HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Hato Hone St John and call handler breach man's rights

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A man's rights under the Code of Health and Disability Services Consumers' Rights were breached by Hato Hone St John, and a call handler, said the Deputy Health and Disability Commissioner Deborah James, in a decision released today.

The decision centres on the management of a 111 call from a woman who described symptoms indicating a heart attack being experienced by her husband. An ambulance service took the initial call and then transferred it to St John. The call was prioritised as 'serious but not immediately life threatening.'

Approximately 30 mins later, a dispatcher launched an initial assignment tool to identify which ambulances were available. The tool indicated a 27-minute wait for an ambulance and suggested the use of a first response team (Fire and Emergency NZ), which was available to respond. The dispatcher decided this was unnecessary as the patient was alert, breathing easily and had no cardiac history.

Thirty minutes after her first call, the woman called 111 again because her husband's condition had deteriorated. Another call handler picked up this call and advised her that an ambulance had not been assigned due to demand, but she did not re-triage the call. The woman told the call handler she would drive her husband to the hospital. The call handler then closed off the incident. Sadly, the man had a heart attack three minutes from the hospital and could not be revived.

Deborah James found the call handler (Ms B) had deviated from St John's standard operating procedure (SOP). "...the St John incident review identified that when Mrs A advised Ms B that she would take Mr A to hospital herself, there was a need for Ms B to advise that it might be a good idea to continue waiting for the ambulance response. I note that Ms B's failure to re-triage Mrs A's second 111 call may have affected her decision not to advise Mrs A to wait for the ambulance to arrive."

Unfortunately, despite the man's wife telling the call handler that her husband's condition had worsened, the call handler did not ask for any further information about his symptoms. As a result, Ms James found the call handler had breached the Code by not providing services that complied with professional standards.

Deborah James found St John had also failed the man by not meeting expected wait times when there was a 30-minute delay in using the initial assignment tool, nor was a welfare check undertaken.

"There will undoubtedly be times where ambulances are unavailable to respond to incidents immediately. However, it is St John's responsibility to find ways to mitigate the risks associated with unavailable ambulances. In my view, conducting welfare checks every 30 minutes (as outlined in St John's SOP) is an appropriate tool in mitigating such risk."

She also found St John breached the Code by not providing the man (through his wife) with information he could have expected to receive under the circumstances. This included not conducting a welfare check and not advising the woman about delays in dispatching an ambulance, or for her to wait for an ambulance response.

Ms James made an adverse comment about the St John dispatcher who launched the initial assignment tool noting her concerns about the delay, despite the busyness at the time, saying it was a useful safety netting tool that should have been deployed. Ms James was also critical that the dispatcher did not document his reasons for not dispatching the first response unit.

Ms James has recommended the call handler formally apologise to the woman. Further recommendations include that St John provide additional training for call handling and dispatch staff, on the importance of welfare checks and to update its dispatching guides to be clearer about how to use the initial assignment tool.

St John has made a range of changes since the event which are outlined in the decision.

14 October 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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