Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Ambulance call handler breaches Code for incorrectly recording and classifying triage questions

21HDC00463

Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found an ambulance call handler breached the Code of Health and Disability Services Consumers' Rights (the Code).

An ambulance call handler took a call from a mother whose teenage daughter was having an asthma attack. The call handler incorrectly interpreted and entered critical details about the teen's breathing into the software that determines triage categorisation. This meant the seriousness of the teenager's condition was not fully appreciated and affected the subsequent dispatch of an ambulance to her location.

Just under twenty minutes later, when the teenager's condition had deteriorated further, the family made a second call to 111 and an ambulance was dispatched immediately. However, by the time they arrived, the teenager was unresponsive and not breathing and was, tragically, declared deceased shortly afterwards.

Dr Caldwell found the call handler breached Right 4 of the Code, for not providing services of an appropriate professional standard.

Dr Caldwell said she considered that the systems and protocols used by the ambulance service are a reasonable equivalent of "national standards" for call-handlers.

"Although the call-handler asked the correct questions, according to the software, he failed to correctly record and classify two questions regarding the teen's breathing and failed to clarify the answers with the teen's mother," said Dr Caldwell.

Dr Caldwell made an adverse comment about one of the ambulance dispatchers from the second ambulance service involved in this case, whose "error in judgement" resulted in the nearest ambulance not being dispatched immediately.

She also made an adverse comment regarding the ambulance staffing levels and called for them to ensure that cover was adequate to maintain effective communication and not negatively impact dispatching decisions when staff were handing over for meal breaks.

Since the events, the ambulance services and staff involved have made several changes, outlined in the report. Dr Caldwell made further recommendations, for the ambulance service and the call handler and dispatcher concerned.

13 May 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 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%.

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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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