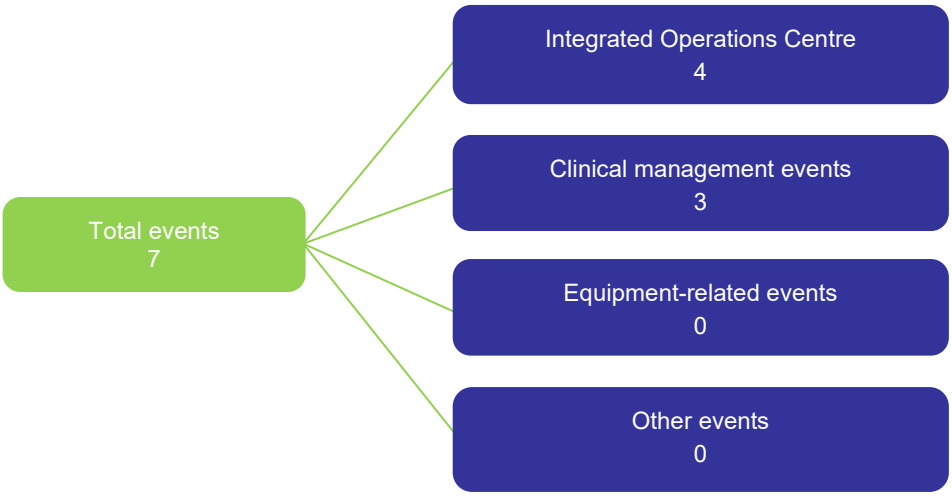
Emergency Ambulance Service Reportable Events: April – June 2026

Total number of reportable events and near misses

- Seven closed SAC 1 and SAC 2 reportable events were reported to the National Ambulance Team for the period. Of the SAC 2 incidents, three were downgraded to SAC 3 incidents and one was downgraded to SAC 4.
- 10 SAC 2 reportable events remained open as at the end of the quarter.



Integrated Operations Centre

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP35690 [1]	Incident prioritised GREY did not receive a clinical telephone assessment (CTA).	In four of the patient's subsequent 111 calls escalating to a Clinical Support Officer due to increasing pain should have been considered. Staffing levels for CTA were below optimal due to unexpected personnel sickness. As the incident remained prioritised GREY the incident was considered clinically safe to wait for a callback.	Debrief and clinical support will be provided outlining the importance of adhering to CHSOP 2.10 (Subsequent calls) by checking if there has been any change to the patient's condition and escalating to a Clinical Support Officer (CSO) for further review when increasing pain is mentioned.	Debrief and clinical support enacted. A review of the Welfare Check and Subsequent Calls SOP has been completed, and a new SOP entitled 'Delayed Response Checks' has been implemented.
REP36230	Delayed ambulance attendance to high-acuity patient.	The call-handler did not identify high-velocity mechanism of injury, resulting in an incorrect determinant and lower priority response. Dispatch procedures were not consistently followed, this	A learning from harm session was facilitated with the Integrated Operations Centre (IOC) for review and system-level improvement.	Development of the de-identified case study (to be enacted).

		included delays in utilising Initial Assign, delays in ambulance dispatch and failure to notify allied emergency services.	Publication of a de-identified case study with key lessons learned highlighted for wider sharing and review.	
REP36365 [2]	Delayed ambulance attendance to high-acuity patient.	The dispatcher cancelled an incorrect incident with a similar identified when the intended incident could not be located.	A learning from harm session was facilitated with the Integrated Operations Centre (IOC) for review and system-level improvement. Publication of a de-identified case study with key lessons learned highlighted for wider sharing and review.	Development of the de-identified case study (to be enacted).
REP36484 [2]	Delayed ambulance attendance to high-acuity patient.	The review found failures in clinical oversight, including missed 30-and 90-minute reassessments and an initial assessment that did not recognise indicators requiring a higher priority. The case was repeatedly viewed by multiple CSOs without escalation or further patient contact. These gaps led to inappropriate triage, lack of reassessment, and risk of missed clinical deterioration.	Development of targeted education to address clinical decision making when reviewing incidents.	Development of targeted education to address clinical decision making when reviewing incidents (to be enacted).

[1] Downgraded to SAC 4 incident
[2] Downgraded to SAC 3 incident

Clinical Management

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP35702 [2]	Previous attendance within 24 hours for a high-acuity patient.	The advice for the patient to be seen in ED was appropriate given the presence of red flags. Recommending that the patient self-transport to ED, which was only 5 minutes away, was reasonable given proper safeguards. The clinical documentation regarding the patient's ability to mobilise and ability to be self-	Feedback provided to the attending personnel.	Feedback enacted. A podcast entitled "Standards of Documentation" has been developed by Clinical Education and is under review.

		transported should have been expanded.		
REP36652	High acuity patient transported to a non-stroke facility.	Ambulance personnel did not recognise acute peripheral vision loss as a potential presentation of posterior circulation stroke and did apply relevant clinical practice guidelines to determine an appropriate transport destination.	The development of national target education to address knowledge gaps and improve recognition of posterior stroke symptoms.	The development of education is yet to be enacted.
REP36694	Delayed arrival of high acuity patient to appropriate treatment facility.	The attending CCP did not recognise the severity of the patient's condition, including the need for advanced airway intervention (RSI) and the requirement for transport to a Major Trauma Hospital with neurosurgical capability.	The development of a de-identified case study to be shared for wider system learning.	Development of the de-identified case study (to be enacted). An organisation wide Airway Registry has been published to share learnings about advanced airway intervention and encourage the development of a learning culture.

[2] Downgraded to SAC 3 incident