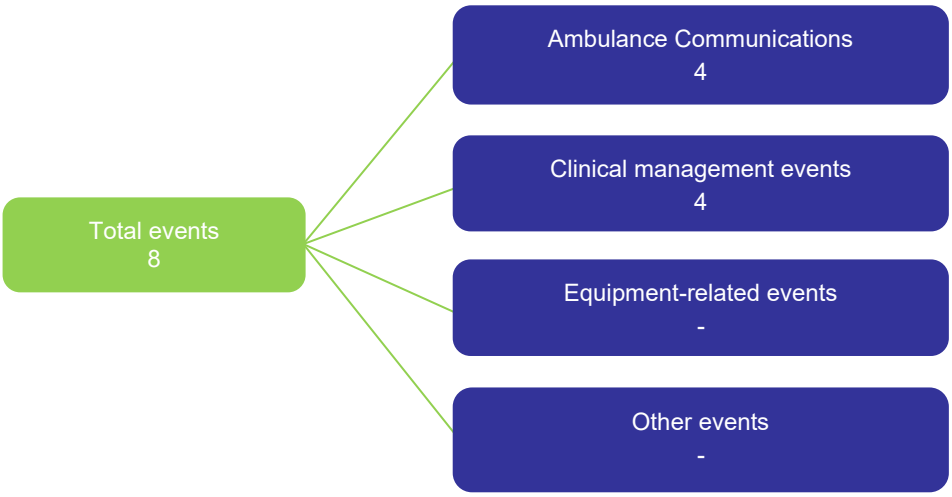
Emergency Ambulance Service Reportable Events: July-September 2025

Total number of reportable events and near misses

- Eight closed SAC 2 reportable events were reported to NASO for the period.
- 11 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
REP32056	Address verification error resulting in delayed arrival of responding ambulance to a high acuity patient.	Following a review of the call handling process it was found that the address verification process was not followed which resulted in the incorrect address being added to the incident. Ambulance resources were assigned in a different region causing a delay in resources arriving at the correct location.	Debrief and coaching to be provided following non-compliant reviews.	Debrief and coaching enacted. New educational platforms have been introduced which imbed learnings from reviews for continued professional development. This includes de-identified case studies with discussion.
REP33063	Address verification error resulting in delayed arrival of responding ambulance to a high acuity patient.	Review of the 111-calls found that the correct address verification process was not followed resulting in a delay of approximately 10 minutes in locating the address. The sequence of events has resulted in confusion for responding crews. A review of the first 111-call found that while an incorrect address point was given. The correct address verification process was not followed, and the address was	Debrief and coaching to be provided following non-compliant reviews.	Debrief and coaching enacted. New educational platforms have been introduced which imbed learnings from reviews for continued professional development. This includes de-identified case studies with discussion.

		entered to an incorrect intersection. A review of the second 111-call found that while the address was correctly updated, the incident was initially entered to a block range that did not contain the address point.		
REP33519	Delayed dispatch of an ambulance to a high acuity patient.	Following a review of the dispatch decisions, it was identified that two different incidents were incorrectly appended which resulted in the initial incident being incorrectly closed and a delay in care.	Debrief and coaching to be provided to dispatcher.	Debrief and coaching enacted.
REP33854	Delayed dispatch of an ambulance to a high acuity patient.	Review of the initial 111-call found that the call had been incorrectly triaged under a traumatic rather than a medical protocol. This resulted in a missed opportunity to dispatch an ambulance to the patient immediately as the call was prioritised for clinical telephone assessment.	Debrief and coaching be provided to call-handler.	Debrief and coaching enacted.

Clinical Management

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP32583	Medication administration resulted in the patient requiring a higher level of care.	The review determined the initial telephone assessment undertaken and the advice to administer the first dose of Midazolam by the CSO was safe and reasonable. However, when the care of the patient was transferred to the second attending crew following the administration of the first dose of Midazolam, it was highlighted further telephone assessment of the patient's condition and discussion with the second attending officer was indicated. This would have enabled a better clinical understanding of the safety risks posed by the patient's behaviour to better determine the requirement of further doses of sedation.	All attending ambulance personnel be involved in a clinical support officer (CSO) facilitated debrief of the incident. The CSO working in the Integrated Operations Centre (IOC) be involved in a deputy clinical director facilitated debri ef of the incident.	Debriefs enacted.

REP32763	A delay in the commencement of cardiopulmonary resuscitation.	The review determined the care provided by the first attending ambulance crew to be unsafe and unreasonable. The required clinical equipment was not initially taken into the patient's address, and the initial patient assessment was not performed to the expected standard which has resulted in a delay in commencing cardiopulmonary resuscitation.	Refer initial attending personnel to the Authority to Practice Credentialing Committee.	Referral enacted.
REP32878	Non-recognition of the severity of the patient's condition.	The clinical review determined the attending ambulance personnel failed to recognise the severity of the patient's condition despite the patient presenting with concerning physical symptoms and significant abnormalities following an echocardiograph reading.	Attending ambulance personnel to be involved in a guided debrief with a CSO with a focus on the clinical review findings and key improvements.	Debrief enacted.
REP32922	Administration of a medication that was outside of the clinical scope of the attending ambulance personnel.	The administration of out-of-scope midazolam presented a significant clinical risk to the patient particularly when administered when the patient was no longer having a seizure.	Attending ambulance personnel to participate in a documented debrief regarding the learnings of this review. Referral of one of the attending ambulance personnel to the Authority to Practice Credentialing Committee.	Debrief enacted. Referral enacted.