Gold Coast Region

Authority:

By authority of Assistant Commissioner, Mr Peter Warrener, Gold Coast Region, Queensland Amb nce Service

Executive Summary:

On Monday 14 March 2022 at 9.46am, the Queensland Ambulance Servi QAS) re ived a Triple Zero (000) call for a Irrelevant patient in cardiac arrest at a residenc in Surf Para

The incident was prioritised by the Medical Priority Dispat System MPDS as re iring a Code 1A (Actual Time Critical - immediate response with lights and/or siren). e patie ' care sup ort worker (the caller) initiated Cardio Pulmonary Resuscitation (CPR) under instructi by the Emergen y Medical Dispatcher (EMD), who remained on the telephone with the caller until the re onding p amedics arrived on scene.

The incident location was initially incorrectly entered the tim of the riple Zero (000) call, resulting in the responding paramedics attending an incorrect addr ss. The cident address was subsequently updated, and paramedics arrived at the correct address at 1 04am 18 mi tes after the Queensland Ambulance Service received the Triple Zero (000

Due to the carer's effective CPR he Queen and Ambu Service was able to achieve a Return of Spontaneous Circulation and ansported th patient to the Gold Coast University Hospital. However sadly, the patient passed away in the mergenc t

Gold Coast Region Clinical cident Summary Report:

The Gold Coast Clinical Education Unit EU) assessed the patient record to determine if the care provided was appropriate, with no clinical issues no d and documentation completed to the standard required.

Southport Operations Centre Summary Report:

Southport Operations Centre conducted a comprehensive investigation of the incident to determine if the operational response was appropriate.

Timeline

Time Stamps

Description	Date	Time	User
Phone Pickup	14/03/2022	09:46:27	
1st Key Stroke	14/03/2022	09:46:27	
In Waiting Queue	14/03/2022	09:49:03	
Call Taking Complete	14/03/2022	10:13:44	Staskiewicz, Darcy
1st Unit Assigned	14/03/2022	09:49:37	
1st Unit Enroute	14/03/2022	09:49:49	
1st Unit Arrived	14/03/2022	10:04:39	
Closed	14/03/2022	12:53:12	Liekmeier, Rachelle

Elapsed Times

Description	Time
Received to In Queue	00:02:36
Call Taking	00:27:17
In Queue to 1st Assign	00:00:34
Call Received to 1st Assign	00:03:10
Assigned to 1st Enroute	00:00:12
Enroute to 1st Arrived	00:14:50
Incident Duration	03:06:45

Resources Assigned

Unit	Assigned	Disposition	Enroute	Staged	Arrived	At Patient	Delay Avail	Complete	Odm. Enroute	Odm. Arrived	Cancel Reason
A606851	09:49:37	Treated Other Unit Transport	09:49:49		10:19:08		11:06:56	11:12:23			
601502	09:49:37	A Case Completed	09:49:49		10:04:39			11:34:32			
A606311	09:50:16	A Case Completed	09:51:23		10:05:56			12:08:38			
A606573	09:53:06	A Case Completed	09:53:11		10:19:06		11:50:44	12:53:12			

Call taking

The initial Triple Zero (000) call, was taken at Southport Operations Centre (OpCen) The incident location w s initially incorrectly detailed by the EMD as being at Irrelevant , Surfers Paradise, however was act ally located at Irrelevant , Surfers Paradise, the two locations are 2.0 kilometres apart.

- The caller stated the address was Irrelevant , Southport".
- The EMD searched the Computer Aided Dispatch (CAD) System and asked for clari cation, at this time the caller stated "Surfers Paradise" as the suburb.
- The EMD requested the caller repeat the address for clarification. The caller stated Irr lev nt Surfers Paradise" at the Irrelevant ".
- The EMD asked if the premise was known as Irrelevant ", the alle confirmed Irre ant Irrelevant"

The QAS Standard Operating Procedure for identifying the incident location in lves a robu hree stage process to minimise errors.

On this occasion, the EMD identified the correct apartment complex name, b selec d th incorrect street name.

This was compounded by the caller having a thick acc t and p ssib havin a non-English speaking background, they may not have clearly understood the addre name layed by he EMD when confirming the address location.

The coding QAS Code 1A (Actual Time Critical - imme respon with lights and/or siren) response was correct.

Dispatch

An Advanced Care Paramedic II A te Unit as disp hed imm diately. The Gold Coast High Acuity Response Unit was also dispatch d, as was e Senior ons Supervisor who was nearby to the scene. These crews were deemed to e the closes most appropriate at the time.

The responding paramedics who rrive irst at the ini al scene address provided, identified the address was incorrect and requested further info tion. At this time the correct address detail was provided to all responding units.

OpCen Management while pending

The EMD remained on the telephone with the caller until the responding paramedics arrived at the correct address. During this time, the EMD provided the caller with life-saving instructions whilst reassuring the caller that an ambulance is on the way. While the EMD remained on the line, they were able to re-clarify the address and ensured any units still responding were diverted to the correct location.

System Pressures

n 14 March 2022, at 9.40am the Gold Coast Region was experiencing a moderate to high workload, both w in the Southport Operations Centre and the Gold Coast Region. There was a surge in workload of ar und 20 incidents waiting for QAS response at that time.

ld Coast Health and Hospital Service was impacted with Gold Coast University Hospital on an internal esc ation level 6.3 and an escalation level 2 in place due to delays in unloading QAS patients within the Emergency Department at the time of this incident.

Operational Response

T e responding paramedics were assigned at 9.49am and arrived on scene at the incorrect location at 9.56am, seven minutes after being dispatched from Irrelevant , Southport (5 kilometres away), the route

taken is deemed the quickest, most appropriate route. Based on Automatic Vehicle Location (AVL) markers, this crew travelled past the correct incident location at approximately 9.52am, which would have had the first officer on scene within 3 minutes of dispatch.

After the incident address was updated, the responding paramedics arrived at the correct address at 10.04am, meaning there was an overall delay of approximately 12 minutes due to the incorrect detail provided.

The delay would have been approximately 6 minutes under normal traffic conditions, however this delay increased due to significant traffic congestion at the time.

Review Recommendations:

The review identified that the delayed response was due to the QAS geo-verification error. The EMD who made the error is recognised to be normally very diligent in his duties.

Follow up was undertaken with the EMD on the 14 March 2022. A file note of this conversation is kept on file in the Southport Operations Centre.

Executive Manager Operations, Kym Meredith provided the EMD with support at the time of the incident and followed up the next day. EMD declined PSO involvement.

Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- OpCen review
- Relevant audio (wav) files;

IDR		**eARF**	
Eclipse Review		**OpCen Review (including audio files)**	

LASN Endorsement

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

Role	Name	Signature	Date
Assistant Commissioner	Peter Warrener	Irrelevant	8/04/2022

Department of Health
Queensland Ambulance Service

Significant Incident Review Version 0.3

Metro South Region

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

Executive Summary:
On Wednesday 16 March 2022 at 22:23hrs QAS received a Triple Zero (000) call for assist ce (incide t number 15614174) at Irrelevant Kangaroo Point 4169 to attend a Irrelevant , alarm activat n, fall and sounds hurt.

There was a response time of 41 minutes to respond an available paramedic un to th incide from when the incident entered the waiting queue to when the first unit arrived on scene).

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

The case was initially prioritised in the Advanced Medical Prio y Dispa h System (AMPDS) as 17B04G (Fall Unknown Status on Floor) requiring a Code 1C response.

A second triple-zero call was received at 22:50hrs ad sing t patien ad a fall with pain and shortness of breath. At this time the case was reprioritised in the Advance Medical P iority Dispatch System (AMPDS) as 17D04G (Fall on Floor Not Alert) requiring a Code B resp nse.

The first ambulance was assigned t 22:55h and arr d on sc ne at 23:07hrs.

A third triple-zero call was re ved at 23:0 rs advising the pain is increasing with difficulty in breathing. The case was re-prioritised in the A anced M dica Dispatch System (AMPDS) as 10D01 (Chest Pain not Alert) requiring a Code 1B respon

On QAS arrival patient was alert but app ared peri-arrest. Nine minutes after arrival the attending crew advised the patient was in cardiac arrest and co menced CPR, with a return of spontaneous circulation after 14 minutes. The patient was transported to Princess Alexandra Hospital in a critical condition.

Terms of Reference:
This review will review all aspects of ambulance response to incident 15614174. 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*.

gion Clinical Review:
Th Metro South Region Clinical Education Unit have undertaken a clinical review of this incident. The clinical a essment, treatment and transport was completed to an appropriate standard. It was noted the c ntation had an extended period of time with no vital signs recorded, however a note by the attending Paramedic tate; Paperwork VSS abbreviated due to concurrent Workload. There are no concerns with the clinical management of this case.

OpCen Review:
AS received a call from Vital Call. The Call was appropriately coded as a Code 1C. The Emergency Medical Dispatcher (EMD) attempted to call family members who were attending the scene. On arrival the patient's granddaughter has contacted QAS via Triple Zero (000). The EMD has re triaged the call through PROQA

appropriately and upgraded the incident to 1B. After review, both call taking and dispatch were considered appropriate during the call cycle.

Incident Review/Investigation:

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

Background:
QAS was called to attend a Irrelevant patient who had a fall, complaining of pain and shortness of breath.

Timeline:
22:23 – Triple Zero (000) call received
22:26 – In waiting queue
22:50 – Second Triple Zero (000) call received updating the patient's condition, incident reconfigured to a Code 1B.
22:55 – 1st unit dispatched.
23:04 – Third Triple Zero (000) call received updating the patient's condition with the response code remaining unchanged.
23:07 – QAS arrive on scene.
23:15 – Critical Care Paramedic dispatched.
23:40 – Critical Care Paramedic arrive on scene.
23:55 – Depart Code 1 to Princess Alexandra Hospital.
00:16 – Arrive at Princess Alexandra Hospital.

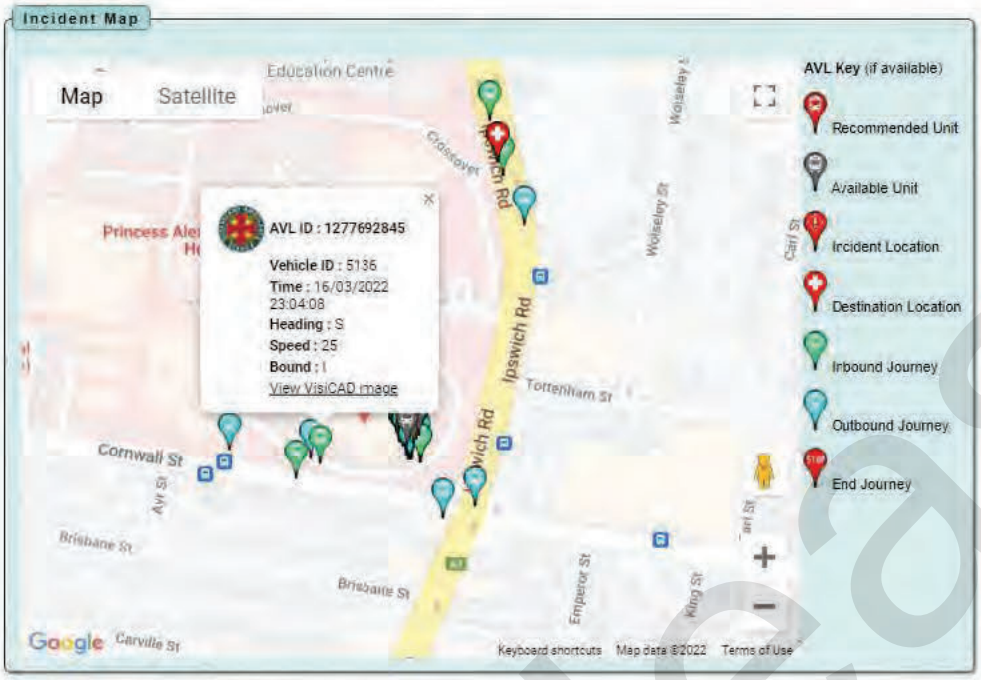
Operational Review:

Operational Dispatch to Incident
There was a response of 41 minutes to respond an available paramedic unit to the incident (from when the incident entered the waiting queue to when they arrived on scene) due to existing ambulance workload across Metro South Region.

There were significant wait times for code 1 and 2 incidents throughout the day of the 16 March 2022. Fifteen-minute snapshots for pending cases within the Brisbane Operations Centre (BOC) response area at the time of the call and hourly until dispatch reveal high numbers of pending cases within the community as follows:

	Priority	Number of Incidents	Average Wait (hh:mm:ss)	Maximum Wait (hh:mm:ss)
22:15 to 22:29 (16/03/2022)	1	18	0:42:13	2:17:47
	2	29	2:09:20	7:51:44
22:45 to 22:59 (16/03/2022)	1	10	0:47:04	1:34:51
	2	26	2:16:44	8:21:48

The 1st unit assigned to the incident at 22:55 advised the Brisbane OpCen via radio that they were delayed completing paperwork from previous case (15613831). This case was for a mental health patient who required sedation and QPS assistance. The responding crew commenced driving to scene from the Princess Alexandra Hospital at 23:04hrs as per AVL data.



Hospital Status

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

	Hospital	Total no. ambulances at Hospital (with pts on stretcher)	Total no. ambulances ramped (>30 mins POST)	Maximum ramped time	Escalation level
22:15 to 22:29 (16/03/2022)	Logan Hospital	6	3	3:22:39	3
	Mater Adults Hospital	4	4	2:37:52	2
	Princess Alexandra Hospital	4	3	1:23:54	2
	Queen Elizabeth Hospital	5	3	1:43:04	3
	Redlands Hospital	-	-	0:00:00	2
22:45 to 22:59 (16/03/2022)	Logan Hospital	2	1	0:44:18	3
	Mater Adults Hospital	5	4	3:07:56	3
	Princess Alexandra Hospital	5	1	0:30:57	2
	Queen Elizabeth Hospital	4	4	2:09:10	3
	Redlands Hospital	2	-	0:00:00	-

On 16 March 2022, the QAS Metro South Region experienced 98.76 hours of 'Lost Availability' at Emergency Departments. Lost availability is calculated as the time elapsed between the At Destination timestamp and the Partially Available timestamp, less 30 minutes. This lost availability equates to approximately 10 paramedic crews over the period of the day, being unavailable to be dispatched to the community.

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

crews are unable to be released from hospitals. The outcome results in QAS prioritising the most urgent of incidents (i.e. Code 1 lights and sirens).

Metro South Region Staffing

The Metro South Region including Brisbane South and Logan Districts had the following resourcing against approved rosters for the 16 March 2022;

- Afternoon Shift – 1 vacancy (Officers)
- Night Shift – 3 vacancies (Officers)

Outcomes:

- 94-year-old female reported to have fall, initial Triple Zero (000) call was a third-party call.
- The call taking and dispatch of the incident was found to be appropriate.
- The clinical aspects of the case were found to be appropriate.
- High demand for service and hospital delays at the time of the call was noted, reducing the availability of ambulances.

Review Recommendations:

- Nil

Appendix:

- Incident Detail Report
- Ambulance Report Form
- Clinical Review

Region Endorsement

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

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Significant Incident Review Version 1.0 August 2020

Gold Coast Region

Authority:

By authority of District Director, Gold Coast Region, Queensland Ambulance Service

Executive Summary:

Incident 15654376 – at 13:12, Friday 25 March 2022 at 13:12 the QAS rec ved reque for service to attend Irrelevant Coombabah for an Irrelevant p tient, elf reporting that he had been feeling sick and unwell all week. Mermai Wate LAR t 608308 self-dispatched as a primary response at 14:00 and arrived on scen at 14 2.

Following his initial assessment LARU/ACP officer Paul elevan det mined that the patient required specific investigation by a medical officer at Gold Coast University Hospital. Officer Irrelevant exited the residence (without the patient) to ret rn h equipm nt to the vehicle. While returning back inside the residence, the patient was wit essed t be walking out to meet officer Irrelevant on his own accord with assistance from Irrelevant. Whil neg tiating he doorway at the building entry point the patient has lost his balanc causi him fall forward which resulted in an injury to the patient's right shoulder. The atient was ubsequen y eassessed by officer Irrelevant prior to departing to the Gold Coast Universi Hospital.

The patient was diagnosed at G U with a fractured clavicle secondary to the fall. A regional follow up occurred with the patient's Irrel ant on Monday 28 March 2022 who reported that the patient was in hospital for his initial complain nd that his clavicle did not require any surgical intervention or orthopaedic review.

Terms of Reference:

- This review will investigate all aspects of ambulance response to incident 15654376.
- The review will examine ambulance operations prior to, during and following the response.
- This review will include all requirements outlined in the *Operational Incident Review Process*.

Gold Coast Region Clinical Incident Summary Report:

The Gold Coast Manager of Clinical Education determined:

- Minimal standard documentation, considering the officers extended scope of practice and experience
- CEU has completed an eclipse review of the incident, attached to the investigation.
- There is no history of similar events occurring with Officer Dell and he is not under ny current investigation

Incident Review/Investigation:

Scope:

The process of this SIR is to review the clinical or operational aspects of this i nt in the inter st of generating learning where possible and promote best practice prehosp tal car o stakeholders whilst ensuring the safety of QAS staff is upheld.

Through the analysis of the data provided both positive and negative indicato s are i entified. This analysis should be used to determine actions that create oppor unities r imp ment.

Review:

The review will consider all available pertinent ocum ntatio including the IDR & EARF for the incident. Patient care records were assessed b the G Regional Clinical Education Unit.

Background:

On Friday 25 March at 14: ACP LARU offic Paul Irrelevant self-dispatched utilising information obtained from IROAM to inciden 5654376. Following his initial assessment it was determined that transport to hospital was required nd it was appropriate for this to occur in 608308 (Hyundai iLoad).

In prepar dness for nsport officer Irrelevant removed all operational equipment (Corpuls/PRK) from the re ence, placing it ack inside the LARU vehicle whilst making a phone call to the HHS. While ret ning ack to the patie (inside the residence), the patient was witnessed by officer Irrelevant to be walking wit ssistance from Irrelevant to meet him outside. While negotiating the doorway at the building entry p int (glass sliding door) the patient has tripped on the rail causing Irrelevant to fall forward, ulting in a righ oulder injury. Officer Irrelevant ran back towards the patient and with the assistance of bystander prevented the patient from suffering further injury.

i nt was reassessed as per the DARF and officer Irrelevant recommended that the patient's clavicle would require review at hospital. The patient reportedly denied the offer of pain relief and officer Irrelevant applied a collar and cuff sling. Officer Irrelevant did not follow SOP03.3 'notification of QAS Seniors Officers', instead documented the incident on his DARF and notified the receiving facility of the i cident.

On Saturday 26 March 2022 at 14:45 Irrelevant contacted 000 to provide notification of the incident. Speaking to OCS Tanya Linnett (Southport OPCEN) Irrelevant stated that the officer was very nice, thorough and helpful. She recalled that whilst Paul had returned to the QAS unit the patient had attempted to negotiate the glass sliding door at the entry of the residence when the 'walker went one way and Irrelevant went the other'. Irrelevant advised OCS Linnett that the patient had been diagnosed with a clavicle fracture following the fall and wanted this to be documented in case of any ongoing complications.

Timeline

Time Stamps		
Description	Date	Time
Phone Pickup	25/03/2022	13:12:33
1st Key Stroke	25/03/2022	13:12:34
In Waiting Queue	25/03/2022	13:14:27
Call Taking Complete	25/03/2022	13:16:12
1st Unit Assigned	25/03/2022	14:00:19
1st Unit Enroute	25/03/2022	14:01:21
1st Unit Arrived	25/03/2022	14:08:00
Closed	25/03/2022	15:59:23

Crew:

Unit	Name
608308	Irrelevant Paul Irrelevant

Regional Follow-up:

Gold Coast Region SOS William Houghton followed up with Irrelevant n Monday 28 March 2022 to offer an apology:

- During the conversation Irrelevant tated words to the effect of ... *Paul apparently asked if the patient was able to walk at all and the patient answered yes, with my walker.* Irrelevant *advised that when Paul went to the ambulance to get something or make a call that* Irrelevant *attempted to go through the sliding door to the steps and stumbled across the rail of the door.* Irrelevant *advised the patient fell forward onto the balcony and Paul ran towards* Irrelevant *and helped* Irrelevant *up.*
- Irrelevant reported that Irrelevant felt awful calling QAS again however Irrelevant daughter was concerned regarding the possibility of future complications following the patient's injury.
- Irrelevant advised SOS Houghton that the patient was still in GCUH with Irrelevant initial complaint (unrelated to the fall) and that Irrelevant clavicle did not require surgical repair.
- SOS Houghton advised Irrelevant that an investigation was underway and that a representative from the QAS would make contact with Irrelevant with an outcome of the review.
- Overall, Irrelevant thanked the QAS and advised that all of their interactions with the Service were positive.

Outcomes:

- The Gold Coast Clinical Education Unit (CEU) assessed the patient record and determined that the care provided to the patient was appropriate.
- Officer Irrelevant was provided with a copy of SOP03.3 'notification of QAS senior officers'
    - Officer Irrelevant stated he was unaware of the requirement to notify the Seni Operations Supervisor/SOCC of the patient's fall given that he had informed the HS upon handover & documented the incident on the eARF.
- On the 11th April 2022 A/SCE Craig Sanky provided officer Irrelevant with feedback regarding t quality of his paperwork given his extended scope of care. The outcome of this conversation was that officer Irrelevant self-identified that his paperwork was below the stan ard e c d from an extended scope paramedic. A/SCE Sanky spoke about the need to provide appropriate documentation specific to each incident. Moreover, a fa r assessment nd clinical frailty score were performed by officer Irrelevant (according to he CEU iew) however omitted from the eARF. This information would have demonstrat d to n inv igator that officer Irrelevant had minimised the risk of this event occurring.
- According to A/SCE Sanky, officer Irrelevant has reflected on t is inci nt an is ow providing a more comprehensive approach to his documentation.

Post OIRR actions:

- Staff Support services were offered to officer Irrelevant fol wing the incident.
- Feedback regarding the investigation to be pro ded to e patient and family by a regional delegate.

Review Recommendation

- As a reflective tool old Coast EU has requested that officer Irrelevant complete an ECLIPSE review, due by 17th ril 2022
- Gold Coast CEU conclu d at although the paperwork was not to the standard expected officer Irrelevant had performed falls risk assessment to reduce the risk of this incident occurring, albeit he omitted it from his ARF. With this considered in addition to the witness account provided Irrelevant, the patien has mobilised without instruction from officer Irrelevant on his ow accord. erefore it is recommended that no further action is required at this time.

Appendix of relevant documents/files:

- Incident detail report (IDR)
- Electronic Ambulance Report Form (eARF).
- Local level clinical review (Eclipse); Attached within CEU review
- OpCen Review
- PACH Logs

Incident Details Report	IDR 15654376 - Fall in QAS LARU care.pc
GCLASN Notifiable PSDU Notification	Nil
dARF/dCRF	eARF 15654376 - Fall in QAS LARU car
Voice Logs	
Southport OpCen Brief	260322%20DAY%20 SOUTHPORT%20OP
OpCen Review	
Clinical Review	QAS GOL CEU CIM 15654376 - Fall.pdf Record of Interview -Paul Irrelevan CIM15565
Other Documents	Re_ Coombabah complaint ID 15654 FW_ Coombabah complaint ID 15654 Coombabah complaint ID 15654 FW_ Coombabah complaint ID 15654

Region Endorsement

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

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

Department of Health

Queensland Ambulance Service

Significant Incident Review

IR31-2022 Wide Bay District

Sunshine Coast and Wide Bay Region

Authority:

By authority of Hayley Salethorne, Acting District Director, this Significant Incident Review (SIR) was undertaken by Nigel Jones, Senior Operations Supervisor. This SIR is in relation to incident 15660870 and has been assigned the unique identifier IR31-2022.

Executive Summary:

On Saturday 26 March 2022 at 21:00 hrs the QAS received a Triple 000 call for assistance at Irrelevant Irrelevant Buxton to attend a Irrelevant who had been "hit in the head" and was presenting with an altered level of consciousness. It was not made clear during the initial call how the injury had occurred. The patient's Irrelevant informed attending paramedics the injury was from a mechanical fall; the patient had fallen backward striking base of skull on vehicle tow ball. It was also established that the injury had occurred at 19:00 hrs 2 hours prior to the call for QAS assistance.

When single officer Samuel Irrelevant n unit B4442 arrived at 21:34 hrs as first QAS resource on scene the patient was noted to be "combative and would not allow thorough assessment, removing bandages and a collar that were applied.

A second paramedic crew consisting of Tony Irrelevant and Natasha Irrelevant in unit B4433 arrived at incident location at 22:15 to assist with patient care and transport to the Hervey Bay Hospital, which commenced in unit B4442 at 22:26 hrs with officer SC as patient care and officer NS driving. Officer TH was following in unit B4433.

AT 22:41 the patient became combative and threatening toward paramedics, necessitating a request to the Queensland Police Service (QPS) for assistance, shortly after that request the patient's behaviour further escalated resulting in unit B4442 pulling off the road and stopping, during the patients heightened state officer SC was struck in the face, the patient was also attempting to damage equipment in the ambulance. Both officers exited the ambulance with officer SC grabbing the drug kit on the way out.

With both officers out of the vehicle the patient has climbed through to the driver's compartment, officer NS attempted to re-enter the vehicle to retrieve the keys however was prevented from doing this when the patient threw an object at her. The patient has subsequently driven off in ambulance vehicle 4442. Officers SC, NS and TH have remained static in unit B4433 and advised the Maroochydore Opcen of situation. On receiving advice from QPS that the patient and stolen unit were located at Hull St, unit B4433 proceeded to that location.

The Maroochydore Opcen has advised QPS via ICEMS at 22:48, "Urgent – Patient inside vehicle smashing vehicle, require urgent QPS assistance" and then at 22:54 "Officer has been assaulted, van has been stolen"

The Maroochydore Opcen has assigned a Duty Officer Janelle White and Critical Care Paramedic Gavin Becker to the case, both responding in O4492. Wide Bay Senior Operations Supervisor Nigel Jones was also advised, who proceeded to the case with the Acting District Director Hayley Salethorne in vehicle 4S07.

At 23:05 Unit 4442 was subsequently located in a residential street in Buxton where a member of the public has restrained the patient and notified Queensland Police whom subsequently notified QAS

Unit 4442 appeared to be undamaged following being driven by the patient.

Officer SC was assessed at this location and found to have no substantial injuries he was subsequently transported in unit B4442 to Childers Hospital for assessment.

The patient was sedated by CCP GB and transported in B4433 with QPS escort to Bundaberg Hospital detouring via Childers Hospital to pick up second officer.

Terms of Reference:

This review will investigate all aspects of ambulance response to incident 15660870. The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

Region Clinical review:

CEU review of the incident found that the case was a difficult case to manage, particularly in the initial stages as a single officer. It was highlighted in the clinical review, that the crew may have benefited from earlier sedation given the patient's behaviour during the first attempt to transport. The review states that "*overall the paramedic did quite well*".

OpCen Review:

Incident Review/Investigation:

Scope:

Sunshine Coast and Wide Bay Region reviewed the response, clinical performance and operational decision making to ensure appropriate ambulance response and management of this incident was achieved. It is intended that any operational, clinical and Opcen performance issues identified are addressed to ensure lessons learnt are used to improve future performance

Background:

QAS received a Triple 000 call for assistance at Irrelevant Buxton to attend a Irrelevant who had been "hit in the head" and was presenting with an altered level of consciousness.

Timeline:
20:56- Call received
21:00- In waiting queue
21:06- 1st unit assigned
21:06- 1st unit responding
21:11- 2nd unit assigned
21:11- 2nd unit responding
21:34- 1st unit on scene
21:46- Sitrep GCS14 C-Sine pain continue back up code 1
22:15- 2nd unit on scene
22:46- B4442 Transporting to Hervey Bay Hospital
22:41- Sitrep Patient has become non-compliant, verbally threatening to crew. Crew is safe but require QPS

22:44- Sitrep - B4442 continuing transport via Bruce Hwy and Torbanlea Road
22:48- ICEMS to QPS- Urgent – Patient inside vehicle smashing vehicle Require urgent QPS assistance
22:54- ICEMS to QPS- Officer has been assaulted, van has been stolen
22:55- ICEMS – QPS Enroute
22:56- ICEMS to QPS – Vehicle is tracking to the end of Hull St
23:05- ICEMS from QPS – Male and ambulance is located at 23 Hull St
23:05- ICEMS to QPS – Male is now on the QAS radio
23:10- ICEMS from QPS – Civilian has called stating ambulance is at end of Hull St, offender is pinned down
23:11- SOS responding, picking up A/Director enroute
23:13- QPS on Scene
23:14- QPS on scene, QAS approaching scene.
23:25- CDS updated SOCC
23:53- Sitrep – DO on scene, officer has been assessed with no substantial injuries, vehicle appears undamaged.
00:04- A4433 transporting patient with QPS escort to Bundaberg Base Hospital, via Childers.
00:05- SOS and A/Director located at Childers Hospital awaiting crews.
00:10- B4442 transporting Officer Clough to Childers Hospital
00:32- Both units arrived at Childers Hospital. Officer Clough to be assessed at Chiders, A4433 will pickup driver (Officer Howse) and continue to Bundaberg Base Hospital
00:37- Sitrep from A4433- patient kicking off again, has chewed through monitor leads. Requires replacement monitor so patient can be sedated.
00:40- Sitrep from A4433- patient kicking off again, has chewed through monitor leads. Requires replacement monitor so patient can be sedated.
01:56- A4433 arrived at Bundaberg Base Hospital

Review:

In review of the information available,

- The initial QAS response to this incident was appropriate given the information obtained during initial call taking.
- The initial patient care provided by the single officer was appropriate however consideration could have been given to early patient sedation when the second ambulance arrived.
- The tactical withdrawal from the ambulance unit was warranted due to the volatile situation and officer safety being a priority.
- The initial attending officers should be commended with continuing with the patient care following location of the patient and ambulance.
- When advised of the situation the Opcen has attached further resources, informed QPS and alerted managers all in line with procedure.
- The District Director met with attending paramedics to provide support and ensure welfare needs were attended to.
- QPS- QPRIME No: QP2200521683 was assigned to the incident
- Patient is required to attend court on 9 May 2022 for charges detailed below

Review Recommendations:

This review finds the following recommendations:

1. That the Queensland Ambulance Service pursue a complaint of:
    a. Serious Assault ***Actioned***
    b. Unlawful use of motor vehicle ***Actioned***
    c. Wilful damage ***Actioned***
2. That the crews involved be offered Priority One support. ***Actioned***
3. Clinical follow up with initial attending paramedics to discuss benefits of early sedation.

Appendix of relevant documents/files:

- Briefing notes identifying response information;
- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Relevant audio (wav) files;
- Any reports or documents received from the Queensland Police Service (QPrime Number).

LASN Endorsement

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

Name	Position	Signature	Date
Russell Cooke	LASN Director	Irrelevant	11-4-2022
Stephen Gough	Assistant Commissioner		12/4/22