(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2023] NZHRRT 32**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 050/2022
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**TE WHATU ORA - HEALTH NEW ZEALAND**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms SJ Eyre, Chairperson
Ms SP Stewart, Member
Ms SB Isaacs, Member

REPRESENTATION:
Ms C McCulloch Director of Proceedings
Ms A Lane and Mr J Coates for defendant

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **11 October 2023**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] Decision is to be cited as *Director of Proceedings v Te Whatu Ora* [2023] NZHRRT 32. Note publication restrictions.

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 9 November 2022.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make orders by consent. The parties have filed:

[2.1] A statement of claim dated 9 November 2022

[2.2] A consent memorandum dated 9 November 2022.

[2.3] An Agreed Summary of Facts, a copy of which is **annexed** and marked 'A'.

[3] In the consent memorandum dated 9 November 2022 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2(a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that Southern District Health Board ("DHB") has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>
> 2(b) A final order pursuant to s 107(3)(b) of the Human Rights Act 1993 prohibiting publication of the name and all identifying details of the aggrieved person in this matter (Mrs A, deceased)

[4] Having considered the Agreed Summary of Facts, the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person and her daughter (who is also referenced in the agreed summary of facts), for the following reasons.

[6] The Tribunal may order final suppression orders under s 107(3) of the Human Rights Act 1993 if it is "satisfied it is desirable to do so". In this context, "desirable" is considered from the point of view of the proper administration of justice; a phrase that must be construed broadly to accommodate the particular circumstances of individual cases as well as broader public interests. Any name suppression order should do no more than is necessary to achieve the proper administration of justice. For an order there must be some material before the Tribunal to show specific adverse consequences that are sufficient to justify an exception to the fundamental rule of open justice; see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 and *Director of Proceedings v Smith (Application for Final Non-Publication Orders* [2019] NZHRRT 32.

[7] Mrs A was the consumer in this matter. The Agreed Summary of Facts contains sensitive details about her private health information and the circumstances of her death. As Mrs A is deceased it is not possible to seek her opinion on suppression of her name and identifying details. Mrs A's daughter and husband represented her throughout the proceedings. Publication of Mrs A's name and identifying details would cause her daughter and husband significant distress and their strong preference is that their mother and wife's name be suppressed. Likewise, publication of Mrs A's daughter's name will also identify her daughter and their family.

[8] There is public interest in the details of the defendant's failures being published, as set out in the Agreed Summary of Facts. There is, however, little or no interest in the publication of Mrs A's name or her daughter's name, nor in her being identified in connection with this case. In these circumstances, the privacy interests of Mrs A (deceased) outweigh any public interest in knowing her name or her daughter's name. The publication of Mrs A's name would cause her husband and daughter specific adverse consequences.

[9] The presumption of open justice is satisfied by publication of the Tribunal's decision and the detailed Agreed Summary of Facts, with Mrs A's name and identifying details redacted as well as her daughter's name.

[10] Accordingly, the Tribunal is satisfied the order sought by the parties in paragraph 2(b) of the Consent Memorandum should be made.

DECISION

[11] The decision of the Tribunal is that:

[11.1] A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

[11.2] A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person, Mrs A (deceased) or her daughter, Mrs B.

[11.3] There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms SJ Eyre	**Ms SP Stewart**	**Ms SB Isaacs**
Chairperson	**Member**	**Member**

'A'

This is the Agreed Summary of Facts marked with the letter 'A' and referred to in the annexed decision of the Tribunal delivered on 11 October 2023.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT 050/22

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **THE DIRECTOR OF PROCEEDINGS**

Plaintiff

AND **TE WHATU ORA - HEALTH NEW ZEALAND**

Defendant

REDACTED AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Courtney McCulloch - Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").
2. The "aggrieved person" in these proceedings is Mrs A (deceased). At all material times the aggrieved person was a consumer of health care services.
3. At all material times Southern District Health Board ("SDHB") was a health care provider within the meaning of s 3 of the Act, and was providing health care services to the aggrieved person within the meaning of s 2 of the Act.
4. In April 2020 the aggrieved person's daughter, Mrs B, complained to the Health and Disability Commissioner ("the Commissioner") about services provided to her mother by SDHB.
5. On 29 November 2021 the Commissioner (appointed under s 8 of the Act) finalised her opinion that SDHB had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred SDHB to the plaintiff.
6. Following the Pae Ora (Healthy Futures) Act 2022 coming into force on 1 July 2022, these proceedings transferred to the defendant, Te Whatu Ora - Health New Zealand.

BACKGROUND

7. On the morning of 27 November 2019, Mrs A (aged 68 years) presented to her general practitioner ("GP") with a five day history of shortness of

breath ("SOB"). Her blood pressure ("BP") was high at 161/102mmHg.[1] Prior to this Mrs A was fit and well.

8. The GP suspected a pulmonary embolism ("PE")[2], and administered a 70mg dose of clexane (a blood-thinning medication) before referring Mrs A to Dunedin Hospital via ambulance at 1.10pm (arriving at 2.23pm).

CARE PROVIDED BY THE DEFENDANT

Emergency Department

9. At Dunedin Hospital Mrs A was assessed by an Emergency Department ("ED") registrar who noted Mrs A's short history of SOB, some mild swelling[3] in her ankles, and her blood work, which showed significant heart strain. The registrar documented that Mrs A looked "pale, sallow[4] and unwell". Her impression was "?PE/NSTEMI[5]".

10. While in ED Mrs A had a brief episode of light-headedness and feeling faint when going to the toilet, and her oxygen saturation dropped to 71%.[6]

11. At about 5pm a CT pulmonary angiogram[7] confirmed a large PE of both the left and right main pulmonary arteries, with evidence of right-sided heart strain.

Handover

12. At 6pm Mrs A was reviewed by the admitting registrar ("the admitting registrar") for handover to the respiratory team. The admitting registrar documented Mrs A's main problem as a "massive PE [with] significant haemodynamic [cardiovascular function] effect". Mrs A also had an

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[1] A blood pressure of around 120/80mmHg is considered to be within the normal range.
[2] A blockage in one of the pulmonary arteries in the lungs, usually caused by blood clot.
[3] Pitting oedema - swelling in the body caused by excess fluid, which can indicate a systemic problem with the heart, kidneys, or liver function.
[4] An unhealthy, often yellow, skin colour.
[5] A non-ST-elevation myocardial infarction - a type of heart attack.
[6] The normal range of oxygen saturation for adults is 94–99%.
[7] A scan of the arteries in the lungs.

abnormal ECG[8], an elevated troponin[9] and high pro-BNP[10] level, all in-keeping with significant heart strain. The admitting registrar also noted Mrs A's brief episode of light-headedness and feeling faint.

13. The admitting registrar noted that Mrs A had a PE Severity Index ("PESI") of class IV and documented that this indicated an "intermediate–high risk" of mortality.

14. The admitting registrar discussed Mrs A's case by telephone with the respiratory consultant on call ("the respiratory consultant"). The admitting registrar advised the Commissioner that: "we both agreed that at that point, the risk of systemic thrombolysis[11] outweighed any benefit and that thrombolysis was not indicated as she was a high intermediate risk."

15. The respiratory consultant recalls that the plan was to admit Mrs A to the Coronary Care Unit ("CCU") for observation, administer a further dose of blood-thinning medication, and consider thrombolysis if Mrs A's blood pressure dropped or she went into shock.

16. The respiratory consultant recalls that he and the admitting registrar talked about thrombolysis and the definite indication that if Mrs A's systolic BP dropped to less than 90mmHg for more than 15 minutes, they should discuss urgent thrombolysis.

17. The respiratory consultant cannot recall the admitting registrar addressing the severity of the PE (documented in the clinical notes as "massive") specifically or Mrs A's brief episode of light-headedness and faintness in the ED.

18. Mrs A was handed over to the respiratory team under the care of the respiratory consultant.

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[8] Electrocardiogram - records the electrical signal from the heart.
[9] Muscle fibres that regulate muscular contraction in the heart.
[10] Proteins produced in large amounts by the heart when it needs to work harder.
[11] Administration of thrombolytic medication to dissolve blood clots.

19. On the day Mrs A presented to the ED there was a significant "access block" through Dunedin Hospital such that there were not enough inpatient beds for transfer of patients after treatment in the ED. Accordingly, despite being handed over to the respiratory team, Mrs A remained in the ED while waiting for a bed in the CCU.

Continued care in ED

20. While in ED, Mrs A was monitored using (among other things) an Early Warning Score ("EWS").

21. An EWS is calculated from routine vital sign measurements and increases as vital signs become increasingly abnormal. The EWS triggers an escalating clinical response so that clinicians with the appropriate skills can intervene and manage the patient's deterioration.

22. The defendant's 'Adult Vital Sign and Early Warning Score Observation Recording and Escalation' policy at the time in question documented that patients in the "Red Zone" (patients who have an EWS of 8–9) must have their case discussed with the responsible Senior Medical Officer ("SMO"). The policy stated that for all patients with an EWS of 6–7, a documented assessment must occur, which included the plan, intervention, escalation, and review time-frame.

23. The ED nursing notes document that Mrs A was reviewed by a medical registrar at 7.30pm because of hypotension and given 1 litre of saline, and that the decision was made for BP observations every five minutes. The vital signs chart records that Mrs A's BP was 90/60mmHg, her pulse rate was 120 beats per minute and her respiratory rate was 27 breaths per minute. The EWS was 9. Neither the medical registrar's review nor the name of the registrar are documented.

24. Between 7.30pm and 7.50pm Mrs A's EWS in the ED was 9 on three occasions, and her systolic BP dropped to 90mmHg. As per the defendant's policy, at this time Mrs A's condition should have been

discussed with the responsible SMO (the respiratory consultant) but this did not occur.

25. At 8pm Mrs A's progress notes document that her BP was "fluctuating". Mrs A was moved to the resuscitation bay "to allow closer monitoring + management if deteriorates further". At this time, Mrs A was still awaiting a bed in the CCU, and it was noted that there was a one-hour wait.

26. At 9pm Mrs A's systolic BP dropped from 110mmHg to 88mmHg, and a second bag of saline was commenced in an attempt to raise this. Her systolic BP was then measured again, and noted to have risen to 100mmHg. It is not clear from the clinical notes whether a registrar was contacted at 9pm, but a nursing note at 9.20pm indicates that a respiratory registrar was involved in Mrs A's care at this time. Mrs A's care was not escalated to the respiratory SMO at this time.

27. At 10.21pm Mrs A had another period of hypotension where her systolic BP dropped to 86mmHg. The respiratory registrar was contacted by a nurse via telephone, who recommended checking Mrs A's BP again in 15 minutes. The notes document that Mrs A was placed in the semi-trendelenburg position[12] in an attempt to raise her systolic BP, which was documented to have increased to 99mmHg at 10.35pm. The nursing notes document that the respiratory registrar was informed of this result, and Mrs A was transferred from the ED to the CCU at 11.12pm.

28. The defendant's 'Thrombolysis in Pulmonary Embolism' policy identifies that a "systolic BP <90mmHG with no other cause apparent" is an indication for thrombolysis. As per this policy, thrombolysis should have been considered at 9.00pm and at 10.21pm.

Care provided in CCU

[12] Lying flat on the back on a 15–30 degree angle.

29. There is little documentation in Mrs A's clinical progress notes regarding her time in CCU.

30. At 3.30am on 28 November 2019, a registered nurse ("the RN") documented Mrs A's vital signs[13] and noted that she had had "1x vomit" when she was being moved into her bed from the ED. The recorded plan of care was: "Monitor. May need thrombolysis if BP [lower than] 90mmhg. Hourly [observations]."

31. Mrs A's vital signs chart records that a house officer reviewed Mrs A at 4am. However, her clinical records contain no further mention of the review.

32. Mrs A was administered another dose of clexane at 4.44am. This is documented in the electronic administration chart, but not in Mrs A's clinical notes, and it is not clear who administered the medication.

33. At 6am the RN asked the house officer on duty ("the house officer") to review Mrs A because of her increased SOB and anxiety, and recorded that a medical registrar was also telephoned. However, no changes to the plan were made at that stage, on the basis that Mrs A's vital signs were "holding". At this time, her vital signs were a systolic BP of 92mmHg, heart rate of 110 beats per minute, and respiratory rate of 22 breaths per minute. The house officer recalls reviewing Mrs A again at the RN's request, but the review is not documented.

34. At 6.30am the medical registrar reviewed Mrs A but did not document the review. The medical registrar recalls that Mrs A's BP had been around 90–100mmHg most of the night, and that the instructions to her had been to administer thrombolysis if the blood pressure dropped below 90mmHg. At that time the medical registrar felt the trend of Mrs A's blood pressure and other vitals had not been deteriorating but rather staying much the same (albeit with no improvement) so the medical

[13] Heart rate 100–110bpm, systolic BP 91–103mmHg, oxygen saturation 96%, and respiratory rate 16–24 breaths per minute.

registrar made the decision to continue the current care and speak to the consultant in the morning.

35. In a retrospective note made at 7.35am, the RN documented that Mrs A was reviewed multiple times during the night, with her vital signs remaining stable, but that her work of breathing had increased and she was not settling. The RN also documented that he discussed Mrs A's condition with the Clinical Team Coordinator as well as the house officer and the medical registrar, during the early morning of 28 November 2019, but that Mrs A was "not for thrombolysis during this time".

36. While in the CCU, Mrs A's EWS scores were documented on her vital signs chart as follows: 6 at 3am, 5 at 4am and 5am, 7 at 6am, and 6 at 6.30am. Mrs A's systolic BP was documented as being 90mmHg at 4am, and it was still 90mmHg when it was checked again at 5am.

37. As per the defendant's 'Adult Vital Sign and Early Warning Score Observation Recording and Escalation' policy, there should have been a documented assessment (which included the plan, intervention, escalation and review time frame) at 3am, 6am and 6.30am. There is no evidence that an assessment occurred at 3am, and although assessments were undertaken at 6am and 6.30am, these were not documented. Mrs A's care was also not escalated to the respiratory SMO during this time.

38. At 7.10am Mrs A's daughter pressed the emergency bell in response to an episode of lost consciousness. Attempts at resuscitation (which included the administration of thrombolysis) were unsuccessful, and Mrs A suffered a cardiac arrest (due to the large PE). Sadly, Mrs A died at 7.50am.

39. The respiratory consultant was not contacted during Mrs A's stay in the ED (after the handover discussion with the admitting registrar), or in the CCU until after Mrs A's death. As stated above, the defendant's 'Thrombolysis in Pulmonary Embolism' policy indicates that a "systolic

BP <90mmHG with no other cause apparent", or "a sustained fall of more than 40mmHg in systolic BP with no other cause apparent" are indications for thrombolysis.

40. SDHB has acknowledged that discussions with the on-call SMO (the respiratory consultant) should have occurred on 27 November at 7.30pm, 7.50pm, 9.15pm, and 10.25pm, and at 4am and 5am the following morning.

41. The respiratory consultant advised the Commissioner that he should have been contacted during the night in question. As such, he had not been made aware of the treatment with IV fluids, or the low BP readings in the middle of the night. The respiratory consultant stated:

> "Unfortunately, an opportunity was missed to consider treatment with thrombolysis at 7.30pm on 27 November 2019. Rather than discuss the hypotension and high early warning score with the on-call consultant, and monitor for hypotension that might fulfil definite thrombolysis criteria, fluid resuscitation was commenced to treat Mrs A's hypotension. This would not be usual treatment in sub-massive or massive pulmonary embolism such as in Mrs A's case."

EXPERT ADVICE

42. The Commissioner obtained independent expert advice from respiratory medicine expert (Dr Nicola Smith) and emergency medicine expert (Dr David Prisk).

Dr Prisk – emergency medicine expert

43. Dr Prisk advised that Mrs A's case raises questions about the responsibility of ED medical staff for patients in these situations. Handover to the respiratory team occurred while Mrs A was still in the ED and it appears that the respiratory team assumed overall responsibility for her care after that. Dr Prisk advised that this decision

appears to be at odds with the Australasian College for Emergency Medicine's 'Statement on Responsibility for Care in Emergency Departments' which says that with regard to patients in ED awaiting inpatient beds, the ED retains the primary responsibility for the management of the patient including observation, medication administration, nursing care, and the immediate response to any emergent situation.

44. In Dr Prisk's opinion, the severity of Mrs A's illness was not fully appreciated by medical staff and her PE Severity Index score was miscalculated; Mrs A fell into the high risk category, not intermediate to high risk. This influenced the initial decision to withhold thrombolytic treatment, and likely influenced decisions throughout the night to withhold thrombolytic treatment. Dr Prisk stated that it seems the junior medical staff's focus remained on Mrs A's blood pressure, and not her overall clinical picture.

45. Dr Prisk advised that the first line of treatment recommended for PE is aggressive anticoagulation. The administration of 3 litres of IV fluid and, after 7:30pm on 27 November 2019, the withholding of thrombolytic treatment, was a severe departure from the standard of care. Likewise, Dr Prisk considered the lack of involvement of the responsible SMO to also be a severe departure from the standard of care.

46. Further, treatment of Mrs A's hypotension with IV fluids and reverse trendelenburg position was inappropriate. Mrs A was clearly in shock between 7.30pm and 10.35pm and was a candidate for thrombolysis, not simply temporising measures to correct her BP. At admission, the admitting registrar documented that thrombolysis was a possible treatment option if Mrs A became hypotensive. There was no further documentation of this as a consideration until retrospectively in relation

to the resuscitation attempt. There is no other documentation of medical decision-making by any junior or senior medical officer.

47. Mrs A developed hypotension which suggested thrombolysis had become indicated. She was anuric (not urinating - the significance of which seems only to have been recognised by her daughter, Mrs B), she was anxious and agitated, and toward the end of the night she appeared to be shutting down peripherally. The ward nurse noted the registrar opted not to administer thrombolytics because Mrs A's vitals were 'holding'. However, Mrs A remained hypotensive, hypoxic and tachycardic. It is unclear why this clinical picture was thought to be reassuring. Mrs A was critically ill with PE and although she had many signs suggesting that she had a high risk of early mortality, these were apparently not recognised or acted upon by junior medical staff. There were several missed opportunities to administer thrombolytics to Mrs A, which may have given her a chance of survival.

48. Dr Prisk advised that handover to the respiratory ward seems to have been inadequate (significant things were not discussed, like the syncopal event and severe hypoxia when Mrs A returned from the toilet in the ED early in her admission, and the hypotension as an indication for thrombolysis) which was a moderate departure from the standard of care.

49. In addition, Dr Prisk stated that the medical documentation was poor. The admission note was inadequate, and there was poor medical documentation thereafter. Dr Prisk considered this to be a severe departure from the standard of care. Dr Prisk also advised that communication with the family generally appears to have been poor and was a moderate to severe departure from the standard of care.

Dr Smith - respiratory medicine expert

50. Dr Smith advised that three opportunities for giving thrombolysis to Mrs A were missed:

    i) At 7.30pm when Mrs A had deteriorating vital signs indicating development of shock. Her BP was 90/60mmHg (down from an initial BP of 161/102mmHg), her pulse rate 120bpm, and her EWS was 9;

    ii) At 10.21pm when Mrs A's BP fell further to 86/68mmHg. The RN informed the respiratory registrar who advised to repeat the BP in 15 minutes. This advice was contradictory to the SMO's treatment plan; and

    iii) Thirdly, during the period between 4am and 7am in the CCU on 28 November 2019, during which Mrs A's systolic BP was consistently 90mmHg and her EWS score was 9. The SMO had instructed that Mrs A be given thrombolysis if there was evidence of shock or hypotension.

51. During the three time periods identified as missed opportunities, Mrs A's BP was in the Red Zone of the Vital Signs Chart and the EWS system mandated that a registrar review occur, that there was discussion with the on-call SMO, and consideration of referral to critical care.

52. Dr Smith advised that the failure of the medical staff involved in Mrs A's care to follow the EWS policy and to discuss a critically ill and deteriorating patient with the on-call SMO would constitute a serious departure from accepted practice. Dr Smith stated that: "It is expected that medical staff are able to recognise a critically ill and deteriorating patient and that they will escalate care by discussing with the on-call SMO or Intensive Care Unit."

53. Dr Smith also criticised the poor standard of clinical documentation, in particular the lack of documentation of apparent medical reviews

undertaken at 7.30pm, 4am and 6.30am (having been recorded in the nursing notes that they occurred). Dr Smith advised that "accepted practice is for any clinical review of a patient to be documented by the doctor undertaking the review in the clinical record". If a house officer or registrar review is undertaken but not documented, then this would be "a serious departure from the required standard of documentation".

BREACH OF RIGHT 4(1) OF THE CODE

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

55. SDHB acknowledges that there were multiple missed opportunities by SDHB staff to exercise sound clinical judgement and assess Mrs A's deteriorating condition critically and to follow the DHB's policy to escalate Mrs A's care to the responsible respiratory SMO, and to initiate thrombolysis on a number of occasions when it was clinically indicated, and to communicate effectively with one another.

56. SDHB accepts the Commissioner's findings that this is a service delivery failure for which, ultimately, SDHB is responsible at an organisational level.

57. SDHB also accepts that it has responsibility to foster a culture that ensures junior staff are aware that they are able to escalate care to SMOs when necessary.

58. In addition, SDHB acknowledges that the documentation deficiencies in this case can be attributed to multiple staff at Dunedin Hospital, both doctors and nurses[14] across both the ED and the CCU. SDHB acknowledges that patient records are a crucial part of medical practice,

[14] With the exception of the RN.

as they reflect a doctor's reasoning and are an important source of information about a patient's care.[15]

59. Accordingly, in light of the above, the defendant accepts that it failed to provide services to the aggrieved person with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

_____

Courtney McCulloch
Director of Proceedings

Date:

I, Hamish Brown, agree that the facts set out in this Summary of Facts are true and correct.

_____

Hamish Brown, Group Director of Operations
On behalf of Te Whatu Ora - Southern

Date:

[15] As per the Medical Council of New Zealand's statement on "Managing Patient Records https://www.mcnz.org.nz/assets/standards/0c24a75f7b/Maintenance-patient-records.pdf.