Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC02297)

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. It concerns the treatment Mrs A received on 15 June 2021 at a beauty therapy clinic.

2. Mrs A complained to HDC that she was badly burned during a body contour treatment at the clinic in June 2021. Mrs A believes that her treatment was administered with a machine that the clinic knew had a faulty part that required replacement, and, as a result, she suffered a large third-degree burn[1] on her abdomen. Mrs A said that this was extremely painful and required a skin graft, and she spent nearly a week in hospital.

3. The following issue was identified for investigation:

   - *Whether the clinic provided Mrs A with an appropriate standard of care.*

4. This report sets out the Deputy Commissioner's opinion on the quality of the treatment Mrs A received from the clinic.

[1] A third-degree burn (also referred to as a full-thickness burn) destroys all layers of the skin and may damage underlying tissue.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Background

5. The body contour treatment Mrs A underwent was thermal shock lipolysis (TSL). TSL uses a combination of hot and cold temperatures to target fat cells and is intended to help people who are seeking 'spot reduction' in specific areas. The treatment is administered in three stages, by heating the targeted area, then cooling it, then heating it again.

6. The clinic used a machine to administer Mrs A's TSL. The machine has several applicators with contoured heads, which are positioned on the areas of the body being treated, to deliver heating and cooling. The machine's treatment guide[2] states that TSL treatment may cause moderate discomfort, a feeling that the skin is being pulled into a vacuum, and/or a stinging or cold sensation for the first 20 minutes, after which the client should feel 'quite comfortable'.

Key events

7. On 15 June 2021, Mrs A attended an appointment at the clinic to have TSL treatment. Mrs A had received the treatment once before without issue, on 18 May 2021.

8. The clinic told HDC that TSL clients are informed that they should only ever feel a slight warming sensation when the machine is in the heating phase, and that they should report any pain or discomfort to the beauty therapist immediately. The clinic stated that Ms B, the apprentice beauty therapist who administered Mrs A's TSL, provided this information to Mrs A prior to treatment. In addition, Mrs A signed an electronic consent form on 18 May 2021, prior to her first TSL treatment. The consent form stated that she might experience tenderness, stiffness, redness, swelling, and bruising in the areas being treated. In addition, the consent form stipulated that Mrs A had been advised and fully informed by the clinic about the treatment she was undertaking and any possible adverse side effects, and she accepted that occasionally the treatment may not produce the desired effect and understood that 'occasionally human error occurs'.

9. The clinic stated that the treatment at this appointment was to Mrs A's lower abdomen,[3] and comprised 10 minutes of heating at 42°C, 35 minutes of cooling down to -2°C, then 10 minutes of heating at 42°C. Mrs A told HDC that the machine 'overheated' during the last few minutes of the final heating stage, causing her 'extreme pain and discomfort'. The clinic said that this was due to an applicator head heating up beyond the pre-set maximum of 42°C, and the machine not having an indicator to show that a fault had occurred.

10. Mrs A said that she alerted Ms B, who told her that pain was normal on the stomach area, and that there were only four minutes left if Mrs A could 'stick it out'. Mrs A said that the pain was unbearable, but she was concerned that stopping the treatment early might leave

[2] The treatment guide provides instructions for administering treatment, and general guidance on operating and maintaining the machine.
[3] TSL was administered to Mrs A's thighs at the same time without issue.

her with a 'frozen block of fat' in that area.[4] Mrs A said that she 'tried to put up with the pain' as Ms B was not decisive about whether she would be left with a 'frozen block of fat' and she personally had doubts about whether stopping would be safe. Mrs A said that Ms B checked the applicator head and the machine's screen and said, '[E]verything looks fine, but we can remove [the applicator] if you want,' before leaving the treatment room. Mrs A said that she was left to make a decision she should not have had to make.

11. Ms B told HDC that when Mrs A first told her that she felt 'stinging' under the applicator, she looked to be in 'quite a bit of discomfort'. Ms B said that she suggested that the applicator be taken off to review the area, but Mrs A was concerned that she would be left with a solid block of fat as the treatment still had six minutes to go. Ms B stated that she advised Mrs A that the area could be massaged out, if necessary, as in cryolipolysis treatment, but Mrs A told her not to remove the applicator as 'the stinging sensation had eased and gone away'. The clinic told HDC that this delayed the removal of the applicator. Ms B stated that she left the room and told her colleague, Ms C, that she did not feel right about the treatment and wanted to remove the applicator to check Mrs A's skin. In her statement to HDC, Ms C's recollection of this conversation is consistent with Ms B's.

12. Mrs A stated that Ms B came back into the room 'a couple of minutes later' and asked her if she was still having pain. Mrs A said she confirmed that the pain was 'beyond manageable' and she asked if the applicator could be removed, at which time Ms B did so. Mrs A said that 'this revealed a huge, popped blister, showing thick skin ripped off and a big flaming red burnt patch of raw skin approximately 10cm x 10cm' on her lower abdomen.

13. Ms B said that she went back into the room and told Mrs A that she was going to remove the applicator. The clinic told HDC that Ms C also went into the room at this point. When Ms B removed the applicator, she said 'everything appeared normal', but when she removed the antifreeze membrane[5] from Mrs A's skin, the top layer of her skin 'peeled back' with it. Ms B told HDC that she does not recall having had any training about 'recognition and management of unexpected concerns' resulting from TSL treatment.

14. Ms B left the room and returned with Ms D, the owner of the clinic. Mrs A told HDC that neither woman showed immediate concern, and they were 'chuckling and commenting … about [her] high pain threshold'. Ms D and Ms B deny that they laughed at Mrs A, or minimised her pain, at any point. Mrs A said that she was 'shaking and in shock … [and] knew it was bad', and she 'just wanted to get to a medical centre'. Mrs A said that at that point, Ms C entered the room and told her that when the machine was being trialled, she too had received a burn, but it had not been so bad, indicating with her hand that the burn had been around the size of a 50-cent coin. Mrs A said that staff were also very quick to inform her that her burn had been caused by a faulty part on the machine, and that the supplier would be sending them a replacement part.

[4] Cryolipolysis is similar to TSL but without the heat component. A rare side effect of cryolipolysis, called paradoxical adipose hyperplasia, occurs when the number of fat cells in a treated area increase rather than decrease, leaving a firm and typically painless mass under the skin.
[5] Used to protect the skin during cooling.

15. In her response to the provisional opinion, Ms D told HDC that the machine was not awaiting a replacement part and that the head that had burned Ms C was disposed of and replaced with a spare head that the clinic had in stock. Ms D stated that the clinic did not treat Mrs A with a machine that it knew or ought to have known posed a risk of harm, as the replacement head had been in use for four months without issue, including on the morning of 15 June 2021, prior to Mrs A's treatment. Ms D stated that the clinic believes that the faulty head involved in Ms C's treatment 'reflected an isolated incident which had been resolved', and it did not know that the head used in Mrs A's treatment was faulty.

16. Mrs A said that the first aid and aftercare the clinic provided for her burn was neither informed nor professional. She stated that Ms D gave her an icepack and told her that her burn was superficial, and she should go to the doctor 'for reassurance' if needed. Mrs A said that as she was in 'excruciating pain', she did not question this information at the time and left to see her general practitioner (GP) immediately. The clinic told HDC that a cold compress and icepack were placed on Mrs A's abdomen, and Ms D and Ms B dressed Mrs A's wound after Ms C went to the pharmacy to purchase dressings. The clinic said that Mrs A was advised to see her GP immediately, and that this advice was reiterated by Ms B when she telephoned Mrs A later that day and was told that Mrs A had only purchased burn repair cream from a pharmacy. The clinic stated that these steps were prompt and appropriate first aid for Mrs A's injury.

17. Ms B said that she also apologised to Mrs A during the telephone call and offered her free treatments once her burn had healed — two to three sessions of dermal needling and serum to help with any scarring and repair of her skin barrier. Ms B said that she advised Mrs A that the clinic would cover the cost of any medical treatments she needed.

Subsequent medical care

18. Mrs A saw a GP at her usual medical centre on the afternoon of 15 June.[6] Her records state that the burn and surrounding inflammation measured approximately 15cm in diameter and the burn and skin blistering were considered superficial at that time. Mrs A's burn was dressed, and she was prescribed pain relief. Mrs A said that at a follow-up review on 17 June, she was advised to monitor the burn closely as it would be prone to infection, especially as it had a large surface area.

19. On 21 June, Mrs A saw a GP again. The GP documented that Mrs A was feeling unwell and feverish, with a fast heart rate, and her wound was weepy, sore, and itchy. Mrs A was prescribed oral flucloxacillin (an antibiotic) and was to be reviewed after 24 hours. At the review on 22 June, the GP noted that Mrs A was still unwell. The inflammation around her wound had increased, and therefore she was started on intravenous (IV) cefazolin (another antibiotic).

20. At a further review on 23 June, the GP documented that Mrs A's wound appeared better, but Mrs A was feeling numbness in areas of the wound. Mrs A said that this indicated that the burn was deep and had affected some nerve endings. The GP decided to refer Mrs A to

[6] It appears that Mrs A saw several different GPs at her GP practice in this period in relation to her burn.

the plastic surgery service at the public hospital on the basis that her burn was potentially deep and/or a third-degree burn.

21. On 25 June, a GP at the medical centre discussed Mrs A's burn with a plastic surgery registrar at the public hospital. The registrar reviewed photographs of the burn, which was documented as having 'features of a full thickness burn' at that time. It was agreed that the plastic surgery service should assess Mrs A's burn to see if it would require a skin graft. Mrs A was admitted to hospital that evening and was found to have an infected full-thickness burn. On 26 June, Mrs A underwent surgery to debride[7] the burn site and apply a skin graft taken from her left thigh, to encourage her wound to heal. Mrs A remained in hospital until 1 July.

Additional information

Further comments — the clinic

22. The clinic's records show that the machine was purchased online on 18 February 2021 from overseas. The clinic received the machine around three months before the events. During its enquiries into Mrs A's complaint, the New Zealand Board of Professional Skin Therapies (NZBPST)[8] documented that Ms D said that she purchased the machine from overseas as the machines available in New Zealand were very expensive. In her response to the provisional opinion, Ms D said that the issue was not that the machines are expensive, but that they are not available, and she does not know of any New Zealand-based supplier. Ms D told HDC that she is aware of other clinics in New Zealand that use the same equipment from the same overseas supplier.

23. Ms D stated that the machine did not require much set-up and had not undergone any maintenance before being used for Mrs A's treatment. Ms D, Ms B, and another beauty therapist had trained to use the machine by reading the user manual and having a WhatsApp call with the manufacturer. The NZBPST documented that Ms D said that the manufacturer also provided an online video with the machine's operating instructions, but the clinic did not provide that information to HDC. Ms D said that the set-up and training on the machine was easy as it is 'relatively basic and easy to operate', especially for anyone who was already trained to use other machines, such as those used for laser treatment and tattoo removal, as she and her staff were. The clinic told HDC that it had a TSL procedure in place from the time it started providing the treatment at the clinic in March 2021, and its staff were trained in accordance with that procedure. The clinic's TSL procedure is set out in Appendix A.

24. The machine's treatment guide states that the applicators must always be kept clean and must always be inspected visually before treating a client and, if any damage is apparent, the applicator/s should not be used.

25. The clinic said that the temperature settings on the machine are 'checked on set up and before the treatment is performed. The treatment cannot be set higher than 42°C, so there is no room for therapist error.' The clinic said that 'no particular checks' were done on the

[7] Remove dead or unhealthy tissue.

[8] The NZBPST is a membership organisation for skin therapy and beauty professionals in New Zealand.

machine prior to Mrs A's treatment, and typically none were required. The machine had been used for 90 minutes on the morning of 15 June 2021 without issue. The clinic said that it stopped using the machine after the events, and eventually it was removed from the clinic, as 'staff were no longer comfortable undertaking the treatment'.

26. Ms D is a member of the New Zealand Association of Registered Beauty Professionals (NZARBP).[9] The clinic said that it is therefore subject to NZARBP's rules and regulations, health and hygiene guidelines, and code of ethics.

Complaint to clinic

27. On 27 June 2021, Ms F emailed a complaint to Ms D at the clinic on behalf of her sister, Mrs A. Ms F advised that Mrs A's burn and her need to undergo surgery had had a considerable impact not just on Mrs A, but also her family, her business, and her income. Ms F stated that Mrs A's injury should never have happened, and she was seeking compensation for it. Ms F asked Ms D to respond to her 'with some ideas as to how/what you think is reasonable, beyond simply paying for her medical bills'.

28. On 28 June 2021, Ms D sent four emails to Ms F about her complaint. Ms D said that she would like to speak to Mrs A, but Ms F asked that Ms D contact her instead. Ms D sought, and obtained, Mrs A's permission to speak to Ms F about her complaint, and asked Ms F when she would be available to discuss the complaint by telephone.

29. On 30 June 2021, Ms D and Ms F had a telephone conversation about the complaint. There is no record of the conversation, although a later email indicates that Ms D gave Ms F information about LED light therapy[10] that the clinic could provide to help Mrs A's wound to heal. Following the conversation, Ms F emailed Ms D to request that she provide her 'thoughts and details around compensation'. Ms F said that she would put the information to Mrs A, her husband, and their lawyer.

30. On 7 July 2021, Ms F emailed Ms D stating that she had shown an absence of compassion and had made no offer of compensation for Mrs A's 'consequential losses'. Ms F said that they would pursue a civil prosecution and go public by way of media and social media if the clinic was not willing to offer compensation.

31. On 9 July 2021, Ms D responded to Ms F on behalf of the clinic. Ms D said that she was sorry about Mrs A's injury and the impact it had had on her and was very concerned that the incident had happened. Ms D apologised for not responding to Ms F earlier, saying that the clinic's insurers had been notified and were working on the matter, including contacting Ms F. Ms D said that the clinic was 'wholly sympathetic' to Mrs A's experience.

32. Ms D said that the clinic had investigated and found that a malfunction in one of the attachments on the machine had caused its temperature to rise above the set level. She said that Mrs A's injury was not due to any of the clinic's therapists. Ms D stated that the

[9] The NZARBP is a membership organisation for beauty industry professionals in New Zealand.
[10] A non-invasive treatment that soothes inflammation in the skin, while stimulating the skin's natural cell turnover process.

defective equipment had been replaced and additional protocols were put in place to avoid the fault happening again.

33. Ms D said that the clinic had been advised that Mrs A's injury was covered by the Accident Compensation Act 2001, and it had no legal liability to pay her compensation. ACC's records show that it approved Mrs A's treatment injury claim on 17 June 2021.[11] Ms D stated:

> '[E]ven if there was a legal basis for [Mrs A] to seek compensation from the clinic (which there is not), our legal advice is that the clinic has not been negligent and there would be no basis for any liability.'

34. Ms D said that her solicitors also advised that Ms F's 'threat' to publicise Mrs A's experience in media and social media was 'very inappropriate'. Ms D confirmed that the clinic would support Mrs A with LED light therapy.

35. Mrs A told HDC that she received only verbal apologies from the clinic, despite having permanent scars from the burn and skin graft. In addition, she said that Ms D failed to take responsibility for the incident or answer any of her specific questions, including queries about the machine's manufacturer, safety protocols, and training.

Worksafe investigation

36. On 26 July 2021, Mrs A made a complaint to WorkSafe about the clinic.[12] On 20 August 2021, following an investigation, WorkSafe wrote to the clinic to confirm that it had been non-compliant with the Health and Safety at Work Act 2015 in Mrs A's case. WorkSafe stated that the clinic had put 'the health and safety of [its] client … at risk by exposing them to the risk of overheating their skin resulting in a burn that required medical treatment'. WorkSafe stated that formal enforcement action would not be taken but the clinic must ensure that it was compliant and could do that by ensuring that the machine had a system to ensure that it does not exceed the maximum and minimum temperature parameters set out in its treatment guide. No follow-up action was indicated by WorkSafe in this respect.

Complaints to industry organisations

37. Mrs A raised complaints about the clinic with other industry bodies, including the NZARBP and NZBPST. Both organisations contacted the clinic to investigate Mrs A's complaint and were advised by the clinic that the machine used for Mrs A's treatment had been faulty, but it had since been repaired, and new protocols were being implemented to safety test the machine every morning.

[11] The Accident Compensation Corporation (ACC) may pay for, or contribute to, the cost of treatment, rehabilitation, and compensation where a patient has received an injury during treatment.
[12] The primary regulator of workplace health and safety in New Zealand.

Responses to provisional opinion

Mrs A

38. The section of my provisional opinion that comprised the information gathered during my investigation was shared with Mrs A for comment. Mrs A confirmed that she had no further comments.

Clinic

39. The provisional opinion was shared with the clinic, and it was invited to respond. The clinic told HDC that it 'accepts the findings of the Deputy Commissioner and considers that the proposed recommendations are reasonable in the circumstances'. The clinic provided clarification about several matters, which has been incorporated into this report as necessary. The clinic also advised that both its clinics now have first aid kits that are equipped with supplies beyond the minimum requirements specified by the NZARBP, and all staff know where the kits are located. The clinic also stated:

> 'All machines purchased for both its clinics were purchased from [a company] in New Zealand. The only machine that had been purchased elsewhere was the TSL machine, which is not in use and has not been in use since the incident. No machinery is purchased from any other supplier. [The company] also offers training which has been taken up by the clinic, together with extra training …'

40. The clinic confirmed that TSL treatment will not be reintroduced in its clinics.

Opinion: Clinic — breach

41. I do not underestimate the impact of these events on Mrs A. She suffered a serious third-degree burn during a treatment that she expected would contour her body. Instead of the intended results, Mrs A required hospitalisation for surgical debridement and a skin graft. Mrs A's graft and skin graft donor sites took many months to heal, and she has described being left with permanent scars and trauma from the incident, which took a 'huge toll' on her life.

42. This report discusses the adequacy of the treatment the clinic provided to Mrs A and the clinic's response to Mrs A's complaint about that treatment. Having undertaken a thorough assessment of the information gathered, I am critical that systemic issues at the clinic culminated in Mrs A being injured during the treatment. I have set out my decision below.

Provision of treatment — breach

43. The TSL treatment Mrs A received at the clinic was clearly not of an appropriate standard. The injury she suffered was serious and should not have happened. I am concerned that the clinic did not have appropriate systems in place to safeguard Mrs A from harm during her TSL treatment, and that the clinic was aware of problems with the machine before it was used for Mrs A's treatment.

44. Although the New Zealand beauty industry is largely unregulated, there are clear standards regarding how the clinic should conduct itself as a provider of health and beauty treatments.

As a member of NZARBP, the clinic is subject to (and stated that it complies with) NZARBP's rules and regulations, health and hygiene guidelines, and code of ethics. Moreover, the clinic is required to comply with the Code of Health and Disability Services Consumers' Rights (the Code),[13] which sets out the rights of consumers and the obligations and duties of healthcare providers.[14] Right 4(4) of the Code is especially relevant to Mrs A's complaint, as it stipulates that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Removal of applicator

45. When Mrs A first told Ms B that she was experiencing considerable pain, it appears that Ms B was not certain how to respond. That is unsurprising, given that Ms B told HDC that she could not recall having received any training about recognising and managing 'unexpected concerns' resulting from TSL treatment. As a result of the uncertainty, the overheating applicator remained on Mrs A's abdomen for 'a couple of minutes' until Ms B removed it. I consider it likely that the delay in removing the overheating applicator was exacerbated by deficiencies in the clinic's TSL procedure, which is not clear about who should remove the applicator if a client is feeling pain or discomfort. The procedure states: '[T]here should be no burning or stinging sensation. If this is experienced at all the client is to let the therapist know and the head will be removed immediately.' However, the procedure twice mentions the client's ability to remove the applicator: '[T]he clients are able to remove the heads themselves if they ever become uncomfortable and are shown how to do this at the start of the treatment.' There is no indication that Mrs A was made aware, prior to the start of treatment, that she could remove the applicators herself.

46. I cannot reconcile the different accounts Mrs A and Ms B provided in terms of who wanted to remove the applicator and when. However, Mrs A's injury clearly demonstrates that this decision should have been made, or at least guided, by a TSL-trained beauty therapist. I accept Mrs A's view that she should not have had to decide whether to remove the applicator herself, as she did not know the possible consequences of stopping her treatment early and was not reassured by Ms B saying that she did not think it would result in fat freezing. In my view, a beauty therapist administering treatment should be clear on what to do if a problem arises and be familiar enough with the treatment to answer a client's questions, including the possible implications of stopping the treatment early.

47. I note that Ms B does not appear to have asked Mrs A any questions when she reported that the treatment had become painful. Mrs A told HDC that Ms B instead told her that it was normal to feel pain in the stomach area. It would have been appropriate for Ms B to have questioned Mrs A promptly to assess the severity of her pain. Based on the treatment guide, TSL treatment may cause moderate discomfort, a feeling that the skin is being pulled into a vacuum, and/or a stinging or cold sensation for the first 20 minutes, after which the client should feel 'quite comfortable'. As Mrs A described the pain as 'unbearable' and she was

[13] The Code is a regulation under the Health and Disability Commissioner Act 1994.

[14] TSL treatment, and advice pertaining to that treatment, are 'treatment services' and services to promote and/or protect Mrs A's health, within the definition of 'health services' under section 2 of the Health and Disability Commissioner Act 1994 (the Act). As such, the clinic is a healthcare provider under section 3(k) of the Act and is required to comply with the Code.

nearly at the end of her treatment, the pain she reported should have been taken more seriously. Improved communication could have established that the applicator needed to be removed immediately, and avoided Mrs A having to endure the pain for the additional two minutes it took Ms B to leave the room to speak to Ms C.

Aftercare

48. The accounts of Mrs A and the clinic also differ in terms of the care Mrs A received once her burn was discovered. At that point, the severity of the burn was not evident. However, the size of the burn and Mrs A's severe pain clearly indicated that she required first aid. The NZARBP's Health and Hygiene Guidelines (2020)[15] (the guidelines) state:

> 'All beauty professionals on the premises are advised to have a current first aid certificate. There must be at least one person in the clinic/premises at all times with a first aid certificate. All beauty clinics/premises must have a first aid kit containing pressure bandages,[16] a single use disposable resuscitation mask and triangle bandage (St John or Red Cross first aid kits preferred) …
>
> Beauty professionals must have procedures for managing accidents and unforeseen events. These procedures include keeping a registry to record any incidents involving the client or operator where there is exposure to blood or bodily fluids, including the name and address of those exposed and the steps undertaken to respond to the incident. Procedures must also be in place to record and manage incidents where prolonged or unexpected bleeding occurs.'

49. In my view, Ms D, as an NZARBP member and owner of the clinic, did not comply with these guidelines. There is no indication that the clinic had a process for managing accidents, and the TSL procedure did not include any information in that respect. The first aid provided to Mrs A was also lacking. Basic first aid for a burn such as Mrs A's involves pouring cool water over the burn for at least 20 minutes and covering the burn with a non-adhesive sterile dressing or loose cling film.[17] Unfortunately, Mrs A was treated with an icepack, rather than cool water. The clinic also did not have any bandages/dressings for Mrs A's wound and Ms C had to leave to purchase them.

TSL procedure

50. Given the issues I have identified above, I consider that the clinic's TSL procedure did not include sufficient information to ensure that its staff administered TSL treatment consistently, safely, and correctly every time. Notably, the undated procedure (which is included at Appendix A) comprised only half a page of information. Although it outlined the general steps for providing TSL, the procedure had a strong focus on how the beauty therapist should describe the treatment, and its stages, to the client. I am critical that the

[15] The version of the guidelines that was current at the time of the events.
[16] Non-adhesive bandage that helps to minimise swelling, protect wounds from contamination or additional trauma, and prevent heat and fluid loss.
[17] Hato Hone St John, First Aid Guides - Burns, accessed 29 April 2024.

procedure omitted key information which, if applied at the time, could have mitigated the risk of Mrs A being injured and/or suffering a deep burn.

51. The procedure did not include the precautionary information from the treatment guide that states that the applicators must always be kept clean and must always be visually inspected before treating a client and, if any damage is apparent, the applicator/s should not be used. In this respect, I note that Ms D told HDC that the machine required 'no particular checks' prior to Mrs A's treatment. While inspection of the applicators may not have changed anything for Mrs A on the day she was burned, it is important that equipment is used in accordance with the manufacturer's instructions and that staff are made aware of those instructions.

52. As illustrated above, it would also have been appropriate for the procedure to have included guidance on when the beauty therapist administering the treatment should ask for help or advice, and who they should speak to. It should include guidance on what the beauty therapist should do if a client expresses pain at any stage during the treatment, especially extreme pain as in Mrs A's case. The procedure should also have advised staff to provide appropriate first aid if an injury occurred, with the assistance of the first aid certified staff member. Unfortunately, it is likely that these omissions in the clinic's TSL procedure contributed to Mrs A's injury.

Consideration of risk

53. Ms C told HDC that she received a burn the size of a 50-cent piece from a faulty applicator head on the machine. She said that the pain was intolerable, but the machine showed the temperature as normal, and no alarm sounded. Mrs A told HDC that immediately after she was burned, staff told her about Ms C's burn and said that the machine had a faulty part that had caused her burn. The clinic's account differs, in that Ms D said it was unaware of any fault with the machine, which had been working without issue for around four months prior to the incident.

54. From the information available, I cannot establish what was said about a fault with the machine when Mrs A's burn was discovered. Therefore, I have not seen evidence that the clinic used the machine for Mrs A's treatment in the knowledge that it had a faulty part awaiting replacement.

55. Nevertheless, it is troubling that the clinic continued to use the machine despite knowing that it had malfunctioned and burned Ms C. In my view, the circumstances of Ms C's burn revealed a risk to consumers that the machine could overheat without any warning or alert. That should have prompted the clinic to review its use of the machine. While the clinic later requested a software update from the manufacturer to prompt an alert if a temperature exceeded the preset temperature, the update should have been requested and implemented before the machine was used again after the malfunction, to ensure that it was safe for consumers. The NZARBP code of ethics (2020) specifically addresses this scenario, stating that 'no employer, senior beauty professional/manager or owner will allow

staff to use machinery which they know to be faulty, under powered or not delivering its full capabilities in a treatment/service that they receive financial gain from'.[18]

56. I note that WorkSafe's investigation made a similar finding. Worksafe found that the clinic was not compliant with the Health and Safety at Work Act 2015 and directed it to become compliant by ensuring that the machine could not exceed the maximum and minimum temperatures in the machine's treatment guide. I agree with WorkSafe's conclusion. It is troubling that the machine does not appear to have had, at a minimum, a system to alert the operator to a serious malfunction, such as the overheating that occurred in Mrs A's case.

57. The issues I have identified in this report indicate that the clinic took a more casual approach to the provision of TSL treatment than is appropriate. This extends to the clinic's approach to purchasing, and training on, the machine. NZBPST records state that Ms D said that she purchased the machine from overseas to avoid paying for a more expensive machine in New Zealand. Ms D told HDC that in fact she was not aware of any supplier of TSL machines in New Zealand. Irrespective of the reason the machine was purchased from abroad, it is not clear that the clinic had sufficient information about the manufacturer and the quality and safety of the machine prior to purchase, such as what safety protections the machine had to alert the operator to a serious malfunction, and guard against such malfunctions.

58. The safety of professional beauty equipment that is sourced from abroad must be a fundamental consideration for beauty therapy providers, especially where that equipment can cause harm, such as burns. In previous investigations,[19] I have referenced Auckland Council's Health and Hygiene Bylaw 2013, which requires certain health and beauty services to be licensed and to comply with separate health and beauty codes of practice.[20] In the absence of broader national regulation of the beauty therapy sector, this bylaw helps to regulate certain beauty treatments in the areas covered by Auckland Council. Like most councils in New Zealand, the district council where the clinic is based does not have a similar bylaw. Based on my findings in this investigation, the district council may wish to consider introducing such a bylaw.

59. Ms D stated that initial training on the machine, and all communications with the manufacturer, took place over WhatsApp. The clinic did not have easy access to help and technical support, as might have been anticipated, with the manufacturer being based overseas. That may have been partially mitigated had the machine arrived with sufficient training materials and operating instructions. However, the machine was supplied with a 20-page treatment guide only, which Ms D, Ms B, and a third beauty therapist used to train themselves to operate it.

60. I am not satisfied that the clinic properly considered the risks posed by TSL once it became aware of Ms C's burn, as it failed to take appropriate action to provide the treatment in a manner that minimised potential harm to Mrs A and other consumers. I acknowledge that

[18] The version of the code of ethics that was current at the time of the events.
[19] 21HDC00153 and 19HDC00698, available at https://www.hdc.org.nz/.
[20] https://www.aucklandcouncil.govt.nz/plans-projects-policies-reports-bylaws/bylaws/Pages/health-and-hygiene-bylaw.aspx

the clinic told HDC that it has taken several actions to avoid a similar event happening in future. The clinic did not provide evidence that those actions were implemented, as it told HDC that neither the machine, nor any other TSL machine, has been used in the clinic since Mrs A's treatment.

61. The clinic had a responsibility to provide Mrs A with treatment of an appropriate standard, and to provide that treatment in a manner that minimised potential harm to her and optimised her quality of life. Mrs A's TSL treatment at the clinic on 15 June 2021 was not provided in that manner. I am critical that the clinic failed to:

- Provide staff with clear guidance on how to respond to a client reporting pain during TSL treatment.
- Provide Mrs A with appropriate first aid for her burn.
- Have an appropriate procedure in place for the provision of TSL treatment.
- Properly consider, and appropriately respond to, the risks of providing TSL treatment with a machine that had previously burned a staff member.

62. Mrs A's complaint highlights how seriously beauty clinics must take all treatments, even those that are non-invasive, such as TSL. Appropriate processes must be in place to reduce the risks of the treatment to consumers and guide staff to carry it out consistently, safely, and correctly every time. Regrettably, Mrs A was treated with a machine that had malfunctioned previously and had no warning to show that it was malfunctioning again, resulting in a serious injury that has had an ongoing detrimental effect on Mrs A's life. Accordingly, I find the clinic in breach of Right 4(4) of the Code.

Complaint handling — no breach

63. Right 10(3) of the Code stipulates that 'every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints'. The NZARBP's code of ethics similarly requires that 'a member shall maintain a high standard of professionalism including being willing to address any treatment complaints, without charge, that have occurred due to poor delivery on the part of themselves, or any of their employees, or for faulty products'.

64. Ms D formally responded to Ms F's complaint on behalf of the clinic within 10 working days. While I recognise that Ms F felt that Ms D was slow to contact her after their initial telephone conversation about the complaint on 30 June 2021, I consider that Ms D's email response of 9 July 2021 was prompt. Ms D appropriately provided an apology for Mrs A's injury and accepted that it was caused by the malfunction of one of the TSL machine's applicators. The clinic also offered Mrs A several free skin treatments once her burn had healed.

65. It appears that there was little chance of remedying the complaint further as Ms F asked that the clinic offer Mrs A financial compensation for her injury. Ms F did not specify an amount in the available correspondence but, in a later social media post in July 2021, Ms D said that a member of Mrs A's family had suggested that the compensation sought was upwards of 'tens of thousands' of dollars (exceeding any goodwill payment the clinic had considered offering).

66. Ms D's complaint response to Ms F correctly stated that ACC was an appropriate avenue to explore regarding any compensation or financial support that could be provided in relation to Mrs A's treatment injury claim. I am not critical that the clinic did not provide Mrs A with financial compensation. I also note that the clinic offered Mrs A relevant skin treatments at no cost after her wound had healed. Although I understand that Mrs A, not unreasonably, chose not to return to the clinic, the treatments the clinic offered were tangible and appropriate as part of an overall remedy for the complaint. I have concluded that the clinic did not breach the Code in its handling of Ms F's complaint about Mrs A's treatment.

Changes made since events

67. The clinic told HDC that several actions were taken in response to Mrs A's experience:

a) The faulty head on the machine, which caused Mrs A's injury, was replaced.

b) The clinic requested a software update from the machine's manufacturer in relation to the temperature controls and notification of a temperature that exceeds the pre-set temperature.

c) An updated TSL treatment protocol was drafted.

d) Three staff members undertook first aid training, and two staff were booked to attend first aid refresher training in July 2024. In-house first aid training was also provided to staff, using relevant scenarios.

e) The clinic's solicitors assisted with the drafting of an updated safety and treatment policy for the machine.

f) The clinic ceased using the machine after the events and said that it would not be using the machine until it was satisfied that the protocols and testing it has implemented will prevent the same fault happening again. (Subsequently, the clinic told HDC that the machine has been removed from the premises and it is not offering TSL treatment.)

g) The clinic's suppliers were reviewed, and it has moved to purchase most machinery from New Zealand-based suppliers.

Recommendations

68. I recommend that the clinic:

a) Provide a written apology to Mrs A that reflects on the deficiencies identified in this report. The apology should be sent to HDC, for forwarding to Mrs A, within three weeks of the date of this report.

b) Provide copies of current first aid certificates from a recognised first aid training provider for the first aid trained staff and confirm that the clinic has at least one staff member with current first aid training in each clinic at all times. This information should be provided to HDC within three months of the date of this report.

Follow-up actions

69. I will request that the relevant district council consider the adoption of Auckland Council's Health and Hygiene Bylaw 2013 to mitigate future harm of this nature to consumers.

70. I will request that the New Zealand Association of Registered Beauty Professionals consider issuing a caution to its members about the purchase of equipment that does not meet New Zealand standards, does not have adequate safety mechanisms, and has limited post-purchase support.

71. A copy of this report with details identifying the parties removed will be sent to WorkSafe, the New Zealand Association of Registered Beauty Professionals, and the district council, and placed on the Health and Disability Commissioner website, hdc.org.nz, for educational purposes.

Appendix A: Thermal shock lipolysis procedure

- Explain treatment protocol to client. Main points — how the treatment works, number of treatments needed, aftercare, what may be experienced during the treatment, including the feeling of going from hot to cold.
- Take client's measurements and before and after photos.
- Area to be treated needs to be wiped down so there is no moisturiser etc on the skin.
- Apply anti-freeze membrane to the areas [being] treated.
- Machine's temperatures will have been set prior to treatment depending on area being done. Check these times and temperatures. Record area [being] done and time and temperatures [being] used on each area.
- Apply one head at a time adjusting suction to client's comfort, show client how to remove the head if they become uncomfortable at all.
- Therapist to stay with the client during the full first heating phase to make sure client is comfortable and not experiencing any form of overheating. The heating phase is explained to the client as if you were in a warm spa pool, there should be no burning or stinging sensation if this is experienced at all the client is to let the therapist know and the head will be removed immediately. The therapist also asks the client how the heating is feeling every few minutes during this first phase.
- The heads will then go into cooling phase. Explain to the clients once again at no point this should feel painful. The area will change from feeling warm to a super cold feeling as if you put a bag of cold peas on the area. The anti-freeze membrane helps protect the skin during this phase. While the cooling phase is on the client is checked on every few minutes to make sure they are feeling comfortable (the clients are able to remove the heads themselves if they ever become uncomfortable and are shown how to do this at the start of the treatment).
- The machine will then go into the last phase of heating which the therapist must stay with the client for the full duration of the last phase. This phase should feel the same as phase one. It's the nicest part of the treatment as it is heating up the area that has just been in freezing stage.
- Once treatment is complete take heads off one at a time, remove anti-freeze and massage each area for up to 5 minutes.
- Go through aftercare with the client once more, rebook their after photos/second session.