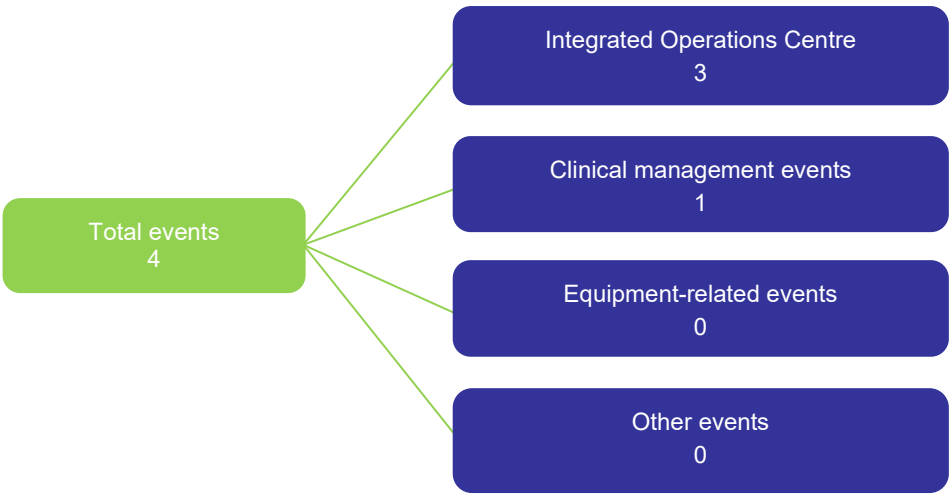
Hato Hone St John

Emergency Ambulance Service Reportable Events: July – September 2026

Total number of reportable events and near misses

- Four closed SAC 2 reportable events were reported to the National Ambulance Team for the period. One SAC 2 incident was downgraded and determined to be a non-SAC event.
- 13 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
REP37423	Delayed ambulance attendance due to difficulties locating patient.	A CAD incident was not generated, linked to the initial call and re-triaged when a subsequent call was received. There was an ambulance in the vicinity. The opportunity was missed to get the patient to present himself to ambulance personnel.	The Integrated Operations Centre (IOC) has identified an opportunity to strengthen organisational learning and staff engagement through the re-introduction of the Coffee & Cases programme.	An educational bulletin is being developed by the IOC.
REP38118	Delayed ambulance attendance to a high acuity patient.	The call was incorrectly triaged as an 'obvious death.'	The IOC has identified an opportunity to strengthen organisational learning and staff engagement through the re-introduction of the Coffee & Cases programme.	An educational bulletin is being developed by the IOC.

REP38272 [1]	Delayed ambulance attendance to a high acuity patient.	The decision to place the incident in the clinical telephone assessment (CTA) queue was appropriate, given the patient's presenting complaint and the information available at the time. There is no evidence that the Navigator decision or subsequent clinical process was inappropriate, and no evidence that the interval between the initial call and ambulance dispatch caused or contributed to the patient's death.	Not applicable.	Not applicable.

[1] *Downgraded to non-SAC event*

Clinical Management

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP37273	Patient incorrectly verified as deceased.	Ambulance personnel did not undertake a complete assessment resulting in an incorrect clinical decision not to commence resuscitation at initial ambulance attendance.	Implement refresher training on cardiac arrest management.	Round 2 of continuing clinical education (CCE) is being delivered and has a focus on resuscitation and managing patients in cardiac arrest.