Decision CAS-13776-Z7D6H8

29 June 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Inadequate monitoring of patient by St John following opioid medication administration

## Executive summary

1. Whilst Mrs A was in an ambulance, 'ramped'[1] and awaiting admission to the local public hospital's Emergency Department (ED), she was administered opioid medications by a paramedic. Two emergency medical technicians (EMTs) were also present. Shortly after the medication administration, the paramedic left the EMTs to monitor Mrs A while she updated the ED triage nurse about Mrs A's medical status. When the paramedic returned, Mrs A was noted to be unconscious and not breathing. Oxygen was applied, and Mrs A was transferred to the ED, where medication was administered to reverse the effects of the opioids.

2. I have found that The Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (trading as Hato Hone St John Ambulance Services (St John)) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services to Mrs A with reasonable care and skill.

## Recommendations

3. I support and endorse the changes St John has already implemented because of these events, which will be discussed further below in this report.

4. Given the changes that have already occurred, and the apology already provided to Mrs A and her whānau by St John, I recommend that St John: share the anonymised final report across its localities to support education about providing safe care to patients, including the importance of monitoring and documentation. Evidence that this has occurred should be provided to the Health and Disability Commissioner (HDC) within six months of the date of this report.

## Background

5. On 2 May 2024, Mrs A experienced abdominal pain at work and an ambulance was called, arriving 32 minutes later. Mrs A was transported to the ED at the local public hospital by EMTs. During the transportation, Mrs A was given the pain relief medication methoxyflurane.[2]

6. On arrival to the hospital, the EMTs were unable to take Mrs A into the ED, as they were ramped. Due to the level of Mrs A's pain and discomfort, despite the already administered medication, assistance was sought and provided by a paramedic from another ambulance crew.

[1] A phrase used to describe when a patient arrives at the ED via ambulance but cannot be admitted within 30 minutes.

[2] Methoxyflurane is an inhaled medication classified as a volatile anaesthetic, used primarily for short-term, rapid-onset pain relief.

7. Intravenous access was obtained, and a total of 200mcg of fentanyl[3] in 50mcg doses was given over a period of 20 minutes and a 1.25mg dose of droperidol[4] was also administered. Mrs A was left in the care of EMTs whilst the paramedic left to update the ED triage nurse. When the paramedic returned, Mrs A was noted to be unconscious and not breathing. Oxygen was applied, and Mrs A was transferred to the ED where the medication naloxone[5] was given to reverse the effects of the opioid medication administered by the paramedic.

8. Following the events, submitted ambulance records did not contain records of Mrs A's vital signs before and after each administration of fentanyl.

9. On 23 May 2024, this Office received a complaint from Mrs A's father, Mr B, who raised concerns that:

- The paramedic left Mrs A after having administered opioid medication to be monitored by junior staff who did not have this in their scope of practice.
- The EMTs did not monitor Mrs A sufficiently to notice that she was pale, cyanosed,[6] unresponsive, and in respiratory arrest.
- The documentation that followed is substandard.

10. St John told HDC that there were differing accounts of the discussion that took place as the paramedic left the ambulance and that the paramedic should have remained in attendance with Mrs A following administration of the medications. In addition, St John stated that:

> 'Notwithstanding, recognising signs of patient deterioration are requirements of all clinical personnel … on this occasion, the positioning of the EMTs did not support effective monitoring of the patient.'

11. St John further found that the paramedic could have considered alternative medication, that escalation to the triage nurse should have been pursued earlier, and that the paramedic could have asked one of the EMT staff to do this.

12. For the sake of completeness, I note that this investigation was provided statements from the two EMTs, the paramedic who assisted that crew, and the second paramedic who observed what occurred in the wake of Mrs A's collapse. There are differences in those accounts, particularly regarding the precise actions that were taken once it was noticed Mrs A was cyanosed, and the sequencing of those actions. It would appear, given the unexpected nature of the collapse, that the situation was somewhat heightened, with directions being given for the printout of an ECG strip, the replacement of the oxygen monitoring probe, and the delivery of oxygen. In this respect, I am satisfied the EMTs were told by the observing paramedic to administer high-flow oxygen, which occurred prior to Mrs A being taken to the

[3] Opioid medication.
[4] Medication which sedates and prevents nausea and vomiting.
[5] Naloxone is a life-saving medication used to rapidly reverse opioid overdoses by restoring normal breathing.
[6] A bluish-purple discoloration of the skin or mucous membranes (lips, tongue, nail beds) caused by a lack of oxygen in the blood or poor circulation.

ED resuscitation room. The ED clinical record shows that with 10L of oxygen by facemask, Mrs A's saturations came up to 90%. Mrs A required brief ventilator support via bag mask in the ED. It is not possible on the information before this investigation to identify the time between Mrs A's collapse, the EMTs noticing her cyanosis (although this is believed to be about a minute after the paramedic's departure), the delivery of oxygen, and her subsequent attendance by ED staff. While appreciating Mr B's concern that there was a delay in administering treatment that he believes should have occurred in the ambulance (including naloxone, and bag masking – which was ultimately administered by ED staff), I am not critical of the decision to transfer Mrs A to the ED for that intervention, given its proximity, that high-flow oxygen was being administered, and that it was an appropriate environment for urgent treatment. While unable to make specific findings about timings, I am also not persuaded that there was any significant delay in the provision of emergency treatment to Mrs A.

**Resolution proposal**

13. On 4 November 2025, I notified St John of HDC's investigation of this matter. I proposed that HDC find St John in breach of Right 4(1) of the Code, based on a review of the complaint and St John's response.

14. On 16 December 2025, St John accepted the proposed breach finding and that the care provided to Mrs A was not an appropriate standard of care.

**Changes made as a result of this event**

15. All three ambulance personnel were referred for a clinical debrief with the clinical support officer regarding the incident, with specific points of reflection on the appropriate graded administration of analgesia to reduce incidents like this from occurring again and adequate monitoring of a patient following administration of medications.

16. Following the incident, the paramedic involved acknowledged that leaving the patient in the care of two EMTs was not a good decision. The paramedic has since altered their practice and has since remained with the patient when medication within their scope has been administered.

17. The relevant operating policy related to ramping at a hospital has been updated.

18. St John has implemented an Early Warning Score (EWS) system, which included a six-month trial between 18 March and 25 August 2024 across six hospitals nationwide. An EWS system is a clinical tool used to detect patient deterioration by enabling the calculation of a score based on vital signs and other physiological parameters. It helps determine escalation pathways. Feedback from the EWS trial indicated that relaying the EWS to the ED triage nurse expedited patient entry into the ED, ultimately decreasing ramping time.

**Responses to provisional decision**

19. Mr B provided comments, which have been incorporated where applicable.

20. St John provided a written apology to Mrs A and her whānau but no further comments to this opinion.

21. The attending paramedic and two EMTs were also provided the opportunity to comment on the provisional decision.

**Decision**

22. Right 4(1) of the Code states that the consumer has the right to services of an appropriate standard, in that 'every consumer has the right to have services provided with reasonable care and skill.' In Mrs A's case, unfortunately this did not occur.

23. There are three key points that I have considered in my assessment of the standard of care provided to Mrs A: the monitoring, the physical position of the EMTs in relation to Mrs A while in the ambulance, and the clinical records.

24. I am highly critical that the paramedic left Mrs A in the care of two junior EMTs when they went to update the triage nurse about Mrs A's medical status. In statements, the EMTs expressed concern that no monitoring instructions were provided, and it is self-evident that they failed to notice Mrs A's deteriorating condition until such time as she started posturing (having abnormal movements). Noting the seniority of the paramedic, it would have been more appropriate for them to have monitored Mrs A, especially noting the potentially serious effects of opioid administration. In this respect, I consider that the paramedic could have explored alternative options, such as asking one of the EMTs to update the ED nurse. That said, it should be well within the scope of an EMT's practice to monitor and recognise deterioration, particularly airway compromise. It seems more likely than not that the EMTs were not adequately focussed on the clinical condition of Mrs A – which may have been due, in part, to their positioning in the ambulance. In this respect, I accept the incident review conclusions that the EMTs were not positioned (stationed) in an ideal way to ensure optimal monitoring of Mrs A's condition.

25. In addition, it is my view that the update to the triage nurse could have occurred earlier, at the time when the administered medication did not appear to have alleviated Mrs A's severe symptoms of pain and discomfort (noting that the crew was endeavouring to manage Mrs A's pain during the period they were waiting for entry into the ED, and there was the opportunity to have escalated concerns).

26. Having perused the records submitted after this event, I am also concerned that vital signs pre- and post-fentanyl administration were not consistently recorded.

*Conclusion*

27. The critical failure in this matter was the failure to adequately monitor Mrs A in the period following opiate administration. This failure was contributed to across several staff, and, in that context, it is appropriate for the breach to be made against St John. I note that St John has acknowledged and accepts these shortcomings in Mrs A's care. For the reasons I have

outlined above, I do not consider that Mrs A was provided services with reasonable care and skill, and accordingly I find St John in breach of Right 4(1) of the Code.

28. I consider that it was appropriate for St John to have considered how it could mitigate the risk of this type of adverse event occurring again. I commend it for taking steps to ensure that systems are in place to prevent an event like this re-occurring, as evidenced by the implemented changes made as a result of this event.

**Comment**

29. It is important to acknowledge that this incident occurred while the ambulance was ramped at the local public hospital, with limited entry to the ED. In that respect, it is illustrative of the patient safety risks that occur when EDs are pressured beyond their capacity. While St John staff are ultimately accountable for their own practice, I will take the opportunity to share this opinion with Health New Zealand | Te Whatu Ora and the Ministry of Health to demonstrate the impacts of this practice on patients.

**Follow-up actions**

30. A copy of the decision, with details identifying the parties removed, except St John, will be sent to Health New Zealand | Te Whatu Ora (National) and the Ministry of Health.

31. A copy of the final report with details identifying the parties removed, except St John, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
**Health and Disability Commissioner**