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

Incident Review/Investigation:

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

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

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

Operational Review:

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

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

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

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

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Hospital Status

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

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

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

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

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

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

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

Outcomes:

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

Review Recommendations:

- Nil

Appendix:

- Incident Detail Report
- Ambulance Report Form
- Clinical Review

Region Endorsement

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

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Significant Incident Review Version 1.0 August 2020

Gold Coast Region

Authority:

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

Executive Summary:

Incident 15654376 – at 13:12, Friday 25 March 2022 at 13:12 the QAS received a request for service to attend Irrelevant Coombabah for an Irrelevant patient, self reporting that he had been feeling sick and unwell all week. Mermaid Waters LARU unit 608308 self-dispatched as a primary response at 14:00 and arrived on scene at 14:02.

Following his initial assessment LARU/ACP officer Paul Irrelevant determined that the patient required specific investigation by a medical officer at Gold Coast University Hospital. Officer Irrelevant exited the residence (without the patient) to return his equipment to the vehicle. While returning back inside the residence, the patient was witnessed to be walking out to meet officer Irrelevant on his own accord with assistance from Irrelevant. While negotiating the doorway at the building entry point the patient has lost his balance, causing him to fall forward which resulted in an injury to the patient's right shoulder. The patient was subsequently reassessed by officer Irrelevant prior to departing to the Gold Coast University Hospital.

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

Terms of Reference:

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

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Gold Coast Region Clinical Incident Summary Report:

The Gold Coast Manager of Clinical Education determined:

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

Incident Review/Investigation:

Scope:

The process of this SIR is to review the clinical or operational aspects of this incident in the interest of generating learning where possible and promote best practice prehospital care to stakeholders whilst ensuring the safety of QAS staff is upheld.

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

Review:

The review will consider all available pertinent documentation, including the IDR & EARF for the incident. Patient care records were assessed by the GC Regional Clinical Education Unit.

Background:

On Friday 25 March at 14:00 ACP/LARU officer Paul Irrelevant self-dispatched utilising information obtained from IROAM to incident 15654376. Following his initial assessment it was determined that transport to hospital was required and it was appropriate for this to occur in 608308 (Hyundai iLoad).

In preparedness for transport officer Irrelevant removed all operational equipment (Corpuls/PRK) from the residence, placing it back inside the LARU vehicle whilst making a phone call to the HHS. While returning back to the patient (inside the residence), the patient was witnessed by officer Irrelevant to be walking with assistance from Irrelevant to meet him outside. While negotiating the doorway at the building entry point (glass sliding door) the patient has tripped on the rail causing Irrelevant to fall forward, resulting in a right shoulder injury. Officer Irrelevant ran back towards the patient and with the assistance of a bystander prevented the patient from suffering further injury.

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

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

Timeline

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

Crew:

Unit	Name
608308	Irrelevant Paul Irrelevant

Regional Follow-up:

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

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

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Outcomes:

- The Gold Coast Clinical Education Unit (CEU) assessed the patient record and determined that the care provided to the patient was appropriate.
- Officer Irrelevant was provided with a copy of SOP03.3 'notification of QAS senior officers'
    - Officer Irrelevant stated he was unaware of the requirement to notify the Senior Operations Supervisor/SOCC of the patient's fall given that he had informed the HHS upon handover & documented the incident on the eARF.
- On the 11th April 2022 A/SCE Craig Sanky provided officer Irrelevant with feedback regarding the quality of his paperwork given his extended scope of care. The outcome of this conversation was that officer Irrelevant self-identified that his paperwork was below the standard expected from an extended scope paramedic. A/SCE Sanky spoke about the need to provide appropriate documentation specific to each incident. Moreover, a falls risk assessment and clinical fraility score were performed by officer Irrelevant (according to the CEU review) however omitted from the eARF. This information would have demonstrated to an investigator that officer Irrelevant had minimised the risk of this event occurring.
- According to A/SCE Sanky, officer Irrelevant has reflected on this incident and is now providing a more comprehensive approach to his documentation.

Post OIRR actions:

- Staff Support services were offered to officer Irrelevant following the incident.
- Feedback regarding the investigation to be provided to the patient and family by a regional delegate.

Review Recommendations:

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

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Appendix of relevant documents/files:

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

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

Region Endorsement

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

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

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Department of Health

Queensland Ambulance Service

Significant Incident Review

IR31-2022 Wide Bay District

Sunshine Coast and Wide Bay Region

Authority:

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

Executive Summary:

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

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

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

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

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

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

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

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

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

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

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

Terms of Reference:

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

Region Clinical review:

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

OpCen Review:

Incident Review/Investigation:

Scope:

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

Background:

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

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

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

Review:

In review of the information available,

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

Review Recommendations:

This review finds the following recommendations:

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

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Appendix of relevant documents/files:

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

LASN Endorsement

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

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

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