

**Significant Incident Review Template** Version 1.0 August 2020**Townsville Local Ambulance Service Network****Final Report**

Irrelevant

**Executive Summary:**

The Townsville Operations Centre (TSV OpCen) received a request for service via the 000 system on 12 January 2021 at 1821hrs.

This request was in relation to an alleged assault that had occurred between Irrelevant, with a Irrelevant Irrelevant patient receiving a head injury after falling during a scuffle. There were no scene safety concerns despite the offender being on scene and making the 000 call to the Queensland Ambulance Service (QAS).

The incident was placed in the queue for dispatch at 1822hrs but due to no units being available for dispatch there was a 40-minute delay in the first unit being assigned to the incident.

The incident was assigned a code 2A response, there was no Clinical Deployment Supervisor (CDS) review requested by the call taker.

A second call was received by the TSV OpCen at 1932hrs, with the caller advising that the patient was rambling.

The first unit dispatched from Kirwan station was diverted to a higher priority incident 7 minutes after being dispatched and the second unit also dispatched from Kirwan station was diverted 1 minute later to a higher priority incident. The third unit dispatched from Townsville station 56 minutes after the receipt of the call, arrived on scene at 1943hrs, 1 hour and 22 minutes after the request for service was received by the TSV OpCen.

QAS transported a Irrelevant patient to Townsville University Hospital (TUH) with a closed head injury at 2013hrs.

The Irrelevant patient passed away in TUH 10 days later, on 22 January 2021.

Irrelevant













# Significant Incident Review

Version 1.0 August 2020

## Metro North Local Ambulance Service Network

Irrelevant

### Executive Summary:

Metro North LASN responded to an incident (IDR **Irrelevant**) on 20 January 2021, at **Irrelevant** **Irrelevant** for a **Irrelevant** patient complaining of abdominal pain, with vomiting and dizziness.

Brisbane Operations Centre, Deployment Supervisor advised the Metro North Senior Operations Supervisor (SOS) that the case was in the pending queue for approximately 60 minutes.

On arrival, the Queensland Ambulance Service (QAS) crew found the patient deceased.

Irrelevant





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# Significant Incident Review Template Version 1.0 August 2020

## Metro South Local Ambulance Service Network

Irrelevant

### Executive Summary:

QAS responded to incident Irrelevant at Irrelevant at 01:21hrs on 26 February 2021 to a Irrelevant sick with flu and difficulty in breathing. Case coded as 1C, delayed response due to workload. Second call, patient now unconscious. Case upgraded to Code 1A. Response time 27mins. Bravo crew and CCP attended and resuscitation attempted. Patient deceased on scene. Patient handed over to QPS.

Irrelevant



# Significant Incident Review Template Version 1.0 August 2020

## West Moreton Local Ambulance Service Network

Irrelevant

### Executive Summary:

Queensland Ambulance Service (QAS) received a request for service for Irrelevant at 09:29 on the 16th of April 2021. QAS was requested for a Irrelevant who had collapsed and was not responsive. The total response time to this incident was 34 minutes. During this period of time South East Queensland (SEQ) was experiencing moderate pressure with Ipswich Hospital (IH) on a Level 2 Escalation resulting in limited resource availability. Two common calls were made by the Southport Opden and at 09:36 a Bravo Unit was assigned from St Andrews Hospital, Ipswich with an ETA to scene of 16 minutes. At 09:53 the incident was reconfigured to a 1A response with CPR in progress and the Logan West OIC was attached as the nearest available CCP resource with an ETA of 14 minutes. On arrival at scene at 10:04 Advanced Life Support (ALS) was commenced for a period of 21 minutes however the patient remained in asystole for the duration and therefore CPR ceased at 10:26 and Recognition of Life Extinct (ROLE) was completed.

Irrelevant













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**Queensland Ambulance Service: Operational Incident Reporting**

Schedule 3, section 10(1)(a)

Irrelevant









# Significant Incident Review

Version 1.0 August 2020

## Metro South Local Ambulance Service Network

Irrelevant

### Executive Summary:

On 29 April 2021 at 23:04 the Queensland Ambulance Service (QAS) received a Triple Zero (000) call in the Brisbane Operations Centre (OpCen), from a second party caller on scene for a **Irrelevant** who had shortness of breath and was described as fatigued and not alert.

The case was initially prioritised in the Advanced Medical Priority Dispatch System (AMPDS) as MPDS Determinant 06D01 determining the ambulance response was a Code 1B, immediate response with lights and/or sirens.

The incident entered the Computer Aided Dispatch (CAD) Waiting Incident Queue (WIQ) at 23:06, with a second Triple Zero (000) call received at 23:21 in Brisbane Operations Centre requesting an estimated time of arrival (ETA) of the ambulance. The caller, waiting outside for the ambulance was unable to provide an update of the patients condition, however was able to provide the contact number for the carer on scene. The EMD attempted to make contact and left a voice message for them to contact QAS if the patient condition worsened.

A third Triple Zero (000) call was received at 11:28 pm advising the patient was struggling to breath, with the call unfortunately disconnecting. The EMD notified the Clinical Deployment Supervisor (CDS) prior to another (fourth) triple zero call being received at 11:31 pm confirming that the patient was sweating profusely, sometimes stops breathing and the caller was concerned with the a QAS single officer response unit, Critical Care Paramedic (CCP) dispatched from Kedron Park complex, assigned at 11:41pm and arrived second on scene at 11:54 pm. The CCP dispatched at this time was recommended at 23:07 located in Fortitude Valley with a response time of 3 mins 17 seconds.

At 11:42 pm the CDS contacted the Operations Supervisor (OS) at PAH to release a crew to respond and if unable to, for B507316 (OS) to proceed. The QAS dispatched single officer Operations Supervisor (OS) paramedic unit to respond located at Princess Alexandra Hospital (PAH), this officer was "on case" at 11:44 and was the first officer on scene, arriving at 11:49 pm, 43 minutes after the case entered the waiting queue.

A QAS paramedic responded as a two officer unit located in a "partially available" status at Cannon Hill arrived on scene at 11:51 pm.

At 11:53, after being on scene for four minutes the OS provided a situation report that the patient was now unconscious and CPR was about to commence, at 11:56 the crew confirmed CPR was in progress and at 00:45 the paramedics advised the patient was deceased and requested Queensland Police Service attend.

The Triple Zero (000) call entered the waiting queue at at 11:06pm, at 11:07 pm the Emergency Medical Dispatcher (EMD) notified the Clinical Deployment Supervisor that there were no "recommended" units available (CAD recommend function is a protocol that identifies recommendable units to respond) and enacted the procedure known as "Common Call" at 11:07pm and again at 11:21 pm, "Common Call" broadcasts a radio message to all units on the dispatch board of an urgent case in anticipation a potential responder may be nearing completion of a previous case and are able to respond.

At the time of the Triple Zero (000) call, the Brisbane Operations Centre experienced a number of pressures affecting paramedic availability to respond to emergency cases in the community. This included a high demand for ambulance services for several hours before and after, indicates a high level of demand for



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service and activity in the OpCen across South Eastern Queensland with Call backs being regularly performed, multiple "common calls" on dispatch boards and a significant pending queue existed.; a number of unscheduled staff vacancies in the Brisbane area which were unable to be backfilled, despite all usual attempts being made; in addition to QAS experiencing delays offloading patients at Metro North and Metro South Hospital and Health Service (HHS) public hospital Emergency Departments (ED's).

Irrelevant















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Schedule 3, section 10(1)(a)









