Registered Nurse, RN C

The Ultimate Care Group Limited (trading as Allen Bryant)

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01539)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 13 Month1[1] 2016, Mr B was admitted to Allen Bryant Rest Home (the rest home) for respite care.

2. Mr B discussed his wishes regarding resuscitation in the event of a collapse with the general practitioner (GP) at the rest home. Mr B was given an information pamphlet entitled "What does 'Do Not Resuscitate' mean to me?" and he completed a "resuscitation status" consent form. Mr B ticked the option on the consent form that expressed his wish to be resuscitated and signed the form. Mr B did not sign a DNR order.[2]

3. On 29 Month2, Mr B was readmitted to the rest home following an operation. Mr B's routine at the rest home included dressing himself and wheeling himself to breakfast. He was seen by the GP on 3 Month6 and, apart from a cough, he was deemed to be medically stable.

4. On the morning of 4 Month6, Mr B collapsed in his bathroom. Registered nurse (RN) RN C discovered him at 6.40am. He was slumped between the toilet and the wall with his head touching the floor. He was wearing only a pyjama top.

5. RN C called for assistance and, with the help of a caregiver, moved Mr B so that he was lying on the floor. RN C performed a brief "signs of life" assessment but she did not attempt to resuscitate Mr B.

6. RN C told HDC that she directed the caregivers to attend to other patients. She left Mr B lying partially covered on the floor and went to reception and rang an ambulance. She told the dispatcher that she thought that Mr B was already dead. She then attended to other duties and returned to Mr B at the same time that the ambulance officer arrived.

7. The ambulance officer told HDC that Mr B was still warm when she arrived and that she commenced CPR. The CPR was unsuccessful.

8. The GP certified that the cause of death was a heart attack.

Findings

9. RN C should have attempted to resuscitate Mr B, and her decision not to do so was a failure to provide an essential and potentially life-saving service to Mr B. RN C made this critical decision and a number of other poor decisions. RN C made only a brief assessment for signs of life, she left Mr B alone at the scene, and she failed to protect his dignity by covering him. Accordingly, RN C failed to provide services to Mr B with reasonable care and skill and, as a result, breached Right 4(1) of the Code.

10. The "Cardio Pulmonary Resuscitation/Serious Illness Policy" (the Policy) and the "resuscitation status" consent form at the rest home differentiate between a witnessed and an unwitnessed collapse. It is not standard practice in aged care residential facilities to

[1] Relevant months are referred to as Months 1-6 to protect privacy.
[2] A DNR order is a legal order made by a person to withhold resuscitation if he or she collapses or suffers a medical event.

differentiate between witnessed and unwitnessed collapses, and the Policy and the consent form were therefore not consistent with standard practice. As a result, The Ultimate Care Group Limited did not take steps as were reasonably practicable to prevent the acts and omissions of RN C that breached the Code. Accordingly, The Ultimate Care Group Limited was vicariously liable for RN C's breach of Right 4(1) of the Code.

11. Adverse comment was made about the lack of insight demonstrated by the rest home in its response to this complaint. The rest home said that the registered nurse's decision not to resuscitate the man was the correct decision as the form that Mr B signed stated that he had requested resuscitation in the event of a witnessed collapse, and the collapse was unwitnessed. The consequences of this interpretation are highly concerning, as it means that in its view, any resident who has not signed a DNR order and wants to be resuscitated will not be resuscitated unless the collapse was witnessed.

Recommendations

12. It is recommended that RN C provide a formal written apology to Mr B's family for her breach of the Code and undertake further training in resuscitation.

13. It is recommended that the Nursing Council of New Zealand consider whether a review of RN C's competence is warranted.

14. It is recommended that The Ultimate Care Group Limited trading as Allen Bryant provide a formal apology to Mr B's family for its breach of the Code, and review its information and consent documents and its policy regarding resuscitation, to ensure consistency with the accepted standards of practice for aged care residential facilities.

Complaint and investigation

15. The Commissioner received a complaint about the services provided by The Ultimate Care Group Limited (trading as Allen Bryant Rest Home) to the late Mr B. The following issues were identified for investigation:

- *Whether registered nurse RN C provided an appropriate standard of care to Mr B in 2016.*
- *Whether The Ultimate Care Group Limited t/a Allen Bryant Rest Home provided an appropriate standard of care to Mr B in 2016.*

16. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

17. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's executor
RN C	Provider/registered nurse
The Ultimate Care Group Limited	

t/a Allen Bryant Rest Home	Provider

18. Information was reviewed from:

Ms D Ambulance Service	Ambulance Officer

Also mentioned in this report:

Dr E	General practitioner

19. Independent expert advice was obtained from a registered nurse, Megan Sendall.

Information gathered during investigation

Admission to the rest home

20. Mr B was admitted to the rest home on 13 Month1 for two weeks of respite care while awaiting an operation.

21. On 13 Month1, Mr B had a discussion with his GP, Dr E,[3] about whether he wanted to be resuscitated in the event of a collapse. Mr B also read an information pamphlet entitled "What does 'Do Not Resuscitate' mean to me?", and he completed a "resuscitation status" consent form.

"Cardio Pulmonary Resuscitation/Serious Illness" Policy

22. The rest home had a policy on "Cardio Pulmonary Resuscitation/Serious Illness" (the Policy) in place between Month1 and Month6.

23. The Policy defined cardiopulmonary resuscitation (CPR) as "[a] set procedure used in an emergency situation to restore a person's heartbeat and breathing". The definition also included the following statement: "(Without a DNR order in place healthcare providers are required to perform CPR as required.)"

24. The Policy's definition of a DNR order is as follows: "Do not [resuscitate] (NO CPR); are written instructions … telling healthcare providers not to perform CPR or other life-saving measures … A DNR order does not apply to emergency interventions such as treatment of an obstructed airway by manual airway control."

25. The Policy provides the following:

> "1) In our facility we believe that Attempted Resuscitation in the case of a witnessed collapse is a right for all. Attempting CPR on the frail elderly is likely to be unsuccessful and serious complications may arise, therefore residents will be given the opportunity to make an informed decision regarding their wishes.
>
> 2) Staff will ensure the involvement of the resident in decision-making. Residents will be asked on admission whether they wish CPR to be done in the event of a cardiac

[3] Dr E is a GP at a medical centre which provides medical services to the rest home.

or respiratory arrest. The resident is encouraged to discuss this matter with their family/whanau. Refer *Policy on Informed Consent, Appendix C, Advanced Directives* for details and considerations.

3) Provide the resident … with a copy of the Policy 'What does Do Not Resuscitate Mean to me' at time of admission.

4) It is our policy that Cardio Pulmonary Resuscitation is practiced for all staff/contractors/visitors to the Home/Hospital who have a cardiac or respiratory arrest.

DNR

Those residents who do not wish to be resuscitated will have their wishes recorded in their medical notes on admission. (See Advanced Directive)

A DNR order must be completed by the medical practitioner with discussion and agreement with the resident.

The DNR order can be cancelled at any time by the resident."

The "resuscitation status" consent form

26. The "resuscitation status" consent form recorded that Dr E deemed Mr B competent to make a decision regarding his resuscitation status.

27. The "resuscitation status" consent form stated:

> "Having read and understood the document 'What does "Do Not Resuscitate" mean to me?' and understanding the general risks and benefits, this is my acknowledgement and consent."

28. The "resuscitation status" consent form continued:

> "I have been informed and I understand that in the event of a witnessed sudden unexpected cardio pulmonary[4]collapse:
>
> - I want resuscitation attempts to be undertaken []
> - I do not want resuscitation attempts to be undertaken []."

29. Mr B ticked the first option, which expressed his wish to be resuscitated, and signed the form.

30. The sentence that read "I do not want resuscitation attempts to be undertaken" was not ticked. the rest home told HDC that when a resident ticks this option, the form is treated as a DNR order.

31. Mr B did not sign a DNR order at this time or at any other time.

[4] Relating to the heart and the lungs.

"What does 'Do Not Resuscitate' mean to me?" information pamphlet

32. Mr B read the information pamphlet entitled "What does 'Do Not Resuscitate' mean to me?" and certified that he understood it.

33. The information pamphlet advised that "without a DNR order in place healthcare providers [were] required to perform CPR as required". It also stated that even if a DNR order was in place, the DNR order did not apply to emergency situations, and healthcare providers were therefore required to perform resuscitation in these circumstances.

Readmission to the rest home

34. Following the operation, Mr B was discharged to the rest home for hospital-level care. His condition improved and, on 29 Month2, he was transferred to rest-home level care at the rest home.

35. The rest home told HDC that in the days leading up to 4 Month6, Mr B usually woke up at about 6am, and he would then turn on the radio and dress himself. Between 6am and 6.45am Mr B would wheel himself, in his wheelchair, to the dining room for breakfast.

36. On 3 Month6, Mr B attended Dr E for his three-monthly medical review. Dr E recorded that Mr B had had a cough for two weeks and she prescribed an inhaler. Dr E then completed a "Monthly Doctor's Visit Exemption" form that certified that Mr B was "sufficiently medically stable to qualify for a routine 3-monthly doctor's review".

Events of 4 Month6

37. RN C was on duty at the rest home on the morning of 4 Month6. She was the only registered nurse on duty and she was supported by two caregivers. RN C was stationed in the hospital wing and the caregivers were stationed in the rest-home wing. Together, RN C and the caregivers were responsible for the care of 45 residents.

38. At 4.00am RN C checked Mr B and recorded in the progress notes that she had read the doctor's notes and that Mr B was asleep.

39. RN C told HDC that at about 6.40am she started the last round of resident checks before her shift finished. She noticed that Mr B's room was empty, and said that this was unusual because normally Mr B would be getting dressed or listening to the radio at this time. RN C checked two other residents and then returned to Mr B's room. The door to Mr B's bathroom was closed, and when she opened it she discovered Mr B slumped between the toilet seat and the wall. His head was touching the floor but his bottom half was still positioned on the toilet seat. He was wearing only a pyjama top.

40. RN C told HDC that she pressed the staff assist button to alert the caregivers. RN C said that Mr B was unconscious and that when a caregiver arrived, they moved Mr B so that he was lying on the floor.

41. RN C told HDC that Mr B was not breathing and that she did not notice any obstruction of his airway. She said that there was no rise or fall of Mr B's chest, and she could not hear any breathing sounds or feel any breath coming out of his nose. RN C told HDC that she

could not feel Mr B's carotid pulse,[5] and that his skin was turning blue. She said that there was no bleeding.

42. RN C did not attempt to resuscitate Mr B.

43. RN C told HDC that following her assessment of Mr B, she directed the caregivers to attend to the palliative patients. RN C left Mr B, lying uncovered on the bathroom floor, to go to the nurses' station to ring the medical centre's after-hours number.

44. RN C's calls to the medical centre went to voicemail. RN C called 111, and the transcript of the call records that RN C said: "I think he's dead already, but it's just that I can't reach the on-call doctor." She told the operator at the ambulance service: "I think he died from a head trauma." The call was made at 6.46am and lasted for 6.09 minutes.

45. RN C then checked two of her palliative patients. When she was returning to Mr B's bathroom, RN C met the paramedic, and they both attended to Mr B on the floor of his bathroom.

46. The ambulance officer, Ms D, noted that Mr B was still warm, that there were no signs of trauma, and that resuscitation had not been attempted. Ms D, with the assistance of RN C, attempted to resuscitate Mr B with a defibrillator, but this was unsuccessful. Ms D told HDC that when she arrived to attend to Mr B he was almost naked. She said: "[T]he staff were surprised to learn he was still warm."

47. Dr E certified that the cause of death was acute myocardial infarction.[6]

Information provided by RN C

48. RN C told HDC:

> "I am aware that [Mr B] is for resus[citation] but the collapse was unwitnessed and was not sure how long has he been in that state, so CPR was not initiated.
>
> …
>
> I know it's just a simple task covering someone's body for dignity but when you are already in an emergency situation, sometimes you miss simple yet important details. Although I still should have covered [Mr B's] lower body.
>
> …
>
> [The purpose of the call was] to ask for help to attend to [Mr B] so I can attend to my palliative residents. I had to prioritise the dying over the dead as I was the only RN [at] that time."

Information provided by Allan Bryant Rest Home

49. In its initial response to HDC on 30 August 2018, the rest home told HDC that a full assessment to determine death was not completed. In its view, "[RN C] was completely

[5] Pulse from the carotid arteries, which are the major blood vessels in the neck.
[6] Heart attack.

justified in not commencing [resuscitation] and in fact was complying with the resident's wishes and informed consent."

50. The rest home also submitted:

> "[RN C] did in fact comply with the … policy[7] and by not attempting [resuscitation] she was upholding the wishes of the resident. This was an appropriate response to the situation she was presented with, that being an unwitnessed collapse.
>
> …
>
> [Mr B] had signed to be resuscitated after a witnessed cardiopulmonary arrest [and] [h]er decision not to commence [resuscitation] was correct."

51. In a response received by HDC on 6 November 2017, the rest home submitted: "[RN C] was correct in not commencing CPR." In particular, the rest home submitted that RN C complied with Mr B's wishes, as the form that Mr B signed stated that he had requested resuscitation in the event of a witnessed collapse. the rest home stated: "[Mr B's] collapse was **not witnessed**" (emphasis in the original).

Updated policy

52. Following these events, the rest home updated the Policy (in Month6). A new section was added to address a situation in which a resident collapsed, but the collapse was not witnessed. A distinction was made between what action was to be taken in the event of a witnessed collapse and what action was to be taken in the event of an unwitnessed collapse.

53. The new policy for an unwitnessed collapse is as follows:

> "1. Where a resident's collapse is unwitnessed, staff will on finding the resident, assess the situation taking into account the resident's documented wishes about intervention.
> 2. Staff will on deciding what is required proceed accordingly to carry out CPR or otherwise to carry out comfort care, the appropriate communications with staff, medical practitioner and family.
> 3. The registered nurse will ensure following the emergency that clear and concise documentation is written in the progress notes regarding the decision to not resuscitate if the resident's documented wish is for resuscitation.
> 4. Where residents collapse in a state of partial dress or undress, staff will take steps to preserve their dignity by covering them as soon as practicable with a blanket, sheet or clothing."

54. The part of the Policy referring to DNR remains unchanged.

55. In November 2017, the rest home amended the "resuscitation status" consent form for its residents. Instead of reading, "I have been informed and I understand that in the event of a

[7] The policy referred to in this part of the rest home's response is an updated policy that was not in place at the time of these events.

witnessed sudden unexpected cardio pulmonary collapse I want resuscitation attempts to be undertaken", as it did when Mr B signed the form, it now reads: "I have been informed and I understand that in the event of a cardio pulmonary collapse I want resuscitation attempts to be undertaken." The reference to a witnessed, sudden, and unexpected collapse has been removed.

Responses to provisional opinion

56. A response to the provisional opinion was received from Ms A and, where appropriate, this has been incorporated into the report.

57. A response to the provisional opinion was received from the rest home and, where appropriate, this has been incorporated into the report.

58. RN C was given an opportunity to respond to the provisional opinion. RN C stated:

> "I think I have taken the consent form literally as **witnessed** was stated on the form. After that incident, I have learned and realised that regardless [of whether] the collapse was witnessed or unwitnessed, if a person wishes to be resuscitated, CPR has to be commenced. Since then, I have been more careful and aware now when it comes to people who wish to be resuscitated at work or if there is no DNR form signed by a patient. I am very sorry to [Mr B] and the family that I didn't meet the standards."

Opinion: RN C — breach

59. RN C was responsible for Mr B's care on the morning of 4 Month6. She was aware that Mr B was "for resuscitation" and that there was no DNR order in place. When RN C discovered Mr B, unconscious, partially dressed, and slumped between the bathroom wall and the toilet, she moved him to the floor with the assistance of a caregiver, assessed him briefly for signs of life, and decided not to attempt to resuscitate him. She left him alone and only partially covered on the bathroom floor while she attended to other duties.

60. My expert advisor, registered nurse Megan Sendall, advised that "the care provided to [Mr B] [by RN C] departed from accepted standards". In particular, Ms Sendall advised that in the event of a sudden collapse, either witnessed or unwitnessed, resuscitation should be attempted. She stated:

> "To the best of my knowledge and that of my colleagues, it is not standard practice in [aged residential care] to differentiate between witnessed and unwitnessed collapse … Registered Nurses are guided by Advanced Directives (AD) and Do Not Resuscitate (DNR) orders. Should a resident become suddenly unresponsive either witnessed or unwitnessed, the AD and DNR orders are accessed if not already known, and action to resuscitate if no DNR is in situ or AD indicate an active resuscitation response."

61. Ms Sendall advised that it could be difficult to ascertain the cause of a collapse, and that "therefore commencing compressions to maintain circulation is a priority". Ms Sendall stated:

> "Regardless of the outcome, an attempt to follow an emergency response would be expected.
>
> …
>
> The assessment for signs of life following [Mr B's] collapse [was] brief. More focussed assessment for signs of life, [RN C] remaining in attendance, subsequent actions to initiate CPR and preserving [Mr B's] dignity should have taken priority."

62. Ms Sendall advised that "[d]irecting the 2 other Care Assistants to complete other tasks would have been a more effective course of action".

63. I am deeply concerned that RN C made no attempt to resuscitate Mr B. RN C was aware that there was no DNR order in place and that Mr B had indicated a desire for resuscitation. Whether the collapse was witnessed or unwitnessed was of no relevance to the decision to resuscitate or not to resuscitate Mr B. I accept Ms Sendall's advice that RN C's conduct was a departure from accepted standards.

64. Further, RN C assessed Mr B for signs of life, but the assessment was brief. Having decided not to resuscitate Mr B, RN C left Mr B alone and uncovered on the bathroom floor. RN C has since expressed her regret that she did not cover Mr B.

65. For the reasons outlined, RN C should have attempted to resuscitate Mr B, and her decision not to do so was a failure to provide an essential and potentially life-saving service to Mr B. RN C made this critical decision and a number of other poor decisions. RN C made only a brief assessment for signs of life, she left Mr B alone at the scene, and she failed to protect his dignity by covering him. Accordingly, RN C failed to provide services to Mr B with reasonable care and skill and, as a result, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[8]

Opinion: The Ultimate Care Group Limited (trading as Allen Bryant) — breach

66. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

67. In Month6, RN C was an employee of The Ultimate Care Group Limited. Accordingly, The Ultimate Care Group Limited is an employing authority for the purposes of the Act. As set out above, I have found that RN C breached Right 4(1) of the Code for deciding not to provide resuscitation to Mr B.

[8] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

68. The Ultimate Care Group Limited provided HDC with its Policy on "Cardio Pulmonary Resuscitation/Serious Illness". Ms Sendall advised:

> "[I]t is not standard practice in [aged residential care] to differentiate between witnessed and unwitnessed collapse. Sudden collapse is a rare event in [aged residential care] and more commonly health declines … over a period of time … In my opinion as both a clinician and auditor it is not standard practice to differentiate between unwitnessed and witnessed collapse in [aged residential care] and could lead to confusion for attending clinicians."

69. Ms Sendall advised, on this basis, that the original policy would be in keeping with standard practice.

70. Although Ms Sendall has advised that the Policy was consistent with standard practice, she has based her advice on her understanding that the policy did not differentiate between an unwitnessed and a witnessed collapse. While the definition section of the Policy states that "without a DNR order in place healthcare providers are required to perform CPR", I note that the Policy also provides the following:

> "In our facility we believe that Attempted Resuscitation in the case of a witnessed collapse is a right for all. Attempting CPR on the frail elderly is likely to be unsuccessful and serious complications may arise, therefore residents will be given the opportunity to make an informed decision regarding their wishes." (Emphasis added.)

71. By mentioning only a witnessed collapse, this part of the Policy differentiates between a witnessed and an unwitnessed collapse. I accept the advice of Ms Sendall that it is not standard practice to differentiate between witnessed and unwitnessed falls. However, I do not accept her implicit finding that the Policy in this case did not make such a distinction. The "resuscitation status" consent form also refers only to a witnessed collapse, and so treats it differently from an unwitnessed collapse. For these reasons, I do not consider that the Policy and form were consistent with standard practice.

72. As such, I do not consider that The Ultimate Care Group Limited took such steps as were reasonably practicable to prevent the acts and omissions of RN C that breached the Code. Accordingly, The Ultimate Care Group Limited is vicariously liable for RN C's breach of Right 4(1) of the Code.

Adverse comment

73. Further, I am highly critical of the attitude and lack of insight demonstrated by the rest home in its responses to this complaint.

74. The rest home provided its residents with an information brochure that outlined the meaning of "Do Not Resuscitate". The brochure stated that in the event of a collapse, and in the absence of a DNR order, staff were expected to resuscitate.

75. By ticking the "I want resuscitation attempts to be undertaken []" option, Mr B expressed a desire to be resuscitated in the event of a witnessed collapse. The fact that this option did not specifically address Mr B's wishes in the event of an unwitnessed collapse (as opposed

to a witnessed collapse) did not mean that he was choosing not to be resuscitated in such a circumstance; it meant only that the form was silent as to his wishes in the event of an unwitnessed collapse. The default position was as stated in the definition of DNR in the Policy ("without a DNR order in place healthcare providers are required to perform CPR as required") and reinforced by the information pamphlet provided to Mr B, which stated that "without a DNR order in place healthcare providers [were] required to perform CPR as required".

76. The consequences of this interpretation by the rest home are highly concerning, as it means that in its view, any resident who has not signed a DNR order and wants to be resuscitated, will not be resuscitated unless the collapse was witnessed by a staff member. On the rest home's interpretation, there is no mechanism for a resident to express a wish to be resuscitated in the event of an unwitnessed collapse. I am highly concerned by the ongoing lack of insight demonstrated by the rest home in its responses to HDC.

77. Further, the rest home had a duty to ensure that Mr B received appropriate services and care. This included providing clear, appropriate, and unambiguous instructions to its staff about the actions to be taken in the event of collapse, and information to its residents about resuscitation. While I cannot make a finding as to whether this attitude existed at the time of these events and was communicated to staff, I am concerned that such an attitude could potentially create or contribute to a dangerous environment for residents, in which it would be acceptable to withhold resuscitation when a person is unable to make a decision in his or her own interests and the person has not signed a DNR order.

Recent policy — other comment

78. The rest home has amended its policy and associated documents since these events.

79. In the "resuscitation status" consent form it has deleted the reference to a "witnessed sudden and unexpected" cardiopulmonary collapse, and there is no longer a distinction between a witnessed and an unwitnessed cardiopulmonary collapse in an emergency situation.

80. However, I am concerned that the Policy, which reflected the accepted standard of practice, has now been amended to distinguish between a witnessed and an unwitnessed cardiopulmonary collapse. In my view, this distinction does not reflect the accepted standard of practice in emergency situations and may cause confusion for staff when they are faced with a collapse, and may result in a resident's wishes to be resuscitated not being upheld.

Recommendations

81. I recommend that RN C:

a) Provide a formal apology to Mr B's family for her breach of the Code. The apology is to be sent to HDC for forwarding to Mr B's family, within three weeks of the date of this report.

b) Undertake further training in resuscitation, and provide evidence of that training to HDC within three months of the date of this report.

82. I recommend that the Nursing Council of New Zealand consider whether a review of RN C's competence is warranted.

83. I recommend that The Ultimate Care Group Limited trading as Allen Bryant:

a) Provide a formal apology to Mr B's family for its breach of the Code. The apology is to be sent to HDC for forwarding to Mr B's family, within three weeks of the date of this report.

b) Review its information and consent documents, and its policy regarding resuscitation, to ensure consistency with the accepted standards of practice for aged care residential facilities. The Ultimate Care Group Limited trading as Allen Bryant is to report back to HDC with the terms and results of the review, within three months of the date of this report.

Follow-up actions

84. RN C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

85. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Ultimate Care Group Limited trading as Allen Bryant, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

86. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Ultimate Care Group Limited trading as Allen Bryant, will be sent to the district health board and HealthCERT, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

87. The Director of Proceedings decided not to issue proceedings.