# Significant Incident Review Template

Version 1.0 August 2020

## Townsville District – Northern Region

### Authority:

By authority of James Cunington, A/Assistant Commissioner, Northern Region.

### Executive Summary:

On the 15 April 2022 at 00:16hrs, The Queensland Ambulance Service (QAS) Townsville Operations Centre received a triple zero (000) call for assistance at Irrelevant to attend a Irrelevant male who was complaining of difficulty in breathing, difficulty in speaking between breaths, with a history of blood clots.

The call entered the In Waiting Queue (IWQ) at 00:17hrs. When an incident enters the IWQ it means enough information has been obtained to be able to respond a QAS resource. The case was coded as a 1B (immediate response; lights and sirens).

At 00:18hrs the first unit was assigned being the single Emergency Availability (EA) Officer from Irrelevant AT 00:27hrs it was identified the patient was no longer conscious and not breathing and the case was upgraded to a 1A (immediate response; lights and sirens). A Townsville crew and Critical Care Paramedic unit were assigned at 00:28hrs to backup Irrelevant The first unit assigned from Irrelevant arrived on scene at 00:37hrs with the backup from Townsville arriving at 01:02hrs and the CCP arrived at 01:06hrs.

After an extensive resuscitation effort and consultation with the QAS Clinical Consult Line resuscitation efforts were ceased, and the patient was declared deceased. The patient was left in the custody of Queensland Police Service (QPS).

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident 15751326.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

### Regional Clinical Review:

An ECLIPSE review was undertaken by Townsville Clinical Education Unit to ensure the patient received appropriate care as outlined by the QAS Clinical Practice Guidelines and Clinical Practice Procedures. The incident was managed appropriately clinically, At Standard.

### OpCen Review:

An AQUA review was undertaken by OCM Joyce Daley. The review result was compliant.

The correct MPDS code of 06D02A was determined along with the correct response code of 1B.

## Incident Review/Investigation:

### Scope:

Townsville District has reviewed the response, clinical performance and operational decision making to ensure the appropriate ambulance response and case management 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 operational responses.

### Background:

The QAS was called to attend a Irrelevant male who was complaining of difficulty in breathing, difficulty in speaking between breaths, with a history of blood clots.

### Timeline:

**Time Stamps**

| Description | Date | Time | User |
|---|---|---|---|
| Phone Pickup | 15/04/2022 | 00:16:11 | |
| 1st Key Stroke | 15/04/2022 | 00:16:11 | |
| In Waiting Queue | 15/04/2022 | 00:17:46 | |
| Call Taking Complete | 15/04/2022 | 00:17:46 | Irrelevant |
| 1st Unit Assigned | 15/04/2022 | 00:18:05 | |
| 1st Unit Enroute | 15/04/2022 | 00:26:08 | |
| 1st Unit Arrived | 15/04/2022 | 00:37:07 | |
| Closed | 15/04/2022 | 02:31:28 | Irrelevant |

**Resources Assigned**

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient |
|---|---|---|---|---|---|---|
| 1126 | 00:18:05 | A Case Completed | 00:26:08 | | 00:37:07 | |
| B1103 | 00:28:29 | A Case Completed | 00:28:41 | | 01:02:40 | |
| A1514 | 00:28:34 | A Case Completed | 00:29:40 | | 01:06:42 | |

**Elapsed Times**

| Description | Time |
|---|---|
| Received to In Queue | 00:01:35 |
| Call Taking | |
| In Queue to 1st Assign | 00:00:19 |
| Call Received to 1st Assign | 00:01:54 |
| Assigned to 1st Enroute | 00:08:03 |
| Enroute to 1st Arrived | 00:10:59 |
| Incident Duration | 02:15:17 |

| Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|
| | 02:31:28 | | | |
| | 01:57:05 | | | |
| | 02:14:12 | | | |

### Operational Review:

Operational Dispatch to Incident:

Less than 2 minutes elapsed from call pickup to 1st unit assigned.

8 minutes from assigned to 1st Unit enroute. Officer Irrelevant is of the belief that 8 minutes is a "standard response time" for EA and that this a common belief at Irrelevant Officer Irrelevant described Irrelevant response to this incident as "standard practice for Irrelevant". (File note attached). No other mitigating factors were identified as influencing Officer Irrelevant response time of 8 minutes.

Further to this conversation Officer Irrelevant has provided an email response (Appendix attached) citing: *Certified agreement section 25.3 states "An acceptable response time will be 10 minutes" in relation to response times whilst on call.*

Per IDR, 19 minutes elapsed from the Irrelevant EA Officer being assigned the 1B case until the unit arrival on scene. Distance from EA Officer Irrelevant residential address to the patient's address is 1.6km's according to Google Maps.

A review of PTT data has identified a discrepancy in on scene time with PTT showing on scene time of 00:34hrs. This is supported by radio transmissions of Officer Irrelevant "going into the house" at 00:34hrs. The corrected timeline would have QAS Unit 1126 arriving 3 minutes sooner (at 16 minutes) than the IDR would indicate.

It was not until the case was upgraded to a 1A did the Townsville Operations Centre Dispatch backup of an Advanced Care Paramedic crew and the Critical Care Paramedic from Townsville.

A review of resource availability and management of the incident revealed the Irrelevant EA Unit 1126 was available to respond from Irrelevant with additional resources available to respond from Townsville.

Hospital Status:

There were no significant delays at TUH while this incident was pending, which would have impacted on resource availability. TUH was at Level 1 Escalation at the time of this incident.

Lost Time does not appear to have been an associated factor that contributed to a delay in this case at the time of the call. 'Lost Time' occurs when ambulances are unable to be released from hospitals and reduces the number of ambulances available to deploy to pending incidents.

Townsville Staffing:

At the time of the call at 00:16hrs the following resources were rostered at Irrelevant

- 1 x Day shift officer on EA from 18:00hrs to 06:00hrs.

The following resources were rostered at Townsville, Kirwan and Northern Beaches Stations. All three Stations form the Townsville Cluster and service the Townsville catchment.

- 7 x Night shift crews
- 1 x CCP Pod night shift single officer
- 1 x ACP Flight Paramedic night shift single officer

There were no vacancies to the night shift roster.

Outcomes:

- "Assigned to enroute" time delay of 8 minutes attributed to misconception by Officer of acceptable timeframe to respond from EA. Identified as potential broader misconception among staff.
- Review of the IDR response timeline (19 minutes) for first unit to arrive on scene corrected per PTT evidence (16 minutes). The incident was 1.6km's from the Paramedics EA residence a drive time of 2 minutes at road speed.

## Review Recommendations:

Officer Irrelevant has been counselled by A/District Director regarding requirement to respond on EA as quickly as possible, not to a perceived timeframe. Officer Irrelevant has been informed there is no value of maximum time associated with EA response.

Follow up meeting to be arranged at first opportunity for Officer Irrelevant to meet with James Cunnington, Townsville Region A/AC.

District Communique to be disseminated regarding expected standards for EA dispatch to on case.

**Appendix of relevant documents/files:**

- IDR 15751326
- DARF 15751326
- CORPULS Summary
- iROAM Data
- CAD Data
- AVL Data
- Unit Activity Log
- Cluster Roster
- File note conversation with EA Officer Irrelevant
- Google maps EA residence to incident location
- PTT log

**Region Endorsement**

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

| Name | Position | Signature | Date |
|---|---|---|---|
| Amanda Harper | A/Director TSV | Irrelevant | 04/05/2022 |
| James Cunnington | A/Assistant Commissioner TSV | | 04/05/2022 |

# Significant Incident Review



## Metro North Region
## Queensland Ambulance Service

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

### Executive Summary:

On the 26 April 2022 at 10.46 pm, the QAS received a Triple Zero (000) call for assistance (Incident 15800894) at Irrelevant Caboolture South to attend a Irrelevant female patient who had abdominal pain. Based on the caller's response to questions asked by the Emergency Medical Dispatcher the call was appropriately coded as a Code 2B (non-lights and/or siren) response.

At 11.58 pm, a Senior Medical Officer within the QAS Clinical Hub conducted a call back to the scene. The doctor did not recommend any change to the incident's priority coding.

At 12.27 am, the QAS received a second Triple Zero (000) call from the scene advising that the patient was having a seizure with the case promptly upgraded to require a Code 1B (immediate response, light and/or siren) response. During the second Triple Zero (000) call, the caller later advised the patient was not breathing, resulting in the incident being further upgraded to require a Code 1A response, being the highest possible priority.

The first paramedic unit arrived on scene at 12.37 am, approximately 10 minutes following the case being upgraded to a Code 1A response. The total response time to attend the patient was 1 hour and 50 minutes following the case entering the dispatch waiting queue.

Upon arrival, QAS paramedics reported locating the patient on a couch with Irrelevant Irrelevant QAS resuscitation was commenced, however, despite their resuscitation efforts, the patient was declared deceased at 1.02 am.

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

### Terms of Reference:
This review will investigate all aspects of ambulance response to incident 15800894.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

### Regional Clinical Incident Summary Report:
This case presented a very difficult situation to manage with multiple life-threating factors requiring immediate attention. The care provided to this patient was of high quality and in line with QAS clinical practice.

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

The initial Triple Zero (000) call was received at 10.46 pm found to be of partial compliance with some deviations that did not affect the final coding.

The second Triple Zero (000) call was received at 12.25 am, 1 hr and 39 minutes after the initial call. The call was found to be non-compliant. The call contained a number of technical deviations however the priority was appropriate and would not have altered the dispatch decision for the case.

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

## Incident Review/Investigation:

### Scope

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

### Background

On 26 April 2022 at 10.46 pm, the QAS received a Triple Zero (000) call for assistance (Incident 15800894) at Irrelevant Caboolture South to attend a Irrelevant female patient who had abdominal pain.

### Timeline

22:46 1st keystroke
22:47 000 call received, Irrelevantfemale with difficulty in breathing. 2BL response
23:56 Delay in dispatch due to workload
00:25 Second 000 call, patient having a seizure. Case upgraded to 1B
00:27 First unit attached
00:28 Patient now has ineffective breathing. Case upgraded to 1A
00:29 Critical Care Paramedic pod unit attached
00:32 CPR in progress
00:37 First unit arrived on scene
00:40 CPR in progress by QAS
01:02 CPR ceased by QAS, QPS requested
02:23 MN OS arrived on scene

### Clinical Hub Review

At 11.58 pm, a QAS a Senior Medical Officer within the Clinical Hub conducted a call back to the scene. The doctor did not recommend any change to the incident's priority coding. Dr Stephen Rashford, Medical Director QAS reviewed the relevant call back. Dr Rashford identified that there were areas for improvement in relation to this call and discussed these directly with the relevant Senior Medical Officer.

### Hospital Status

At 10.46 pm on 26 April 2022, the time of the call for incident 15800894, there were 8 QAS units located at Metro North Hospital and Health Service (HHS) hospitals and of these 4 had been 'ramped' for over 30 minutes, with the longest being 1 hour 13 minutes at Caboolture Hospital. At the time of the call Caboolture Hospital was on level 2 escalation. QAS Senior Operations Supervisor had spoken with the Level 3 contact requesting for the release of ambulances to attend pending cases.

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

| | Hospital | Total no. ambulance units at Hospital (with pts on stretcher) | Total no. ambulance units ramped (>30 mins POST) | Maximum ramped time | Hospital escalation level |
|---|---|---|---|---|---|
| 21:45 to 21:59 26/04/2022 | RBWH | 3 | 0 | 28 mins | |
| | Redcliffe Hospital | 2 | 1 | 50 mins | 3 |
| | Caboolture Hospital | 4 | 1 | 37 mins | |
| | Prince Charles Hospital | 3 | 1 | 32mins | |
| 22:45 to 22:59 (TOC 22:46) | RBWH | 2 | 1 | 50 mins | |
| | Caboolture Hospital | 3 | 2 | 1 hr 13 mins | 2 |
| | Prince Charles Hospital | 3 | 1 | 1 hr 5 mins | |
| 23:30 to 23:44 | Caboolture Hospital | 1 | 1 | 45 mins | 2 |
| | Prince Charles Hospital | 2 | 1 | 32 mins | |
| 00:15 to 00:29 | Caboolture Hospital | 2 | 0 | 27 mins | |
| (time dispatched 00:27) | Prince Charles Hospital | 1 | 1 | 43 mins | |

## Operational Review

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

| | Priority | Number of Incidents | Average Wait (h:mm:ss) | Maximum Wait (h:mm:ss) | No. incidents pending > 1hour |
|---|---|---|---|---|---|
| 21:45 to 21:59 26/04/2022 | 1 | 3 | 0:11:06 | 0:20:27 | 15 |
| | 2 | 29 | 1:26:58 | 4:09:43 | |
| 22:45 to 22:59 (TOC 22:46) | 1 | 14 | 0:36:08 | 3:43:43 | 17 |
| | 2 | 26 | 1:49:43 | 5:09:51 | |
| 23:30 to 23:44 | 1 | 14 | 1:05:04 | 4:28:23 | 23 |
| | 2 | 28 | 2:14:27 | 5:54:51 | |
| 00:15 to 00:29 (time dispatched 00:27) | 1 | 24 | 0:59:02 | 5:13:35 | 31 |
| | 2 | 31 | 2:37:51 | 6:39:43 | |

**QAS Resourcing** – no significant resourcing issues identified

| AFTERNOON SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | IRT | LARU | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | 5 | 3 | 0 | -1 | -5 | -1 | | | | 1 | 3 | 3 | 1 |
| | | 108% | | 75% | 50% | 50% | | | | | | | |

| NIGHT SHIFT COVERAGE | VARIANCE (% indicates coverage compared with approved resource profile) | | | | | | | | | Supervisors (OIC, CSO, SCE) on shift | Ops Supervisors (OS, SOS) on shift | ABSENTEEISM | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PTOs | Paras | Rural | Twilight | EA | MH Co-responder | CCP | FCCP | HARU | | | SL/FL | Other |
| MTN | | 0 | 0 | 9 | 0 | | 0 | | | 0 | 1 | 1 | 0 |
| | | 100% | | | | | 100% | | 100% | | | | |

## System Pressures

On 26 April 2022, the Metro North HHS hospitals experienced 82.97 hours of 'Lost Time' at Emergency Departments. This Lost Time equates to approximately 8 paramedic crews over the period of a day being unavailable to be dispatched to the community.

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

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

## Outcomes

- ACP crew and CCP responded, arriving on scene 10 minutes after the case was upgraded.
- Resuscitation attempted, time of death 1.02 am, 27th April 2022.
- QAS Supervisor attended scene and supported the Irrelevant of the deceased patient who was appreciative of the QAS response and efforts.
- QAS Supervisor notified Senior Officers.

## Post review actions

- Hot issues brief completed.
- QAS Supervisor spoke with next of kin (father) the following day advising the case was being reviewed. The father was notably distressed by the sudden passing of his daughter but was appreciative of the call.

## Appendix of relevant documents/files:

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

## Regional Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Dave Hartley | A/Assistant Commissioner | Electronically endorsed | 23/05/2022 |
| Lisa Dibley | A/District Director | Electronically endorsed | 23/05/2022 |

# Sunshine Coast District Significant Incident Review



## 1. Authority

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

## 2. SIR Incident Description

On the 08th of June 2022, Queensland Ambulance Service received a request to attend Irrelevant Irrelevant Buddina for a baby born, not breathing. Two (2) minutes into the '000' call the baby was breathing and pink in colour.

## 3. Executive Summary

The request for service was received at Maroochydore Operations Centre (MOC) at 14:45 from Irrelevant located with the patient at Irrelevant Buddina. The incident was categorised through the Medical Priority Dispatch System (MPDS) as a 24C04; 1C response; Incident Detail Report (IDR) 15993245

The '000' first party caller stated that a baby had been born however was not breathing, two (2) minutes later the baby was breathing and pink in colour. The pregnancy was reported to be full-term with no complications. The baby could be heard crying in the background of the '000' call.

The Emergency Medical Dispatcher (EMD) had recorded in the IDR that it was difficult to gain adequate history from the bystander. The birth was a water birth and was a baby girl.

Based on information provided, Maroochydore OpCen dispatched a Bravo unit, and two (2) minutes later dispatched the Critical Care Paramedic (CCP) POD.

The first Situation Report (SR) provided stated that the newborn had an APGAR score of ten (10) and was pink all over. Thirty-one (31) minutes later a further SR advised that the mother was in cardiac arrest, departing code one (1) for Sunshine Coast University Hospital (SCUH) with CCP and intern onboard.

The mother was later declared deceased in the Operating Theatre at SCUH. The baby doing well and is healthy.

## 4. Terms of Reference

This review will:

- investigate all aspects of ambulance response to incident 15993245.
- examine ambulance operations prior to, during and following the response; and
- include all requirements outlined in the Operational Incident Review Process.

## 5. District Clinical Incident Review - Summary Report

An Eclipse Report is not required for this incident.

## 6. State OpCen ProQA Assessment

State OpCen ProQA assessment has been requested.

## 7. Incident Review/Investigation

### a) Scope

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

- Sunshine Coast District was down two officers on afternoon shift (12-22), one officer on the LARU shift (11-21) and one officer on night shift (18-06)
- SEQ was on EXTREME escalation
- The incident was categorised as a 24C04, 1C response

A code 1C response requires an immediate response, lights, and sirens, of the closest most appropriate unit, the CCP POD was dispatched given the initial case details of the baby not breathing. This case was dispatched in accordance with Dispatch Standard Operating Procedures (SOPs). This incident was appropriately resourced, and the response was timely (7 minutes 54 seconds).

### b) Background

Queensland Ambulance Service received a request to attend a newborn who was born at home in a water bath.

Initial reports suggested the baby was not breathing when it was born, however was reportedly breathing normally during the '000' call.

The mum was still in the water bath when QAS arrived and was alert and oriented. After the initial assessment of the baby, permission was gained to clamp and cut the umbilical cord. The DARF documents that the baby was APGAR 7 with cool extremities and noisy breathing, equal air entry bilaterally. Baby was warmed and dried with gross improvement and consistent cry. The baby was handed to a family member.

Mum then reported that the placenta was yet to deliver. Permission was gained to administer oxytocin, consent provided by mother who was removed from bath and placed in a supine position. Placenta delivered with a 'normal' amount of blood loss, estimated to be 100-150mls. Mother requesting to sit up as she is uncomfortable on her back, Grandmother also requesting for mum to be placed in seated position. Paramedics provided brief explanation and reassurance that given weak radial pulse patient should remain laying down.

Mother still GCS15 was moved to stretcher which was positioned next to her. At this point there was a rapid decline in patients GCS, stating she needed air, bilateral chest auscultation was performed with no abnormalities detected. IV access obtained, patient then became cyanotic around lips, pale, no radial pulse present, brachial and carotid pulses palpated. During extrication patient rapidly deteriorated, upon loading into vehicle patient was GCS3, trismus and seizure activity present. Rhythm assessed, VT arrest, nil spontaneous respirations, single shock delivered, asystole. PEA arrest for duration of transport to SCUH. CCP viewed vagina with sweep, nil haemorrhage observed with QAS.

Mother treated in the resuscitation area at SCUH, later transferred to surgery and then declared deceased.

QAS resources attending this incident included:

| Unit | Name | | |
|---|---|---|---|
| 401789 | Irrelevant | (31534); Irrelevant | (30682) |
| 406708 | Irrelevant | (30735); Irrelevant | (21145) |

c) **Timeline – Chronology may be incorrect due to CAD failure**

14:47 – Waiting in Queue
14:48 – B401789 dispatched
14:49 – EMD case entry 'Baby now breathing – pink in colour'
14:50 – A406708 dispatched
14:57 – B401789 at scene
14:59 – A406708 at scene
15:02 – B401789 SR newborn APGAR 10 good cry, pink all over
15:33 – SR mother in arrest, transporting hot to SCUH ETA 10 minutes
15:35 – EMD notified SCUH of incoming cardiac arrest
15:36 – CDS case entry mum asystolic arrest suspected PE, baby travelling behind in another unit
15:42 – 401789 arrived at SCUH

**d) Outcomes**

- 41yof declared deceased post interventions at SCUH
- Newborn baby healthy and well

**e) Post review actions**

- Audio files requested from Maroochydore Operations Centre
- Notification to District Director
- Priority One notification
- SOS attended SCUH and officers taken OOS for extensive debrief and provided support

## 8. Recommendations

- That this SIR be noted and filed

## 9. Appendix of relevant documents/files

A. Incident Detail Report (IDR)
B. SOS End-of-Shift report
C. Maroochydore OpCen Brief
D. DARF 504438068, 504438129

## 10. Prepared by

| Name | Position | Signature | Date |
|---|---|---|---|
| Danielle Williams | Senior Operations Supervisor | *Danielle Williams* | 09/06/2022 |

## 11. District/Regional Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Robert Cornthwaite | District Director | Irrelevant | 05/07/22 |
| Stephen Gough | Assistant Commissioner | | 07/07/2022 |

## 12. Lodgement

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

DARF_504438129-Mother.pdf
DARF_504438068 - baby.pdf
Incident Detail Report 15993245.pdf
080622 DAY MAROOCHYDORE OP(0600-1800) SCT DIST
2022_06_08 DIST

# Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **15993245**
ProQA number: **18965424**
Console name: **PA401**
Incident Date: **08/06/2022 14:45:13**
Last Updated:

## Incident Information

| | | | |
|---|---|---|---|
| **Incident Type:** | ACUTE | **Alarm Level:** | |
| **Priority:** | 1C | **Problem:** | BABY BORN NO COMPLICATIONS |
| **Determinant:** | 24C04 | **Agency:** | QAS |
| **Base Response#:** | 036834 | **Jurisdiction:** | 4 Sunshine Coast |
| **Confirmation#:** | 00625328 | **Division:** | 4 Kawana |
| **Taken By:** | Beagley, Bree | **Battalion:** | 4 Kawana |
| **Response Area:** | 4 Kawana | **Response Plan:** | Acute |
| **Disposition:** | A Case Completed | **Command Ch:** | |
| **Cancel Reason:** | | **Primary TAC:** | TLK GRP 117/UHF Ch 22 BUDDINA |
| **Incident Status:** | Closed | **Secondary TAC:** | |
| **Certification:** | ACUTE | **Delay Reason (if any):** | |
| **Longitude:** | 26870920 | **Latitude:** | 63308362 |
| **Patient Name:** | LAUREN | **Patient DOB:** | UNK |

## Incident Location

| | | | |
|---|---|---|---|
| **Location Name:** | Irrelevant | **County:** | SUNSHINE COAST |
| **Address:** | | **Location Type:** | |
| **Apartment:** | | **Cross Street:** | Irrelevant |
| **Building:** | | **Map Reference:** | |
| **City, State, Zip:** | BUDDINA QLD 4575 | | |

## Call Receipt

| | | | |
|---|---|---|---|
| **Caller Name:** | Irrelevant | **Original CLI Phone** | Irrelevant |
| **Method Received:** | | **Call Back Phone:** | |
| **Caller Type:** | | **Caller Location:** | |

## Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| **Phone Pickup** | 08/06/2022 | 14:45:13 | |
| **1st Key Stroke** | 08/06/2022 | 14:45:13 | |
| **In Waiting Queue** | 08/06/2022 | 14:47:35 | |
| **Call Taking Complete** | 08/06/2022 | 14:59:45 | Beagley, Bree |
| **1st Unit Assigned** | 08/06/2022 | 14:48:57 | |
| **1st Unit Enroute** | 08/06/2022 | 14:49:47 | |
| **1st Unit Arrived** | 08/06/2022 | 14:57:41 | |
| **Closed** | 08/06/2022 | 16:18:00 | Urquhart, Matthew |

## Elapsed Times

| Description | Time |
|---|---|
| **Received to In Queue** | 00:02:22 |
| **Call Taking** | 00:14:32 |
| **In Queue to 1st Assign** | 00:01:22 |
| **Call Received to 1st Assign** | 00:03:44 |
| **Assigned to 1st Enroute** | 00:00:50 |
| **Enroute to 1st Arrived** | 00:07:54 |
| **Incident Duration** | 01:32:47 |

## Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 401789 | 14:48:57 | A Case Completed | 14:49:47 | | 14:57:41 | | | 16:17:49 | | | |
| A406708 | 14:50:29 | A Case Completed | 14:50:41 | | 14:59:39 | | | 16:18:00 | | | |

## Personnel Assigned

| Unit | Name |
|---|---|
| 401789 | Harris, Rickie-Lee 31534 (31534); Okulov, Michael 30682 (30682) |
| 406708 | Gerrard, Kylie 30735 (30735); Watson, Bradley 21145 (21145) |

## Pre-Scheduled Information

**No Pre-Scheduled Information**

## Transports

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 401789 | QH SUNSHINE COAST UNIVERSITY HOSPITAL HOLLOWS LANE | | Hot | Pre Hosp - patient condition | 0.0// | 15:32:26 | 15:42:51 | 16:17:49 |
| 406708 | SCUH (A&E) Hollows Lane | | Cold | Pre Hosp - patient condition | 0.0/0.0/0.0 | 16:04:04 | 16:04:05 | 16:18:00 |

## Comments

| Date | Time | User | Type | Comments |
|---|---|---|---|---|
| 08/06/2022 | 14:47:34 | 4BREBEA | Response | [ProQA Dispatch] Dispatch Level: 24C04 (Baby born (no complications)) Response Text: 1C Age unknown, Female, Conscious, Breathing. Problem Description: BABY BORN - NOT BREATHING |
| 08/06/2022 | 14:47:34 | 4BREBEA | Response | [ProQA: Key Questions] 1. This is not a reported MISCARRIAGE or STILLBIRTH. 2. She is in her 3rd TRIMESTER. 3. The baby is completely out. 4. This is not a multiple birth. 5. No complications with the baby or mother reported at this time. |
| 08/06/2022 | 14:48:45 | 4BREBEA | Response | [Notification] [QAS]-[Private] Review priority - EMD requested CDS to review |
| 08/06/2022 | 14:48:58 | PS | Response | [Page] Dispatch page sent to Unit:401789, Sent From: KEDCADQASPIS01 |
| 08/06/2022 | 14:48:58 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:49:05 | PS | Response | [Page] Dispatch page to Unit:401789 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:49:07 | PS | Response | [Page] Dispatch page to Unit:401789 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:49:37 | 4BREBEA | Response | BABY IS NOW BREATHING - PINK IN COLOUR |
| 08/06/2022 | 14:49:47 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:49:58 | PS | Response | [Page] Dispatch page sent to Unit:401789, Sent From: KEDCADQASPIS01 |

| | | | | |
|---|---|---|---|---|
| 08/06/2022 | 14:50:05 | PS | Response | [Page] Dispatch page to Unit:401789 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:50:07 | PS | Response | [Page] Dispatch page to Unit:401789 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:50:29 | PS | Response | [Page] Dispatch page sent to Unit:406708, Sent From: KEDCADQASPIS01 |
| 08/06/2022 | 14:50:30 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDEN |
| 08/06/2022 | 14:50:36 | PS | Response | [Page] Dispatch page to Unit:406708 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:50:37 | PS | Response | [Page] Dispatch page to Unit:406708 complete to Irrelevant Message sent successfully to Whispir |
| 08/06/2022 | 14:53:09 | 4BREBEA | Response | 40/40 GESTATION. UNSURE G AND P. NIL KNOWN COMPLICATIONS DURING PREGNANCY. BABY HEARD TO BE CRYING IN BACKGROUND. |
| 08/06/2022 | 14:53:10 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:53:10 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:53:21 | 4BREBEA | Response | DIFFICULT TO GAIN ADEQUATE HISTORY FROM BYSTANDER. |
| 08/06/2022 | 14:53:22 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:53:23 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:55:08 | 4BREBEA | Response | BABY GIRL |
| 08/06/2022 | 14:55:09 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:55:09 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:56:09 | 4BREBEA | Response | POOL BIRTH |
| 08/06/2022 | 14:56:10 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:56:11 | 401789 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 14:58:31 | 4BREBEA | Response | [ProQA: Key Questions] 1. This is not a reported MISCARRIAGE or STILLBIRTH. 2. She is in her 3rd TRIMESTER. 3. The baby is completely out. 4. This is not a multiple birth. 5. No complications with the baby or mother reported at this time. |
| 08/06/2022 | 14:58:31 | 4BREBEA | Response | [ProQA] : Age unknown, Female, Conscious, Breathing. |
| 08/06/2022 | 14:58:32 | 406708 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 08/06/2022 | 15:02:18 | 4ASHPAR | Response | 401789 NEWBORN APGAR 10 GOOD CRY AND PINK ALL OVER - Backup Not Required - CONTINUING ASSESSMENT |
| 08/06/2022 | 15:33:19 | 4MATURQ | Response | 401789 MOTHER IN ARREST Tx HOT TO SCUH ETA 10 MINS |
| 08/06/2022 | 15:35:31 | 4EMIMCD | Response | [Notification] [QAS]-[Private] SPOKE TO RACHEL @ SCUH - ADVISED CREW ETA |
| 08/06/2022 | 15:36:39 | 4RYASTO | Response | S/R MUM AYSTOLE ARREST SUSPECTED PE. BABY TRAVELLING BEHIND IN ANOTHER UNIT |
| 10/06/2022 | 14:06:53 | 4JULHOD | Response | /AHP |
| 10/06/2022 | 14:07:09 | 4JULHOD | Response | Antepartum Haemorrhage |
| 10/06/2022 | 14:08:27 | 4SHEBEA | Response | [Private] OPENED FOR HOSP INQ RE PLACENTA |
| 10/06/2022 | 14:09:17 | 4JULHOD | Response | Premise Case Hx accessed for the purpose of obtaining additional information DISDREGARD PREVIOUS COMMENT |

**Priority Changes**

**No Priority Changes**

**Call Activities**

| Date | Time | Radio | Activity | Location | Comments | User |
|---|---|---|---|---|---|---|
| 08/06/2022 | 14:45:14 | | AML Data Received | | Center of caller area HELI: -26 41.488800, 153 7.769400 ESCAD: #-26.69148/153.12949 | SDSIAML |
| 08/06/2022 | 14:47:34 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 08/06/2022 | 14:47:35 | | Incident in Waiting Queue | | | |
| 08/06/2022 | 14:47:35 | | ANI/ALI Statistics | | INT Insert:Jun 08 2022 14:45:10 / INT SendNP:Jun 08 2022 14:45:09 / WS RecvNP:Jun 08 2022 14:45:11 / WS Process:Jun 08 2022 14:47:35 | 4BREBEA |
| 08/06/2022 | 14:47:35 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4BREBEA |
| 08/06/2022 | 14:47:35 | | ProQA | Irrelevant | ProQA determinant sent | 4BREBEA |
| 08/06/2022 | 14:47:44 | | Incident in Waiting Queue Timer Clear | | | |
| 08/06/2022 | 14:47:45 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 08/06/2022 | 14:48:03 | | Read Incident | | Incident 424 was Marked as Read. | 4ASHPAR |
| 08/06/2022 | 14:48:46 | | UserAction | | User clicked Initial Assign | 4ASHPAR |
| 08/06/2022 | 14:48:48 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 401789 (00:07:01) | 4ASHPAR |
| 08/06/2022 | 14:48:57 | 401789 | Dispatched | | Response Number (036834) | 4ASHPAR |
| 08/06/2022 | 14:48:57 | | UserAction | | User clicked Exit/Save | 4ASHPAR |
| 08/06/2022 | 14:49:47 | 401789 | Resp | | Responding From = SUNSHINE COAST PRIVATE HOSPITAL ACCS\ELSA WILSON DR | VisiNET |
| 08/06/2022 | 14:49:55 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4ASHPAR |
| 08/06/2022 | 14:50:19 | | UserAction | | User clicked Exit/Save | 4ASHPAR |
| 08/06/2022 | 14:50:29 | 406708 | Dispatched | | Response Number: 036842; | 4ASHPAR |
| 08/06/2022 | 14:50:41 | 406708 | Resp | | Responding From = 4(06) MAROOCHYDORE CCP | 4ASHPAR |
| 08/06/2022 | 14:51:15 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4MARSTE |
| 08/06/2022 | 14:52:39 | | UserAction | | User clicked Exit/Save | 4MARSTE |
| 08/06/2022 | 14:55:43 | | UserAction | | User clicked Exit/Save | 4SHAPUN |
| 08/06/2022 | 14:55:49 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 14:57:37 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4RYASTO |
| 08/06/2022 | 14:57:41 | 401789 | At Scene | | | VisiNET |
| 08/06/2022 | 14:57:52 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 14:59:39 | 406708 | At Scene | | | VisiNET |
| 08/06/2022 | 14:59:45 | | UserAction | | User clicked Exit/Save | 4BREBEA |
| 08/06/2022 | 15:05:56 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4RYASTO |
| 08/06/2022 | 15:06:08 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 15:10:50 | | UserAction | | User clicked Exit/Save | 4BREBEA |
| 08/06/2022 | 15:11:37 | | UserAction | | User clicked Exit/Save | 211NICHAU |
| 08/06/2022 | 15:32:26 | 401789 | Dep | QH SUNSHINE COAST UNIVERSITY HOSPITAL | | VisiNET |
| 08/06/2022 | 15:33:51 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4EMIMCD |
| 08/06/2022 | 15:35:32 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4RYASTO |
| 08/06/2022 | 15:35:38 | | UserAction | | User clicked Exit/Save | 4EMIMCD |
| 08/06/2022 | 15:42:51 | 401789 | Dest | HOLLOWS LANE [QH SUNSHINE COAST | | VisiNET |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | UNIVERSITY HOSPITAL] | | |
| 08/06/2022 | 15:42:52 | 401789 | Transport Time | | Depart Scene Time: 15:32:26, Arrive Destination Time: 15:42:51 | VisiNET |
| 08/06/2022 | 15:43:06 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4MATURQ |
| 08/06/2022 | 15:43:35 | | UserAction | | User clicked Exit/Save | 4MATURQ |
| 08/06/2022 | 15:43:44 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 15:48:20 | | UserAction | | User clicked Exit/Save | 4ASHPAR |
| 08/06/2022 | 16:04:04 | 406708 | Dep | SCUH (A&E) | | 4MATURQ |
| 08/06/2022 | 16:04:05 | 406708 | Dest | Hollows Lane [SCUH (A&E)] | | 4MATURQ |
| 08/06/2022 | 16:04:05 | 406708 | Transport Time | Hollows Lane [SCUH (A&E)] | Depart Scene Time: 08/06/2022 16:04:04, Arrive Destination Time: 08/06/2022 16:04:05 | 4MATURQ |
| 08/06/2022 | 16:06:01 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 16:07:12 | | UserAction | | User clicked Exit/Save | 4MARSTE |
| 08/06/2022 | 16:09:27 | | UserAction | | User clicked Exit/Save | 4RYASTO |
| 08/06/2022 | 16:12:51 | | Incident Late | | Active incident marked as late | |
| 08/06/2022 | 16:14:13 | 401789 | Reset System Timer | | Days Warn before expiration Passwords | 4MATURQ |
| 08/06/2022 | 16:17:49 | 401789 | Available | HOLLOWS LANE [QH SUNSHINE COAST UNIVERSITY HOSPITAL] | | 4MATURQ |
| 08/06/2022 | 16:17:49 | 401789 | Disposition | Irrelevant | A Case Completed | 4MATURQ |
| 08/06/2022 | 16:18:00 | 406708 | Available | Hollows Lane [SCUH (A&E)] | | 4MATURQ |
| 08/06/2022 | 16:18:00 | 406708 | Disposition | Irrelevant | A Case Completed | 4MATURQ |
| 08/06/2022 | 16:18:00 | 406708 | Response Closed | | Response Disposition: A Case Completed | 4MATURQ |
| 08/06/2022 | 16:27:05 | | UserAction | | User clicked Exit/Save | 11MICFAR |
| 08/06/2022 | 17:12:40 | | UserAction | | User clicked Exit/Save | 4ASHPAR |
| 10/06/2022 | 14:08:12 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4SHEBEA |
| 10/06/2022 | 14:09:21 | | UserAction | | User clicked Exit/Save | 4JULHOD |
| 10/06/2022 | 14:09:59 | | Read Comment | | Comment for Incident 424 was Marked as Read. | 4SHEBEA |
| 10/06/2022 | 14:14:42 | | UserAction | | User clicked Exit/Save | 4SHEBEA |

Edit Log

| Date | Time | Field | Changed From | Changed To | Reason | Table | Workstation | User |
|---|---|---|---|---|---|---|---|---|
| 08/06/2022 | 14:45:13 | Call_Back_Phone | | 0438953337 | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:20 | City | SIPPY DOWNS | BUDDINA | Updated City | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:20 | City | SIPPY DOWNS | BUDDINA | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:44 | Address | (Blank) | Irrelevant | New Entry | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:56 | Address | Irrelevant | | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:56 | Latitude | 0 | 63308362 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:56 | Longitude | 0 | 26870920 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | Jurisdiction | | 4 Sunshine Coast | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | Division | | 4 Kawana | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | Battalion | | 4 Kawana | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | Response_Area | | 4 Kawana | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | ResponsePlanType | 0 | 0 | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:45:57 | Primary_TAC_Channel | | TLK GRP 117/UHF Ch 22 BUDDINA | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:46:12 | ProQaCaseNumber | | 18965424 | (Response Viewer) | Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Problem | | BABY BORN NO COMPLICATIONS | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Response_Plan | | Acute | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | DispatchLevel | | Normal | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | ResponsePlanType | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Incident_Type | | ACUTE | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Priority_Number | 0 | 3 | Updated by ProQA | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Determinant | | 24C04 | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | EMD_Used | 0 | 1 | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Pickup_Map_Info | (Blank) | S80G6 | | Response_Transports | POLCADQASCXA154 | 4BREBEA |
| 08/06/2022 | 14:47:35 | Map_Info | | S80G6 | | Response_Master_Incident | POLCADQASCXA154 | 4BREBEA |
| 08/06/2022 | 14:48:03 | Read Call | False | True | (Response Viewer) | Response_Master_Incident | PA403 | 4ASHPAR |
| 08/06/2022 | 14:49:46 | Current_UnitRespPriorityDesc | 401789: 1C | HOT1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 08/06/2022 | 14:49:55 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA403 | 4ASHPAR |
| 08/06/2022 | 14:51:15 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA406 | 4MARSTE |
| 08/06/2022 | 14:54:28 | Field_Data | | LAUREN | Patient Name: | Response_User_Data_Fields | PA401 | 4BREBEA |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 08/06/2022 | 14:54:34 | Field_Data | | UNK | Patient DOB: | Response_User_Data_Fields | PA401 | 4BREBEA |
| 08/06/2022 | 14:57:37 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA405 | 4RYASTO |
| 08/06/2022 | 14:58:31 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:58:31 | ProQATerminationStateCode | | C | (Response Viewer) | Incident | PA401 | 4BREBEA |
| 08/06/2022 | 14:59:39 | Current_UnitRespPriorityDesc | 406708: 1C | COLD1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 08/06/2022 | 15:05:56 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA405 | 4RYASTO |
| 08/06/2022 | 15:32:25 | Map_Info | (Blank) | S90A11 | | Response_Transports | KEDCADQASMDI01 | VisiNET |
| 08/06/2022 | 15:33:51 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA412 | 4EMIMCD |
| 08/06/2022 | 15:35:32 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA405 | 4RYASTO |
| 08/06/2022 | 15:35:34 | Read Comment | False | True | (Comment Notification Window) | Response_Master_Incident | PA405 | 4RYASTO |
| 08/06/2022 | 15:43:06 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA404 | 4MATURQ |
| 08/06/2022 | 16:04:04 | Map_Info | (Blank) | S90A11 | | Response_Transports | KEDCADQASCXA264 | MATURQ |
| 10/06/2022 | 14:08:12 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA406 | 4SHEBEA |
| 10/06/2022 | 14:09:59 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA406 | 4SHEBEA |

Metro North Region

Queensland Ambulance Service

**Authority:**

By authority of Assistant Commissioner Tony Armstrong, Metro North Region, Queensland Ambulance Service (QAS).

**Executive Summary:**

On the 09th of June 2022 at 8:40pm the Queensland Ambulance Service received a Triple Zero Call (000) request for assistance at Irrelevant Albany Creek (CN 15999217) to attend a Irrelevant female patient who Irrelevant The incident was originally coded as a 1B 25D3 (not alert). The incident was reviewed by the Clinical Deployment Supervisor (CDS) at 8:45pm and downgraded to a 2A response

# Irrelevant

At 10:53pm Irrelevant second call back, with no changes in the patient's condition noted. Following this call back, a second triple zero call was received at 11:35pm requesting an estimated time of arrival for the responding paramedics. The caller was advised of the delay in responding due to workload.

QAS paramedics arrived on scene at 00:15am, 3 hrs and 35 mins after the initial request for service. The Brisbane Operations Centre was experiencing a high demand for service across the period.

On arrival, the responding officers reported that the patient was compliant and answering questions normally. At 00:29am, the patient was loaded and transport to hospital commenced. The attending paramedics later identified to the supervisor that the patient became erratic during transport, lunging at the patient care officer, resulting in the officers retreating from the vehicle for their safety.

At 00:43am, the paramedics requested Queensland Police Service (QPS) to attend the corner of Hamilton and Webster Road code 1. Following this transmission, the crew have activated the duress on their portable radio and provided additional information over the radio advising that the patient was now in control of their vehicle. At 00:49am, the Metro North Operations Supervisor (OS) was attached to the incident.

The patient has the continued to remain in control of the vehicle and travel to the Prince Charles Hospital (PCH). On arrival at the hospital the patient has decamped from the vehicle prior to being returned to the Emergency Department at PCH by QPS.

The officers involved in the incident were not physically injured and all drugs and equipment in the vehicle were accounted for. There were no reports of damage to the vehicle following the incident.

**Terms of Reference:**

This review will investigate all aspects of ambulance response to incident 15999217. 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*.

**Incident Review/Investigation:**

**Scope**

Metro North has reviewed the operational response and management of the incident and will identify any operational concerns with the incident.

**Background**

On the 09th of June 2022 at 8:40pm, the Brisbane Operations Centre received a request for service for a Irrelevantfemale who was described Irrelevant
15999217).

**Timeline**

- 8:40pm: Phone pick up
- 8:40pm: 1st key stroke
- 8:42pm: In queue 25D03 (not alert)
- 8:45pm: Incident downgraded by CDS from 1B to 2A (patient condition)
- 9:27pm: Irrelevant all back conducted
- 10:53pm: Irrelevant conducts 2nd call back
- 11:35pm: 2nd triple zero call received from caller
- 11:40pm: Case assigned to B501482
- 11:45pm: B501482 diverted to 1B at Aspley
- 11:56pm: Case reassigned to B501242
- 00:15am: B501242 crew arrived on scene
- 00:17am: B501242 crew at patient
- 00:29am: B501242 departed scene for Prince Charles Hospital
- 00:43am: Sitrep from B501242 requesting QPS code 1
- 00:44am: Crew stopped at the roundabout of Webster and Hamilton Rd (AVL data)
- 00:44am: ICEMS request to QPS “QPS req L&S at round-about Webster and Hamilton”
- 00:45am: B501242 Portable 501242P1 duress activation
- 00:46am: QPS attached to the incident via ICEMS
- 00:47am: B501242 sitrep requesting supervisor to be attached to the incident
- 00:47am: Vehicle mobile towards Prince Charles Hospital (AVL data)
- 00:48am: QPS were marked as responding to the incident
- 00:49am: B501242 sitrep requesting QPS and Supervisor code 1 with both paramedics located on the corner of Webster Rd and Hamilton at the roundabout
- 00:49am: B501242 confirm that they have taken up with QPS
- 00:50am: B501242 sitrep crew advising they are they are with QPS now and one QPS vehicle is following the ambulance
- 01:00am: Vehicle located at Prince Charles Hospital (AVL)
- 01:08am: B507352 confirmed crew are safe and patient has been taken into the hospital with QPS

## Operational Review

An operational review of the incident included a review of Incident Detail Report (IDR), Electronic Ambulance Report Form (eARF), AVL data, incident notification and audio files.

During transport to TPCH, the paramedics describe that the patient has become aggressive, lunging at the patient care officer. The paramedics have paused transport on the corner of Webster and Hamilton Road at which time the paramedics have retreated from the vehicle for their safety, following the Responding to High Risk Situations Operational Procedure.

At 00:43am the paramedics have transmitted a radio request for QPS to attend their location code 1, with the EMD following Standard Operating Procedure (SOP) 02.8 Police Required – Signal One Duress, immediately notified QPS via the Inter-agency CAD Electronic Messaging System (ICEMS). At 00:45am, the paramedics have activated their portable duress. QPS have responded to the incident quickly, arriving on scene at 00:49am, 6 minutes after the initial request for assistance from QPS.

At 00:47am an OS was attached to the incident. The OS has provided appropriate briefings to senior officers including the State Operations Coordination Centre (SOCC) Room Manager, District Director and Assistant Commissioner. Additionally, the OS has ensured support was provided to the crew through an operational debrief and engagement of Priority One for follow up.

On arrival at the PCH, the patient has absconded from the scene, however returned to the Emergency Department in the care of QPS.

## Call Taking Review

A review by the Brisbane Operations Centre has identified some deviations in questioning during the initial triple zero call. The CDS has reviewed the case following initial receipt, downgrading the initial response from a code 1B to a 2A response. Through the review, it was identified that the CDS did not conduct a call back prior to downgrading the case.

The Irrelevant has undertaken a call back at 9:27pm and confirmed the patient's recent Irrelevant his has not altered the response for the incident.

An additional call back was conducted by the MHLC at 10:53pm where the caller confirms that there is no change in the patient's condition, with the response remaining unchanged.

At 11:35pm the original caller makes a 2nd triple zero call, providing advice to the call taker that the situation is becoming more difficult to manage. During the review it was identified that this call was not re-triaged appropriately.

## Training Review

A review of the officers LMS showed that both paramedics have successfully completed their Occupational Violence and Safety Training.

## Review Findings/Outcomes

## Paramedic Actions

- The officers involved were not injured, no equipment or drugs were identified as missing from the vehicle and no damage to the vehicle was identified;
- Responding to High Risk Situations Operational Procedure was followed by the paramedics; and
- The paramedic actions in retreating from the patient was considered appropriate and in accordance with Occupational Violence and Safety Training;

**Supervisor Actions**

- Appropriate staff support mechanisms were implemented by the QAS supervisor;
- The appropriate level of supervision responded to the incident; and
- Appropriate senior officer notification was implemented in accordance with the relevant SOP.

**OPCEN Actions**

- The EMD has not re-triaged the case appropriately.
- The EMD's notes in the case do not accurately reflect what the caller has stated.
- Timely notification was provided to senior officers and the SOCC in accordance with the relevant SOP.
- The Operations Centre EMD requested QPS in accordance with SOP 02.8 Police Required – Signal One Duress;
- It is identified the CDS did not perform the appropriate patient call back prior to downgrading the incident from a 1B to 2A. However, the actions to downgrade the case was considered appropriate based on the patient's presentation; and
- The patient was referred to the MHLC who conducted appropriate call backs to review the patient's condition. This has been considered an appropriate course of action.

**Outcome Summary**

The QAS response to this incident was appropriate. Whilst, there was a delay in the response due to increased demand for other emergency incidents, the patient was appropriately reviewed by the Irrelevant who considered the patient to be low risk. In relation to staff support, adequate mechanisms were initiated to ensure the paramedics involved safety was maintained and they implemented strategies in accordance with their training.

**Review Recommendations:**

- Liaison with the QAS Irrelevant for patient management strategies - complete
- Apply caution note to the patient's residential address identifying management strategies - complete
- Feedback to be provided to the relevant CDS regarding relevant processes for downgrading cases
- Feedback to be provided to the relevant EMD regarding the appropriate re-triage of secondary triple zero calls

**Appendix of relevant documents/files:**

- Incident Notification;
- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Audio findings;

- Relevant audio (wav) files;

**Regional Endorsement**

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | Assistant Commissioner | Electronically endorsed | 19/07/2022 |
| Jessika Brind | Acting Director | Electronically endorsed | 19/07/2022 |

# Metro North Local Ambulance Service Network

## Authority:
By authority of Assistant Commissioner, Metro North Local Ambulance Service Network.

## Executive Summary:
On the 16th of June 2022 at 4.47 am, the QAS received a Triple Zero (000) call for assistance (Incident 16027591) at Irrelevant Kippa Ring to attend a Irrelevant male patient who had a fall with hip pain. Based on the caller's response to questions asked by the Emergency Medical Dispatcher the call was appropriately coded as a Code 2C (non-lights and/or siren) response.

At 06.07 am, a Paramedic within the QAS Clinical Hub conducted a call back to scene with the patient reported to have been assisted into bed and appeared to be comfortable. The incident was upgraded from a 2C to a 2A response priority following this call back.

At 11.51 am, QAS received a subsequent Triple Zero (000) call with bystanders asking if the patient could have his prescribed medication with advice provided to follow Dr instructions. No change in patient condition was reported.

At 2.02 pm, QAS arrived on scene requiring Irrelevant Irrelevant QAS arrived at Redcliffe Hospital at 3.23 pm with the patient ramped with QAS until 5.33 pm.

The QAS received notification from the Coroner that the patient passed away later that day.

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

## Terms of Reference:
This review will investigate all aspects of ambulance response to incident 16027591 at Irrelevant Kippa-Ring. 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 Incident Summary Report:
The Clinical Incident review identified some deficits in the documentation of the case. The crew recorded insufficient vital sign survey, no clinical details of a head-to-toe assessment, perfusion assessment or pain assessment and limited documentation of social or mobility status. There was inadequate documentation after the administration of medication.

The officers involved will receive a face-to-face education session with a clinical support officer on their return from scheduled leave on the 25th of July 2022.

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

The initial Triple Zero (000) call was received at 4.49 am found to be compliant

The second Triple Zero (000) call was received at 08.51am (4hrs and 4 minutes after the initial Triple Zero (000) call). The call was found to be non-compliant. The call contained a number of technical deviations however the priority was appropriate and would not have altered the dispatch decision for the case.

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

The third Triple Zero (000) call was received at 11.51am (7hr 4 minutes after initial Triple Zero (000) call). The emergency disconnect rule was in place at the time and the EMD did not interact with ProQA or check the patient was alert prior to instruction to take medication.

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

Director OpCen has confirmed this EMD follow up has occurred regarding QFES delay.

## Clinical Hub Review:

At 06.07 am, a Paramedic within the Clinical Hub reviewed the call. The review of the Clinical hub call back was that the Clinician maintained a high-level professional conversation and engaged with the caller. Small opportunities of improvement were identified to assess the baseline cognitive state for the patient. Clinician appropriately. The incident was appropriately upgraded to a Code 2A following this clinicians call.

## Incident Review/Investigation:

### Scope

9-hour and 15-minute response (from time of initial Triple Zero (000) call received time to first QAS unit on scene) for a Irrelevant male patient complaining of hip and groin pain post mechanical fall.

### Background

QAS received a call for assistance on the 16 June 2022 at 04.47 am for a male patient post mechanical fall. The patient was assisted from the ground and back into bed by the caller prior to QAS arriving on scene. Due to the competing pressures of significant hospital ramping delays and subsequent extreme workload – the first crew attached to assist was assigned 8 and a half hours after the initial 000 call. The patient was assessed and treated on scene without further delay and transported to local emergency department at Redcliffe Hospital.

The total call cycle from phone pick-up to crew clearing hospital was 12 hours and 55 minutes.

### Timeline

| | | |
|---|---|---|
| **1st Key Stroke** | 16/06/2022 | 04:47:04 |
| **In Waiting Queue** | 16/06/2022 | 04:49:45 |
| **Call Taking Complete** | 16/06/2022 | 04:51:46 |
| **1st Unit Assigned** | 16/06/2022 | 13:17:34 |
| **1st Unit Enroute** | 16/06/2022 | 13:19:25 |
| **1st Unit Arrived** | 16/06/2022 | 14:02:50 |
| **Closed** | 16/06/2022 | 17:42:31 |

## Review

- The initial call for QAS assistance was received at 0447hrs.
- The Clinical Hub performed a call back at 0617hrs and provided comprehensive notes regarding the mechanism of injury and the patient's current clinical condition. The case was subsequently upgraded from a 2C to a 2A.
- There were two further call backs from the original caller throughout the call cycle:
    - 0851hrs – advising that pain in hip and groin was getting worse and patient was lying in bed.
    - 1151hrs – caller asked if patient could have his usual prescribed medications. The Brisbane OPCEN advised the caller of the current workload and confirmed there was nil change in the patient's condition.
- The first and only crew were attached to incident at 1317hrs from the Mater Public Hospital, South Brisbane with an ETA of approximately 30 mins.
- The crew arrived on scene at 1402hrs without further delay. Nil clinical SITREP was provided throughout on scene time.
- Irrelevant
- The patient was loaded into ambulance and transported to Redcliffe Hospital at 1514hrs and transported without any further delay.
- The crew were subsequently ramped at Redcliffe Hospital for 2 hours. Hospital has been advised of patient outcome and review from Coroner. RDH recommended to review internally as per MN HHS process.
- There were significant ramping pressures throughout the day of incident in Metro North HHS.
- Information sourced from Metro North PACH shows QAS Level 3 escalations (ramping delays >1 hour) as per below:

| Hospital | QAS Level 3 Escalations |
|---|---|
| Caboolture Hospital | 1140hrs -2100hrs<br>(Internal Tier 3 – from 1030hrs) |
| Redcliffe Hospital | 1500hrs-1950hrs |
| Prince Charles Hospital | 0620hrs-0805hrs and 1445hrs-0435hrs |
| Royal Brisbane & Women's Hospital | 1300hrs-0129hrs<br>(Internal Tier 3 –from 0905hrs) |

- In addition, Brisbane Operations Centre consistently had between 38 and 65 priority response code 1 and 2 incidents pending during this time.
- The Metropolitan Workforce Planning Unit rostering profile shows a deficit of 9 Officers (-4.5 crews) on day shift, however had 6 additional Officers (+3 crews) on afternoon shift for the day of incident. There were no vacancies for the night shift on 15 June 2022.

## Outcomes

- Patient was transported to Redcliffe Hospital and subsequently ramped for approx. 2 hours prior to being allocated to a hospital bed.
- Patient passed away later in RDH Emergency Department.
- A number of supervisory resources were identified during the period the incident was pending. A/District Director Moreton has liaised with the Brisbane OpCen Director regarding consideration of utilisation of all available resources, and reiteration of resource utilisation has been addressed.

## Post review actions

- Significant Incident Review completed
- OpCen Review
- Clinical Review
- ProQA review completed – and actioned

## Review Recommendations:

- Clinical review feedback to be provided to Officers on 25th July (return from scheduled leave).
- EMD feedback delivered – actioned by Director Brisbane OpCen.
- Liaised with RDH regarding delayed Off stretcher time and QAS internal review. RDH consultation of review occurred on the 15th July 2022.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- MWPU Staffing Profile & Worksheets

## LASN Endorsement

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

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | Assistant Commissioner | Verbally endorsed | 18/07/2022 |
| Andrew Blumson | Acting District Director - Moreton | Verbally endorsed | 18/07/2022 |

# Significant Incident Review Version 0.3

## Metro South Region

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

### Executive Summary:
On Saturday 18 June 2022 at 09:47hrs QAS received a Triple Zero (000) call for assistance (incident number 16038273) at Irrelevant Mount Cotton 4165 to attend an Irrelevant female, unconscious not breathing.

The case was prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as 9E01 (Nil Beathing) requiring a Code 1A response.

There was a response time of 7 minutes to respond an available paramedic to the incident (from when the incident entered the waiting queue to when the first unit arrived on scene). This first QAS response to arrive was a Senior Operation Supervisor followed by a Paramedic unit.

On QAS arrival the patient was found to be in cardiac arrest with CPR being undertaken Irrelevant Patient met rapid discontinuation and was subsequently pronounced deceased on scene. GP not willing to complete death certificate, patient subsequently handed over to QPS.

The patient's Irrelevant advised the attending SOS that QAS attended to the patient the previous day post a fall. The patient was not transported from scene. It was reported by the SOS the family were happy with QAS care.

On review, it has been identified that on Friday 17 June 2022 at 08:59hrs QAS received a Triple Zero (000) call for assistance (incident number 16033340) at Irrelevant Mount Cotton 4165 to attend an Irrelevant Irrelevant female, who had a fall could not get up, complaining of nil injuries.

The case was prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as 17A04G (Fall No Injury / Symptoms on Ground) requiring a Code 2C response. Clinical Hub attempted call back without success and upgraded the incident to Code 2A at 09:16hrs.

There was a response time of 63 minutes to respond an available paramedic to the incident (from when the incident entered the waiting queue to when the first unit arrived on scene).

A clinical review of this case showed some concerns regarding the non-transport decision and associated documentation of this.

### Terms of Reference:
This review will review all aspects of ambulance response to incident 16038273 and 16033340. 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:
QAS Metro South Region CEU have undertaken a clinical review of the non-transport incident – 16033340.

Below are the salient points of the review;

- Patient was hypertensive and possibly hyperglycaemic (depending on what is normal for the patient).
- eARF shows it was a mutual decision not to transport with the disposition selected by the Paramedic is Transport not required Following Paramedic Assessment.

- No falls risk assessment completed, despite mention of increasing need for fulltime care due to worsening weakness over the last few weeks. Mention of increasing weakness potential need for review of support services.
- Some slight variation in vital signs recorded verse captured on Corpuls data. For Example, BP 206/106 captured and 201/99 recorded. It appears the case sheet was completed sometime later following case so this may account for this.
- Times of vital sign survey recorded in the eARF do not match the Corpuls data. eARF records vital signs at 10:11am and 10:21am. They were captured on the Corpuls at 10:18am and 10:21am.

## OpCen Review:

Not Required – Nil issues noted requiring OpCen review.

## 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 an Irrelevant female, unconscious not breathing.
- QAS had attended to the patient 24 hours prior for a fall reported with nil injuries.

**Timeline - 16033340:**

08:59 – Triple Zero (000) call received
09:02 – In waiting queue.
09:16 – Clinical Hub attempted call back without success. Case upgraded to Code 2A.
09:20 – 1st unit assigned.
09:29 – 1st unit diverted to higher priority incident.
09:45 – 2nd unit assigned.
10:05 – ACP arrived on scene.
10:38 – SITREP – Patient and family has opted to stay at home against advice.
10:39 – Incident Closed.

**Timeline - 16038273:**

09:47 – Triple Zero (000) call received
09:49 – In waiting queue.
09:49 – CCP and ACP crew assigned.
09:50 – SOS (CCP) assigned as closes response.
09:53 – CPR commenced by son.
09:56 – SOS arrived on scene.
10:00 – SITREP – CPR in progress.
10:04 – ACP crew arrived on scene.
10:05 – SITREP – discontinuing CPR.
10:06 – CCP stood down
10:55 – Patient handover to QPS.
11:32 – Incident Closed.

**Operational Review:**

Nil issues identified with the response to either case.

**Outcomes:**

- An Irrelevant female pronounced deceased on scene.
- QAS attended patient 24 hours prior for a fall, patient not transported.

## Review Recommendations:

- Follow up with the attending Paramedic by CEU to discuss;
  - Patient presentation
  - Disposition of patient – was this a refusal against advice, mutual decision, transport not required.
  - CSO to provide education regarding:
    - Correct disposition
    - Paperwork requirements when a nil transport.
    - A one off missed dose of antihypertensives is unlikely to result in a BP of 200/105. This requires further medical review to determine if underlying pathophysiology or if an alteration in antihypertensives is required.
  - CEU review of non-transport cases for the attending Paramedic.

## Appendix:

- Incident Detail Report x 2
- Ambulance Report Form x 2
- Clinical Review

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Irrelevant | 27/06/2022 |
| Anthony Hose | Acting District Director South Brisbane | | 27/06/2022 |

# Gold Coast Region

## Authority:

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

## Executive Summary:

On Monday 20 June 2022, at 17:09, the Queensland Ambulance Service (QAS) received a Triple Zero (000) call for an Irrelevant male patient experiencing back pain and numbness to his right leg and left foot, at a residential address in Hope Island (IDR 16048938).

The incident was initially prioritised as a Code 1C at 17:09 and changed to a 2A at 17:12 due to patient condition by the CDS Barnes following a call back. The case was then upgraded back to a 1C following a second call at 17:33. A delay in response occurred with unit 601305, dispatched at 18:04 and arrived on scene 18:20.

Crew of unit 601305 located an Irrelevantmale CO thoracic region with nil radiation, worse on palpation and movement, described as a constant dull ache. The pain in his left foot was resolved however, the patient was complaining of pain in right leg and altered sensation. The unit departed scene at 18:57 with a destination of Gold Coast Private Hospital (GCPH), arriving at 19:23. The choice of destination was not due to a Gold Coast University Hospital (GCUH) Private Hospital Load Share Direction.

Whilst at GCPH the patient was ramped, during this time the crew indicated on four (4) occasions they were ramped.

OS Irrelevant attended early on (unknown time) and was unable to rectify the ramping issue before escalating the matter to DD Irrelevant

The last radio updated at 21:51 indicated one of the officers was proceeding to GCUH to pick up equipment.

A/SOS Irrelevant proceeded to GCPH around 22:50 as the crew were not providing timely status updates. On arrival crew were busy assisting resus after the patient deteriorated whilst on stretcher.

The patient was later transferred to Gold Coast University Hospital at 00:09 in a critical but stable condition and off stretcher at 00:20.

## Gold Coast Region Clinical Incident Summary Report:

The Gold Coast Clinical Education Unit (CEU) conducted a clinical review of incident 16048938 in the context of the patient deteriorating on a QAS stretcher whilst ramped for 3 hours 17 minutes.

The review found:

- Crew did not utilise the Corplus to monitor the patient between the hours 19:17-00:09 (total of 5 hours in QAS care). The Corplus data reflects that the monitor was switched off at 19:19 and not turned on again for the duration of care.

- As per documented in IDR, at 21:30 one of the officers of 601305 (not identified) left Gold Coast Private hospital, with the monitor still on the vehicle to “query retrieving equipment from GCUH”. A Single officer (unidentified) was left with the patient, without quick access of defibrillator or monitoring.

- When the patient deteriorated, it was documented that the officers assisted in providing airway management and monitoring, however these interventions were not documented on the eARF.

- Further concern regarding lacking documentations includes,
  - only three sets of vital signs provided from the first half hour of care,
  - nil reassessment of the patient's pain documented,
  - nil documentation of the urgent transfer from GCP DEM to GCUH DEM.
- The Corplus was not utilised for the urgent doctor escort transfer to GCUH, not documented why this did not occur.
- Information obtained from GCUH identified the patient was managed palliatively and passed away within 48 hours of admission.

## Southport Operations Centre Review:

Southport Operations Centre conducted a review and determined 'Nil issue with the call backs to EMD's at Southport'.

17:09 Initial call taken by EMD at Brisbane OpCen. Call correctly coded Priority 1C – 05C03

17:12 CDS Irrelevant A/CDS did a call back and downgraded to a 2A at 17:12

17:33 Second call back from caller to EMD at Southport. Upgraded back to a Code 1C as per PROQA due to not completely awake. Upgraded back to a 1C at 17:34.

17:45 Third call back from caller to EMD at Southport. Went through PROQA and remained a code 1C.

Below is Brisbane's review of the initial 000 call.

IDR 16048938 EMD 20 June 2022

- The initial caller Irrelevant speaking to the Pt who had some pain like a back spasm
- The patient takes over the call & explains what has happened
- The Pt stated he picked up a small bucket, which weighed about 2 kg & had this massive pain right up the back, a spasm a huge spasm, hurt like "bloody buggery", the sweats, he managed to somehow sit down, the numbness has gone right through my right leg and it's in my left foot, it's uncomfortable it hurts, I'm conscious & can move all my hands
- Started 30-40mins ago
- "What caused the back pain?" "Do you know what caused the back pain or it just suddenly come on?" the caller replied "It just came on, I wasn't lifting anything heavy or anything like that"
- The answer above even though the question was leading throws doubt on the possible cause of the pain. I can see why the EMD selected unknown and remained on P5
- The EMD has omitted asking the patient to describe the pain – this didn't alter the final response of a 1C however can alter the CDS clinical review – it is noted shortly after the Q6 CDS downgraded the case to a 2A.

## Incident Review:

The Gold Coast Region OS Irrelevant attended the hospital in the early stages unable to facilitate an offload and escalated the ramping issue to DD Irrelevant DD Irrelevant escalated the issue to Irrelevant

There was no PACH on afternoon shift, A/SOS Irrelevant was managing PACH responsibilities and later attended GCPH, following up with all attending officers in real time, with peer support provided.

A review of iROAM identified at the time of the initial call @ 17:09, there were 6 cases pending (5 x 2A and 1 2CL).

GCHRB A&E @ 19:00 – 19:14, not on any escalations, GCUH @ 19:00 – 19:14 - Level 3 (commenced 13:14), 5 units ramped (longest 52:43) 2 units proceeding.

In addition to this a review of the Gold Coast Region rosters identified the Gold Coast District were down 6 full crews and 1 POD.

Unit 601305 was ramped GCPH from 19:23 to approximately 22:40 (no SITREP provided, determined by A/SOS arrival at GCPH). Total ramped time was 3 hours 17 minutes.

The Corpuls indicated it was switched off at 19:19 with no further observations or pain management by the treating officers.

A/SOS Irrelevant proceeded to GCPH around 22:50 as the crew were not providing timely status updates. On arrival crew were busy assisting resus after the patient deteriorated whilst on stretcher. The crew advised OS that they tried to call OpCen however, it was busy, and they could not get through on the radio.

During the time the patient was ramped at GCPH, he deteriorated requiring onward transport Code 1B MATA 2 - IDR 16050281 at 00:09 to GCUH with confirmed Aortic Dissection.

The final outcome clinically for this patient shows the patient was managed palliatively and passed away within 48 hours of admission.

## Review Recommendations:

Following the clinical review, it has been determined; the patient presentation was very difficult to determine, making the choice of destination appropriate.

The monitoring of the patient through the 'ramp' phase was subpar and subsequently this was used to highlight the need for a Medical Circular and an amendment in the Clinical Practice Guideline, which has since been developed (Medical Circular 25/2022 and the Clinical Practice Guideline: Other / Standard Cares, section pertaining to (post-triage responsibilities). The Medical Circular was distributed to all staff on the 15 August 2022.

The crew have been provided feedback on the issues identified in the clinical review, reflected on the incident, and no further development process is recommended. QAS Professional Standard has reviewed the clinical aspect of the report and are satisfied that no further follow up is required.

Clinical Deployment Supervisor (CDS) call back was reviewed and reflected upon. MDO advised that clinician follow up and further education was going to be conducted via the Gold Coast MCE.

District Director Irrelevant escalated the issue to Irrelevant Gold Coast Private Hospital in real time and further followed the incident up 21 June 2022 highlighting the ramping issue as unsustainable. Nil further feedback has been received.

## Appendix of relevant documents/files:

| | |
|---|---|
| **Incident Details Report** | IDR CN16048938.pdf<br>IDR CN 16050281.pdf |
| **dARF/dCRF** | eARF 504470886.pdf |

| | |
|---|---|
| **Clinical Review** | CIM Case 16048938 - V3.pdf<br>FW_ ROIs completed for CIM1 |
| **Other Documents** | AVL CN 16048938.pdf |
| **GCLASN Notifiable PSDU Notification** | Notifiable Incident IDR 16048938.msg |
| **Voice Logs** | 17.09.35 Ph 000 Call from 0416679798 20<br>20-06-2022 5.15.30 Audio CDS CB Hope<br>20-06-2022 5.32.38 Audio 000 2nd CB IN<br>20-06-2022 5.45.01 Audio 000 3rd CB IN |
| **OpCen Review** | FW_ Notifiable Incident_ Monday 2<br>RE_ Notifiable Incident_ Monday 2<br>RE_ Notifiable Incident_ Monday 2 |
| **Southport OpCen Brief** | 200622%20NIGHT%20SOUTHPORT%20 |
| **Other Documents** | RE_ Notifiable Incident_ Monday 2<br>RE iROAM GCUH 20 June 2022.msg<br>Incidents attended 20_21 June 2022.doc |

## Region Endorsement

| Role | Name | Signature | Date |
|---|---|---|---|
| Assistant Commissioner | Andrew Hebbron | Irrelevant | 06/09/2022 |

# Incident Detail Report

Data Source: **QACIR**
Incident Status: **Closed**
Incident number: **16048938**
ProQA number: **19024016**
Console name: **QA541**
Incident Date: **20/06/2022 17:09:37**
Last Updated:

## Incident Information

| | | | |
|---|---|---|---|
| **Incident Type:** | ACUTE | **Alarm Level:** | |
| **Priority:** | 1C | **Problem:** | BACK PAIN FAINT =>50 |
| **Determinant:** | 05C03 | **Agency:** | QAS |
| **Base Response#:** | 095900 | **Jurisdiction:** | 6 Southport Gold Coast |
| **Confirmation#:** | 00672890 | **Division:** | 6 Runaway Bay |
| **Taken By:** | Irrelevant | **Battalion:** | 6 Runaway Bay |
| **Response Area:** | 6 Runaway Bay | **Response Plan:** | Acute |
| **Disposition:** | A Case Completed | **Command Ch:** | |
| **Cancel Reason:** | | **Primary TAC:** | TLK GRP 111/UHF Ch 103 |
| **Incident Status:** | Closed | **Secondary TAC:** | |
| **Certification:** | ACUTE | **Delay Reason (if any):** | |
| **Longitude:** | 26644319 | **Latitude:** | 62152036 |
| **Patient Name:** | Irrelevant | **Patient DOB:** | Irrelevant |

## Incident Location

| | | | |
|---|---|---|---|
| **Location Name:** | Irrelevant | **County:** | GOLD COAST |
| **Address:** | | **Location Type:** | Irrelevant |
| **Apartment:** | | **Cross Street:** | |
| **Building:** | | **Map Reference:** | |
| **City, State, Zip:** | HOPE ISLAND QLD 4212 | | |

## Call Receipt

| | | | |
|---|---|---|---|
| **Caller Name:** | Irrelevant | **Original CLI Phone** | Irrelevant |
| **Method Received:** | | **Call Back Phone:** | |
| **Caller Type:** | | **Caller Location:** | |

## Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| **Phone Pickup** | 20/06/2022 | 17:09:37 | |
| **1st Key Stroke** | 20/06/2022 | 17:09:37 | |
| **In Waiting Queue** | 20/06/2022 | 17:11:53 | |
| **Call Taking Complete** | 20/06/2022 | 17:14:21 | Roati, Kevin |
| **1st Unit Assigned** | 20/06/2022 | 18:04:34 | |
| **1st Unit Enroute** | 20/06/2022 | 18:04:54 | |
| **1st Unit Arrived** | 20/06/2022 | 18:20:32 | |
| **Closed** | 21/06/2022 | 00:09:21 | Sathiaseelan, Avernita |

## Elapsed Times

| Description | Time |
|---|---|
| **Received to In Queue** | 00:02:16 |
| **Call Taking** | 00:04:44 |
| **In Queue to 1st Assign** | 00:52:41 |
| **Call Received to 1st Assign** | 00:54:57 |
| **Assigned to 1st Enroute** | 00:00:20 |
| **Enroute to 1st Arrived** | 00:15:38 |
| **Incident Duration** | 06:59:44 |

## Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 601305 | 18:04:34 | A Case Completed | 18:04:54 | | 18:20:32 | | | 00:09:21 | | | |

## Personnel Assigned

| Unit | Name |
|---|---|
| 601305 | Irrelevant (35454); Irrelevant (35738) |

## Pre-Scheduled Information

**No Pre-Scheduled Information**

## Transports

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 601305 | GOLD COAST PRIVATE HOSPITAL 14 HILL ST | | Cold | Pre Hosp - patient condition | 0.0// | 18:57:07 | 19:23:13 | 00:09:21 |

## Comments

| Date | Time | User | Type | Comments |
|---|---|---|---|---|
| 20/06/2022 | 17:11:52 | 5KEVROA | Response | [ProQA Dispatch] D el: 05A01 (NON-TRAUMATIC back pain) Response Text: 2A Irrelevant Male, Conscious, Breathing. Problem Description: BACK PAIN - NUMBNESS ON RIGHT LEG AND LEFT FOOT |
| 20/06/2022 | 17:11:52 | 5KEVROA | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is completely alert (responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He has not fainted or nearly fainted. |
| 20/06/2022 | 17:11:59 | 5KEVROA | Response | [ProQA Reconfigure] Reconfigure Level: 05C03 (Fainting or near fainting >= 50) Response Text: 1C Irrelevant Male, Conscious, Breathing. Problem Description: BACK PAIN - NUMBNESS ON RIGHT LEG AND LEFT FOOT |
| 20/06/2022 | 17:11:59 | 5KEVROA | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is completely alert (responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:12:29 | 5KEVROA | Response | EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS |
| 20/06/2022 | 17:12:39 | 6ADRBAR | Response | [Private] CDS reviewing CDS TO C/B WHEN EMD DISCONNECTS |

| | | | | |
|---|---|---|---|---|
| 20/06/2022 | 17:13:13 | 5KEVROA | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is completely alert (responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:13:13 | 5KEVROA | Response | [ProQA] : Irrelevant Male, Conscious, Breathing. |
| 20/06/2022 | 17:18:46 | 6ADRBAR | Response | CDS perfo ck (CDS to document) CASE AS STATED - PT PICKED UP 2KG WEIGHT APPROX 1630, ACUTE ONSET PAIN IN THORACIC SPINE BETWEEN SHOULDERS, PT NOW STATES SLIGHT NUMBESS R LEG AND L FOOT. NIL PMHX, NIL HX SIMILAR PAIN. PT CALM, SITTING UPRIGHT, ADV OF EXTENSIVE DELAYS |
| 20/06/2022 | 17:21:47 | 6HOSEFA | Response | [Private] Delay in dispatch due to workload |
| 20/06/2022 | 17:33:02 | 6GEOSCH | Response | Duplicate call appended to incident at 17:33:02 |
| 20/06/2022 | 17:34:09 | 6GEOSCH | Response | [ProQA Reconfigure] Reconfigure Level: 05D01 (Not alert) Response Text: 1C Irrelevant Male, Conscious, Breathing. Problem Description: BACK PAIN - NUMBNESS ON RIGHT LEG AND LEFT FOOT |
| 20/06/2022 | 17:34:09 | 6GEOSCH | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is not completely alert (not responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:35:33 | 6GEOSCH | Response | CB FROM SCENE WITH AN UPDATE PT C/O SEVERE PAIN IN THE R) LEG BELOW THE KNEE 9/10 BECOMING VERY PALE AND TIRED EMD UPDATE PROQA DETAIS BP 192/95 |
| 20/06/2022 | 17:35:35 | 6GEOSCH | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is not completely alert (not responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:35:35 | 6GEOSCH | Response | [ProQA] : Irrelevant Male, Conscious, Breathing. |
| 20/06/2022 | 17:45:17 | 6BREKUB | Response | Duplicate call appended to incident at 17:45:17 |
| 20/06/2022 | 17:46:36 | 6BREKUB | Response | [ProQA Reconfigure] Reconfigure Level: 05C03 (Fainting or near fainting >= 50) Response Text: 1C Irrelevant Male, Conscious, Breathing. Problem Description: BACK PAIN - NUMBNESS ON RIGHT LEG AND LEFT FOOT |
| 20/06/2022 | 17:46:36 | 6BREKUB | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is completely alert (responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:46:50 | 6BREKUB | Response | 3RD CALL PT BECOMING CLAMMY AND PALE |
| 20/06/2022 | 17:47:29 | 6BREKUB | Response | RIGHT LEG GONE NUMB |
| 20/06/2022 | 17:48:05 | 6BREKUB | Response | [ProQA: Key Questions] 1. This started (happened) now (less than 6hrs ago). 2. It's not known what caused his back pain. 3. He is not having difficulty breathing. 4. He does not have chest pain or chest discomfort. 5. He is completely alert (responding appropriately). 6. An ashen or grey colour change has not been reported. 7. He has not been diagnosed with an aortic aneurysm. 8. The caller cannot ask the patient to describe the pain. 9. He had a near fainting episode. |
| 20/06/2022 | 17:48:05 | 6BREKUB | Response | [ProQA] : Irrelevant Male, Conscious, Breathing. |
| 20/06/2022 | 17:54:24 | 6DARSTA | Response | [Private] D atch due to workload |
| 20/06/2022 | 18:04:35 | PS | Response | [Page] Dispatch page sent to Unit:601305, Sent From: KEDCADQASPIS01 |
| 20/06/2022 | 18:04:37 | 601305 | Response | [PRIVATE] ACKNOWLEDGEMENT OF INCIDENT RECEIVED BY MDT. |
| 20/06/2022 | 18:04:43 | PS | Response | [Page] Dispatch page to Unit:601305 complete to Irrelevant Message sent successfully to Whispir |
| 20/06/2022 | 18:04:43 | PS | Response | [Page] Dispatch page to Unit:601305 complete to Irrelevant Message sent successfully to Whispir |
| 20/06/2022 | 19:37:18 | 6AVESAT | Response | 601305 RAMPED GCP |
| 20/06/2022 | 20:24:55 | 6DARSTA | Response | [Page] Units: 601305, Sent From: PA605, Please update your current status via radio |
| 20/06/2022 | 20:25:15 | 6DARSTA | Response | 601305 RAMPED |
| 20/06/2022 | 21:14:43 | 6DARSTA | Response | [Page] Units: 601305, Sent From: PA605, ALL CREWS GCP ON REDIRECT. CONSIDER ALL OTHER OPTIONS |
| 20/06/2022 | 21:34:16 | 6DARSTA | Response | [Page] Units: 601305, Sent From: PA605, Please update your current status via radio |
| 20/06/2022 | 21:34:48 | 6AVESAT | Response | 601305 RAMPED GCP |
| 20/06/2022 | 21:51:54 | 6AVESAT | Response | 601305 HEADING TO GCUH TO PICK UP EQUIPMENT WHILE PARTNER STAYS AT GCP |

**Priority Changes**

| Date | Time | Changed from Priority | Reason | User |
|---|---|---|---|---|
| 20/06/2022 | 17:11:59 | 2A | Patient Condition | Irrelevant |
| 20/06/2022 | 17:12:26 | 1C | Patient Condition | |
| 20/06/2022 | 17:34:09 | 2A | Patient Condition | |

**Call Activities**

| Date | Time | Radio | Activity | Location | Comments | User |
|---|---|---|---|---|---|---|
| 20/06/2022 | 17:09:38 | | No AML Data Received | | No AML data received with this call | SDSIAML |
| 20/06/2022 | 17:11:53 | | Incident in Waiting Queue | | | |
| 20/06/2022 | 17:11:53 | | ANI/ALI Statistics | | INT Insert:Jun 20 2022 17:09:34 / INT SendNP:Jun 20 2022 17:09:33 / WS RecvNP:Jun 20 2022 17:09:34 / WS Process:Jun 20 2022 17:11:53 | 5KEVROA |

| | | | | | | |
|---|---|---|---|---|---|---|
| 20/06/2022 | 17:11:53 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 5KEVROA |
| 20/06/2022 | 17:11:53 | | Incident in Waiting Queue | | | |
| 20/06/2022 | 17:11:53 | | Incident in Waiting Queue | | | |
| 20/06/2022 | 17:11:53 | | Incident in Waiting Queue | | | |
| 20/06/2022 | 17:11:53 | | ProQA | 5298 Marine Dr N | ProQA determinant sent | 5KEVROA |
| 20/06/2022 | 17:11:53 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:11:59 | | Incident Priority Change | | Incident priority changed from 2A to 1C due to Patient Condition | 5KEVROA |
| 20/06/2022 | 17:11:59 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:11:59 | | ProQA | 5298 Marine Dr N | ProQA determinant sent | 5KEVROA |
| 20/06/2022 | 17:12:03 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:12:03 | | Incident in Waiting Queue Timer Clear | | | |
| 20/06/2022 | 17:12:15 | | Read Incident | | Incident 016 was Marked as Read. | 6ADRBAR |
| 20/06/2022 | 17:12:15 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6ADRBAR |
| 20/06/2022 | 17:12:26 | | Incident Priority Change | | Incident priority changed from 1C to 2A due to Patient Condition | 6ADRBAR |
| 20/06/2022 | 17:12:26 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:12:27 | | Priority Upgrade/Downgrade Prompt | | Change From 1C to 2A? - User clicked OK | 6ADRBAR |
| 20/06/2022 | 17:12:37 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:12:37 | | Incident in Waiting Queue Timer Clear | | | |
| 20/06/2022 | 17:13:37 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 5KEVROA |
| 20/06/2022 | 17:14:21 | | UserAction | | User clicked Exit/Save | 5KEVROA |
| 20/06/2022 | 17:18:50 | | UserAction | | User clicked Exit/Save | 6ADRBAR |
| 20/06/2022 | 17:19:39 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6HOSEFA |
| 20/06/2022 | 17:19:44 | | UserAction | | User clicked Exit/Save | 6HOSEFA |
| 20/06/2022 | 17:21:46 | | UserAction | | User clicked Exit/Save | 6HOSEFA |
| 20/06/2022 | 17:32:35 | | AML Data Received | Irrelevant | AML data appended from duplicate call (Incident #16049026): Center of caller area HELI: -27 50.869200, 153 21.331200 ESCAD: #-27.84782/153.35552 | SDSIAML |
| 20/06/2022 | 17:33:02 | | Duplicate Call Warning | | Duplicate Call Warning - New call appended to incident | 6GEOSCH |
| 20/06/2022 | 17:33:03 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6GEOSCH |
| 20/06/2022 | 17:34:09 | | Incident Priority Change | | Incident priority changed from 2A to 1C due to Patient Condition | 6GEOSCH |
| 20/06/2022 | 17:34:09 | | ProQA | Irrelevant | ProQA determinant sent | 6GEOSCH |
| 20/06/2022 | 17:34:09 | | Waiting Pending Incident Time Warning | | Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:34:10 | | Incident Late | | | |
| 20/06/2022 | 17:34:10 | | Pending Incident Time Warning | | Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:34:16 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6HOSEFA |
| 20/06/2022 | 17:34:18 | | UserAction | | User clicked Exit/Save | 6HOSEFA |
| 20/06/2022 | 17:34:20 | | Remove Waiting Pending Incident Warning | | Removing Waiting Pending Incident Time Warning timer expired | |
| 20/06/2022 | 17:35:37 | | UserAction | | User clicked Exit/Save | 6GEOSCH |
| 20/06/2022 | 17:41:11 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6LISNG |
| 20/06/2022 | 17:41:13 | | UserAction | Irrelevant | User clicked Exit/Save | 6LISNG |
| 20/06/2022 | 17:44:56 | | AML Data Received | | AML data appended from duplicate call (Incident #16049088): Center of caller area HELI: -27 50.871600, 153 21.348600 ESCAD: #-27.84786/153.35581 | SDSIAML |
| 20/06/2022 | 17:45:17 | | Duplicate Call Warning | | Duplicate Call Warning - New call appended to incident | 6BREKUB |
| 20/06/2022 | 17:45:19 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6BREKUB |
| 20/06/2022 | 17:46:36 | | ProQA | Irrelevant | ProQA determinant sent | 6BREKUB |
| 20/06/2022 | 17:48:06 | | UserAction | | User clicked Exit/Save | 6BREKUB |
| 20/06/2022 | 17:54:16 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 17:54:26 | | UserAction | | User clicked Exit/Save | 6DARSTA |
| 20/06/2022 | 18:03:53 | | Read Comment | | Comment for Incident 016 was Marked as Read. | 6AVESAT |
| 20/06/2022 | 18:03:56 | | UserAction | | User clicked Initial Assign | 6AVESAT |
| 20/06/2022 | 18:03:57 | | Incident Timer Clear | Irrelevant | Incident Late Timer cleared for 16048938 | 6AMAKUH |
| 20/06/2022 | 18:03:57 | | Reseting Late Timer | | [Reset Reason]CDS Approved [Next Late Check Time]Jun 20 2022 20:04:57 | 6AMAKUH |
| 20/06/2022 | 18:03:57 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 601486 (00:07:56) | 6AVESAT |
| 20/06/2022 | 18:04:02 | | VisiCAD Recommendation | | 601305: 00:12:55, 601594: 00:14:20, 601553: 00:16:08, 601508: 00:17:50, 601562: 00:21:03, | 6AVESAT |
| 20/06/2022 | 18:04:32 | | UserAction | | User Accepted 601305 | |
| 20/06/2022 | 18:04:32 | | Initial Assignment | | The following unit(s) is (are) recommended for assignment: 601305 (00:12:55) | 6AVESAT |
| 20/06/2022 | 18:04:34 | | Initial Assignment | | The following unit(s) is (are) cleared from assignment: 601486 | 6AVESAT |
| 20/06/2022 | 18:04:34 | 601305 | Dispatched | Irrelevant | Response Number (095900) | 6AVESAT |
| 20/06/2022 | 18:04:41 | | UserAction | | User clicked Exit/Save | 6AVESAT |
| 20/06/2022 | 18:04:54 | 601305 | Resp | | Responding From = 6(02) RUNAWAY BAY | VisiNET |

| | | | | | |
|---|---|---|---|---|---|
| 20/06/2022 | 18:06:35 | | Read Comment | Comment for Incident 016 was Marked as Read. | 6AVESAT |
| 20/06/2022 | 18:06:50 | | UserAction | User clicked Exit/Save | 6AVESAT |
| 20/06/2022 | 18:20:32 | 601305 | At Scene | | VisiNET |
| 20/06/2022 | 18:57:07 | 601305 | Dep | | VisiNET |
| 20/06/2022 | 19:23:05 | 601305 | Transport Time | Depart Scene Time: 18:57:07, Arrive Destination Time: 19:23:13 | VisiNET |
| 20/06/2022 | 19:23:13 | 601305 | Dest | | VisiNET |
| 20/06/2022 | 19:53:13 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 19:54:35 | | Read Incident | Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 19:54:35 | | Read Comment | Comment for Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 19:54:42 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 20:24:42 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 20:24:48 | | Read Incident | Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 20:25:01 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 20:30:01 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 20:31:10 | | Read Incident | Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 20:31:10 | | Read Comment | Comment for Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 20:31:17 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 21:01:17 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 21:02:54 | | Read Incident | Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 21:03:03 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 21:33:03 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 21:34:07 | | Read Incident | Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 21:34:07 | | Read Comment | Comment for Incident 016 was Marked as Read. | 6DARSTA |
| 20/06/2022 | 21:34:22 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 21:39:23 | | Incident Late | Active incident marked as late | |
| 20/06/2022 | 21:39:39 | 601305 | Reset System Timer | Days Warn before expiration Passwords | 6DARSTA |
| 20/06/2022 | 23:59:44 | | Read Comment | Comment for Incident 016 was Marked as Read. | 6AMAKUH |
| 20/06/2022 | 23:59:55 | | UserAction | User clicked Exit/Save | 6AMAKUH |
| 21/06/2022 | 00:09:21 | 601305 | Available | | 6AVESAT |
| 21/06/2022 | 00:09:21 | 601305 | Disposition | A Case Completed | 6AVESAT |
| 21/06/2022 | 00:09:21 | 601305 | Response Closed | Response Disposition: A Case Completed | 6AVESAT |



Edit Log

| Date | Time | Field | Changed From | Changed To | Reason | Table | Workstation | User |
|---|---|---|---|---|---|---|---|---|
| 20/06/2022 | 17:09:37 | Call_Back_Phone | | 0416679798 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:42 | City | BURLEIGH HEADS | HOPE ISLAND | Updated City | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:42 | City | BURLEIGH HEADS | HOPE ISLAND | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:47 | Address | (Blank) | 5298 | New Entry | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:50 | Address | | | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:50 | Latitude | 0 | 62152036 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:50 | Longitude | 0 | 26644319 | Entry Selected/Returned from GeoLocator | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | Jurisdiction | | 6 Southport Gold Coast | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | Division | | 6 Runaway Bay | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | Battalion | | 6 Runaway Bay | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | Response_Area | | 6 Runaway Bay | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | ResponsePlanType | 0 | 0 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:09:51 | Primary_TAC_Channel | | TLK GRP 111/UHF Ch 103 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:10:05 | ProQaCaseNumber | | 19024016 | (Response Viewer) | Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Problem | | BACK PAIN NON TRAUMATIC | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Response_Plan | | Acute-Str | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | DispatchLevel | | Normal | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | ResponsePlanType | 0 | 1 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Incident_Type | | ACUTE-STR | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Priority_Number | 0 | 4 | Updated by ProQA | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | Determinant | | 05A01 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:53 | EMD_Used | 0 | 1 | (Response | Response_Master_Incident | QA541 | 5KEVROA |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Viewer) | | | |
| 20/06/2022 | 17:11:53 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:54 | Pickup_Map_Info | (Blank) | B327R19 | | Response_Transports | POLCADQASCXA025 | KEVROA |
| 20/06/2022 | 17:11:54 | Map_Info | | B327R19 | | Response_Master_Incident | POLCADQASCXA025 | KEVROA |
| 20/06/2022 | 17:11:59 | Priority_Description | 2A | 1C | Patient Condition | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | Priority_Number | 4 | 3 | Patient Condition | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | Response_Plan | Acute-Str | Acute | Updated by ProQA | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | Incident_Type | ACUTE-STR | ACUTE | Updated by ProQA | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | Problem | BACK PAIN NON TRAUMATIC | BACK PAIN FAINT =>50 | Updated by ProQA | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | Determinant | 05A01 | 05C03 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:11:59 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:12:12 | Field_Data | | DAVID RUDDOM | Patient Name: | Response_User_Data_Fields | QA541 | 5KEVROA |
| 20/06/2022 | 17:12:15 | Read Call | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6ADRBAR |
| 20/06/2022 | 17:12:15 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6ADRBAR |
| 20/06/2022 | 17:12:25 | Field_Data | | 14/1/41 | Patient DOB: | Response_User_Data_Fields | QA541 | 5KEVROA |
| 20/06/2022 | 17:12:26 | Priority_Description | 1C | 2A | Patient Condition | Response_Master_Incident | PA601 | 6ADRBAR |
| 20/06/2022 | 17:12:26 | Priority_Number | 3 | 4 | Patient Condition | Response_Master_Incident | PA601 | 6ADRBAR |
| 20/06/2022 | 17:12:27 | Priority_Description | 1C | 2A | Priority Change Accepted | Response_Master_Incident | PA601 | 6ADRBAR |
| 20/06/2022 | 17:13:08 | Call_Back_Phone | 0416679798 | 0422 589 559 | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:13:13 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:13:13 | ProQATerminationStateCode | | C | (Response Viewer) | Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:13:37 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | QA541 | 5KEVROA |
| 20/06/2022 | 17:15:19 | Field_Data | | 1717AB | Call Back | Response_User_Data_Fields | PA601 | 6ADRBAR |
| 20/06/2022 | 17:15:45 | Field_Data | | Irrelevant M BACK PAIN | Pt Comments | Response_User_Data_Fields | PA601 | 6ADRBAR |
| 20/06/2022 | 17:19:39 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6HOSEFA |
| 20/06/2022 | 17:33:03 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | Priority_Description | 2A | 1C | Patient Condition | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | Priority_Number | 4 | 3 | Patient Condition | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | Problem | BACK PAIN FAINT =>50 | BACK PAIN NOT ALERT | Updated by ProQA | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | Determinant | 05C03 | 05D01 | (Response Viewer) | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:09 | ProQATerminationStateCode | C | | (Response Viewer) | Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:34:16 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6HOSEFA |
| 20/06/2022 | 17:35:36 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA614 | 6GEOSCH |
| 20/06/2022 | 17:41:11 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6LISNG |
| 20/06/2022 | 17:45:19 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:46:36 | Problem | BACK PAIN NOT ALERT | BACK PAIN FAINT =>50 | Updated by ProQA | Response_Master_Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:46:36 | Determinant | 05D01 | 05C03 | (Response Viewer) | Response_Master_Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:46:36 | ProQATerminationStateCode | C | | (Response Viewer) | Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:46:37 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:48:05 | CIS_Used | 0 | null | (Response Viewer) | Response_Master_Incident | PA608 | 6BREKUB |
| 20/06/2022 | 17:54:16 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA605 | 6DARSTA |
| 20/06/2022 | 18:03:53 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6AVESAT |
| 20/06/2022 | 18:04:46 | Current_UnitRespPriorityDesc | 601305: 1C | HOT1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 20/06/2022 | 18:06:35 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA606 | 6AVESAT |
| 20/06/2022 | 18:57:00 | Current_UnitRespPriorityDesc | 601305: HOT1C | COLD1C | Field Response | Response_Vehicles_Assigned | KEDCADQASMDI01 | |
| 20/06/2022 | 18:57:00 | Map_Info | (Blank) | G28M10 | | Response_Transports | KEDCADQASMDI01 | VisiNET |
| 20/06/2022 | 19:54:35 | Read Comment | False | True | (Recall Window) | Response_Master_Incident | PA605 | 6DARSTA |
| 20/06/2022 | 20:31:10 | Read Comment | False | True | (Recall Window) | Response_Master_Incident | PA605 | 6DARSTA |
| 20/06/2022 | 21:34:07 | Read Comment | False | True | (Recall Window) | Response_Master_Incident | PA605 | 6DARSTA |
| 20/06/2022 | 23:59:44 | Read Comment | False | True | (Response Viewer) | Response_Master_Incident | PA601 | 6AMAKUH |

# 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 Monday 20 June 2022 at 8:49pm QAS received a Triple Zero (000) call for assistance (incident number 16049737) at Irrelevant South Brisbane 4101 to attend an Irrelevantmale, complaining Irrelevantbleeding.

There was a response time of 2 hours and 24 minutes to respond an available paramedic unit to the incident (from when the incident entered the waiting queue to when the first unit arrived on scene).

The case was prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as 21D04 (Haemorrhage / Laceration Medical) requiring a Code 1C response.

At the time the call came in there was significant workload across South-East Queensland (SEQ) with multiple Code 1 and Code 2 cases pending in the community and extensive delays at hospitals in offloading QAS patients.

A second Triple Zero (000) call was received at 9:07pm which was an accidental duplicate call.

The Clinical Hub Doctor performed a call back at 9:28pm and spoke to the carer on scene who stated the patient is Irrelevantand had asked for QAS to be called forIrrelevantbleeding for last hour.

At 9:33pm a common call was made by the Emergency Medical Dispatcher (EMD) over the radio with no ambulances available to respond.

A third Triple Zero (000) call was received at 10:02pm requesting ETA as the patient has now become dizzy, starting to droop, still bleeding. The case was reprioritised through the Advanced Medical Priority Dispatch System (AMPDS) as 21D03 (Haemorrhage / Laceration, Not Alert, Medical) requiring a Code 1C response

A fourth Triple Zero (000) call was received at 10:58pm advising the patient is now unconscious and blood everywhere. The case was reprioritised through the Advanced Medical Priority Dispatch System (AMPDS) as 31D02 (Unconscious / Abnormal Breathing) requiring a Code 1B response

At 11:02pm and 11:08pm a common call was made by the EMD over the radio with no ambulances available to respond.

At 11:09pm the EMD advised CPR in progress due to agonal breathing and the case was upgraded to a Code 1A response.

The first ambulance was assigned at 11:10pm and arrived on scene at 11:14pm where the patient was found to be ALOC with a significantIrrelevantbleed. A Critical Care Paramedic and the High Acuity Response Unit (HARU) also attended scene to assist in the assessment and treatment of the patient.

The patient was treated and transported to the Princess Alexandra Hospital in a serious but stable condition.

## Terms of Reference:

This review will review all aspects of ambulance response to incident 16049737. The review will examine ambulance operations prior to, during and following the response. This review will include all requirements outlined in the *Operational Incident Review Process*.

## Region Clinical Review:

The Metro South Region Clinical Education Unit have undertaken a clinical review of this incident. The clinical assessment, treatment and transport was completed to an appropriate standard. However, the electronic Ambulance Report Form was not at standard, with patient identification information missing, such as name and date of birth.

## OpCen Review:

**Brisbane Operation Centre:**

The Triple Zero (000) call has been reviewed by the Brisbane OpCen Director and no identified issues. The case has not been audited by the Brisbane OpCen in the event it requires a State Quality Assurance review.

**Professional Standards:**

The performance of call-back clinicians should be reviewed with the context of the OpCen environment at that time. At 21:28, Dr Irrelevant Clinical Hub (CHUB) called the facility to discuss the patient's condition. Upon review, this call back would have benefited from further questioning, such as whether the patient was pale, or dizzy upon standing. That being said, there were no resources available and a significant pending queue. Dr Irrelevant A/Medical Director, has provided Dr Irrelevant feedback regarding Irrelevant call.

## 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 an Irrelevant male, with a serious Irrelevant bleed.

**Timeline:**

20:49 – Triple Zero (000) call received
20:50 – In waiting queue.
21:07 – 2nd Triple Zero (000) call received.
21:28 – CHUB Doctor call back scene.
21:33 – Common Call made by the EMD.
22:02 – 3rd Triple Zero (000) call received.
22:58 – 4th Triple Zero (000) call received, and case upgraded to Code 1B.
23:02 – Common Call made by the EMD.
23:08 – Common Call made by the EMD.
23:09 – Incident upgraded to Code 1A.
23:10 – 1st unit assigned.
23:10 – CCP assigned.
23:14 – 1st unit arrived on scene.
23:16 – HARU assigned.
23:19 – CCP arrived on scene.
23:24 – HARU arrived on scene.
23:36 – Depart Code 1 to Princess Alexandra Hospital.
23:44 – Arrive at Princess Alexandra Hospital.

**Operational Review:**

Operational Dispatch to Incident

There was a response of 2 hours and 24 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 20 June 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) |
|---|---|---|---|---|
| 20:45 to 20:59 (20/06/2022) | 1 | 17 | 0:29:50 | 1:20:03 |
| | 2 | 55 | 2:34:57 | 8:38:31 |
| 21:45 to 21:59 (20/06/2022) | 1 | 19 | 1:04:06 | 3:58:43 |
| | 2 | 47 | 2:55:42 | 9:38:40 |
| 22:45 to 22:59 (20/06/2022) | 1 | 16 | 0:57:55 | 4:00:25 |
| | 2 | 53 | 3:10:14 | 10:38:34 |

Hospital Status

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

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 20:45 to 20:59 (20/06/2022) | Logan Hospital | 7 | 3 | 2:52:31 | 3 |
| | Mater Adults Hospital | 2 | 2 | 0:49:48 | 0 |
| | Princess Alexandra Hospital | 9 | 7 | 2:57:35 | 3 |
| | Queen Elizabeth Hospital | 4 | 4 | 2:08:02 | 3 |
| | Redlands Hospital | 4 | 4 | 3:12:16 | 3 |
| 21:45 to 21:59 (20/06/2022) | Logan Hospital | 7 | 6 | 3:52:39 | 3 |
| | Mater Adults Hospital | 3 | 2 | 1:39:29 | 2 |
| | Princess Alexandra Hospital | 8 | 7 | 3:57:43 | 3 |
| | Queen Elizabeth Hospital | 4 | 4 | 3:08:10 | 3 |
| | Redlands Hospital | 4 | 4 | 3:11:05 | 3 |
| 22:45 to 22:59 (20/06/2022) | Logan Hospital | 7 | 4 | 03:36:32 | 3 |
| | Mater Adults Hospital | 8 | 7 | 2:39:24 | 3 |
| | Princess Alexandra Hospital | 7 | 6 | 2:59:56 | 3 |
| | Queen Elizabeth Hospital | 3 | 2 | 3:34:47 | 3 |
| | Redlands Hospital | 2 | 2 | 3:59:27 | 3 |

Metro South Region Staffing

The Metro South Region including Brisbane South and Logan Districts had the following resourcing against approved rosters for the 20 June 2022;

- Afternoon Shift – 6 vacancies (Officers)
- Night Shift – Nil vacancies

**Outcomes:**

- 88-year-old male, complaining of significant rectal bleed.
- The clinical aspects of the case were found to be at appropriate standard.
- The review determined the delay was due to the significant system pressures noted at the time.

## Review Recommendations:

- Follow up with the attending Paramedics around ensuring patient details are included in documentation.

## Appendix:

- Incident Detail Report
- Ambulance Report Form
- Triple Zero (000) Calls
- Clinical Review

## Region Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Matthew Green | Acting Assistant Commissioner | Irrelevant | 02 06 2022 |
| Anthony Hose | Acting District Director South Brisbane | | 22/06/2022 |

# Significant Incident Review Version 1.0 July 2020

## Darling Downs and South West Region

### Authority:

By authority of Acting Assistant Commissioner Glen Maule - Darling Downs and South West Region.

### Executive Summary:

On Sunday 26 June 2022 at 1802 hours the Queensland Ambulance Service (QAS) received a call for service from Irrelevant located in Toowoomba area requesting ambulance attendance for a Irrelevant male resident with abdominal distension and dysuria since 1000 hours that morning. An ACP crew responded and transported the patient with Irrelevant escort to Toowoomba Base Hospital.

On arrival at Toowoomba Hospital the patient was triaged then placed into the hallway due to offloading delays. QAS paramedics continued care for the patient for a significant period awaiting an Emergency Department bed to become available for handover. Shortly after the patient was moved onto a hospital bed, patient went into cardiac arrest.

The Incident Detail Report (IDR) number is 16075961.

### Terms of Reference:

This review will investigate all aspects of ambulance response to incident 16075961.
The review will examine ambulance operations prior to, during and following the response.
This review will include all requirements outlined in the *Operational Incident Review Process*.

### Regional Clinical Incident Summary Report:

Summary of case:

QAS received a call for service for a Irrelevant male Irrelevantwith abdominal distension and dysuria. An ACP crew from Toowoomba station arrived on scene and received a handover from Irrelevantwhich is recorded as history of left leg becoming more swollen yesterday, mottled and grey in colour and warm to touch Irrelevanthad also noted increased distension of his abdomen and decreased urinary output. Both Irrelevant oted a general mental decline over the last month, recording a GSC of 11 throughout the week.

Patient had an Acute Resuscitation Plan (ARP) in place, requesting comfort cares. Examination was well documented. It was recorded in the documentation that patient of periods of apnoea and described as Cheyne's-stokes. Primary diagnosis recorded by crew bowel obstruction, and secondary diagnosis was deep vein thrombosis, with query palliative.

**ECLIPSE Audit: (55169)**

Documentation: At Standard
Drug Therapy Protocol: At Standard
Clinical Practice Guidelines: At Standard
Clinical Practice Procedures: At Standard
Final Outcome: At Standard

## Incident Review/Investigation:

- Scope: This review has considered all aspects of this case as it relates to delays off-loading this patient at Toowoomba Hospital.

- Background: The Queensland Ambulance Service (QAS) received a call from Irrelevant Irrelevant Toowoomba requesting ambulance attendance for a resident with abdominal distension and dysuria since 1000 hours that morning.

- After transport and arrival at Toowoomba Hospital the patient was triaged then placed into the hallway with the attending QAS paramedics waiting an Emergency Department bed to become available for handover.

- The patient remained on the ambulance stretcher with the attending crew for approximately 3 hours 26 minutes then transferred to a cubicle in the emergency department.

- Toowoomba Hospital Emergency Department was at a Stage 3 escalation at the time with both an "Off-Load Paramedic" and "Flow Assist Nurse" active in the department managing patients located in the hallway not yet off stretcher.

- Sometime after transfer off ambulance stretcher (approximately 10 minutes) QHealth advised the patient deteriorated and went into cardiac arrest.

  Timeline:

  18:02 Call received
  18:04 Bravo Unit 301192 assigned from Toowoomba (priority 1C – 01D01 determinant)
  18:05 Unit 301192 enroute
  18:09 Unit 301192 on scene at Irrelevant
  18:43 Unit 301192 departed scene for Toowoomba Hospital
  18:52 Unit 301192 arrived Toowoomba Hospital
  19:08 Patient triaged at Emergency Department
  19:23 Crew report bed blocked at Toowoomba Hospital with no ETA
  20:11 Crew report still bed blocked at Toowoomba Hospital with no ETA
  20:36 Crew report still bed blocked at Toowoomba Hospital with no ETA
  22:34 Crew report the patient is "off stretcher"
  22:40 Unit 3301192 Clear

- Review:
  - The closest most appropriate response was despatched for the case.
  - The timeframes are consistent with distance travelled and regarding the information provided at the time of initial call.
  - The crew remained with the patient after arrival and triage at ED.

- Outcomes:
  - The patient deteriorated and was declared deceased sometime after transfer to a hospital bed.

- Post OIRR actions:
  - Priority one to be advised for staff welfare follow up.

## Review Recommendations:

- Crew had recognised Cheyne-stokes pattern of breathing and recorded periods of apnoea indicating the severity of the patient's condition which does not match the lack of urgency for this patient. Additionally, the recorded symptomology does not match the final diagnosis. Further clinical discussion into differential diagnosis and recognition of a deteriorating patient.

- Further clarification with Offload Paramedic around any discussions that occurred with the Flow Assist Nurse regarding off stretcher plans.

- Further clarification with crew around any discussions that occur for patient advocacy and with whom.

## Review Outcomes:

- Meeting was conducted with the Toowoomba ACP officers who managed this case, with oversight from the QAS Professional Standards unit. Both officers were engaging and demonstrated high level of critical reflection and had self-identified knowledge gaps surrounding end of life and have highlighted the need for further education. QAS Professional Standards advised this area of clinical care has been raised for future state-wide education. Both interviews have been attached as Appendix G and H.

- At the time of the case, the Offload Paramedic had taken over care of several ramped patients at Toowoomba Base Hospital. Officer confirmed no interaction with crew and no discussions occurred with the Flow Assist Nurse or a Senior Operations Supervisor regarding off stretcher plans for this case.

- From the review, the case was well documented, the crew were professional and compassionate, and the patient was managed within QAS expectations. Additionally, feedback from Toowoomba Base Hospital Executives, the clinical management or the offloading delay did not contribute to the patient's death but highlights the systemic issues surrounding lengthy delays.

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

- Appendix A Incident Detail Report: 16075961
- Appendix B Electronic Ambulance Report form 504486991
- Appendix C Eclipse Audit 55169
- Appendix D Workload 1 hour prior to IDR 16075961
- Appendix E Workload 1 hour after IDR 16075961
- Appendix F Unit snapshot IDR 16075961
- Appendix G Record of Conversation Irrelevant
- Appendix H Record of Conversation

## Regional Endorsement

| Role | Name | Position | Signature | Date |
|---|---|---|---|---|
| Acting Assistant Commissioner | Glen Maule | Acting Assistant Commissioner | Irrelevant | 18/07/22 |

# Significant Incident Review



## Metro North Region

### Authority:
By authority of Assistant Commissioner, Metro North Region.

### Executive Summary:
On 15th July 2022 at 4.47pm the Queensland Ambulance Service (QAS) received a request for assistance (Incident number 16162034) at Irrelevant Zillmere, for an Irrelevant Irrelevant female patient with a provisional diagnosis by the Doctor on scene of a stroke Ambulance Medical Officer reviewed incident at 8:55 pm, including a call back, upgrading the incident to a Code 1 (lights and sirens response). The first unit arrived on scene at 10:32 pm and subsequently transported the patient Code 1 to Royal Brisbane and Women's Hospital with acute stroke symptoms.

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

### Incident Review/Investigation:

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

#### Background
- On the 15th of July 2022, at 4:47pm QAS received a request for assistance for a Irrelevant female patient with stroke symptoms at a residential Irrelevant Zillmere.
- A doctor assessed the patient as having a possible stroke and requested a QAS road speed response.
- Ambulance Medical Officer reviewed incident at 8:55 pm, including a call back, and upgraded the incident to a Code 1 (lights and sirens response).
- The first QAS unit arrived on scene at 10:32 pm
- The patient was transported lights and sirens to the Royal Brisbane and Women's Hospital arriving at 11:22pm.

#### Timeline

Time Stamps

| Description | Date | Time | User |
|---|---|---|---|
| Phone Pickup | 15/07/2022 | 16:47:25 | |
| 1st Key Stroke | 15/07/2022 | 16:47:25 | |
| In Waiting Queue | 15/07/2022 | 16:48:40 | |
| Call Taking Complete | 15/07/2022 | 16:50:10 | Irrelevant |
| 1st Unit Assigned | 15/07/2022 | 22:16:11 | |
| 1st Unit Enroute | 15/07/2022 | 22:16:19 | |
| 1st Unit Arrived | 15/07/2022 | 22:32:40 | |
| Closed | 16/07/2022 | 00:02:30 | |

Elapsed Times

| Description | Time |
|---|---|
| Received to In Queue | 00:01:15 |
| Call Taking | 00:02:45 |
| In Queue to 1st Assign | 05:20:11 |
| Call Received to 1st Assign | 05:29:26 |
| Assigned to 1st Enroute | 00:00:08 |
| Enroute to 1st Arrived | 00:15:41 |
| Incident Duration | 07:15:05 |

Resources Assigned

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 501238 | 22:16:51 | A Case Completed | 22:16:19 | | 22:32:40 | | 00:02:24 | 00:02:30 | | | |

Personnel Assigned

| Unit | Name |
|---|---|
| 501238 | Irrelevant (401914); Irrelevant 02002 (402002) |

Pre-Scheduled Information
No Pre-Scheduled Information

Transports

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 501238 | QH ROYAL BRISBANE HOSPITAL BOWEN BRIDGE RD & HERSTON RD | | Off Stretcher | Pre Hosp - patient condition | 0 0/0 | 23:10:36 | 23:22:23 | 00:02:30 |

Comments

## Sequence of Events

| | | | |
|---|---|---|---|
| 15/07/2022 16:48:30 | 5JENABE | Response | DX CVA? |
| 15/07/2022 16:48:35 | 5JENABE | Response | DEST RBH ED |
| 15/07/2022 16:49:16 | 5JENABE | Response | Irrelevant |
| 15/07/2022 16:49:28 | 5JENABE | Response | [ProQA Session Aborted] MATA |
| 15/07/2022 16:49:32 | 5JENABE | Response | EIDS Tool Utilised CALLER ANSWERED NO TO ALL QUESTIONS |
| 15/07/2022 16:50:09 | 5JENABE | Response | DR REQ ROAD SPEED |
| 15/07/2022 17:25:11 | 5KATOLI | Response | CDS reviewing |
| 15/07/2022 17:26:19 | 5KATOLI | Response | Unable to be contacted by CDS - NO ANSWER |
| 15/07/2022 18:23:05 | 5BREHER | Response | [Private] Delay in dispatch due to workload |
| 15/07/2022 19:13:48 | 5JUDWEI | Response | [Private] Delay in dispatch due to workload |
| 15/07/2022 20:35:57 | 5VALMOR | Response | [Private] Delay in dispatch due to workload |
| 15/07/2022 20:46:13 | 11ROWMCC | Response | AMO Reviewing Incident |
| 15/07/2022 20:55:17 | 11ROWMCC | Response | CALL BACK TO EN - PT IN GYM THIS AM - SOME WEAKNESS, RIGHT SIDE, PAST HX OF FACIAL DROOP, SEEN BY DR ?CVA. BG: HYPONATRAEMIA, OA. OBS WITHIN NORMAL LIMITS, ABLE TO MOBILISE WITH 1 ASSIST AND WALK BELT. ADVISED OF DELAYS. GIVEN ?STROKE WILL UG TO 1C. |
| 15/07/2022 20:55:41 | 11ROWMCC | Response | Following Clinicial Hub review, incident upgraded |
| 15/07/2022 20:56:52 | 5ASHWIL | Response | [Private] COMMON CALL Delay in dispatch due to workload |
| 15/07/2022 21:08:48 | 4ALLROS | Response | Duplicate call appended to incident at 21:08:48 |
| 15/07/2022 21:11:11 | 4ALLROS | Response | CALL BACK >> PT IS CONS AND BREATHING AND SYMPTOMS AR THE SAME |
| 15/07/2022 22:16:51 | PS | Response | [Page] Dispatch page sent to Unit:501238, Sent From: KEDCADQASPIS01 |
| 15/07/2022 22:36:13 | 5ASHWIL | Response | 501238 CALL BACK TO GET SOMEONE TO MEET AT FRONT |
| 15/07/2022 22:39:34 | 5ASHWIL | Response | 501238 MADE CONTACT |
| 15/07/2022 23:10:51 | 5JUDWEI | Response | 501238 CODE 1 TO RBH WITH ACUTE CVA SYMPTOMS, HD STABLE |

## Hospital Status

At 4:47pm on the afternoon of 15th July, 2022, the time of call for incident 16162034 , there were 26 QAS ambulances located at Metro North (MN) Hospital and Health Services (HHS) hospitals and of these 13 had extended Patient Off Stretcher Times (POST) for over 30 minutes, with the longest being 2 hours and 3 minutes at Caboolture Hospital. At the time of the call Royal Brisbane and Women's Hospital was on level 2 escalation and Prince Charles and Caboolture Hospitals were on a level 3 escalation. Fifteen-minute snapshots for hospital delays at MN HHS hospitals prior to the call and while it was pending reveal significant delays at hospitals (table below).

| | Hospital | Total no. ambulances at Hospital (with pts on stretcher) | Total no. ambulances ramped (>30 mins POST) | Maximum ramped time | Escalation level |
|---|---|---|---|---|---|
| 15:45 to 15:59 (15/07/2022) 1 hour prior to incident | Prince Charles Hospital | 3 | 2 | 0:54:43 | 3 |
| | RBWH | 6 | 3 | 1:25:09 | 2 |
| | Redcliffe Hospital | 4 | 1 | 0:32:38 | |
| | Caboolture Hospital | 2 | 2 | 1:03:47 | |
| 16:45 to 16:59 (15/07/2022) | Prince Charles Hospital | 6 | 2 | 0:39:28 | 3 |
| | RBWH | 8 | 7 | 1:13:37 | 2 |
| | Redcliffe Hospital | 5 | 0 | N/A | |
| | Caboolture Hospital | 7 | 4 | 2:03:46 | 3 |
| 17:45 to 17:59 (15/07/2022) | Prince Charles Hospital | 8 | 7 | 1:39:30 | 3 |
| | RBWH | 5 | 3 | 1:38:24 | |
| | Redcliffe Hospital | 8 | 3 | 1:03:17 | |
| | Caboolture Hospital | 6 | 4 | 1:16:37 | 3 |
| 18:45 to 18:59 (15/07/2022) | Prince Charles Hospital | 6 | 4 | 2:03:34 | 3 |
| | RBWH | 4 | 2 | 0:45:05 | |
| | Redcliffe Hospital | 5 | 2 | 1:07:48 | 2 |
| | Caboolture Hospital | 6 | 5 | 2:10:23 | 3 |
| 19:45 to 19:59 (15/07/2022) | Prince Charles Hospital | 4 | 4 | 1:27:52 | 3 |
| | RBWH | 1 | 1 | 0:50:13 | |
| | Redcliffe Hospital | 3 | 0 | N/A | |
| | Caboolture Hospital | 7 | 5 | 2:01:21 | 3 |

## Operational Review

Fifteen-minute snapshots for pending incidents within the Brisbane Operations Centre response area one hour prior to the call and while the call was pending revealed high numbers of pending incidents within the community (table attached). These incidents were triaged according to the MPDS process with regular reviews conducted by the Operations Centre to ensure the incidents (including the subject incident) were triaged correctly.

| | Priority | Number of Incidents | Average Wait (hh:mm:ss) | Maximum Wait (hh:mm:ss) |
|---|---|---|---|---|
| 15:45 to 15:59 (15/07/2022) 1 hour prior to incident | 1 | 4 | 0:34:40 | 1:13:49 |
| | 2 | 46 | 2:46:52 | 7:13:25 |
| 16:45 to 16:59 (15/07/2022) | 1 | 7 | 0:11:05 | 0:16:36 |
| | 2 | 34 | 2:38:16 | 8:13:25 |
| 17:45 to 17:59 (15/07/2022) | 1 | 9 | 0:34:58 | 1:16:37 |
| | 2 | 36 | 2:16:39 | 7:23:57 |
| 18:45 to 18:59 (15/07/2022) | 1 | 11 | 0:59:59 | 4:48:27 |
| | 2 | 45 | 2:37:47 | 8:43:07 |
| 19:45 to 19:59 (15/07/2022) | 1 | 5 | 0:16:33 | 0:54:15 |
| | 2 | 45 | 2:09:24 | 8:48:22 |

## System Pressures

On 15th July 2022, MN HHS hospitals experienced 65.95 hrs of 'Lost Time' at Emergency Departments. This Lost Time equates to approximately 6.5 paramedic crews over the period of a day being unavailable to be dispatched to the community.

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

The Delayed response for this incident was due to significant system pressures being experienced within the Region/HHS at the time the call was received and while it was pending.
Further, this incident occurred during a peak of COVID/Flu/Health demand in Queensland with an associated increased pressure on the whole Queensland health care system.

Metropolitan Workforce Planning Unit rostering profile shows a deficit of 2 Officers in Metro North Region on the afternoon shift and a deficit of 8 Officers for night shifts on the 15th of July 2022. This is not considered significant and did not impact on the operational readiness within the region.

## OpCen Review

- The OpCen review identified that at the time of the incident there were no appropriate units available to dispatch. Further there were seven Code 1 and 12 other Code 2A pending at the time of the call with extensive delays
- The first available ambulance was dispatched 5 hrs 29 mins after the first call
- No issues with the call – Coded as requested by Medical Staff on scene.

## Clinical Review

- A clinical review was undertaken by the Metro North Clinical Education Unit (attached). No clinical issues were noted, and no recommendations were made.
- Pt diagnosis at RBWH was exacerbation of neoplasm on the brain which was an existing condition and not an acute stroke.

## Post review actions

- Case identified by State Operations Coordination Centre post incident.
- SIR and review conducted by Metro North Region

## Review Recommendations:

- Nil further actions recommended.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- Audio files;
- Details of active incidents from 1 hour prior to the SIR and while SIR was active

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | Assistant Commissioner | Irrelevant | 26/7/22 |
| Warren Painting | North Brisbane District Director | | 26/7/22 |
| Matt Salter | Brisbane Operations Centre Director | | 26/07/2022 |

# Metro North Region

## Authority:
By authority of Assistant Commissioner, Metro North (MN) Region.

## Executive Summary:
On 16th July 2022 at 12.43 pm the Queensland Ambulance Service (QAS) received a request for assistance (Incident number 16165517) at Irrelevant Albany Creek, for an Irrelevant Irrelevant male with stroke symptoms (drooling and leaning to one side).
A QAS unit responded lights and sirens but were involved in a road traffic crash with a private car enroute at the intersection of Parton St & Rode Rd, Stafford Heights.
There were two QAS Officers and a University student in the ambulance at the time of the incident.
The female QAS Officer driving (Officer Irrelevant) sustained Irrelevant injuries and was transported to Royal Brisbane and Women's Hospital in a stable condition.
The male Officer (Officer Irrelevant) and female University student (Officer Irrelevant) sustained Irrelevant Irrelevant injuries and were transported to Saint Andrews Hospital (SAH) for review.
Irrelevant

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

## Incident Review/Investigation:

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

### Background
- On 16th July 2022 at 12.43 pm the Queensland Ambulance Service (QAS) received a request for assistance (Incident number 16165517) at ,Irrelevant Albany Creek, for an Irrelevant male with stroke symptoms (drooling and leaning to one side).
- Kenmore unit 501258 proceeded on the case lights and sirens but were involved in a road traffic crash with a private car at the intersection of Parton St & Rode Rd, Stafford Heights.
- 501258 stopped at the red light and then proceeded across the intersection with lights and sirens active, at which time a private car came across their path and the ambulance crashed into the driver's side.
- QAS unit 501388 (proceeding on incident 16165522) witnessed the accident and were first on scene, initiating treatment of the single occupant driver of the private car involved and the QAS Officers on board unit 501258.
- Irrelevant
- The two Officers and University student on board the ambulance were assessed with the following outcomes;

- Officer Irrelevant (driver) transported to RBWH with Irrelevant injuries
- Officer Irrelevant transported to SAH with Irrelevant discomfort
- Officer Irrelevant transported to SAH with Irrelevant discomfort
- Officers Irrelevant and Irrelevant were both transported to SAH by the MN Region Operations Supervisor (OS)

## Timeline

Original Incident 1616517

| Description | Date | Time | User |
|---|---|---|---|
| Phone Pickup | 16/07/2022 | 12:42:05 | |
| 1st Key Stroke | 16/07/2022 | 12:43:06 | |
| In Waiting Queue | 16/07/2022 | 12:46:05 | Irrelevant |
| Call Taking Complete | 16/07/2022 | 12:48:05 | |
| 1st Unit Assigned | 16/07/2022 | 12:48:05 | |
| 1st Unit Enroute | 16/07/2022 | 12:49:01 | |
| 1st Unit Arrived | 16/07/2022 | 13:09:10 | |
| Closed | 16/07/2022 | 13:26:35 | |

| Description | Time |
|---|---|
| Received to In Queue | 00:03:37 |
| Call Taking | 00:06:49 |
| In Queue to 1st Assign | 00:02:16 |
| Call Received to 1st Assign | 00:00:56 |
| Assigned to 1st Enroute | 00:00:56 |
| Enroute to 1st Arrived | 00:37:28 |
| Incident Duration | 01:12:36 |

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 591258 | 12:49:01 | Cancel En Route | 12:49:19 | | | | | 12:54:37 | | | Diverted To Higher Priority |
| 591124 | 13:13:44 | A Case Completed | 13:14:39 | | 13:26:35 | | 13:55:22 | 13:59:42 | | | |

| Unit | Name |
|---|---|
| 591124 | Irrelevant |
| 591258 | |

No Pre-Scheduled Information

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 591124 | QH PRINCE CHARLES HOSPITAL 627 RODE RD | | Off Stretcher | Pre Hosp - patient condition | 0 0/ | 14:04:39 | 14:21:54 | 15:59:42 |

Road Traffic Crash Incident 16165550

| Description | Date | Time | User |
|---|---|---|---|
| Phone Pickup | 16/07/2022 | 12:54:21 | |
| 1st Key Stroke | 16/07/2022 | 12:54:21 | |
| In Waiting Queue | 16/07/2022 | 12:54:21 | |
| Call Taking Complete | 16/07/2022 | 12:54:21 | Moore, Siobhan |
| 1st Unit Assigned | 16/07/2022 | 12:54:21 | |
| 1st Unit Enroute | 16/07/2022 | 12:54:21 | |
| 1st Unit Arrived | 16/07/2022 | 12:54:21 | |
| Closed | 16/07/2022 | 14:41:33 | Moore, Siobhan |

| Description | Time |
|---|---|
| Received to In Queue | 00:00:00 |
| Call Taking | 00:00:00 |
| In Queue to 1st Assign | 00:00:00 |
| Call Received to 1st Assign | 00:00:00 |
| Assigned to 1st Enroute | 00:00:00 |
| Enroute to 1st Arrived | 00:00:00 |
| Incident Duration | 01:47:12 |

| Unit | Assigned | Disposition | Enroute | Staged | Arrived | At Patient | Delay Avail | Complete | Odm. Enroute | Odm. Arrived | Cancel Reason |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 591388 | 12:57:21 | A Case Completed | 12:57:21 | | 12:58:21 | | | 14:18:13 | | | |
| B561258 | 12:54:44 | A Case Completed | 12:54:47 | | 12:58:47 | | | 15:18:45 | | | |
| A566004 | 12:54:45 | Back Up Not Required | 12:55:02 | | | | | 12:57:48 | | | Backup Not Required |
| 0597494 | 12:55:54 | Tx xfed Other Unit Transport | 12:57:06 | | 13:08:52 | | 13:32:09 | 13:33:14 | | | |
| 0591204 | 12:56:56 | A Case Completed | 12:56:10 | | 13:18:39 | | 14:01:02 | 14:01:33 | | | |

| Unit |
|---|
| 591204 |
| 591258 |
| 591353 |
| 597494 |
| 999004 |

Irrelevant

No Pre-Scheduled Information

| Unit | Location/Address | Patient | Mode | Protocol | Mileage Start/End/Total | Depart | Arrived | Complete |
|---|---|---|---|---|---|---|---|---|
| 591353 | QH ROYAL BRISBANE HOSPITAL BOWEN BRIDGE RD & HERSTON RD | | Code | Pre Hosp - patient condition | 0 0/ | 13:25:55 | 13:44:54 | 14:10:13 |
| 591204 | QH ROYAL BRISBANE HOSPITAL BOWEN BRIDGE RD & HERSTON RD | | Code | Pre Hosp - patient condition | 0 0/ | 13:41:22 | 14:05:25 | 14:41:33 |

## Sequence of Events

12:49 pm - 501258 enroute to CN 16165517

12:54 pm – 501258 have been involved in an RTC

12:54 pm – 501388 who were following 501258 attends to crew and driver of the other vehicle

1:02 pm – 501235 dispatched to case 16165522 that 501388 were attending

1:13 pm – 501235 arrive on scene

1:13 pm – 501124 dispatched to case 16165517 that 5011258 were attending

1:26 pm – 501124 arrive on scene

1:26 pm – 501388 tpt injured officer to RBWH

1:41 pm – 501204 tpt injured driver to RBWH

1:44 pm – 501388 arrives RBWH

1:45 pm - 501235 depart for Prince Charles Hospital (PCH)

1:55 pm – 501235 arrives PCH

2:04 pm – 501124 depart for PCH

2:05 pm – 501204 arrives RBWH

2:21 pm - 501124 arrives PCH

## Operational Review

- OS and Officer in Charge follow up with crew post incident ascertained that all warning devices were activated when proceeding through the intersection.
- Crew state they proceeded with caution, stopped at the red light and only proceeded when the other cars had allegedly stopped.
- The private car in question slowed but then allegedly continued into the ambulance's path resulting in the collision.
- Nil further operational issues noted and scene well managed.

## Outcomes

- OS attended the scene, organized another unit to attend for the injured driver and organized for the damaged QAS unit to be towed to a holding facility
- QAS Media contacted Senior Operations Supervisor (SOS) and was briefed accordingly
- QAS Operational group notified of significant incident
- SOS/OS stayed in contact with all officers post event and checked in via phone on 17 July 2022. OS visited Officer Irrelevant in RBWH
- Officer Irrelevant was diagnosed with a Irrelevant
- Officer Irrelevant was diagnosed with Irrelevant
- Officer White was diagnosed with Irrelevant
- Irrelevant
- The patient from the initial case (16165517) was attended by another crew (40-minute response time) and transported to the PCH with a suspected Urinary Tract Infection (UTI)
- Irrelevant

## Post review actions

- SOS stayed in regular contact with Officer Irrelevant throughout incident and the following days
- North Brisbane District Director and Assistant Commissioner were kept updated of Officer Irrelevant condition and have spoken with Irrelevant
- Irrelevant
- All Officers have been well supported

## Review Recommendations:

- Nil – Officer Irrelevant has been cleared of fault, as per QPS advice.

## Appendix of relevant documents/files:

- Incident Detail Report (IDR);
- Electronic Ambulance Report Form (eARF);
- Local level clinical review (Eclipse);
- Workforce planning reports;
- AVL tracking of unit positions at time of incident;

## LASN Endorsement

| Name | Position | Signature | Date |
|---|---|---|---|
| Tony Armstrong | Assistant Commissioner | Irrelevant | 3/8/2022 |
| Warren Painting | District Director North Brisbane | | 4/8/22 |