SCI.0003.0018.0001

Your V for a s	'oice afer, Stronger Health S	NICW	eHealth
To view the NSWH policies page clicl	HERE	don the Galitere	
f you require any assistance, please v			
INC860016 Security and Safe			
Incident Overview			
POPular Constant Sec. 16			
Details and Status			
Reference ID	INC860016	manda el grammana in 20-20 (A -	Tomar and Arrent Stranger
Name of primary person affected	in of a sistem in and it makes for the		The many stangers front in 52.00
Reported date (dd/mm/yyyy)		Durass at the communications of	
Reported time (hh:mm)	06:13	Exercise this no free learned wards to be converted wards and be converted wards and bittlined wards to be converted wards and bittlined	
Incident status	New		
			Thomson and a sequence of the second se
Incident Details			
Incident Details	April Margine and Marginetic and Programs and the State of the second		View Buppenut? Network Augustation
Who or what was <u>most</u> affected? This refers to the primary person affected, not the person who caused it	No Person		
nterity was the disconsignation of strange			Standard Linear Standard Street
Incident Details			
Incident date (dd/mm/yyyy)	14/02/2024		
Incident time (24 hrs) (hh:mm)	05:05		
Is the time estimated?	No		
Incident Details			
What type of NSW Health organisation do you work for?	Local Health District (LHD) / Hosp		tin of our constraints of the second
Health Service			
lealth Service			

14/24, 6:14 AM Health/Ambulance service where	DCIQ: NSWH / WSLHD / WSLHD / Westmead Hospital / WM Emergency Mental Health Pod			
the incident occurred				
Service responsible for clinical				
care/support Please type in and search for the				
Ward/Department/Station first, then				
select the location with the correct				
LHD/Organisation in the name. If you can't find your location please				
see Help Text for examples.				
Additional details about Location	WMHED MH POD			
(e.g., corridor, hallway, community address)				
What Happened? (or could have happened)?	cl)			
Principal incident type is meant to capture inciden	s, near misses and hazards.			
and the first state of the stat		anars bio zikszti		
What Happened? (or could have happened)?				
Details	At 05:05 pt attempting to abscond from MH POD.	Personal (1		
Maximum character limit is 32766	Followed by NS and security duress pulled when pt unable to be redire	ected back to bed space.		
including spaces.	Unfortunately when Duress pulled it did not alert. Duress at the commencement of shift tested and returned a correct self	f test result.		
	Duress at the commencement of shift tested and returned a concert sen Despite this no functional alert was sent to any other duress within the	ED.		
	Leaving staff and limited security to manage the pt.	Kapanah untu dalamati		
	Automatical and Section and the			
What Happened? (or could have happened)?				
Principal incident type	Security and Safety	Machine Bernath		
What Happened?				
(or could have happened)?	Aloren triggated			
Please categorise this incident type further	Alarm triggered	fina intervoldar promoti esteon activitatione jerenationetteon		
What Happened?				
(or could have happened)?				
Additional details	Duress alarm	(VER annound with mattern		
YesWas any equipment involved in t	he incident?	(unit das trat PS) and Malacen		
Alarms Triggered				
Time alarm raised? (hh:mm)	05:05	diaty Diasteries		
Time appropriate personnel	An world dahooff glazonijs na integral (1000 5 (norad) time) i men. 1			
esponded? (hh:mm)	N.			
False alarm?	No			
quipment				
tem / equipment type	Personal Duress alarm			
		en e en		
		and the second		

14/24, 6:14 AM Brand name	DCIQ: AIRSTAR	
Manufacturer	AIRSTAR	
Model number	C4CB6B232C9B	
Identification number(s) / marks	FCC ID: TA7-B400 IC: 6864A-B400	
Outcome / Responses		_
Initial Assessment		
Initial Impact of incident	Threat to safety and security of patients, staff, service	
Initial Care and/or treatment required following incident/near miss	Monitor/review only	
Initial Harm Score	4	-
Responses		-
Responses		
Have you told your manager?	Yes	
Immediate action(s) taken Enter action taken at the time of the incident. Maximum character limit is 32766 including spaces.	Duress placed into broken duress bay. ED NUM alerted and security aware	
Contributing Factors and Prevention		
What things could have contributed to the incident?	Duress faulty and did not alert Security to the need for response	
Was the use of virtual care (i.e., telehealth, video conferencing, store & send or remote monitoring) involved in this incident or near miss?	No	
What could be done to prevent similar incidents?	Duress alarms being in working condition	
Feedback to the Notifier Jse this section to detail any specific feedback to the	notifier.	
Feedback to notifier Maximum character limit is 32766 neluding spaces.		