

Leg burns suffered following laser hair removal

1. On 10 November 2021, Dr B made a complaint to HDC regarding the care she received from beauty therapist Ms C¹ at an appearance medicine provider (Clinic A). Dr B suffered burns to her legs during laser hair removal treatment.

Information gathered

2. Information was gathered from Dr B, Ms C, Clinic A, and independent advisor Ms Heather Thompson (Appendix A). At the outset, I acknowledge that there are conflicting versions of events between Dr B and Ms C.
3. On 5 June 2021, Dr B attended Clinic A for laser hair removal on her legs, which she had received on several occasions over the previous two years. Dr B told HDC that prior to commencing the laser treatment, Ms C did not check the laser settings. Clinic A told HDC that settings are entered into the laser manually at the start of the treatment, as it is highly individualised to each client.
4. Ms C told HDC that prior to commencing the treatment, she undertook her usual preparation (preparing a tech slip), which included checking that Dr B had provided informed consent, noting the treatment number, taking notes of previous treatment plans, analysing hair growth, and reviewing the notes on Dr B's initial consultation and updating photos of the treated area. Ms C said that based on that information, she developed a treatment plan and adjusted the settings in accordance with the thickness of hair, skin type, and genetic background/Fitzpatrick type² and completed a double check to make sure the settings were correct.
5. Ms C told HDC that she performed a test patch prior to completing the full treatment in line with Clinic A protocol (the protocol) whereby she applied the laser to a small patch of skin and asked Dr B to rate the pain on a scale of 1–10.³ Dr B disputes that this was done. The clinical records do not mention whether a test patch was undertaken in the prescribed form, and I note that there is no requirement on the progress notes form to record whether a test patch was completed and, if so, the results.
6. In a statement about this incident provided in December 2021, Ms C said that she does not recall Dr B giving a score out of 10. However, Ms C noted that Dr B replied, '[I]t's fine,' on two occasions when asked.

¹ Ms C had been trained recently and had completed the required 25 hours of supervision.

² The Fitzpatrick skin type describes a way to classify the skin on the amount of melanin pigment and by its reaction to exposure to sunlight. This is determined either at the initial consultation or at the first treatment.

³ A score of 1 indicates that the patient cannot feel the treatment, and a score of 10 indicates that the pain is excruciating.

7. The adverse event report logged the following day (6 June) records that Dr B advised the clinic manager and trainer, Ms D, that a test patch had been performed and she had rated the pain 6/10, and the technician had proceeded with the treatment.
8. Clinic A told HDC that Dr B's answers to questions and her response to the test patch did not give any indication that treatment should not commence, and after Ms C observed no reaction on Dr B's skin after 30 seconds, treatment began.
9. Dr B states that she told Ms C to stop the treatment because of the pain, but the treatment continued. Dr B said that because she was wearing goggles and was lying face down for half of the session, she could not see and was afraid to move and have the laser burn her. Ms C states that Dr B did not ask to stop the treatment, and that had she been asked, she would have stopped immediately. Ms C recalls that during the treatment Dr B was 'fidgety', which prompted her to stop several times to ask Dr B if she was okay to continue. Ms C states that Dr B said that the pain 'was fine', she 'was okay', and 'she could handle it', and therefore the treatment was continued. Clinic A and Ms C told HDC that this treatment can cause clients some discomfort, which is often described as a flick of a rubber band, and that all clients respond to pain differently.
10. Following the completion of the laser treatment, Dr B's legs were swollen, and when she asked Ms C whether this was 'normal', she was told 'yes'. As per usual practice and in line with the protocol, Ms C applied recovery cream and SPF, and went over post-care information⁴ with Dr B. Clinic A and Ms C told HDC that as it is not uncommon for skin to swell and for some irritation to occur post-treatment, initially Ms C thought that the swelling on Dr B's legs was a normal reaction of follicular swelling.⁵
11. Prior to leaving, Dr B booked her next appointment.
12. Around 30 minutes after the appointment, Dr B's partner made a telephone call to Clinic A saying that he was concerned about Dr B's legs post-treatment. He was advised to apply ice, send through photographs of Dr B's legs, and to return to the clinic as soon as possible. Upon arrival, it was clear that Dr B was suffering burns to her legs, and steps were taken to understand what had caused the burns. Various products were provided to help address the burn injuries. Clinic A states that it advised Dr B to visit A&E.⁶ Dr B denies that this occurred. Clinic A provided a verbal apology to Dr B and stated that any costs incurred by Dr B for medical care would be reimbursed by the clinic. Dr B told HDC that medical costs were covered for the first one or two weeks after the incident but stopped after this point.
13. Clinic A told HDC that on reviewing Ms C's tech slip, it was discovered that Ms C had mistakenly set the laser machine for a Fitzpatrick 3 skin type,⁷ as opposed to a Fitzpatrick skin type 4 (the intended setting). Clinic A told HDC that this is the first incident in its clinic

⁴ This advice recommended avoiding sun exposure and using the recovery cream for three days and encouraged the use of ice packs.

⁵ Follicular swelling occurs when hair follicles become inflamed. Sometimes it is a response to hair removal treatment when the skin is heated.

⁶ The hospital Accident and Emergency Department.

⁷ The setting input into the machine was joules (12/6), gauge size (18), hertz (2), and pulse duration (4/5); however, this should have been joules (4/14), gauge size (18), hertz (2), and pulse duration (4/5).

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where settings have been input incorrectly, and it is sincerely regretful that this error occurred.

Opinion

14. Ms C and Clinic A provided Dr B with laser treatment and advice for hair removal. This included assessing Dr B's hair and skin type, obtaining a medical history including medication, obtaining informed consent, treatment planning, application of medical grade laser treatment, post-treatment advice and, subsequently, treatment for Dr B's burns. I am thus satisfied that the laser treatment, subsequent treatment, and advice pertaining to the treatment are 'treatment services' within the definition of health services under section 2 of the Health and Disability Commissioner Act 1994 (the Act). In that context, I therefore consider Ms C and Clinic A to be healthcare providers under section 3(k) of the Act. As such, they are required to comply with the Code of Health and Disability Services Consumers' Rights (the Code).

Ms C — breach

15. My investigation has identified two primary issues of concern: the input of incorrect settings on the laser machine; and the failure to identify earlier than occurred that Dr B had been burned by the machine (and, consequently, that the treatment continued).
16. Independent beauty therapy advice was obtained from Ms Heather Thompson regarding the care provided to Dr B (Appendix A). Ms Thompson identified multiple departures from the accepted standard of care, and I have relied on this advice in forming my decision.
17. It is not in dispute that Ms C input the incorrect settings into the laser machine after several checks were made from previous notes, and there is no clear explanation for why this occurred — although it is suggested that she may have transposed numbers from the protocol chart when inputting them into the machine. It is self-evident that the incorrect settings caused the laser to burn Dr B. Ms Thompson identified this as a severe departure from the expected standard of care.
18. In relation to the failure to identify that injury was being caused to Dr B, there is conflicting evidence. Dr B states that a test patch was not performed, and Ms C does not recall Dr B providing a rating out of 10 for the test patch but does recall Dr B verbalising that she was 'fine'. The adverse event report logged the day after the treatment specifically records that Dr B advised the clinic manager and trainer that she had reported pain of 6/10 during the test patch and that Ms C went ahead with the treatment regardless. Based on this contemporaneous record, I consider it more likely than not that a test patch did occur and that Dr B reported a pain level that should have prompted Ms C to stop and reassess the situation. I consider this to be the first missed opportunity to identify that Dr B was being burned by the machine.
19. Dr B states that she requested the treatment to stop. Ms C denies that this occurred and told HDC that she noticed that Dr B was 'fidgety', and she paused several times to check on Dr B's wellbeing, to which Dr B replied that she 'could handle [the pain]'.

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20. I am unable to reconcile the two versions of events, although I am satisfied that Dr B was experiencing pain and that, at the least, she was expressing her discomfort by ‘fidgeting’. Ms Thompson considers that this was a strong indication that something was wrong. I consider this to be the second missed opportunity to identify that Dr B was being burned by the machine. In addition, Ms Thompson considers that there would have been obvious indications that the skin had overheated, and treatment should have stopped.
21. It is clear from Ms C’s statements to Dr B (that her skin reaction was ‘normal’), and to HDC that the appearance of Dr B’s skin post-treatment was consistent with follicular swelling is at odds with the burns that occurred. Indeed, Ms Thompson notes that if skin has been burnt following laser treatment, the skin often looks raised, angry and red in the shape of the footprint of the laser (as seen in this case) and that a laser burn is immediately visible after the treatment is concluded. In my opinion, it is reasonable to infer that the appearance of Dr B’s skin was not ‘normal’ in the initial period following her treatment — noting that the treatment occurred over a period of 45 minutes and accepting my advisor’s opinion that the appearance of the burns was not consistent with follicular swelling. I consider this to be the third missed opportunity to identify that Dr B was burned by the machine.
22. In these circumstances, Ms Thompson considers that the failure to stop treatment and adjust the settings when Dr B was fidgeting was a severe departure from the accepted standard of care.
23. However, I am mindful that at the time the treatment was provided, Ms C was a junior beautician. She had qualified as a level 5 beauty therapist only six months earlier and had qualified in laser hair removal on 12 May 2021 — only three weeks before Dr B’s treatment. I consider it likely, therefore, that Ms C lacked both the experience and knowledge to fully appreciate that, at the time, Dr B was suffering injury from the laser.
24. Ms C’s inexperience is, in my view, a mitigating factor to the seriousness of the departures of care.
25. I acknowledge the apology and admissions made by Ms C, and I accept that a genuine mistake appears to have been made in this case. However, this does not negate the fact that a significant error occurred causing severe burns on Dr B’s legs. Ms C had a responsibility to provide laser treatment to Dr B in a safe manner, and it is clear that this did not occur.
26. I consider that the standard of care was not met throughout the duration of this treatment, which included incorrect input of laser settings, failure to recognise discomfort and pain during the process, and failure to identify burns correctly post-treatment and escalate appropriately. Accordingly, I find that Ms C breached Right 4(1) of the Code.⁸

Clinic A — adverse comment

27. Ms Thompson considers that Clinic A’s immediate support and aftercare was of an appropriate standard, and she commends clinic staff for going out of their way to offer assistance to Dr B as best they could. I accept this comment and consider that the actions

⁸ Every consumer has the right to have services provided with reasonable care and skill.

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of clinic staff to help Dr B after being made aware of the incident were timely and considerate.

28. In relation to the issue of a test patch being undertaken, Ms Thompson advised that as per Clinic A's policies, this is completed at the start of each treatment, as opposed to the initial consultation, which is what Ms Thompson considers is the correct standard in theory. The purpose of completing a test patch is to gauge the client's reaction to heat and see the immediate skin reaction. Noting that it can take 4–6 weeks to see the full reaction of a client with darker skin, as Ms Thompson has pointed out, it is unlikely that a few seconds of observation will reveal any inflammatory pigmentation developing. I am therefore critical if Clinic A does not routinely complete a test patch for a client who attends an initial consultation to allow for more accurate reactions to the laser treatment to be observed over time before treatment commences. This is especially important with clients who have skin with colour. I encourage Clinic A to reflect on this comment and consider whether changes should be made to its policies to reflect this. Furthermore, Ms Thompson considers there to have been a lack of training provided by Clinic A to its employees on clients with skin of colour. This is quantified as a moderate departure from the standard of care, while acknowledging the 25 hours of supervised training that is provided to its beauty therapists. I accept this advice and have made recommendations in light of this.
29. Acknowledging that a test patch is required at the beginning of each treatment, I am critical that the progress note form does not contain a requirement to record its completion and the reported pain scale/skin reaction. I consider that adding this requirement to the form would provide an additional opportunity to identify and record a client's response to the test patch clearly, and I encourage Clinic A to consider amending its form to include this.
30. Clinic A's complaint policy states that incidents of serious harm or injury to a client must be escalated and reported to head office immediately. In this case, the incident was not reported to head office for two weeks. No explanation has been provided for this delay, and I am critical that Clinic A did not follow its policy.
31. Noting the criticisms made by Ms Thompson above, I am minded to make only adverse comments about Clinic A for the care it provided to Dr B. I trust that my criticisms will be borne in mind when providing laser treatment services to clients in future. I encourage Clinic A to critically reflect on this case and the importance of ongoing and frequent training, and to adhering to its policy when notifying head office of a serious incident.
32. Clinic A was provided the opportunity to comment on my provisional decision. It has accepted the adverse comment and recommendations and worked to implement them. It has acknowledged that a mistake was made when providing services to Dr B and apologised for this incident, noting that it has taken significant steps to understand how the mistake occurred and to make sure a similar mistake is not made in the future.

Clinic A Head Office — educational comment

33. Ms Thompson states that following notification of this serious incident, it appears that no immediate action was taken by the head office to address the issue. Furthermore, Ms Thompson considers that the franchise head office should have better processes relating to

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adverse incidents, and there should have been more immediate support provided from someone with more authority and experience in skin trauma than the clinic owner.

34. Clinic A's 'Open Disclosure/Open Communication Policy' states that the head office's responsibility when an adverse event has occurred is to ensure that the client has received the appropriate intervention and follow-up. This policy also stipulates that the head office is responsible for supporting the Manager and Franchisee in responding to the adverse event and should normally be involved in communication with the client, and that all communications should be 'sincere, compassionate and empathetic'.
35. I am concerned about the time it took the franchise head office to make contact with Dr B directly, the lack of support provided to the clinic, and the six-month delay in providing a formal apology for the incident. I am also concerned that as Ms Thompson states, when the head office made contact with Dr B, there appears to have been no real focus on the outcome sustained, which was not only physical damage to her skin, but also emotional distress, financial loss, and a significant impact on her career timeline. Therefore, in light of the responsibilities of the head office stipulated in the policy, I am concerned that there does not appear to have been adherence to that policy in terms of its responsibilities regarding open disclosure and timely communication. I encourage Clinic A head office to critically reflect on how it responded to this incident and the importance of prompt and compassionate communications with the affected client.
36. Clinic A Head Office were provided the opportunity to comment on the educational comment. It advised that it has reflected carefully on this incident and its response to it and have taken the comments and learnings from this incident very seriously. This has included working with franchisees to make several changes to policies and procedures.

Changes made

37. Clinic A advised that as a result of this case and to prevent recurrence, the following changes have been made:
- a) Protocols for laser hair removal and management of skin post-laser treatment are more visible in the clinic and on staff tech boards.
 - b) It regularly reviews client notes and laser settings and also observes treatments as part of its quality control measures.
 - c) As part of staff training, it ensures that staff are aware that if a client is 'fidgety' during the treatment, then the technician is to stop the treatment, check the laser settings, look at the treated area, and/or turn up the cooling system.
 - d) It reminds staff that mistakes can happen and discusses the steps that staff can take to lessen the risk of mistakes like this occurring in practice.
 - e) It includes training on the Code of Rights as part of its ongoing quality improvement processes, and it has taken steps to ensure that the Code of Rights is visible around the clinic.
 - f) It has issued a new set of protocols regarding laser treatment, which includes larger and easier-to-read tables of laser settings with separate pages for each Fitzpatrick skin type.

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- g) It has developed additional training for staff, including an Adverse Management module, which includes treating on the incorrect settings with laser treatments; all staff must complete this module and pass a corresponding assessment.
- h) It has added the test patch reaction prompt box to the treatment clinical notes and a scale for the client's pain tolerance, so staff are prompted to ask them.

38. Ms C has reflected on the mistake and made the following changes:

- a) She undertook further training, including four hours of supervised laser hair removal treatment and personal supervision by the National Training Manager.
- b) If she notices that a client is uncomfortable in any way or is showing signs of discomfort, she turns down the laser machine immediately.
- c) When undertaking a consultation, she ensures that clients leave with post-care products and an understanding of the importance of these.
- d) She double-checks the settings when entering them into the laser machine.
- e) She undertakes a laser refresher course every six months.

Recommendations

39. I recommend that Ms C undertake the following and report back to HDC within the stipulated timeframes:

- a) Arrange for an audit to be undertaken by someone in her current place of employment to cross-check the accuracies of 20 Fitzpatrick assessments completed, and that the correct laser settings for 20 clients have been input into the machine. Please ensure that the name, qualification, and job title of the person undertaking this audit is included in the report, which is to be provided to HDC within three months of the date of this report; and
- b) Provide evidence that refresher training on Fitzpatrick assessments has been completed. This is to be provided to HDC within three months of the date of this report.

40. In my provisional report, I recommended that Ms C provide an apology to Dr B for the breach of the Code found in this investigation. Ms C has complied with this recommendation.

41. In my provisional report, I proposed that that Clinic A undertake the following recommendations and report back to HDC within three months of the date of this report. In its response, Clinic A advised it has completed the recommendations as follows:

Recommendation	Response
Present an anonymised case summary of this incident to educate staff on preventing a recurrence.	This case has been added to Clinic A Adverse Management training presentation. All staff are required to do this training and must pass an assessment following their training.

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Provide evidence of the change referred to above at paragraph 36(f) regarding the new protocols on laser treatment with separate pages for each Fitzpatrick skin type.	Copies of the new protocols were provided. Each Fitzpatrick skin type is on a separate page with information on each skin type at the top of the page.
Consider updating the current assessment procedures in post-treatment skin reaction and client feedback to ensure that incidents do not go unnoticed.	The treatment notes now include a section to record the post-treatment skin reaction.
Consider adding a section to the prescribed clinical records form to show whether a test patch is completed at the start of the consultation.	The treatment notes now include a record of the test patch conducted.
<p>Noting Ms Thompson's comments regarding further training for employees in relation to clients with darker skin types:</p> <ul style="list-style-type: none"> • Review the current training on Fitzpatrick assessments for clients with darker skin and report back on whether changes have been made to the training; • Provide evidence of changes made to standardise laser settings for clients with darker skin tones; and • Provide evidence that refresher training for assessing Fitzpatrick scores has been provided to staff. 	<p>Training</p> <ul style="list-style-type: none"> • A minimum of 4 hours must be included in laser training hours for Fitzpatrick types 1–4. • A minimum of 2 hours must be included in laser training for Fitzpatrick type 6.⁹ • All trainees must complete a minimum of 25 hours to be signed off as showing competency in each area of the body offered as a service, including Fitzpatrick skin type. • On 3 September 2025 in a meeting with all trainers, the Business and Education manager conducted a refresher on Skin Fitzpatrick. The clinic Mentor Training Ambassadors and Managers will then repeat this training with their teams in the clinics.

42. Having reviewed this information, I accept that Clinic A has completed the recommendations.

⁹ Due to rarity of this type

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Follow-up action

43. A copy of this report with details identifying the parties removed, except my independent advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from beauty therapist Ms Heather Thompson:

'Health and Disability Commissioner

Independent clinical advisor report — Heather Thompson

[Dr B] / [Clinic A]

21HDC02815

I have been asked to provide clinical advice to HDC on case number 21HDC02815. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:

I am a beauty therapist and clinic owner with 35 years' experience; 34 years' experience using a range of lasers and IPL devices. I have gained certification in 2 other countries expanding my own knowledge base over the years. I train clinics in NZ in laser and IPL treatments offering Laser Safety (AS/NZS 4173:2004 Australian/New Zealand Standard™ Guide to the safe use of lasers in health care) Laser and IPL Hair Removal, Skin Rejuvenation and Laser Tattoo Removal. I have many years of using these devices directly on clients and I understand the language and client reactions both emotional and physical to laser and IPL treatments. For instance, there is a fundamentally significant difference in how you treat pale skin versus skin of colour, and how the different devices (different lasers utilise different wavelengths for these reasons) can impact different skin types. I also understand different client cultures and how they may interact with a therapist, as well as how therapists understand clients and laser technology. I have a very in-depth knowledge of technology and the processes used in the running of a clinic.

Factual summary of clinical care provided complaint: Brief summary of clinical events:

We have a client [Dr B] who has made a complaint via email on 10 November 2021 against [Clinic A]. [Dr B] has significant burns to both full legs following a laser hair removal treatment she received at [Clinic A] on 5 June 2021. [Dr B] has been to this clinic on many occasions, having laser hair removal on her legs and other areas before with multiple staff members over an 18-month period. There has not been any noted incident from previous treatments. The appointment in question [Dr B] was having just her full legs treated, and this was the first time she had been treated by [Ms C], who [Dr B] believes was relatively new to the clinic. [Dr B] claims she felt pain during the treatment and asked [Ms C] to stop treatment, which she did not and continued. Due

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to the safety regulations of eyewear [Dr B] couldn't see what was happening until after the treatment when she claimed her legs were swollen. It is clear from her statement that [Dr B] felt anxious and felt unable to move or able to have the treatment stopped in any way. At the end of the appointment [Dr B] expressed concern at the condition of the skin on her legs and groin but was told this skin reaction was normal by [Ms C]. After leaving the clinic she returned later in the day to speak to the manager and express concern her legs were burnt from the laser treatment earlier that day. [Dr B] was told by a staff member now no longer at the clinic she was treated 3.5 times the laser setting normally used on her. [Dr B] felt that sufficient after-care was not provided at the time of the treatment and this may have contributed to the healing outcome.

[Dr B] is expressing concern she has experienced a lengthy healing period that has led to the disruption of her career as a junior doctor at [...] Hospital. Having had a biking accident leading to a concussion only 7 days prior to her laser treatment, she believes the burns have impeded the recovery of her concussion and at the time of her complaint 10 November 2021 is still suffering psychological and emotional impacts of the burns. Her husband has also had to take time off to care for her. There is a loss of income from this incident.

[Dr B] is ultimately wanting to file a complaint under the Human Rights Act for a review into the significant time that she has lost due to the laser burn incident.

[Clinic A] have provided us with significant clinical documentation around [Dr B]'s treatment. The clinic does accept responsibility for a mistake from human error has been made that led to the burns on [Dr B]'s legs. The clinic does though refute several statements made by [Dr B].

The clinic does not accept that [Dr B] told [Ms C] to stop the treatment, and that it was too painful. [Ms C] has documented in her statement on 2 December 2021 that she performed a test patch and asked on a pain scale 1–10 how the shots felt.

The response from [Dr B] was according to [Ms C] "fine" and following a second questioning was told again "fine".

[Ms C] stated she did not hear [Dr B] saying stop, there was no screaming, but did mention that [Dr B] was "fidgety" and stopping treatment several times asked if [Dr B] was ok and comfortable, which the reply was given that [Dr B] was "ok and she can handle it".

With regards to the swelling, the clinic maintains [that on] [Dr B]'s questioning around the reaction and look of the skin on her legs post treatment, [Ms C]'s response] was that follicular swelling is normal.

Post care cream and SPF was applied to [Dr B]'s legs with the observation [that] the clothing worn by the client would have exposed the treated area to the sun.

[Ms D], on reviewing the tech slip, when [Dr B] returned later the day of treatment to show the manager the burns, confirmed a mistake had been made in the settings, which has led to the burns.

The clinic refutes [Dr B] was informed not to go to emergency staff. The manager at the time (no longer employed at [Clinic A]) [Ms D], had noted (retrospectively on [Dr B]'s files), that she did inform [Dr B] to go to A& E.

Question 1: *Whether the care provided to [Dr B] by [Ms C] on 5 June 2021 met accepted standards.*

- The statement provided to us from [Ms C] outlined the steps taken to provide [Dr B] with the laser hair removal treatment.
- The treatment process as relating to the interaction between therapist and client seems to be of acceptable standard going on what [Ms C] recalls in her statement of 2 December 2021 (6 months post treatment). When a therapist has been trained correctly, and with practice in treating clients with lasers, the process of taking the client into the room, appropriate questions asked before beginning treatment and getting the client positioned on the bed, and the treatment procedure begun; eyewear provided, skin analysis, setting machine, test patch, and treatment performed, over time this should become a procedural habit.
- The burns occurred, according to the clinic, as a result of an incorrect setting entered into the laser. One factor here is that the procedure, according to [Clinic A] and [Ms C]'s statement, is to check previous 2 treatment settings. How then after double checking the setting she entered into the laser, as [Ms C] has also stated she performed, can this error have taken place? Looking at a sequence of setting numbers which are 5/13 and 5/14 on the previous 2 legs tmt tech slips, entering the selection as 14/6 and checking that number again, [Ms C] was either flustered at being questioned by [Dr B], nervous about doing her first “real client” as we know she was newly trained, or rushing, or not fully understanding what these numbers mean, or all of these things may have led to the incorrect information input into the laser.
- Yes, the client had her initial consultation, as [Ms C] mentions but we must remember that consultation happened 18 months prior to the treatment in question. Many things change in a client's skin health in that time. I don't think this is something to rely on.
- Although [Dr B]'s previous treatments have caused no injury to her skin, there does seem to be a misunderstanding on her skin colour — which Fitzpatrick [Dr B]'s skin type is. Many of the first treatments being treated on Fitz 5 — but were not following Lumenis and Clinic A setting guidelines of only using NdYAG setting and not using the 755nm. The first 5 legs treatments use 755nm energies.
- I don't see any copy of the standard Fitzpatrick skin type questionnaire being completed either. I have attached a copy of 2 of the standard tests. I see supplied information from Clinic A have a questionnaire for Fitzpatrick but I don't see in [Dr B]'s consultation notes a copy of her completing one.

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SETTINGS EXPANDED ON:

- [Clinic A] procedure is to look at the previous two treatments to decide the day's treatment setting, and according to our email response on 29 January 2025; *the therapist selects the setting from the chart attached to the protocol and manually inputs the settings into the machine.* [Ms C] did not mention this only the 2 previous settings she checked. The setting she entered into the machine, according to the clinic, was incorrect. We have been informed they found out this by looking into the stored settings on the laser, but when questioning the supplier Lumenis on this point, Lumenis replied via email dated 22 January 2025; *"Lumenis have confirmed that the Splendor X does not save patient settings in its memory, nor does it have a memory function to store settings for particular days"*.
- For Legs tmt #11, the previous 2 leg tmts were: #9; 5 (755nm) /13 (NdYAG)J, gauge 20, fitz 4 (for legs, bikini and underarms), and #10; 5 (755nm) /14 (NdYAG) J, gauge 20 fitz 4 (legs bikini and underarms) treatment #11 saw the gauge changed to 18mm. The setting sheet from Lumenis recommends for a fitz 5 Nd YAG only NO 755nm to be used. There is not comment on any treatment date that mentions a change in why the therapists are adding in 755nm wavelengths for fitzpatrick 4. This is a diversion from the supplier recommended settings.

This is not totally uncommon for long term users of a device. I just wanted to point this diversion out.

- In the statement from [Ms C] dated 2nd December 2021, 6 months after the incident, she states she took notes from treatments 7 and 8, 7 months and 5 months prior to treatment #11. Not 9 and 10 as protocol dictates.
- We know that the previous 10 treatments did not cause any skin problems, using 755nm energies.
- [Ms C] noted on the progress notes a setting of 14/6 joules gauge 18. If strictly following protocol her setting should have been the same as treatment # 9 or 10. Aside from transposing the figures, she independently increased the 755nm from 5 to 6 and decreased the gauge from 20 to 18.
- [Ms C] noted on the progress notes the transposed setting — it's been typed out by someone, possibly her.
- It seems she didn't realise the error, did not make anyone aware of the error, especially as [Dr B]'s skin would have been showing signs of the burns.
- [Clinic A] have correctly told us the setting wavelengths were transposed when entered by [Ms C], it is noted on the progress notes by [Ms C] and typed out by who we don't know. The clinic incorrectly told us they saw the error via the Splendor X internal memory. The clinic has also informed us in their letter dated 31 March 2022, that the setting should have been 4/14 joules, gauge 18, for treatment #11. This is a setting for strong hair not the finer hair that would be present at tmt #1, different again from the previous 2 treatments used on [Dr B]'s legs.
- Ultimately, I think there could be more of a standardised settings protocol for darker skin types. A better understanding of skins with colour is recommended.

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- The usual reason for a burn of this nature is user error, i.e. the wrong setting has been selected for the skin type.
- The therapist, after several checks from the previous notes, entering the transposed figures, writing up the treatment and typing it out onto the computer I assume, there was still no awareness of the mistake. I can only think that she was extremely confused or feeling under pressure for some reason or simply didn't understand the different wavelengths.

THIS IS A SEVERE DEPARTURE FROM STANDARD CARE.

Question 2: *Whether the appearance of the skin was in accordance with what might be expected following laser hair removal treatment.*

- This is one of the biggest questions I have about [Ms C]'s treatment of [Dr B], and relates directly to her experience, support and training. "Follicular swelling" looks like tiny "bee sting" lumps. Each hair follicle (and it's often not all) may react to the laser heat by becoming an obvious small, raised lump. This happens with some clients, not all, and in some treatment areas, not all. It's the actual hair follicle radiating heat to the surrounding skin. I notice most treatments on the client notes have this comment made. If the skin has been overheated with laser, to the extent of being burned, you often see a raised, angry, red section of skin — not just the follicles, in the shape of the footprint (with this laser, the documentation refers to the gauge size — the size of the treated area footprint of the laser). You may still get the follicular oedema, but the whole skin is often raised, red/dark and angry looking. Especially when we are treating a darker skin type.
- This redness may not be immediate, it may take a couple of minutes to present, which is the next question I have regarding the observation during the treatment; this type of burn is all over [Dr B]'s legs, firstly the client should be feeling it as quite hot, especially as the treatment continues, so if the version of the clinic correct, that [Dr B] said the treatment was feeling ok? If so the client "fidgeting" which [Ms C] stated, should be a strong indication something is feeling too uncomfortable. The second and most important observation is actually looking at the skin. By the time the first say 10 pulses have been fired (at 2 Hertz — which equates to 2 shots per second) and the distance between each shot going by the photos, let's say the full front of the lower legs covered in 10 or so shots, I am sure there would have been obvious indications in the skin that the skin has been over heated. The treatment at this point should have stopped. If not sooner. Did [Ms C] know what overheated/treated skin looked like (most often seen as images during training) and why didn't [Ms C] stop treatment, question the client further, more accurately. I.e; "out of 10 if 10 is excruciating, what number do you feel?" this sometimes is a better question than are you ok? Some clients believe that stronger feeling is better, this is incorrect, and the therapist should really be taking the lead with this, in terms of what she is seeing.
- The "test patch" may or may not have shown up an error in the setting. A correct standard test patch in theory is often given at the consultation. In theory this is to provide the therapist an indication of how the skin is going to tolerate the laser

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treatment. The rules behind the test patch with skins of colour, ie darker Fitzpatrick skin types, is that it can take 4–6 weeks for any colour change in the form of post inflammatory pigmentation to develop, which would indicate that setting is too high if pigmentation develops, or there are other conditions contributing to the pigmentation. In reality the laser supplier gives a settings sheet with the laser, that is a guide to all skin types, and provides different settings for different skin types, darker skin having more conservative energies and pulse widths etc, so whether most clinics do the full test patch at consultation dictated by the clinic owners' policies.

- The test patch in this case and with the protocols of [Clinic A], is performed at the start of each treatment. This is to gauge the client's reaction to the heat but should also be to watch the skin's immediate reaction. I've already stated that it can take up to 6 weeks to get the full skin reaction in darker skins, so a couple of seconds watching won't reveal pigmentation development. But what it will show the therapist is any immediate swelling and redness (that angry appearance) if the setting was incorrect. Especially on a darker skin type. I will point out here that skin reaction is also impacted by a variety of factors, and one being the amount and type of hair in the area. If the hair is particularly thick and dark the skin reacts more. And the sensation for the client is higher. If the area is boney such as with this test patch, as it was performed on the ankle, it will always feel hotter. The burn occurred at treatment #11, the hair will be finer, quite sparse and paler so the heat feeling from that is less than at the beginning of [Dr B]'s treatments, but over the ankle [Dr B] will still be feeling heat. Other factors include changes in medications being taken, sun exposure, bruising in the area etc.
- Whether at the beginning of the treatment [Ms C] **said** these first shots are the test patch, according to [Dr B], she did not, but that doesn't mean the first shots were not conducted as the test patch. After 10 previous treatments I'm sure [Dr B] was quite familiar with the process and not hearing (as her eyes were now fully covered) the words to the effect "I'll just do the test patch" [Dr B] may feel the test patch was not done.
- Perhaps in future, this is communicated better to the client.
- At the end of the treatment, [Dr B]'s reaction to the look of her legs was to question is this normal? Remembering she's had treatments many times on a few different areas, so she will be quite aware of how her skin should look.
- [Ms C] being new to treating "proper paying clients" rather than friends and colleagues during her training period, may have been nervous, she kept to the script she was trained with.
- I understand [Ms C] keeping to her training protocols, but why did she not acknowledge (to herself at least) the skin looked different at the end of the treatment to other clients' skins she had treated, and go and get a manager/her MTA/or a senior staff member to check on [Dr B]'s skin? A burn from a laser does not in my experience appear hours later. The skin will show signs almost immediately. Full leg laser hair removal takes time, so from the beginning lower legs

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shots, signs would be present when sunscreen was applied at the end. Let's say 30–45 mins later.

- Of course if [Dr B] went under a sunbed, or immediately after the treatment went swimming and sunbathing, then that will impact how the skin reacts. I'm just wanting to point out other causes for not seeing a burn in clinic before the client left. But she questioned [Ms C] so we know there was something out of the ordinary immediately following the procedure.
- One point I'd like to make is that [Dr B], when questioned regarding the new medication by [Ms C] at the beginning of the treatment, did not disclose she had started taking analgesia medication from a biking incident 1 week prior to her laser treatment, or in fact that she was also suffering from concussion. To me this would have made the treatment either, more painful, unless the medication was of a significant pain killer in which case it may have dulled the sensation. Any red flags that pop up during the conversation while the treatment is happening can expose the information that was denied at the beginning of the treatment. Were there grazes on the skin from the biking accident, bruising? "Ooooh you look like you have been in the wars [Dr B], did you have a fall?" something like this may indicate not all is normal. The process then would be to stop and make some judgements based on the skin's reaction, client's sensation.
- I still am adamant therapist observation of the skin is a very important basis to adjust settings in the laser, than how the client feels. Obviously if the client is feeling it more that particular day, then adjustments can be made. By altering, increasing the Fitzpatrick, is one way to lessen sensation, all this depends on the laser etc. The use of a zimmer dramatically alters the actual sensation for the client of the tmt, again observation is vital.

THIS IS A SEVERE DEPARTURE OF CARE.

Question 3: *Whether the advice and aftercare provided to [Dr B] following the incident was appropriate.*

- Here again we have conflict between the client and the clinic. Unfortunately the manager who is now no longer there, but client notes on the computer system note the initial phone call from [Dr B]'s partner 30 mins post appointment that he fears [Dr B]'s legs have been burned. I can see a lot of communication between the clinic and the client, during the first 3 weeks the notes by the clinic give a full description of communications between [Dr B] and the clinic. Multiple emails and phone calls checking in with [Dr B]. This is excellent. The efforts the clinic have gone toward helping heal [Dr B]'s skin are also excellent, offering LED treatments and at times staff taking the machine to [Dr B]'s house for her to use.
- I find this excellent after-care and concern from the clinic for the client. Staff members are going out of their way to offer assistance the best they can.
- [Ms C] in her written statement confirms she applied post care recovery cream and sunscreen. Her mention of applying sunscreen due to [Dr B]'s clothing would expose the treated area when she left the clinic was excellent.

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- [Ms D] noted on 6th June, 1 day post the burn treatment, that [Dr B] was in fact treated on a wrong setting.
- This note also says [Dr B] confirms a test patch was done and was feeling the pulses as a 6/10. Which is the opposite of what [Dr B] said occurred.
- [Dr B] was given burn cream, flamazine, dressings and recovery cream the afternoon of the treatment, I assume when she returned to the clinic. This is excellent. It should have also been noted that an incident report was completed, and that head office was contacted. It was obviously apparent that a burn had taken place.
- I can see the clinic following up with the client, but I don't see immediate action with head office on how to address this. Nobody seems to realise the extent of the damage that is caused to the skin.
- If the communication on 17th June outlining 2 weeks of events was indeed sent to head office, this is a very slow formal outline of the incident if in fact this is how head office is notified.
- On 24 June, 3 weeks post the incident, there are several notes where after a phone conversation with [Dr B], that appears to be taken on 15th June, where [Dr B] is expressing her concern about the amount of time off work, the impact on her training, areas of her skin still raw. It is noted for the first time I can see, that [Dr B]'s biking accident was made apparent to the clinic and the mention of compensation was raised by [Dr B].
- 1 July? more information on [Dr B]'s skin has been added after a conversation with who appears to be [Dr B]'s partner, although no name is given, that the burns are indeed 2nd or 3rd degree and that the pair have suffered financial loss and [Dr B]'s career has been impacted.
- Notes are written up on the computer days post the events ie computer 1st July detailing events from 24 June. Where has this information been written to remember such details?
- 24th June comments are now being made that [Dr B] had not heard from head office and she wanted to forget about it all, clearly stressed, she couldn't take any more photos as she didn't want to look at herself.
- July 1 notes from [...], it seems [...] from head office has contacted [Dr B]'s household but unsure who he was talking to — thought it was her father? Discussing time off work, and the “adverse event”, head office suggesting [...] contact the insurance company.
- There is no further information in the notes following July 4 with some updated photos being sent to the clinic. No further mention of action, and on 30 July [Ms D] says there is no further update, as [Dr B] has not been into the clinic.
- This note taking ends on 12 January with [head office] advising to close the ticket, the insurance company are now involved. This is also the first time the clinic has noted the biking accident [Dr B] had.

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- Communication notes continues to July 30th, 2021, approx 7 weeks post burn treatment, mainly relating to LED arrangements, [Dr B]’s visits to GP for which she sends invoices to the clinic, photo updates from [Dr B] of her legs, etc.
- 4 days post the burn treatment, there is a note from [...] suggesting a refresher training and to discuss the Fitzpatrick skin typing with Ms [C] -. I don’t see any notes that this was done.
- [Clinic A] are a franchise, better processes relating to adverse incidents with the head office and clinic should be in place. The clinic owners may not be highly experienced laser or skin therapists, possibly with no beauty therapists or nurses, and have purchased their franchise because of its highly regarded, well-known brand and good business model. They have also brought the experience and support that comes from a franchise, especially in the case of [Clinic A] being set up in Australia 25 years ago, in the state of Queensland. This state has high aesthetic laser regulations and protocols. As such, there should have been more immediate support from someone with more authority and experience in skin trauma from lasers than this clinic seems to possess. A better process needs to be implemented in the case of burns, as [Dr B] has suffered more than damage to her skin (which as a Fitz 4 or 5 will be long lasting post inflammatory pigmentation. There is very little on the market that can fix this). Her mental health has clearly suffered, she and her partner have suffered financial loss, and the impact this has had on her career timeline is significant.
- I see the clinic has followed due process but with no real focus on the outcome for the client and their skin.
- The fact it took 6 months for [Dr B] to receive a formal letter of apology, dated 17 December 2021 is somewhat insensitive to her condition.
- I recommend the training process be assessed in relation to treating skins with colour. NZ is made up of a variety of ethnicities, and more attention needs to be given to treating this skin, highlighting the laser settings and making sure therapists fully understand this, as well as gaining more observation — which will mean actual treatments — on skins for Fitzpatrick skin type 3–5 (Fitz 6 may or may not be treated by [Clinic A]).

I FIND THE SUPPORT AND AFTERCARE SHOWN TO [DR B] WAS OF A GOOD STANDARD.

I DO THINK HOWEVER, THE TIME IT TOOK FOR THE HEAD OFFICE TO CONTACT THE CLIENT DIRECTLY WAS SLOW, AND I DON’T SEE EVIDENCE OF MUCH SUPPORT FOR THE CLINIC HERE EITHER. TO ME I FIND THE HEAD OFFICE TO BE OF MODERATE DEPARTURE FROM ACCEPTABLE STANDARD.

Question 4: *Whether the induction/orientation and ongoing training provided to [Ms C] by [Clinic A] was adequate.*

[Ms C] training and competence

Note – [Clinic A] provided HDC with copies of [Ms C]’s training log, which demonstrates that she had completed her required 25 hours of training and that she held a level 5 Beauty

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Therapist Certificate. The information in Ms Thompson's report below is incorrect and was not relied upon in forming the final opinion.

- I have gone through the training log given to us by [Clinic A], and I may have miscalculated, but it looks like [Ms C] was still within her 25 hours' practical training period when she treated [Dr B].
- [Ms C] had completed 18 hrs of her 25 hours recommended by [Clinic A] protocols.
- Was [Dr B] aware [Ms C] was still in training, if this is the case.
- If [Ms C] was still within her training period, why was her supervisor not there?
- If [Ms C] was still within her training period, why was her setting not checked.
- Laser Safety qualification is not a licence to practice. It is the prerequisite for practical training. Laser safety gives the therapist a fundamental knowledge of theory of light, skin type classification, laser wavelengths for different treatments in the aesthetic and medical industries, and the risks involved with laser use.
- I've mentioned earlier about what I see to be a lack of dark skin and laser interaction awareness.
- I question the amount of practical training received on clients with skin of colour.
- Need more accurate assessment procedures in skin reaction and client feedback.
- It was recommended more training following this incident, and to focus on the Fitzpatrick skin scale.

I FEEL THERE IS A LACK OF TRAINING FOR CLIENTS WITH SKIN OF COLOUR, WHICH IS A SERIOUS ISSUE WITH THESE VERY ACCESSIBLE CLINICS. THE 25 HOURS' PRACTICAL IS EXCELLENT AND AS SUCH I SUGGEST THIS IS A MODERATE DEPARTURE FROM ACCEPTABLE STANDARD.

Question 5: *Any other matters that you consider warrant comment.*

- Is it protocol to have the supervising therapist (MTA [Ms D] or [...] most commonly seen from her training sheets) in the treatment room during the whole time for all practical treatment sessions?
- Only looking at previous 2 tmts, why limit it to the last 2?
- Who enters the notes on the computer, and from a handwritten treatment record in the treatment room?
- The need for more accurate assessment procedures in skin reaction and client feedback.
- Why did it take 6 months for [Dr B] to receive a formal letter of apology. Sent to her 17 December 2021?
- I accept there are multiple checks in place for entering the settings, looking at past treatments and clinic guidelines, and that [Ms C] made an honest mistake.
- All staff treating [Dr B] had differences of opinion or indecision when deciding on her Fitzpatrick. I suggest a refresher for all staff in this, or if not done, have clients

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fill out one of the attached tests. It's the colour you are born with so it doesn't change. What changes is added tan, or areas that may have pigmented due to rubbing such as the underarm — this area usually goes darker, especially on Fitz 3, 4 and 5.'

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