/Total	Depart	Arrived	Complete
50 4	Irrelevant	Irrelevant	Cold	Pre Hosp - patient condition	-1.0/-1.0/-1.0	04:58:46	05:31:57	06:03:43

Comments

Date	Time	User	Type	Comments
21/06/2021	20:19:04	5ZACMER	Response	DX ?PE UROSEPSIS - IV RUNNING - CARDI MON - 02 - STR - DEST CAH - READY NOW ++MRSA++EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS
06/2021	20:42:41	5CARLAN	Response	[Private] Delay in dispatch due to workload
2 06/2021	23:06:10	5CARLAN	Response	[Private] Delay in dispatch due to workload
21/06/2021	23:12:28	5RICGOU	Response	KILCOY HOSP CALLED FOR ETA - ADV ACC - NIL CHANGES
22/06/2021	01:37:03	5KARVAN	Response	[Private] Call received requesting ETA - adv accordingly
22/06/2021	01:43:36	5CARLAN	Response	[Private] Delay in dispatch due to workload
22/06/2021	03:03:05	PS	Response	[Page] Dispatch page sent to Unit:501383, Sent From: KEDCADQASPIS01
22/06/2021	03:03:06	501383	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
22/06/2021	03:03:17	PS	Response	[Page] Dispatch page to Unit:501383 complete to PIN 0408713499:

				41960517 Message sent successfully.
22/06/2021	03:03:18	PS	Response	[Page] Dispatch page to Unit:501383 complete to PIN 0432376687: 41960518 Message sent successfully.
22/06/2021	03:07:49	5CARLAN	Response	[Private] The unit responding to this incident has been diverted. The case requires immediate review and a response plan formulated. CABOOLTURE
22/06/2021	03:10:43	PS	Response	[Page] Dispatch page sent to Unit:501374, Sent From: KEDCADQASPIS01
22/06/2021	03:10:44	501374	Response	[PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT.
22/06/2021	03:10:57	PS	Response	[Page] Dispatch page to Unit:501374 complete to PIN 0432376740: 41960539 Message sent successfully.
22/06/2021	04:46:05	5CARLAN	Response	[Page] Units: 501374, Sent From: QA507, WELFARE CHECK
22/06/2021	04:47:30	5CARLAN	Response	501374 JUST LOADED PT - ENROUTE TO CAH NOW
22/06/2021	05:37:13	5BENWIL	Response	[Page] Units: 501374, Sent From: QA504, Hey Team, thank you fo uch a busy night, we do have a code one pending in caboolture when y r able to clear. sorry i know its been a long night and you just arrived hospital. thanks CDS Ben
22/06/2021	06:00:14	5CARLAN	Response	[Page] Units: 501374, Sent From: QA507, You have bee hospital 30 minutes. Your Unit will be made Partially Available nless advised of delays via radio.

Priority Changes
No Priority Changes

Call Activities

Date	Time	Radio	Activity	Location	Comments	U
21/06/2021	20:19:04		DEBUG: UserAction		User clicked COMMENT-SA E	5ZACMER
21/06/2021	20:19:04		DEBUG: UserAction		User clicked SAV	5ZACMER
21/06/2021	20:19:06		DEBUG: SystemAction		Saving The Call(31750	5ZACMER
21/06/2021	20:19:06		DEBUG: SystemAction		TxData to RMI DataTyp	5ZACMER
21/06/2021	20:19:06		DEBUG: SystemAction		RMI In gged	5ZACMER
21/06/2021	20:19:06		DEBUG: SystemAction		RM nsert C (17317)	5ZACMER
21/06/2021	20:19:17		Waiting Pending Incident Time Warning		W ting Pendi Incident T e Warning er expir	
21/06/2021	20:19:17		Late Incident			
21/06/2021	20:19:18		Incident in Waiting Queue			
21/06/2021	20:19:26		Read Incident		Inc t 505 was M ked as Read.	5BENWIL
21/06/2021	20:19:28		Remove Waiting Pending Incident Warning		Remo Waiti Pending Incident Time Warn g timer expired	
21/06/2021	20:19:38		DEBUG: UserAction		er clicked EXIT	5BENWIL
21/06/2021	20:20:56		DEBUG: UserAction		U clicked COMMENT-SAVE	5ZACMER
21/06/2021	20:21:00		DEBUG: UserAction		Use cked EXIT	5ZACMER
21/06/2021	20:26:41		DEBUG: UserAction		User clicked EXIT	5CARLAN
21/06/2021	20:41:58		DEBUG: UserAction		User clicked EXIT	5CARLAN
21/06/2021	20:42:41		DEBUG: User		User clicked COMMENT-SAVE	5CARLAN
21/06/2021	20:42:42		DEBUG: U Action		User clicked EXIT	5CARLAN
21/06/2021	20:46:06		DEBUG erAction		User clicked EXIT	5BENWIL
21/06/2021	20:49:18		Pendi ncident Time Wa ng		Pending Incident Time Warning timer expired	
21/06/2021	20:49:18		Inc t Late			
21/06/2021	20:50:41		Incid Timer Cl	12	Incident Late Timer cleared for 144532875	5CARLAN
21/06/2021	20:50:41		Resetin te T er		[Reset Reason]OCS Approved [Next Late Check Time]Jun 22 2021 06:51:41	5CARLAN
21/06/2021	21:43:51		DEBUG: Use tion		User clicked EXIT	10DAVCLA
21/06/2021	21:54:36		DEBUG: UserA n		User clicked EXIT	5BENWIL
21/06/2021	21:59:25		DEBUG: UserActi		User clicked EXIT	5BENWIL
21/06/2021	23:06:10		DEBUG: UserAction		User clicked COMMENT-SAVE	5CARLAN
21/06/2021	23:06:11		DEBUG: UserAction		User clicked EXIT	5CARLAN
21/06/2021	2 2:28		DEBUG: UserAction		User clicked COMMENT-SAVE	5RICGOU
21/06/2021	:12:41		DEBUG: UserAction		User clicked EXIT	5RICGOU
21/06/202	23:31:56		EBUG: UserAction		User clicked EXIT	5JUDWEI
21/06/2	23:43:03		BUG: UserAction		User clicked EXIT	36JOHGLA
22/06 21	46:17		DE G: UserAction		User clicked EXIT	5BENWIL
22 2021	0 03		DEB G: UserAction		User clicked COMMENT-SAVE	5KARVAN
22/06/2021	01:3 6		DEBUG: UserAction		User clicked EXIT	5KARVAN
22/06/2021	01:43:		DEBUG: UserAction		User clicked COMMENT-SAVE	5CARLAN
22/06/2021	01:43:36		DEBUG: UserAction		User clicked EXIT	5CARLAN
06/2021	02:15:50		DEBUG: UserAction		User clicked EXIT	5JUDWEI
22 /2021	02:16:24		DEBUG: UserAction		User clicked EXIT	5KARCOP
22/ 2021	02:44:51		DEBUG: UserAction		User clicked EXIT	5JUDWEI
22 /2021	03:03:05	501383	Dispatched	12 KROPP ST [QH KILCOY HOSPITAL]	Response Number: 101143;	5CARLAN
	03:04:05		Incident Late		Active incident marked as late	
22/06/2021	4:07	501383	Resp	12 KROPP ST [QH KILCOY HOSPITAL]	Responding From = ANZAC AVE\DORALL ST	VisiNET
22/06/2021	03:07:59	501383	ReAssign Vehicle	QH KILCOY HOSPITAL	ReAssign Reason: .Diverted To Higher Priority	5CARLAN
22/06/2021	03:07:59		ReAssign Response	QH KILCOY HOSPITAL	Clearing Primary Vehicle Flag	5CARLAN
/06/2021	03:07:59		ReAssign Response	QH KILCOY HOSPITAL	ReAssign Reason: .Diverted To Higher Priority	5CARLAN
22/06/2021	03:07:59		Waiting Pending Incident Time Warning		Waiting Pending Incident Time Warning timer expired	
22/06/2021	03:07:59		Incident Late			
22/06/2021	03:08:09		Remove Waiting Pending Incident Warning		Removing Waiting Pending Incident Time Warning timer expired	
22/06/2021	03:10:14		Incident Timer Clear	12 KROPP ST	Incident Late Timer cleared for 144532871	0DAVCLA
22/06/2021	03:10:14		Reseting Late Timer		[Reset Reason]OCS Approved [Next Late Check Time]Jun 22 2021 13:11:14	10DAVCLA

22/06/2021	03:10:43	501374	Dispatched	12 KROPP ST [QH KILCOY HOSPITAL]	Response Number: 101152;	5CARLAN
22/06/2021	03:10:43		Read Incident	12 KROPP ST	Incident 505 was marked as read.	5CARLAN
22/06/2021	03:10:46	501374	Resp	12 KROPP ST [QH KILCOY HOSPITAL]	Responding From = 37 Rossini St	VisiNET
22/06/2021	03:18:45		DEBUG: UserAction		User clicked EXIT	5CARLAN
22/06/2021	03:43:06	501374	Calculate Vehicle ETA	DAGUILAR HWY\FRANKS LANE	ETA to Scene Address 12 KROPP ST, KILCOY is 00:24:09	5SARNAD
22/06/2021	03:43:22		DEBUG: UserAction		User clicked EXIT	5SARNAD
22/06/2021	04:16:08	501374	At Scene	12 KROPP ST		VisiNET
22/06/2021	04:46:07		DEBUG: UserAction		User clicked EXIT	5CARLAN
22/06/2021	04:58:46	501374	Dep	CAH (A&E EXT 8888)		5CARLAN
22/06/2021	05:31:57	501374	Dest	120 MCKEAN ST [CAH (A&E EXT 8888)]		VisiNET
22/06/2021	05:31:58	501374	Transport Time		Depart Scene Time: 04:58:46, Arrive Destination Time: 05:31:57	VisiNET
22/06/2021	05:38:27		DEBUG: UserAction		User clicked EXIT	5RHICA
22/06/2021	05:56:23		DEBUG: UserAction		User clicked EXIT	CARLAN
22/06/2021	06:00:16		DEBUG: UserAction		User clicked EXIT	5CARLAN
22/06/2021	06:01:40	501374	Partially Av	120 MCKEAN ST [CAH (A&E EXT 8888)]		VisiNET
22/06/2021	06:03:43	501374	Available	120 MCKEAN ST [CAH (A&E EXT 8888)]		ARLAN
22/06/2021	06:03:43	501374	Disposition	QH KILCOY HOSPITAL	A Case Completed	5CARLAN
22/06/2021	06:03:43	501374	Response Closed	QH KILCOY HOSPITAL	Response Dispositio A C Completed	5CARL

Edit Log

Date	Time	Field	Changed From	Changed To	Reason	Table	W kstation	User
21/06/2021	20:16:17	Field_Data		Stretcher	(Response Viewer)	Response_Us Fields	541	5ZACMER
21/06/2021	20:16:17	Performed_By		Meredith, Zachary	(Response Viewer)	Respons User_Dat ields	QA5	5ZACMER
21/06/2021	20:19:17	Pickup_Map_Info		KCY1F7		Respon Tran rts	POLCADQASCXA155	ZACMER
21/06/2021	20:19:17	Map_Info		KCY1F7		Respons M er_Inciden	POLCADQASCXA155	ZACMER
21/06/2021	20:19:17	Map_Info	(Blank)	B48E18		sponse_ nsports	POLCADQASCXA155	ZACMER
21/06/2021	20:19:17	Map_Info	(Blank)	B48E18		R onse_T orts	POLCADQASCXA155	ZACMER
21/06/2021	20:19:26	Read Call	False	True	(Response View)	Res se_Master_ cident	QA504	5BENWIL
21/06/2021	20:19:38	Field_Data		IHT	espo Viewer)	Respons User_Data_Fields	QA504	5BENWIL
21/06/2021	20:19:38	Performed_By		Wilkin Benja (CDS)	(Respo View	Response_User_Data_Fields	QA504	5BENWIL
21/06/2021	21:43:43	Field_Data		IHT ?PE	esponse er)	Re onse_User_Data_Fields	QA546	10DAVCLA
21/06/2021	21:43:43	Performed_By		Clark, David (S t CD	(Re Viewer)	Response_User_Data_Fields	QA546	10DAVCLA
21/06/2021	23:12:39	Field_Data		2312 RG	(Response Viewer)	Response_User_Data_Fields	QA537	5RICGOU
21/06/2021	23:12:39	Performed_By		Gough, Rick	(Response Viewer)	Response_User_Data_Fields	QA537	5RICGOU
22/06/2021	03:04:07	Cu nt_UnitRespPriorityDesc	501 2A	COLD2A	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
22/06/2021	03:07:59	TimeC ewed	21/06/2021 20:19:26	NULL	Reset Timestamp	Response_Master_Incident	QA507	5CARLAN
22/06/2021	0:43	UnreadIncid	True	False		Incident	QA507	5CARLAN
22/06/202	:10:47	Current_UnitR PriorityDesc	501374: 2A	COLD2A	Field Response	Response_Vehicles_Assigned	KEDCADQASMDI01	
22/06	210 48	Map_Info	(Blank)	B48E18		Response_Transports	POLCADQASCXA235	CARLAN

Department of Health

Queensland Ambulance Service

Significant Incident Review

Metro South Local Ambulance Service Network

Authority:

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

Executive Summary:

On 23 June 2021 at 07:53hrs, QAS received a Triple Zero (000) call for assistanc (incide number 14458972) at Irrelevant Bethan a Q 4205, to attend a Irrelevant patient who had a fall and hit Irrelevant head.

The case was initially prioritised in the Advanced Medical Priority Dispat Sy em (A PDS) as MATA3 requiring a Code 2A response, however the case was upgraded to a ode 1C sponse 12:09hrs after QAS arrived on scene.

The QAS response time was 3 hours and 34 minutes from rec pt of th riple Ze (000) call. There was a delay to identify an available paramedic unit to respond to the ca given i g ambulance workload across Metro South LASN and Metro South Health and Hospital Se ice (HHS) hospital Emergency Department (ED) delays were experienced at most s pe ho itals, a cting paramedic availability.

At 08:23hrs the Clinical Deployment Supervisor (C S) pe ormed call back and the Registered Nurse (RN) advised of delays and patient is stabl all back f c ndition c anges or upgrade is required. At 09:21hrs the CDS performed a second call b ck and re was chang patient remains stable, RN will monitor and call back if required. No rev w by the M dical Officer he Clinical Hub is noted in the Incident Detail Report (IDR).

The first four (4) closest available mb ances were dispatched to the case but were diverted to higher priority cases as below;

	Dispatched	Diverted
Fi	08:06hrs	08:11hrs
Seco d	08:48hrs	09:00hrs
Third	09:44hrs	09:45hrs
Fourth	10:31hrs	10:47hrs

QA resp ded two ambulan s who arrived at the scene:
- The t was the Advanced Care Paramedic (ACP) crew; and
- A Critic Care Paramedic (CCP); and

T first crew that ar ed on scene was assigned at 10:50hrs and arrived on scene at 11:29hrs.

QAS paramedics provided care and transported the patient to the Queen Elizabeth II Hospital (QEII), p t 12:05hrs, arriving at 13:00hrs.

It is understood the patient passed away.

The Coroner wrote to QAS Professional Standards on the 30 June 2021 with a Form 25 requesting in ormation. The Medical Director provided this to the Coroner.

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Terms of Reference:

This review will review all aspects of ambulance response to incident 14458972. 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 OpCen ProQA:

Southport OpCen review noted the following;

- The incident was coded as a MATA 3, 2A response. The call was processed c ectly with the information gathered from a Health Care Professional.
- The case was dispatched as per recommend and diverted four (4) times he first s ond and fourth time the responding units were diverted to a 1B.
- The third unit was diverted at 09:45hrs to a 1C. The OpCen is following up wit the EMD and CDS regarding the approval to divert to a Code 1C.
- As per Incident Detail Report, the CDS has conducted two ca backs a d both s spoke with the RN on scene and took her advice that the patient was stable n face alue

Incident Review/Investigation:

Scope:

Metro South reviewed the response, clinical performance an operation l decision making to ensure the appropriate ambulance response and managemen f this ase w s achieved. It is intended that any operational or clinical performance is entified ith this case are addressed to ensure lessons are learnt to improve future responses

Background:

QAS was called to attend a Irrele an patient at a Irrelevant who had a fall and hit[Irrelevant] head.

Timeline:

07:53 - Trip Zero (00 call received.
07:54 - ll taking comp e waiting in queue.
08:06 rst ambulance dis tched to incident.
08: - Fir Ambulance divert to higher priority incident.
08 23 - CDS rformed a call back and the RN advised the patient is stable, will call back if condition change r upgrade is required.
08:48 - Second am ulance dispatched to incident.
0 00 - Second Amb ance diverted to higher priority incident.
09 1 - CDS performed a call back and there was no change, patient remains stable, RN will monitor and call back if required.
hird ambulance dispatched to incident.
09:45 - Third Ambulance diverted to higher priority incident.
10:31 - Fourth ambulance dispatched to incident.
10:47 - Fourth Ambulance diverted to higher priority incident.
0:50 - Fifth Ambulance dispatched to incident.
1 :29 - First QAS paramedic crew arrives on scene.
12:08 - ACP crew requested CCP Code 1.

12:09 - Case upgraded to Code 1C after SITREP.
12:09 - CCP dispatched to incident.
12:17 - CCP arrives on scene.
12:05 - Patient transported to the QEII with a CCP escort, travelling road speed.
13:00 - Arrived at QEII.

Clinical Review:

Metro South Senior Clinical Educator has clinically reviewed the case and made the following notes;

- No clinical concerns.
- Patient was treated in line with QAS guidelines.
- The patient was transported to an appropriate facility.

Operational Review:

Operational dispatch to incident:

There were four (4) available paramedic units identified and were responded to t inci nt, h ver, they were all diverted to higher priority incidents prior to arriving on scene. This was due to xisting mbulance workload across Metro South LASN and Metro South Health and Hospit ice (H S). H pital Emergency Department (ED) delays were experienced at most in sco e hospit s, affec g paramedic availability.

At the time of the Triple Zero (000) call, the QAS had 9 pendi cases he community: 3 x Code 1 and 6 x Code 2 incidents. There were no delays noted at Metro South H S hosp ED' at the time of call, however, at 10:00hrs the following delays were noted:

- Logan Community Hospital – 2 ambulance nits at h spital, 1 ambulance units ramped (i.e. >30 minutes) with the longest delayed for 1 hou and 4 minu s, 3 ambulance units enroute;
- Redlands Hospital – 4 ambul nits at h p al, 1 am lance units ramped (i.e. >30 minutes) with the longest delayed fo 1 hour a d 14 mi tes, nil ambulance units enroute;
- Queen Elizabeth II Hos al – 3 amb ance units a ospital, 2 ambulance unit ramped (i.e. >30 minutes), with the lon est delayed r 50 minutes, 1 ambulance units enroute;
- Princess Alexandra Ho ital – 2 mbulan at hospital, 1 ambulance unit ramped (i.e. >30 minutes), with the longest l ed for 33 minutes, 2 ambulance units enroute;
- Mater Adults Hospital – 2 am ulance units at hospital, 3 ambulance unit enroute.

Metro South Reg Staffing:

- The Metro S th LASN had the following resourcing; there were twelve (12) Officers down on day sh s and eigh n (18) additional afternoon shifts against approved rosters.

Outc :

- Th Operation Centre propriately assigned available ambulances to the incident, however, due to highe riority cases these ambulances were diverted.
- CDS pe rmed call backs appropriately and spoke with the RN who was made aware of the delays and to con t Triple Zero (000) should it required to be upgraded – nil change in patient condition noted.
- 3 hours and 34 minutes delayed response resulted from impacts on paramedic availability due to Metro South HHS workload, staffing and hospital delay pressures.
- iew undertaken by the Medical Officer in the Clinical Hub.
- Appropriate high standard clinical care was provided by the responding paramedics.

Review Recommendations:

- Review the process of Medical Officer review of cases in the Clinical Hub.
- 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

LASN Endorsement

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner	Irrelevant	
Anthony Hose	Acting Director Operations		14/07/2021

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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 So th LASN.

Executive Summary:

On 7 July 2021 at 21:24hrs, QAS received a Triple Zero (000) call for assistance (i cident mber 14520065) at Irrelevant Alexandra Hills Qld 4161, to attend a Irrelevan patie who was complaining of a cut hand post climbing through a window.

The case was initially prioritised in the Advanced Medical Priority Dispat Sy em (A PDS) as MPDS Determinant 30A02 requiring a Code 2BL response, however the cas was up aded to Code 1C response at 04:16hrs after QAS arrived on scene.

The QAS response time was 6 hours and 21 minutes from rec pt of th riple Ze (000) call. There was a delay to identify an available paramedic unit to respond to the ca given i g ambulance workload across Metro South LASN and Metro South Health and Hospital Se ice (HHS) hospital Emergency Department (ED) delays were experienced at most s pe ho itals, a cting paramedic availability.

At 21:55hrs a second Triple Zero (000) call was rec ved TA w advised accordingly and the EMD gave bleeding control instructions. At 02:29 Clinica D loyment Supervisor (CDS) performed a call back and the number was engaged. Th CDS sen a SMS garding e delays and to call back QAS. No further contact with the scene occurred rior to QAS arrival on sc No review by the Medical Officer in the Clinical Hub is noted in the In dent Detail R port (IDR).

The closest available ambulance s spatched at 03:17hrs from Vulture Street, Mater Private Hospital and arrived on scene 03:50hrs.

QAS responded ee ambulances who a ived at the scene:

- The first wa he Advanced Care Paramedic (ACP) crew;
- A tical Care aramedic (CCP); and
- High Acuity Re onse Unit (HARU).

QA param dics provided car nd transported the patient to the Princess Alexandra Hospital (PAH), departing at 4 3hrs, arriving at 05:23hrs.

Metro South Oper n Supervisor was on a Quarantine Transfer at the time of QAS treating and tr sporting the patie t. The OS did meet with crew at hospital and provided welfare support.

Terms of Reference:

This review will review all aspects of ambulance response to incident 14520065. 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.

OpCen Review:

Review undertaken by Brisbane Operation Centre Quality Assurance Officer found the following;

- Quality Assurance Review indicates incorrect coding on the initial call, should have been a Code C.
- The first Triple Zero (000) call EMD has not confirmed if bleeding was controlled prior to disconnecting call.
- The second Triple Zero (000) call EMD has not confirmed if bleeding was controlled pr r to disconnecting call, has not opened ProQa to re-triage the case.

Incident Review/Investigation:

Scope:

Metro South reviewed the response, clinical performance and operational decision ma ng to e sure the appropriate ambulance response and management of this case was achieved It is in nded that any operational or clinical performance issues identified with this case are ddress to en ssons are learnt to improve future responses.

Background:

QAS was called to attend a Irrelevant patient who was com laining o a cut hand post climbing through a window. Patient reports to have had to break wn hou as partner had keys.

Timeline:

21:24 - Triple Zero (000) call receiv
21:28 - Call taking complete, wait g in queu
21:55 - A second Triple Zero (0 0) call rece ed requesting ETA and the EMD advised accordingly and provided bleeding con l instructi s
02:29 - CDS performed a call ba and e number w engaged. The CDS sent a SMS regarding the delays and to call back QA
03:17 - ACP unit dispatched from Vul e Street, Mater Private Hospital.
03:50 - First QAS paramedic crew arriv on scene.
03:55 - ACP crew vised unable to raise yone, and shortly afterwards was able to raise the residents.
04:09 - ACP rew re sted CCP Code 1, altered level male patient, significant blood loss, seizure activity an blood pres e of 60 systolic.
04:09 - CP unit dispatch
04:1 C S authorised HAR to be attached to case.
04 0 - HA unit dispatched.
04:53 - Patien ransported to the PAH with a CCP escort, travelling road speed, HARU following behind.
05:23 - Arrived a PAH.

C ical Review:

Metro South Senior Clinical Educator has clinically reviewed the case and made the following notes;

- were insistent to assess the patient despite the bystander suggesting they weren't required.
- Sit Rep advising back up was required for the patient with appropriate dispatching of CCP and HARU.
- Overall management of the patient appropriate.

Operational Review:

Operational dispatch to incident:

There was a delay of 5 hours and 49 minutes to identify an available paramedic unit to respond to the case due to existing ambulance workload across Metro South LASN and Metro South Health and Hospital Service (HHS). Hospital Emergency Department (ED) delays were experienced at most in scope hospitals, affecti g paramedic availability.

At the time of the Triple Zero (000) call, the QAS had 25 pending cases in the community: 4 x Code 1 and 1 x Code 2 incidents, as well as having the following paramedic unit impacts due to Metro South H hospital ED delays:

- Logan Community Hospital – 7 ambulance units at hospital, 4 ambulance units rampe . >30 minutes) with the longest delayed for 3 hours and 47 minutes, 3 ambulance u enroute;
- Queen Elizabeth II Hospital – 4 ambulance units at hospital, 2 ambulance nit ram d (i.e. minutes), with the longest delayed for 3 hour 23 minutes, nil ambulance its enr ut
- Princess Alexandra Hospital – 4 ambulance units at hospital, 1 ambulanc unit ampe >30 minutes), with the longest delayed for 34 minutes, 4 ambulance units enroute
- Redlands Hospital - 1 ambulance unit at hospital, nil ambulance nroute and
- Mater Adults Hospital – 5 ambulance units at hospital, 1 amb ance un enroute

Metro South Region Staffing:

- The Metro South Region including Brisbane South, Lo an and est More on Districts was appropriately resourced.
- There were an additional six (6) Officers on afternoon shift d were down five (5) Officers on night shift against approved rosters.

Outcomes:

- Call for service was incorrect co d and s u d have b n a Code 1C.
- 6 hours and 21 minutes d ayed res nse res ed from impacts on paramedic availability due to Metro South HHS hosp al delay pre ures.
- No review undertake y the Medi l Officer in the Clinical Hub.
- Only one call back to sc e com leted whi e was awaiting a crew to respond.
- Appropriate standard clinic are was provided by the responding paramedics.

Review Reco mendations:

- Follow up w EMD's regarding iss es noted in the call taking process.
- Re w call ba requirements with the CDS group.
- R view the proc of Medical Officer review of cases in the Clinical Hub.
- ontinually review ffing in Metro South Region to meet demand.
  C inually work with tro South Hospital and Health Service regarding hospitals delays and facili ed offloads.

A pendix of rel ant documents/files:

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

LASN Endorsement

Name	Position	Signature	Date
Matthew Green	Acting Assistant Commissioner	Irrelevant	29/07/2021
Anthony Hose	Acting Director Operations		14/07/2021

Significant Incident Review Version 1.0 July 2020

Gold Coast (GC) Region

Authority:

By authority of Peter Warrener– Assistant Commissioner Gold Coast Region.

Executive Summary:

QAS GC responded to incident 14528404 Friday 09 July 2021 in Irrelevant Worongary, Queensland, 4213 to attend a Irrelevant presenting with ch t pai

QAS responded a Bravo acute crew 601538. The patient was assessed and tran ported o Gold Coast University were the patient was triaged and ramped.

QAS PACH requested unit 601538 transport the patient Robina ospital due t extensive delays at Gold Coast University Hospital with off-loading ambulance patien into HH b ds.

The crew from unit 601538 determined the patient's condition et the criteria and transported the Patient to Gold Coast University hospital.

Following greater than one-hour of the patient waitin to be o oaded o a hospital bed, the patient went into cardiac arrest. The patient had immediate care rovide and t ansferred into a resuscitation room. Medical Staff along with the QAS staff ided act e re uscitati procedures with a Return of Spontaneous Circulation (ROSC) b ng ach ved at stage, h wever the patient did pass away in the resuscitation room.

Life extinct declared by Gold ast Unive ital Medical Officer.

Terms of Reference:

This review will in stigate all aspects of a bulance response to incident 14528404. The review will examine ambulance perations prior to, during and following the response. This review will include all requireme s outlined i he *Operational Incident Review Process*.

Region inical Inciden Summary Report:

A clinical revie f this case will be conducted by the GC Region Education unit in consultation with the Medical Directors ffice.

Th Gold Coast Regional Manager of Clinical Education conducted a review on the DARF and a summary of th findings are:

rding the decision to transport to GCUH over GCHRB as recommended by PACH:

> "…This is reasonable considering the case was challenging to differentiate prehospitally. Hx of GI and acute sharp epigastric pain. Chest pain with LBBB on the ECG. In either case the preferred option would be GCUH … PACH routinely page destination reviews to ensure crews consider alternative options. This was responded to appropriately by crew"

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Regarding clinical care and suitability of monitoring of the patient's condition:

> "…The patient was provided appropriate care by QAS … Vital signs were taken and recorded along with continuous monitoring. Those recorded would be indicative of specific VSS (vital sign survey) alongside this. There was no change in patient's condition noted in the DARF or in VSS that indicated deterioration. However, VSS may have been recorded more frequently…"
>
> Summary:
>
> > *"…The DARF indicates the patient was assessed and transported in e with QAS guidelines."*
> >
> > The OIC and CSO follow up with the crew to inform some of the decision made during the incident which are not apparent from the docume review.

Outcome Summary and Recommendations:

- Emails show Priority one offered
- Director GC Region has request GC CEU complete clinical revie
- Initial review DARF QAS located the patient and treated as p QAS p ocols.

State OpCen ProQA:

Director Gold Coast Region has requested GC Ops Centre com ete Op Revie of case and capture of voice logs.

The OpCen Professional Development Officer reviewed the I and V ce Logs of communications between the Responding Crew and the EMD.

- It was identified the Crew did t uired b k up for thi ncident
- The crew advised (after b ng pages hat the tients esenting condition met bypass criteria
- The crew notified of bei g ramped a GCUH for an extended period.
- The OS notified the C S of the ca ac arrest after the patient was moved to Resus.
- There were no issues id tified ith the respo se and coding applied to the incident.

Incident Review/Investigation

Scope: This revie is being considered du to Patient ramped at GCUH for one hour six minutes before going into witnessed ardiac arrest and subsequently being declared deceased. Review operational can clinical asp cts of the e including decision to bypass Gold Coast Robina Hospital. Also review of ramping time at G UH.

Bac grou

- Q called to an elderly female patient who was reported to have chest pain.
- Patie was treated and transported to GCUH
- PACH h d reviewed the case and liaised with crew 601538 to transport the patient to GCHRB due to long delays at GCUH
- The Gold Coast Region (GC Region) had been experiencing moderate workload throughout the day into late afternoon. This resulted in infrequent but significant surges into GCUH and building elays at both GCUH and GCHRB. The pending queue was steadily climbing during the duration these periods.
- The GC Region OS and SOS were managing hospital delays
- Crew 604538 stated the patient met by-pass criteria were subsequently the patient was transported to GCUH
- 20:33 patient arrived at GCUH were she was triaged and ramped as no beds available at the time

- Approximately 21:39 patient was still ramped in the hallway at GCUH and went into cardiac arrest.
- Crew 601538 was in attendance and with HHS staff stated resuscitation while moving the patient immediately to resuscitation bay 5.
- Patient was declared deceased after unsuccessful resuscitation.

Timeline:

- 20:03:23 CALL RECEIVED
- 20:05:23 Note in IDR stating delay in dispatch due to workload
- 20:06:21 ASSIGNED B601538
- 20:06:32 ONCASE B601538
- 20:14:43 ONSCENE B601521
- 20:16:37 Note in IDR that page had been sent to Crew 601538 to please transp Robina or provide clinical sitrep if patient meets bypass – thanks PACH
- 20:35:50 Note in IDR NBR
- 21:07:52 DEPART SCENE
- 21:08:32 Note in IDR GCUH experiencing heavy delays please co tact CNC Ph 6686516 to see if they can accept your patient
- 21:09:14 SITREP – PT MEETS BYPASS FOR GI REVIEW
- 21:29:02 AT DESTINATION GCUH
- 21:51 from OpCen Review – crew advised ramped on stre her
- 22:28 from OpCen Review – crew advise that the pat nt is st on the stretcher
- 23:04 from OpCen Review – CDS advised b OS of rdiac arr t on stretcher
- 23:22:57 CASE COMPLETE

Review:

The initial case itself was managed as pe QAS otoco s; the patient was ramped at Gold Coast University hospital due to the e rgency d art ent at c pacity.

- GCUH had a total of 102 atients in e departm t h 21 patients waiting to be attended to
- GCHRB had a total of 3 patients in he department with 15 patients waiting to be attended to
- GCUH went onto a lev 2 escalat 33 hrs and moved to a level 3 escalation at 11:04hrs in the morning and remained o lev 3 escalation up to and including during the timeframe of this event
- GCHRB went between mu le level 2 and level 3 escalations during the day. Being Level 2 at 10:16hrs until it went to a leve at 11:28hrs, this level 3 was removed at 12:00hrs.
- GCHRB ain went to a level 2 t 15:00hrs and moved to a level 3 at 15:45hrs, this level 3 was removed a 6:50hrs.
- GC RB again ent to a level 2 escalation at 17:46hrs and moved to a level 3 escalation at 18:08hrs, t s was remove t 20:06hrs.

W st the crew from 6 538 was ramped at Gold Coast University hospital the patient was continually mon red with QAS staff located next to the patient at all times.

The patie was witnessed to go into cardiac arrest and QAS along with HHS staff carried out full resuscitation rocedures obtaining ROSC once however the patient went back into cardiac arrest and was finally declared signal 4 – Deceased.

The case was debriefed in real time by the OS on site at Gold Coast University hospital who was also present during the resuscitation process.

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IROAM review

On review of pending cases on 9 July 2021 at 2000 when the case was dispatched there were and ramping at the time of the case 9 pending cases on the GC the longest 2 hrs 58 min. On review of response times nil concerns with a 7-minute response no detriment to the patient outcome.

Review of ramping at the 2107 when crew departed scene there were 5 crews ramped at GCUH with another two on the way. GCHRB there was 1 crew ramped longest 30 min with another crew on the way.

At the time the crew arrived at GCUH 2127 there were 10 crews ramped at GCUH longest 55 min. GCHRB there were 3 crews ramped with the longest 20min.

The Operational review of the case indicated that GC PACH was managing load share between GCUH and GCHRB and had indicated that crew 601538 should transport to GCHRB rather than GCUH due to delays at GCUH. On review this, it was the correct decision to manage workload and minimise the potential ramping at time for the patient.

Crew were advised of this but indicated the patient met the Clinical Redirection Policy for Robina Hospital and the crew decided to transport the patient to GCUH were the patient was ramped.

- Clinical review - completed
- OpCen review - completed
- Review of workload and ramping through IROAM - Completed

Post OIRR actions:

- SOS completed notification AC and DO notified of the incident
- Office of Medical Director notified, and review completed
- Peer Support Offered and Officer welfare checked by OIC

Review Recommendations:

- Operational Issues: GCUH experiencing ramping – case not appropriate for GCHRB due to the Clinical Redirection Policy for Robina Hospital. Long delays on stretcher for this and other patients on the ramp at Gold Coast University Hospital.
- OpCen Review: nil issues identified via the OpCen review – coding appropriate and unit dispatched promptly and on scene in 9 minutes.
- Clinical Review: there is some information that requires follow up with the officers, however this appears to not have had a bearing on the patient's outcome. Clinical interventions and patient management were appropriate by the officers and transport destination was in line with GCHHS bypass criteria.
- Officer Wellbeing: OIC to follow up with the officers – indication that staff wellbeing services were offered.

Appendix of relevant documents/files:

- Incident Detail Report (IDR); Attached
- Digital Ambulance Report Form (DARF);
- Local level clinical review (Eclipse);

Incident Details Report	Incident Report 14528404.pdf
GC Region Notifiable PSDU Notification	

DARF/dCRF	DARF 503542380.pdf
Voice Logs	09.07.21 2302 - OS call to CDS to advise; 09.07.21 2228.45-2228.19 - Pt; 09.07.21 2151.02-2151.13 - ra; 09.07.21 2108.54-2109.11 - PT; 09.07.21 2035.25-2035.42 - SF
Southport OpCen Brief	090721 NIGHT SOUTHPORT OPCEN
Supporting Documents	PACH hospital escalations - 09.07.2
Clinical Review	QAS GOL CEU Clinical Review CIM1

Region Endorsement

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

Role	Name	Position	Signature	Date
Assistant Commissioner	Peter Warrener	General Manager	Irrelevant	14/07/2021

Sunshine Coast District Significant Incident Review

Version 1.2 July 2021

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 10th July 2021, Queensland Ambulance Service received a request to attend Irrelevant Meridan Plains for a Irrelevant who was unresponsive.

There was a delayed response of 6 minute and 32 seconds from dispatch to on ca r Caloundra unit 401773. On arrival at scene the patient was declared dece d

3. Executive Summary

The request for service received at 04:06 was categorised by a Health Care Profes ional through the Medical Priority Dispatch System (MPDS) as a MAT 1B res onse; ncident Detail Report (IDR) 14529558.

At 04:07 the incident was Waiting-in-Queue (WiQ) r dispa h 04:08 he Maroochydore Operations Centre dispatched 401773 from Caloundr station s per th Computer Aided Dispatch (CAD) recommendations.

Chronology from the IDR shows 401773 wer enrou to the cident at 04:14. This indicates a delayed response of 6 minutes and 32 seco ds. Th re is no information in the IDR if there were any attempts to contact the crew mobile ho e, radio or the station phone.

401773 arrived at scene at 4:22, at 0 :38 a Situ Report (SitRep) to the Maroochydore Operations Centre (MO advised th t patient is deceased, QPS required as the patient's Doctor cannot be contact d

4. Terms of Reference

This review w ll:

- investigate ll aspects of ambula ce response to incident 14529558.
- exa ine amb ance operations prior to, during and following the response; and
- in luded all requ ements outlined in the Operational Incident Review Process.

5 Distric Clinical Incident Review - Summary Report

An Eclipse eport indicates no deviation from clinical practice.

6 State OpCen P oQA Assessment

State OpCen ProQA assessment is not required, request is a medically authorised transport from a Health Professional.

7. Incident Review/Investigation

a) Scope

OS conducted a review of available documentation and records post incident. The IDR, DARF, District workload and resource availability have been reviewed as part of this incident report.

- Sunshine Coast District was situated with -1 officer down on night shift at Noosa Station
- SEQ was on EXTREME escalation
- The incident was categorised as a MATA2, code 1B response

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

- CAD recommendations:
  - B406991 (Operational Supervisor) available at QAS Birtinya – officer not attache to incident
  - B401773 closest, most appropriate response available at Caloundra station CAD E 06:29
  - B401773 arrived on scene at 04:22, responding from QAS Caloundra
  - At 04:38 a Situation Report was provided confirming the patient was d cea d

Delayed response:

- There was a 6 minute 32 second delay in response from 40 773
- There is no information in the IDR regarding attempts to co tact 4 177
- CAD estimated time of arrival is 6 minutes 29 seconds
- Actual response time = 15 minutes (WiQ to on scen

Audio records from Maroochydore Operations Centre indic e sev ral a tempts were made to contact 401773:

- 04:08 > dispatcher calling 401773 – radio
- 04:11 > dispatcher calling 401773 – radio
- 04:11 > CDS calling unit mobile pho Irrelev nt
- 04:12 > CDS calling unit mobile hone Irr levan
- 04:12 > dispatcher calling 4017 3 – ra o
- 04:13 > 401773 resp ded on r dio

There is no record of any attem ts to c tact th CAT ph ne Irrelevant or the station landline Caloundra Irrelevant .

GWN activity for portable ra s for u 401 tween the hours of 03:00 – 07:00:

- Subscriber ID 42 0 26 – (P2 – 401773) radio activated at 04:13
- Subscriber ID 424 25 – (P1 – 401773) radio activated at 06:23

This report indicates that the port le radios were turned off at the time the dispatcher was attempting to ma contact.

The Digi Ambulanc Report Form (DARF) has been synchronised and no deviation from clinical practi has been identi d

N notificat to the Senior Operations Supervisor regarding delayed response.

b) Backgro d

Q eensland Ambulance Service received a request for service to attend Irrelevant re ortedly non-responsive at Irrelevant , Meridan Plains.

QAS resou ces attending this incident included:

B401773 Irrelevant

e 000 call was from a Health Professional who reported the patient's condition as unresponsive at 04:06.

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B401773 was dispatched according to Standard Operating Procedure SOP02 as the closest most appropriate unit.

B401773 have not proceeded on case until 04:14, 6:32 minutes after dispatch. WAV files have been reviewed, there were several attempts to contact the unit without success.

On arrival at scene attending QAS officers confirmed the patient was deceased.

c) Timeline

1st Key Stroke:	**04:06**
In waiting queue:	**04:07**
Assigned:	**04:08**
Dispatcher > 401773	**04:08 – no response**
Dispatcher > 401773	**04:11 – no response**
CDS calling 401773	**04:11 – no answer**
CDS calling 401773	**04:12 – no answer**
Dispatcher > 401773	**04:13 – responding**
Enroute:	**04:14**
First AVL ping on iROAM	**04:16 – First AVL ping**
At scene:	**04:22**
SitRep	**04:38 patient dece sed**
Unit cleared	**05:57**

d) Outcomes

Patient deceased on QAS arrival

e) Post review actions

- Audio files request d from M oochyd Op rations Centre – received
- ECLIPSE audit equested – il deviation from clinical practice
- Notification to D rict Dire t Cornthwaite
- Priority One notific on and is providing support to officers
- OIC notified and state ents requested from attending crew
- Follow up with the Oper onal Supervisor regarding reporting structure
- Con t with requesting fa ty – no issues raised
- OCM R hard Raymond – advised OpCen Supervisory Group to document all informatio in IDR and contact attempt to contact the station landline and both mobile numbers as ciated with the unit – response received and attached
  Declan Booth m eting held Friday 27th August. Officer counselled regarding perational readiness and Communication devices are to be worn and at an audible le l – file note attached
- Neah Jefferson interview held Monday 13th September. Officer counselled regarding operati al readiness and Communication devices are to be worn and at an audible level – file note attached

Recommendations

- Officers Declan Booth and Neah Jefferson be counselled regarding operational compliance with Communications equipment and that it is turned on and at an audible level – COMPLETED.
- CDS/OCS to try all phone numbers associated with the vehicle and station

- MOC team to document all case information in the IDR, including failed attempts to make contact – COMPLETED.
- Operational Supervisors provided with the appropriate training/mentoring to have a comprehensive understanding of the role and reporting structure.

8. Appendix of relevant documents/files

A. Incident Detail Report (IDR)
B. Electronic Ambulance Report Form (eARF)
C. Local level clinical review (ECLIPSE)
D. AVL tracking 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. GWN network activity from 401773 portable radios
G. Statement from Declan Booth
H. Declan Booth – file note
I. Statement from Neah Jefferson
J. Neah Jefferson – file note
K. Email from OCM Richard Raymond

9. Prepared by

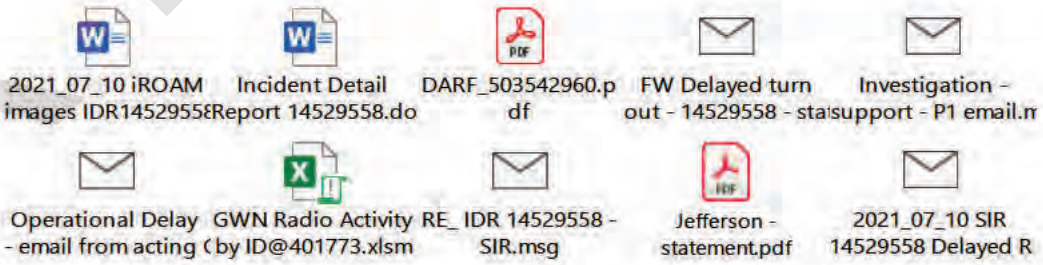
Name	Position	Signature	Date
Danielle Williams	Senior Operations Supervisor		25/09/2021

10. District/Regional Endorsement

Name	Position	Signature	Date
Alexis Hughes	Executive Manager Operations		31.08.2021
Robert Cornthwaite	District Director		31.08.2021
Stephen Gough	Assistant Commissioner		31.08.2021

11. Lodgement

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




2021_08_27_Delayed response_Declan


2021_09_13_Delayed response_Neah Jeffer

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Department of Health

Queensland Ambulance Service

Wide Bay Local Ambulance Service Network

Authority:

By authority Queensland Ambulance Service (QAS) Wide Bay (WB) Local Ambulance Service Network (LASN) WB District Director Russell Cooke.

Executive Summary:

On the 15 July 2021 QAS Maroochydore Operations Centre (OpCen) received a call from Officer in Charge (OIC) Fraser Island Paul Clackett at 15:23 hours. OIC Clackett informed the OpCen of a Irrelevant patient lost, acting bizarre/ paranoid with no clothes on.

This incident was coded as a 2A 25B06 *PSYCH/ABN BEHAV UNK STAT.* The patient was subsequently found suffering from mental health issues. Due to several causative factors both QAS and Queensland Police Service (QPS) staff were injured.

Further to this, there was a communication breakdown were QAS Senior Officers were not notified of the incident in an appropriate timely manner.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 14552380. 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:

WB LASN Clinical Education Unit (CEU) completed two Level One Clinical Reviews in ECLIPSE based of the two Electronic Ambulance Report Forms (eARF). Review of the eARF is summarised below.

eARF 503557558 – Poor grammar makes narrative difficult to read, only once is SAT score recorded, no documentation of mental status assessment.

eARF 503558347 – recording of SHE information has no place in patient's clinical record and should not be documented here – eARF reads as though patient has been spat on. Only one set of observations documented, clearly with such an agitated patient a full set of VSS may not be achievable however visual observations should be recorded particularly with such a high-risk patient.

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Both officers have documented 2 doses of Droperidol in their eARF giving the appearance that the patient was administered 4 doses – given the time stamps allocated for the administration of the drug, the patient has only received 2 doses.

Overall, this will have been a difficult case to manage particularly in an isolated environment with a strong potential for language barrier in addition to the assault of officers.

The review found documentation issues.

Incident Review/Investigation:

Scope

This review investigated the operational, clinical and reporting requirements expected within the QAS into an event that occurred on Fraser Island resulting in the assault of QAS paramedics and QPS police officers.

This report will critically analyse the decisions made by OIC Clackett and the latent clinical presentation of their patent that resulted in physical injury.

This review will also analyse the lack of escalation and notification to senior supervisors and executive management. The review will also consider recommendations into the staging of QAS vehicles on the Kingfisher jetty.

Background

On the 15 July 2021 at 15:23 hours the QAS Maroochydore OpCen received a field imitated call from Paul Clacket Officer in Charge (OIC) who is an Advanced Care Paramedic Level 2 (ACP II) working on Fraser Island.

OIC Clackett advised that he was contacted by Queensland Police Service (QPS) Sergeant Irrelevant OIC Eurong Police Station to advise there were reports of a Irrelevant Irrelevant walking naked near Central station.

Sergeant Irrelevant and OIC Clackett spoke with three of Irrelevant friends regarding abnormally bizarre/ psychotic behaviour the previous night. Furthermore, the friends stated they were walking along a track near Central Station when the patient was becoming increasingly paranoid and stripped off Irrelevant clothes, urinated and covered Irrelevant in urine/ dirt and stated the dingos were going to get Irrelevant These friends reported the incident as the patient wandered off into bushland.

Both OIC Clacket and Sergeant Irrelevant were updated with further information from the Queensland parks and Wildlife Service (QPWS) who had located the patient at the Telstra Tower near Central Station. Both officers proceeded to this location.

On arrival at the location OIC Clackett noticed a near naked Irrelevant covered in dirt, Glasgow Coma Score (GCS) 15 alert, calm however talking very rapidly. OIC Clacket

assessed the patient as documented in the electronic Ambulance Report Form (eARF) document – 503557558.

Both QAS/QPS officers agreed due to patient presentation and past medical history (PMHx), the most appropriate method for transportation would be via the Hervey Bay water Police vessel. Rendezvous was arranged for Kingfisher Bay Resort (Kingfisher).

The patient was subsequently transported from the Telstra Tower to Kingfisher in QAS Unit 4535 without incident. On arrival at Kingfisher they stopped near the public toilet to allow the patient to utilise the amenities.

The patient was subsequently loaded back into 4535 and the vehicle was driven to the end of the jetty. The time was approximately 19:00 hours. Whilst waiting at the end of the jetty for the police launch the patient asked to urinate off the jetty. This was acknowledged by both OIC Clacket and Sergeant Irrelevant The patient moved approximately seven meters away to the end of the jetty and urinated without incident.

After another fifteen minutes the patient again asked to urinate. OIC Clackett did not think this was abnormal as the patient had drank 2.5 litres of water in his care. Both QAS/QPS officers agreed to let the patient walk to the end of the jetty unaccompanied to urinate. The patient was observed dropping Irrelevant blanket off Irrelevant houlders and immediately jumping into the water.

Sergeant Irrelevant drove the QAS Unit 4535 off the jetty onto the beach, whilst OIC Clackett followed the patient in the water by torch light as he walked off the jetty.

The patient then swam towards the shoreline and was screaming and acting psychotic. Irrelevant Sedation Assessment Tool (SAT) score was noted at +3. At times the patient would run out of the water towards both officers screaming and then return to the water. At this time, Sergeant Irrelevant tried to spray the patient with mace spray as Irrelevant came out of the water. Due to windy conditions the mace spray had little impact on the patient but incapacitated Sergeant Irrelevant for approximately forty minutes due to spray entering both eyes.

OIC Clacket then followed the patient parallel to the waterline approximately three kilometres down the beach alone with a torch. The patient continued to show a SAT score +3 and would run out of the water to with in two meters of OIC Clackett trying to hit him then return into the water. This occurred for forty minutes while walking down the beach away from Sergeant Irrelevant who was still at Kingfisher incapacitated.

Sergeant Irrelevant returned in QAS Unit 4535 driving it along the beach. On arrival, Sergeant Irrelevant decided that he would enter the water to waist deep in the dark and arrest the patient. No tactical plan was discussed between the two officers.

OIC Clackett noticed Sergeant Irrelevant enter the water towards the patient. OIC Clacket also entered the water. On reaching the patient Sergeant Irrelevant was overwhelmed/ overpowered with the patient grabbing at the officer's vest and trying to drown him.

OIC Clacket was physically injured during this struggle and received bruising to his left orbit from a punch to the head. After approximately a six-minute struggle in waist to nipple line depth of water both officers managed to place the handcuffs and escort the patient out

of the water. The patient was acting in a physical/ verbally violent manner, with a continued SAT core of +3.

OIC Clacket then noticed the lights of the back crew which consisted of

- 2x Hervey Bay water Police
- 1x QAS paramedic Chris Giltrap

A discussion ensued were it was decided to sedate the patient with Droperidol. Droperidol 10 milligrams (mg) was given Intra-muscular (IMI) injection without any effect noted. Post the sedation attempt; the QAS/QPS officers all decided to load the patient into QAS Unit 4535 - Toyota Landcruiser Troop Carrier. Whilst loading the patient into 4535 the patient spat into ACP Giltrap eyes.

The patient was loaded into 4535 with all officers in the following positions-

- Driver ACP Giltrap
- Front passenger 1x Hervey Bay Water Police
- OIC Clacket in the rear
- 1x Hervey Bay water Police in the rear
- Sergeant Irrelevant in the rear
- Patient secured on the stretcher

During the three kilometre drive down the beach towards Kingfisher the QPS Water Police officer in the rear of the unit was bitten on the right arm with deep teeth marks noted. During the short drive along the beach the patient continued to be physically/ verbally violent with a SAT score of +3.

On arrival at Kingfisher, the QAS Advice and Consultation line was utilised. The patient was sedated with a second dose of Droperidol 10mgs IMI which took a long time to work. During this time, the paramedics requested a Critical care Paramedic (CCP). OpCen advised they crew no CCP's were available on the Fraser Coast. Given this, the paramedics requested the helicopter which resulted in Rescue 8511 with a Doctor and CCP being tasked.

On arrival by 8511 the patient behaviour had subsided to GCS 08 with a SAT score of +1 reported. The medical team assessed the patient and decided not to do a Rapid Sequence Induction (RSI) due to the fact the patient had calmed down whether to the Droperidol and/or loss of Adrenergic drive. They medical team decided to transport the patient on the police launch back to Hervey Bay and transport by road from the jetty to Hervey Bay Hospital (HBH) in QAS Unit 4527. 8511 returned to HBH helipad to retrieve the team before clearing back to the Sunshine Coast.

Operationally; the Operations Supervisor (OS) Logan McIntosh was advised at 21:30 hours that there had been an incident on Fraser Island and to contact OIC Clackett. OS McIntosh tried numerous times before contacting the crew at 21:35. OS McIntosh could hear the patient screaming in the background. At 21:40 OS McIntosh was informed of the evolving situation on Fraser Island. No mention of injuries was were divulged to OS McIntosh. OS McIntosh advised OIC Clackett to consider the helicopter for safe transport.

At 21:50 OIC Clackett rang the OS for further advice. OS McIntosh re-iterated the helicopter was still the safest option. OS McIntosh advised given the patients presenting history travel by boat would be dangerous if he jumped overboard.

It was not until 22:10 when OS McIntosh had a further conversation with the crews and realised the gravity of the situation that unfolded on Fraser Island. OS McIntosh was then informed of the services injuries.

OS McIntosh advised the Senior Operations Supervisor (SOS) Nigel Jones of the events that had occurred. OS McIntosh then completed a DOT Point brief to send to the Executive Managers.

At 20:44 the patient jumped off the jetty, OpCen did not notify the SOS during this event. The OS was not contacted until 21:30, one hour after the patient absconded. No Level One page was sent out regarding this event. The SOS was notified by the OS at 22:36 to advise of the incident on Fraser Island.

Timeline

15:23:18 Phone Pickup (Field initiated by ACP Clackett)

15:24:27 In Waiting Queue

15:25:26 IDR- Officer in 4535 has spoken with QPS Senior Sergeant from Fraser Island. Three backpackers have known the patient for a month and not taking his anti-depressants.? Psychotic episode.

15:26:35 1st Unit Assigned

15:25:26 IDR- PEEMUR MHLC reviewing case- Nil patient details

15:26:27 1st Unit Enroute

15:52:39 IDR- 4535 Situation Report (Sit Rep) QPWS are going the other way and QAS/QPS doing a convoy – Not medicated for 3-4 days-Nothing to drink or eat all day

15:45:16 IDR- ICEMS Police notifying Backpacker having a mental health issue, stripped Irrelevant clothes off and ran into bushland. POI is Irrelevant

17:02:47 IDR- 4535 Located patient near Eurong (Patent located at the Telstra Tower)

17:08:20 IDR- 4535 Having a chat with the patient, calm quiet and co-operative. Will advise further.

17:08:23 1st Unit Arrived

17:25:20 IDR- 4535 StableIrrelevant and taken some form of substance? bush Mushrooms. Patient will be taken QPS Boat and will meet QPS at Kingfisher

17:49:34 IDR- 4535 Organising the QPS boat- Paramedic needs to come over with QPS- a bit unpredictable

17:50:22 IDR- 4535 A little manic and a little confused