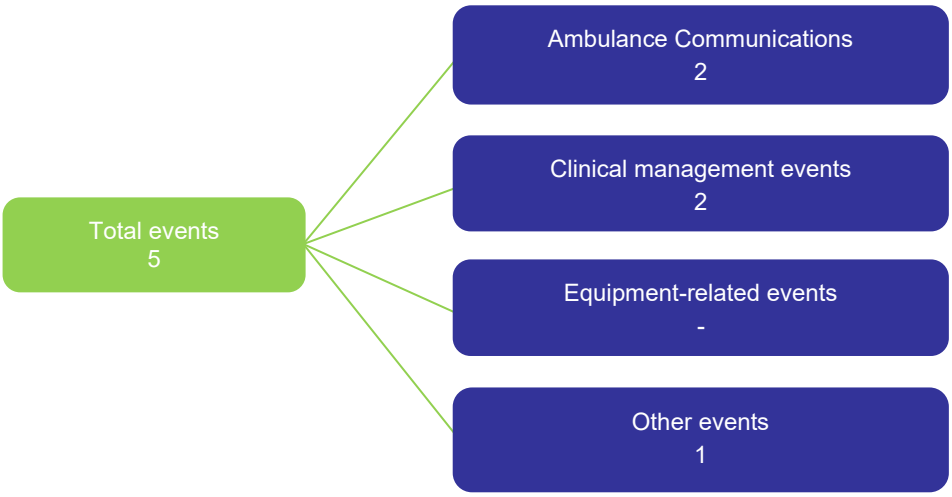
Emergency Ambulance Service Reportable Events: April - June 2025

Total number of reportable events and near misses

- Five closed SAC 2 reportable events were reported to NASO for the period.
- 12 SAC 2 reportable events remained open as at the end of the quarter.



Ambulance Communications

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP31527	Delayed dispatch of an ambulance to a high acuity patient.	Following review of the initial 111-call it was determined the information provided by the caller was sufficient to suspect uncontrollable bleeding or major injury. It would have been more appropriate to triage the incident under the 'Unknown Problem – Life Status Questionable protocol' with an assigned RED1 priority. Resources would have been assigned immediately rather than being held for the night shift.	Debrief and coaching to be provided following non-complaint reviews.	Debrief and coaching enacted. New educational platforms have been introduced which embed learnings from reviews for continued professional development. This includes de-identified case studies with discussion.
REP31633	Delayed dispatch of an ambulance to a high acuity patient.	Following the review of the initial 111-call it was identified the incident should have been coded under protocol 6 with a corresponding RED2 priority. Had this occurred, multiple resources could have been available to respond; the	Debrief and coaching be provided following non-compliant reviews.	Debrief and coaching enacted. New educational platforms have been introduced which embed learnings from reviews for continued professional

		closest resource had an ETA of 5 minutes.		development. This includes de-identified case studies with discussion.

Clinical Management

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP31582	Ambulance attendance with failure to recognise the severity of the patient's condition which resulted in delayed transfer to a higher level of care.	The paramedic in the first ambulance failed to recognise the seriousness of the baby's condition and act accordingly. There was no attempt to escalate the situation by requesting a rescue helicopter to urgently transfer this baby from the rural town to the tertiary-level hospital. Had the seriousness of the baby's condition been recognised earlier, prompt transport to the medical centre or hospital would have been appropriate for additional clinical assistance and staging, while the rescue helicopter responded. While it is uncertain whether this would have changed the outcome, it likely would have ensured the baby was admitted to hospital sooner. Instead, the baby remained at the scene for an extended period, during which; a shift change was prioritised over transport.	The incident underwent clinical review with a referral to the Authority to Practice (ATP) Credentialing Committee.	A referral to ATP Credentialling Committee. A notification to the Paramedic Council has been acted.
REP32638	Ambulance attendance with failure to recognise the severity of the patient's condition which resulted in delayed transfer to a higher level of care.	A comprehensive clinical review identified concerns with communication, handover, crew change, patient management and resuscitation considerations.	All involved clinicians are to participate in a structured debrief and learning review. A line manager guided debrief is to occur regarding OSOP 7.1 (Ambulance Operations and Preparedness policy) and conduct around end of shift times.	Debriefs enacted. A systems review of policies and procedures regarding crew changes during high-acuity patient responses has been initiated and is currently on-going.

Other Events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP31647	Stretcher tip resulting in patient hitting their head	The investigation found that several interacting factors contributed to the stretcher tipping: The stretcher was at full height and in 4-wheel drive mode, making it top-heavy and increasing its ability to move freely in multiple directions. The footpath had a slight slope, leading towards the grass verge, introducing additional instability. The crew member at the rear of the stretcher tripped on a raised door lip, leading to an unintentional release of control. Fatigue was identified as a potential contributing factor, affecting situational awareness and physical coordination.	Stretcher training in internal continuing clinical education to be prioritised relative to other risk. Review fatigue management policy. Equipment configuration and stretcher design evaluation.	Prioritisation of stretcher training in internal continuing clinical education enacted. Fatigue management policy updated. Evaluation enacted.