

# Health Law Bulletin

September 2015



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## Introduction

Welcome to the September 2015 edition of the Holman Webb Health Law Bulletin.

Winston Churchill once said: “Those that fail to learn from history, are doomed to repeat it.”

Over the years, I have acted for hospitals in coronial inquests, defended complaints and claims, participated in Board meetings and hospital risk management committee meetings. I have also presented health law lectures to law students and health management university students. In some of those presentations I explain the case of Vanessa Anderson, the 16 year old schoolgirl who died following medical misadventure after being hit on the head by a golf ball.

After I explained that the case is likely to have settled out of court, a student asked the question “Why are you discussing a case where there is not even a reported decision on a civil law claim?”. My answer was: “This case teaches us a lot from the coroner’s report and this is the case which led to the Garling “Final Report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals” and health system reform in New South Wales.

Root cause analysis, coronial inquests, case law and Government inquiries provide insight into how we can improve our health and aged care system. We should not forget the lessons learnt from those inquiries.

This Health Law Bulletin includes articles on lessons learnt from the Quaker’s Hill Coronial Inquest, palliative care and euthanasia and advance care directives. Why such a morbid theme? The reason is that learning about death can save or improve many lives.

We trust that this edition of the Health Law Bulletin brings to you articles of relevance to the sector.

The health, aged care/retirement living and life science sectors form an important part of the Australian economy. They are economic growth areas, as more Australians retire with a significantly longer life expectancy and complex health care needs.

Against the background, Holman Webb’s health, aged care and life sciences team provides advice that keeps pace with the latest developments. Our team has acted for health and aged care clients over a number of years, both in the “for profit” and the “not for profit” sector.

Some of our team members have held senior positions within the health industry. Please do not hesitate to contact me or any member of our legal team should you have any questions about the Health Law Bulletin content and articles or if one of your colleagues would like to be added to our distribution list.

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## Lessons learnt from the Quakers Hill Coronial Inquest

*By Alison Choy Flannigan, Partner and Zara Officer, Special Counsel*

The tragic death of 14 aged care residents at the Quakers Hill Nursing Home provides a number of lessons for hospital operators and residential aged care operators, including in relation to:

- The recruitment and background/reference checking of potential staff;
- Mandatory reporting;
- Dealing with staff who are impaired with substance abuse and Schedule 8 medications; and
- Emergency evacuation procedures.

### Findings of Deputy State Coroner H C B Dillon delivered 9 March 2015

On 18 November 2011 a fire lit by Mr Roger Dean, a registered nurse employed by the Quakers Hill Nursing Home caused death and serious injury to numerous elderly residents. A combined inquest was conducted into the fire and into the deaths of 14 residents. Mr Dean ultimately pleaded guilty and was convicted of 11 counts of murder by reckless indifference to human life. He also ultimately pleaded guilty and was convicted of recklessly causing grievous bodily harm to a further eight people. He was sentenced to life imprisonment without parole and has appealed against his sentence.

There were approximately 81 aged care residents at the nursing home. Many suffered dementia and some were bedridden. There were no sprinkler systems in the nursing home in 2011, but they have since been installed.

### Staffing

Ordinarily, only one registered nurse was rostered onto the night shift at the Quakers Hill Nursing Home, assisted by four assistants in nursing. Mr Dean worked three or four night shifts per week, commencing on 13 September 2011 (after attending in-service staff training), on three months' probation. He was responsible for the medications cupboard and in particular he had the only keys to the Schedule 8 drugs of addiction cupboard.

Unbeknown to the Quakers Hill Nursing Home prior to employing Mr Dean, Mr Dean suffered from prescription medication addiction. The Coroner described him as a "drug-dependant doctor-shopper who was not identified as either before the fire". A forensic psychiatrist involved in his sentencing hearing also diagnosed him with a personality disorder with cluster B characteristics including narcissistic and histrionic features.

The Quakers Hill Nursing Home was also unaware that Mr Dean had previously worked at St John of God Hospital where in June 2011 he was suspended for appearing under the influence of drugs on one of his shifts. His suspension was lifted with medical clearance from his general practitioner. St John of God Hospital took steps to move Mr Dean onto day shifts so that he was under supervision while at work. Mr Dean resigned from St John of God Hospital on 19 September 2011 for "personal reasons". In the meantime he applied for and secured the position as a night nurse at Quakers Hill Nursing Home. In his application he omitted to mention his work at St John of God Hospital. He presented a curriculum vitae which was misleading, and his references were seriously out of date. No member of the Quakers Hill Nursing Home staff got in touch with his referees or his previous employers. Nevertheless he obtained a permanent part time position at the Quakers Hill Nursing Home as the registered nurse on night duty.

### Theft of medication

On the night shift before the fire Mr Dean was observed by an assistant in nursing to be spending a large amount of time in the treatment room (which housed the medication cupboard) with the doors closed. CCTV footage showed that Mr Dean went in there 36 times over that shift and spent approximately two hours of his shift in there. During the following day staff found there to be 237 tablets of Endone and one tablet of Kapanol (both opioid medications) missing, and Mr Dean was suspected. The Police were called and attended the Quakers Hill Nursing Home to investigate but were called away on more urgent calls and the matter was not dealt with on 17 November. Police were not informed of the staff suspicions that Mr Dean was responsible for the theft of the medication. Even though he was suspected, Mr Dean was allowed to remain on the night shift and in charge of the nursing home.

### The fire

In the early hours of 18 November 2011, at around 5.00am, Mr Dean lit a fire in one wing of the nursing home. Shortly thereafter, he lit a fire in another wing of the nursing home which was not detected for some time. Firefighters were called by an automatic alarm. A "000" call was not made, which delayed the allocation of extra resources to the fire. The responsibility for making the "000" call was the responsibility of the registered nurse in charge (in this case Mr Dean), but no-one else checked whether or not it had been done.

The fire and rescue personnel who first arrived at the scene were engaged in the evacuations of the residents. There were numerous difficulties with the evacuations. Some beds were unable to be wheeled out of the building due to the configuration of one of the exit ramps which were positioned at a 90° angle. There were logjams of patients at exit doors, and debris was on the floor making it difficult to wheel beds.



The fire was eventually extinguished and the residents were evacuated and sent to hospitals. The lack of identification bands made notifying next of kin difficult. Sadly two residents were found dead in their beds after the fire was extinguished and another lady who was evacuated was found to have died at the scene. Eleven other residents died later.

## **Destruction of evidence**

After the fire was extinguished, later that day Mr Dean returned to the treatment room and retrieved the drug books which were still intact. He went home and shredded them and then threw them away in a rubbish bin at the local cheesecake shop where his partner worked. He then returned again to the nursing home. He was interviewed by Police but in the first interview did not mention lighting the fire or stealing the medications. Later that evening the Police informed him he was a suspect in lighting the fires and he then admitted lighting the fires but he did not admit to stealing the medication.

In his later criminal sentencing the Presiding Judge, Her Honour Justice Latham, found that Mr Dean's intention in lighting the fires was either to deflect management from further enquiring into the theft of the medication and/or to destroy the treatment room evidence.

During the investigations undertaken after the fire it was apparent that a number of staff members had concerns about Mr Dean's competence and behaviour at various times during his employment at the nursing home. Some concerns had been reported to management, but not all.



## **Missed opportunities**

The Coroner found with hindsight there may have been an opportunity to diagnose and address Mr Dean's polysubstance abuse if a mandatory report had been made to the Australian Health Practitioner Regulation Agency (AHPRA) by St John of God Hospital about him being under the effect of drugs at work. However, Mr Dean had convinced St John of God Hospital that he was suffering from side effects of prescribed medication. Another opportunity was missed when the Quakers Hill Nursing Home did not make background checks into his previous employment or his references before employing him. There were also missed opportunities to uncover drug abuse behaviours when nursing staff at the Quakers Hill Nursing Home saw him doing worrying things such as waking up patients to give them medications in the middle of night that they had not requested, but did not follow up.

## **Desirability of training and development of protocols for mandatory reporting**

The findings point to the requirements of mandatory reporting under the *Health Practitioner Regulation National Law (NSW) 2009* and the desirability of nurses and health professionals to receive routine in-house training covering the potential misuse of drugs by members of their professions, the signs of impairment due to drug misuse or dependency, and protocols and procedures for reporting any concerns that might indicate a health professional is adversely drug affected.

Coroner Dillon noted a general hesitancy amongst staff members to promptly and decisively take action to quarantine a nurse acting suspiciously and possibly dangerously. While there was no suggestion that the nursing home could have possibly foreseen Mr Dean's extreme response to the discovery that large amounts of Schedule 8 drugs were missing, the nursing home should have taken decisive action to suspend Mr Dean while the missing drugs were investigated, given he was the main suspect.

## Lessons learned

Many lessons can be learned from the Quakers Hill Nursing Home disaster. A comprehensive set of recommendations were made.

Many of these relate to aspects of fire safety, including:

- The necessity of at least one “000” (and preferably more than one) call, instead of relying on automatic systems – personal calls portray the seriousness of the emergency;
- That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheel chairs but that alternative dragging methods may need to be employed;
- That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable;
- That the facility’s fire evacuation plan take into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and make specific provision for addressing those challenges in an emergency;
- That fire exits and doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency; and
- That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

With respect to nursing, nurses and other health professionals working in environments in which Schedule 8 drugs are dispensed to patients should be educated to recognise the signs of possible drug-dependency in their professional colleagues. The table of signs and symptoms developed by the American Nurses’ Association may provide a useful foundation for such education.

With respect to staffing, there are lessons about the management of drug affected health professionals and the “real world” application of the principles of mandatory reporting. There were identified areas of difficulty in interpreting signs and symptoms of drug intoxication and secondly a reluctance of observers to take what might appear to be harsh action against a professional colleague.

A critical lesson from the disaster is to conduct adequate background checks and check references on new employees.

The Coroner considered the task for employers would be easier if the AHPRA registration details of all nurses and other professionals included an employment history that could be checked by prospective employers. This would allow potential employers to check previous employers, and prospective employees would be unable to conceal their previous employment history. A recommendation was made to AHPRA accordingly for its consideration. A further and related recommendation was that AHPRA consider requiring employers to notify it when a registered health professional commences employment and when they leave that employment. ■

## Dr Nitschke and Euthanasia *Nitschke v Medical Board of Australia [2015] NTSC 39*

By Zara Officer, Special Counsel and Vahini Chetty, Associate

Dr Nitschke is a medical practitioner who was not in practice during the relevant period and who has links with the organisation Exit International, a voluntary euthanasia research foundation.

Following a story which aired on ABC’s 7:30 Report on 3 July 2014, the Medical Board of Australia (**the Medical Board**) received six complaints in relation to Dr Nitschke. Included in the list of complainants was the Australian Medical Association, Beyond Blue and members of the medical profession.

The law regulating health practitioners in each state contains provisions which allow the relevant medical board or council to take emergency steps to suspend a practitioner where the board or council forms the view that the practitioner poses a threat to the public that warrants immediate action.

On 23 July 2014, the Medical Board suspended Dr Nitschke’s registration under those provisions. Dr Nitschke appealed the decision in the Medical Tribunal (**the Tribunal**) and on 22 December 2014 the Tribunal upheld the Medical Board’s decision to suspend Dr Nitschke’s registration.

Much of the Medical Board’s reasoning to suspend Dr Nitschke had revolved around the circumstances surrounding the suicide of Mr Nigel Brayley. Mr Brayley was not a patient of Dr Nitschke’s, nor was he terminally ill. On 2 February 2014, he had purchased a copy of the Peaceful Pill Handbook, which had been co-authored by Dr Nitschke. After his purchase of the handbook, Mr Brayley met Dr Nitschke at a workshop in Perth and had briefly corresponded with Dr Nitschke by email.

There was evidence that Mr Brayley had purchased Nembutal, a lethal substance, from China and in February 2014 purchased a test kit from the Exit International website that had been linked to Dr Nitschke which he then used to ensure the Nembutal was pure. On 2 May 2014 Mr Brayley died after consuming the Nembutal.

In the Board’s view, in failing to take steps to discourage Mr Brayley from taking his own life, Dr Nitschke was acting in a manner that was contrary to the *Good Medical Practice: A Code of Conduct for Doctors in Australia* (**the Code**) which requires doctors to promote or protect the health of patients.

Dr Nitschke lodged an appeal in the Northern Territory Supreme Court.

In the decision dated 6 July 2015, the Supreme Court overturned the Medical Board’s decision to suspend Dr Nitschke.





The Court found that Dr Nitschke did not pose a threat to the public which warranted immediate suspension. In particular, the Court stated that it could not accept that a duty could be imposed upon a practitioner to take some action in relation to a person who was not their patient. In the absence of any expert evidence to the contrary, the Court could see no just reason to uphold the Medical Board's suspension.

The relevant paragraph of clause 1.4 of the Code provides that:

*"Doctors have a responsibility to protect and promote the health of individuals and the community."*

His Honour Justice Hiley, held that in his opinion, the clause 1.4 paragraph does not impose an obligation, standard or duty, the breach of which would constitute professional misconduct or unprofessional conduct. The clause 1.4 paragraph is expressed in very general and aspirational terms. It is not couched in imperative terms and does not prescribe and identify any specific obligations, nor does it have clearly identifiable content.

Because there was no evidence, and no evidence to support an inference, that the conduct alleged by the Medical Board could be in breach of the Code or the National Law, the Tribunal could not have formed a reasonable belief that the conduct alleged could be conduct of a kind that could be the subject of the National Law. The Tribunal could not have formed a reasonable belief that because of that conduct the appellant posed a serious risk to persons nor that it was necessary to take immediate action to protect public health or safety.

As in the case of *Dekker v Medical Board of Australia [2014] WASCA 216*, the circumstances of the relationship between the practitioner and the patient in this instance did not give rise to a duty of care on the part of the practitioner. ■

## Why making appropriate entries in medical records is important – *Smythe v Burgman (No 2) [2015] NSWSC 298*

By Zara Officer, Special Counsel

The making of appropriate contemporaneous notes in medical records is best practice for clinical care, but also to facilitate the defence of a claim should an adverse event occur.

### The facts

The plaintiff, Mrs Smythe consulted Dr Burgman between 15 October 2010 and March 2011. On 14 March 2011 Mrs Smythe complained of pain in her left foot. Dr Burgman diagnosed infection and prescribed antibiotics. Mrs Smythe returned on 22 March 2011 with two complaints: pinkness and tenderness in the left foot, and a perianal abscess. Dr Burgman prescribed another course of antibiotics. On 29 March 2011, Mrs Smythe wanted to see Dr Burgman again for pain in her left foot but she saw her husband's general practitioner Dr Follent instead as Dr Burgman was unavailable. On 30 March 2011 Dr Follent referred Mrs Smythe to Tweed Hospital where an ultrasound revealed an arterial clot in the left leg. On 20 April 2011 the left leg was amputated below the knee.

### The issues

The central question was whether Dr Burgman ought to have diagnosed arterial ischemia on 14 March 2011 even though it had an atypical presentation. It was necessary to establish whether or not Dr Burgman had felt the pulses in the feet on the first examination on 14 March 2011. There was no notation about the pulses in the clinical notes. Dr Burgman said she did check the pulses and found them normal, but did not write it down. Mrs Smythe alleged her pulses were not examined. Dr Follent who examined Mrs Smythe on 30 March 2011 found abnormal pulses and referred Mrs Smythe to Tweed Hospital.

### The findings

Dr Burgman owed a duty of care to Mrs Smythe on 14 March 2011 to consider arterial ischemia amongst other diagnoses. In order to confirm or exclude that diagnosis she was required to take Mrs Smythe's dorsalis pedis pulse. If the pulse was abnormal then Dr Burgman would not have been able to exclude the diagnosis without further investigation. If the pulse was normal then Dr Burgman was justified in excluding the diagnosis (which she did) and proceeding to an alternative diagnosis of infection. The Court found Dr Burgman had considered arterio-ischemia and reasonably rejected it after having taken Mrs Smythe's dorsalis pedis pulses on both sides and found them to be normal on 14 March 2011.



## When Do You Need to Notify Your Insurer of an Adverse Event? *Guild Insurance Limited v Hepburn [2014] NSWCA 400*



By Zara Officer, Special Counsel and Vahini Chetty, Associate

For practitioners, knowing what is classified as an adverse event, which must be notified to their professional indemnity insurer, is often difficult. Failing to notify of an adverse event could mean that the practitioner is not covered by their insurer for any claim arising out of the adverse event.

Following the decision reached by the New South Wales Court of Appeal in *Guild Insurance Ltd v Hepburn* [2014] NSWCA 400, a patient's complaint of "excruciating pain" is sufficient to alert a practitioner that a claim may be made in the future.

By statement of claim filed in the NSW District Court on 22 April 2013 Ms Mary Hepburn, the respondent, claimed damages for trespass, assault and negligence from Dr Jasmin White, formerly a practising dentist. Ms Hepburn alleged that she suffered injury as a result of wrongful dental advice and treatment given to her by Dr White between March 2008 and about September 2009. Dr White sought leave to join Guild Insurance (**Guild**) as a party to the proceedings.

The Court considered whether cover should have been provided by Guild under the "claims made and notified" policy held by the practitioner.

Under "claims made and notified" policies, practitioners are entitled to insurance cover under the policy if a claim is made by a patient against the insured practitioner during the policy period and the practitioner notifies the insurer during the policy period. Most medical malpractice/professional indemnity insurance policies are "claims based". This is to be distinguished from "occurrence based" insurance policies during which the insurance policy period covers the date of the event/occurrence/significant event.

In this instance, the adverse event occurred during the policy period but the practitioner did not notify Guild. Furthermore, the claim by the patient was only made after the policy period had expired.

Notwithstanding the absence of a note of it in the clinical notes, the Court accepted expert opinion and Dr Burgman's oral evidence that she had examined the pulses. Mrs Smythe therefore failed to establish a breach of duty by Dr Burgman, and lost her case.

The causation issue in the case was whether amputation would or could have been avoided if ischemia was diagnosed at the first examination on 14 March 2011. The Court found there was insufficient evidence to assess the value of the chance of avoiding amputation if an earlier diagnosis had been made.

### Credit

There were competing versions of what occurred at the consultation on 14 March 2011, and Dr Burgman did not have relevant notes to confirm her assertions. Unfortunately for Mrs Smythe the Court did not accept her evidence in material respects. The Court preferred the evidence of Dr Burgman about the pulses in light of the timing of various versions of what had occurred given by the plaintiff, compared to contemporaneous business records including earlier versions of Mrs Smythe's written statements provided to her solicitors.

### What can be learned from this case?

Practitioners should be aware of the importance of making a note of all significant findings, whether positive or negative. In this case the general practitioner had taken a note of abnormal findings but not of the normal findings which were relevant to excluding a differential diagnosis that was low on her list, considering the whole clinical picture. In this instance the general practitioner was able to defend the claim. In large measure this was because of adverse findings on the credibility of the plaintiff. In many cases the plaintiff is given the benefit of the doubt, and will succeed. A simple message for practitioners to take from this case is always to record their findings on the signs relevant to each differential diagnosis. In particular, if examining pedal pulses, make a note of it, whether they are abnormal or normal.

Holman Webb acted for Dr Burgman in this matter in the Supreme Court of NSW. ■



Section 54 of the *Insurance Contracts Act 1984 (Cth)* precludes insurers from refusing to pay claims in certain circumstances. In particular, s. 54 prevents an insurer from refusing to pay a claim by reason of certain acts of the insured occurring after the date that the contract of insurance was entered into. In such a case, the insurer is not relieved of liability altogether. Rather, its liability is reduced by the amount that fairly represents the extent to which its interests were prejudiced.

There being no evidence to suggest that the insurer was prejudiced by Dr White's failure to notify the potential liability of which she was arguably aware, the Court concluded that it is at least arguable that Ms Hepburn can rely upon s. 54 to avoid the consequences, in whole or in part, of the absence of notification.

This decision is currently the subject of a leave application in the High Court of Australia.

A good rule for practitioners to follow is to always notify their insurer where they believe an outcome could give rise to a claim. The finding in this decision was highly unusual and in circumstances such as these it would be common place for an insurer to deny indemnity in the absence of a notification during the policy period. ■



In Australia, the Directors of Public Prosecutions must decide whether to proceed with a prosecution of persons who have assisted with euthanasia and/or voluntary suicide by another person. All of the Australian State and Territory DPPs have prosecution guidelines, although none have specific guidelines relating to prosecutions for euthanasia or assisted suicide. Broadly speaking, the guidelines focus on two considerations:

- 1) Is there sufficient evidence to support a conviction?; and
- 2) is it in the public interest to prosecute?

In relation to the public interest question, the guidelines set out a number of discretionary factors to determine whether it is in the public interest to proceed with a prosecution.<sup>4</sup>

In England and Wales there are now specific DPP prosecution guidelines on whether to prosecute in cases of alleged assisted suicide. Following a UK House of Lords application for judicial review by Debbie Purdy in 2009,<sup>5</sup> the DPP was ordered to set out a policy to guide decisions to prosecute in cases of encouraging or assisting suicide in England and Wales.<sup>6</sup>

A draft policy was prepared and following wide public consultation, the policy was published in 2010.<sup>7</sup> The policy sets out 16 factors in favour of prosecuting and 6 factors that do not support prosecution.<sup>8</sup>

## Public Interest Factors Tending in Favour of Prosecution under the England and Wales Assisted Suicide Policy

1. The victim was under 18 years of age.
2. The victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.
3. The victim had not reached a voluntary, clear, settled and informed decision to commit suicide.
4. The victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.
5. The victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative.
6. The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim.

<sup>4</sup> For example see the NSW DPP Guidelines, last revised in 2007, at [www.odpp.nsw.gov.au](http://www.odpp.nsw.gov.au).

<sup>5</sup> In *R (on the application of Purdy) v DPP* [2009] UKHL 45.

<sup>6</sup> Note the guidelines do not specifically cover euthanasia where the charge is likely to be murder or manslaughter.

<sup>7</sup> Crown Prosecution Service (England and Wales), *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide: Issued by the Director of Public Prosecutions* (February 2010) <[http://www.cps.gov.uk/publications/prosecution/assisted\\_suicide\\_policy.pdf](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf)>.

<sup>8</sup> Sourced from White B and Downie J, "Prosecutorial guidelines for voluntary euthanasia and assisted suicide: autonomy, public confidence and high quality decision-making", *Melbourne University Law Review* 2012 Vol 36: 656-705.

7. The suspect pressured the victim to commit suicide.
8. The suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.
9. The suspect had a history of violence or abuse against the victim.
10. The victim was physically able to undertake the act that constituted the assistance him or herself.
11. The suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.
12. The suspect gave encouragement or assistance to more than one victim who were not known to each other.
13. The suspect was paid by the victim or those close to the victim for his or her encouragement or assistance.
14. The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.
15. The suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.
16. The suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

## Public Interest Factors Tending against Prosecution under the England and Wales Assisted Suicide Policy

1. The victim had reached a voluntary, clear, settled and informed decision to commit suicide.
2. The suspect was wholly motivated by compassion.
3. The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.
4. The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
5. The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.
6. The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

It is likely that the England and Wales Guidelines will influence decisions made by DPPs in Australia on whether to proceed with a prosecution for aiding or abetting suicide and may also assist in considerations of charges of murder or manslaughter associated with alleged euthanasia.<sup>9</sup>

## What is the current Australian legal position on end of life for persons with a terminal illness?

The legal position in Australia can be summarised as:

1. Withholding or withdrawing life sustaining treatment is lawful in a range of circumstances affirmed by a number of judicial decisions in Australia.<sup>10</sup> These circumstances include:
  - a. a competent adult decides not to have or continue the treatment;
  - b. a valid advance care directive was made by a competent person who subsequently loses their capacity to make such decisions;
  - c. a substitute decision maker (for example, a guardian or person responsible under guardianship legislation) makes a decision not to have or continue the treatment;
  - d. a parent consents in relation to their child and the decision is in the best interests of the child;
  - e. a doctor reasonably determines that the treatment is futile; and/or
  - f. a court order authorises the withholding or cessation of treatment.
2. Provision of palliative care in accordance with a plan agreed by the patient or their substitute decision maker is lawful where the primary intention of the plan is to relieve pain and to support and comfort the patient and not to cause or hasten death (even though that might be a side effect of the actions taken under the plan).
3. Euthanasia and assisted suicide is unlawful in all States and Territories.

## What should health professionals and health services do to ensure that decisions made on end of life care are lawful?

While each situation must involve a detailed consideration of the circumstances for the individual patient or client, the following factors are likely to support a conclusion that the death of the patient or client following withholding of treatment, withdrawal of treatment and/or the implementation of a palliative care plan was lawful.

1. The patient has a terminal illness with no reasonable prospect of cure or recovery and this conclusion is supported by independent health professionals.
2. If the patient is an adult and competent to make decisions regarding their treatment:
  - a. the patient has directed that the treatment should be withheld or withdrawn and/or agreed to the palliative care plan;
  - b. an independent health professional agrees that the patient is competent to make such a decision; and
  - c. the patient is given a reasonable time to reconsider and confirm their decision.
3. If the patient is an adult and is not competent to make these decisions, the patient has made an advance care directive clearly indicating their wishes and/or a substitute decision maker under guardianship legislation has agreed with the proposed decision.
4. If the patient is a child and has not expressed a wish to the contrary, the parent or legal guardian has agreed to the plan and the plan has been confirmed by an independent health professional as being in the best interests of the child.
5. In the absence of (2), (3) or (4), a court has approved the plan. ■

<sup>9</sup> White B and Downie J in their MULR article referenced above attach a set of guidelines that might be used in Australia as an appendix pp 703 – 705.

<sup>10</sup> As noted in a background paper prepared for Australia 21 by White and Willmott, the legal principle underpinning the lawfulness of this action is that it involves a failure to treat where there is no legal duty to treat. See White B and Willmott J: "How should Australia regulate voluntary euthanasia and assisted suicide?" November 2012 at [www.australia21.org.au](http://www.australia21.org.au).



## Advance Care Directives Update

By Alison Choy Flannigan, Partner

The law concerning advance care directives in Australia differs from State to State, with some jurisdictions requiring set forms and others relying upon the common law. This article discusses some of the key cases on advance care directives, including a summary of principles.

New South Wales is one of the States that relies upon the common law. Central Coast Local Health District has recently published a useful workbook "Have a Say in Your Healthcare – Advance Care Planning", containing a recommended advance care directive template form for NSW at: [http://www.cclhd.health.nsw.gov.au/patientsandvisitors/CarerSupport/cpa/Documents/ACP\\_Workbook.pdf](http://www.cclhd.health.nsw.gov.au/patientsandvisitors/CarerSupport/cpa/Documents/ACP_Workbook.pdf).

The Royal Australian College of General Practitioners includes links to advance care directive and enduring guardianship forms for the other jurisdictions at: <http://www.racgp.org.au/your-practice/business/tools/support/acp/>

### Hunter and New England Area Health Service v A (by his Tutor) (2009) 74 NSWLR 88

A was a patient in a hospital operated by the Hunter and New England Area Health Service.

He had been admitted into the emergency department of the hospital on 1 July 2009 suffering from septic shock and respiratory failure and showing a decreased level of consciousness. He was transferred to the ICU the following day, his condition deteriorated and he suffered renal failure. By 14 July 2009, A was being kept alive by mechanical ventilation and kidney dialysis.

A had previously prepared a document a year earlier indicating that he would refuse renal dialysis. A was a Jehovah's witness. He attended a solicitor who had a number of clients who were Jehovah's witness. His solicitor had a practice to explain the risks regarding refusal of blood transfusion. However, had not explained the risk of refusing dialysis. The court reviewed both the documents and the supporting work sheets.

The Area Health Service commenced proceedings seeking a declaration to give effect to the direction.

The common law recognises two relevant but in some cases conflicting interests:

- A competent adult's right of autonomy or self-determination: the right to control his or her own body; and
- The interest of the State in protecting and preserving the lives and health of its citizens.

It is in general clear that, wherever there is a conflict between a capable adult's exercise of the right of self-determination and the State's interest in preserving life, the right of the individual must prevail.

There is a presumption of capacity, whereby an adult "is presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption is rebutted".

In deciding whether a person has capacity to make a particular decision, the ultimate question is whether that person suffers from some impairment or disturbance of mental functioning so as to render him or her incapable of making the decision. That will occur if the person:

- is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or
- is unable to use and weigh the information as part of the process of making the decision.

The court considered A's decision was a voluntary decision and that A was in law capable of making the decision to refuse dialysis. The court granted the declarations and in so doing set out the following summary of principles:

### Summary of principles

There does not appear to be a great body of authority in Australia dealing with the relevant principles. (The decision of Ambrose J in *Re Bridges* [2001] 1 Qd R 574 focused on relevant Queensland legislation, and on its application on the facts of that case.) Accordingly, to assist those faced with advance care decisions, His Honour McDougall J summarised his understanding of the relevant principles (whilst acknowledging that what he said will not apply in every conceivable circumstance):

- 1) Except in the case of an emergency where it is not practicable to obtain consent, it is at common law a battery to administer medical treatment to a person without the person's consent. There may be a qualification if the treatment is necessary to save the life of a viable unborn child.
- 2) Consent may be express or, in some cases, implied; and whether a person consents to medical treatment is a question of fact in each case.
- 3) Consent to medical treatment may be given: by the person concerned, if that person is a capable adult; by the person's guardian (under an instrument of appointment of enduring guardian, if in effect; or by a guardian appointed by the Guardianship Tribunal or a court); by the spouse of the person, if the relationship between the person and the spouse is close and continuing and the spouse is not under guardianship; by a person who has the care of the person; or by a close friend or relative of the person.

- 4) At common law, next of kin cannot give consent on behalf of the person. However, if they fall into one or other of the categories just listed (and of course they would fall into at least the last) they may do so under the Guardianship Act.
- 5) Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.
- 6) A person may make an "advance care directive": a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive. Again, there may be a qualification if the treatment is necessary to save the life of a viable unborn child.
- 7) There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment. However, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on the decision.
- 8) If there is genuine and reasonable doubt as to the validity of an advance care directive, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the court for its aid. The hospital or medical practitioner is justified in acting in accordance with the court's determination as to the validity and operation of the advance care directive.
- 9) Where there is genuine and reasonable doubt as to the validity or operation of an advance care directive, and the hospital or medical practitioner applies promptly to the court for relief, the hospital or practitioner is justified, by the emergency principle, in administering the treatment in question until the court gives its decision.
- 10) It is not necessary, for there to be a valid advance care directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person's decision is based on religious, social or moral grounds rather than upon (for example) some balancing of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by any discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.

- 11) What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of persons volition: if, by some means, the person's will has been overborne or the decision is the result of undue influence, or of some other vitiating circumstance.

The principles apply more broadly than medical treatment provided by hospitals and medical practitioners. The principles apply (including ambulance officers and paramedics) who administer medical treatment. They extend further to other forms of treatment (for example, dental treatment) where, without consent, the treatment would constitute a battery.

## **Brightwater Care Group (Inc) v Rossiter (2009) 40 WAR 84**

Mr Rossiter was a quadriplegic. Over 20 years he suffered three serious injuries which in combination caused that condition. Mr Rossiter was generally unable to move with limited to foot movement and the ability to wriggle one finger. He was only able to talk through a tracheotomy and was totally dependent upon others for the necessity of life. He was unable to take nutrition or hydration orally. He received nutrition through a percutaneous endoscopic gastrostomy tube.

Mr Rossiter was not terminally ill, nor was he dying. If he continued to provide the services he would live for many years, however, was advised that his condition would not improve and in some respects, for example his eyesight, his condition was deteriorating.

He clearly and unequivocally indicated to Brightwater and his doctor that he wished to die on many occasions. He directed Brightwater to discontinue the provision of nutrition and hydration through the PEG on a number of occasions. He was aware that he would die.

His Honour Martin CJ made the following declaration:

- 1) If after Mr Rossiter has been given advice by an appropriately qualified medical practitioner as to the consequences which would flow from the cessation of the administration of nutrition and hydration, other than hydration associated with the provision of medication, Mr Rossiter requests that Brightwater cease administering such nutrition and hydration, then Brightwater may not lawfully continue administering nutrition and hydration unless Mr Rossiter revokes that direction, and Brightwater would not be criminally responsible for any consequences to the life or health of Mr Rossiter caused by ceasing to administer such nutrition and hydration to him.
- 2) Any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) of the *Criminal Code Act 1995 (Cth)* would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

## [Australian Capital Territory v JT \[2009\] ACTSC 105](#)

JT was a 69 year old man of Romanian birth. He severely injured himself falling from his upstairs flat in the belief that he could fly like a dove. He was found to be chronically psychotic suffering from paranoid schizophrenia characterised by religious obsessions. There was a psychiatric history dating back many years. JT refused food and resisted naso-gastric intubation.

The geriatric specialist did not, on balance, recommend artificial feeding largely because of the distress that would be caused to JT in applying the necessary restraints to successfully achieve it. The psychiatrist considered that it might be preferable to adopt a simple palliative approach.

The Court held that JT lacked the capacity to provide informed consent and the “wishes” were the product of delusional and irrational thought, in turn the product of his severe mental illness. It remained a matter of clinical judgement whether any proposed course of treatment would be medically feasible.

The declaration sought, that it would be lawful to decline to give JT medical treatment, was refused.

## [H Ltd v J \[2010\] SASC 197](#)

J was a resident of an aged care facility.

She was born in 1936 and had contracted polio as a child and suffered post-polio syndrome and Type 1 diabetes. She had no use of her right-sided limbs and found her left limbs painful.

On 19 January 2010 she wrote to the aged care facility informing it of her intention to end her life by ceasing to take any food, water and insulin.

H Ltd sought declarations as to whether or not it could comply with those directions.

Kourakis J (at para 56) accepted the distinction between suicide and the individual merely speeding “the natural and inevitable part of life known as death” by refusing food and water.

It is generally accepted as a matter of community standards, and in law, that a competent adult is not under a duty to take life sustaining medication and that a refusal to do so is therefore not suicide.

It was noted (from para 79) that the *Aged Care Act 1997 (Cth)* imposed certain obligations upon approved providers and held that an approved provider does not have a responsibility to provide nutrition or hydration where a resident voluntarily and rationally directs the provider not to provide those services and that H Ltd would not breach its responsibilities under the Act by ceasing provision of nutrition, hydration and insulin if J were to give the direction.

The negation of the duties is dependent upon the continuing operation of the direction. If the direction is withdrawn or revoked in whole or in part, the duties will again be enlivened.

The court granted the order that if J provided the direction to H Ltd, whilst J retained her mental competence and did not revoke the direction, then H Ltd was under no duty and has no lawful justification to feed or provide nutrition to J, even if there are to be likely consequences to her life or health, or to hydrate, other than to palliate pain and discomfort or to administer insulin.

## [X v Sydney Children’s Hospital Network \(Randwick and Westmead\) \[2013\] NSWCA 320](#)

X was a young man, aged 17 years and 8 months at time of the appeal. He suffered from Hodgkin’s disease, a form of cancer. He underwent a number of rounds of chemotherapy, and as a result developed anaemia. In order to deal with the anaemia, he had to have a blood transfusion or cease treatment.

The medical evidence, as at March 2013, was that the tumours had returned and required treatment by chemotherapy at a level which would lead to anaemia and hence an 80% chance of death unless blood products were given.

He and his parents were Jehovah’s witness, so refused to consent to the blood transfusion.

The hospital applied to the Equity Division of the Supreme Court of NSW for an order authorising the blood transfusions to X. At first instance Gzell J found that X had capacity to refuse consent but nevertheless made the orders sought.

The appeal was dismissed.

The fact that the court finds that a minor is of sufficient maturity to make decisions about his or her own health does not impose a general limit on the court’s *parens patriae* (protective) jurisdiction.

The Court held (at para 59) that the legal concept of suicide, being the intentional taking of one’s own life, is not engaged in a case where medical assistance is refused, even in the knowledge of certain death: *McKay v Bergstedt* 801 P 2d 617 (1990) at 626, Steffen J of the Nevada Supreme Court disagreeing with statements of Scalia J in *Cruzan v Missouri Department of Health* 497 US 261 (1989) at 296-297.

The interest of the state in preserving life is at its highest with respect to children and young persons who are inherently vulnerable, in varying degrees. Physical vulnerability diminishes (usually) with age and is at its height with respect to babies. Intellectual and emotional vulnerability also diminish with age but, as the facts of this case illustrate, may be a function of experience (including but by no means limited to education) as well as age. Vulnerability lies at the heart of the disability identified by legal incapacity.



## Re JS [2014] NSWSC 302

JS was a 27 year old patient of John Hunter Hospital in Newcastle. JS was 27 years of age.

Since the age of seven, he had been a quadriplegic and was receiving life sustaining treatment. There were increasing episodes of autonomic dysreflexia that could not be controlled despite treatment as an outpatient. These episodes were associated with extreme respiratory disease. All realistic options to control the dysreflexia were being applied.

In the absence of life sustaining treatment, including artificial ventilation JS would certainly die.

The hospital sought from the NSW Supreme Court a declaration that the responsible medical practitioners could lawfully discontinue all life sustaining treatment and medical support measures for JS including by the withdrawal of ventilation.

A further declaration was sought to the effect that the medical services to be provided at the hospital to JS be limited to services ancillary to the discontinuance of all life sustaining treatment, and medical support measures and palliative measures aimed at providing JS with comfort, pain relief and relief of anxiety or torment.

In this case the evidence established that JS had openly discussed with some family members and medical staff the possibility of withdrawal of life sustaining treatment and the in particular the mechanical ventilation.

JS had authored a considered document expressing his wishes. He had approached the decision in a deliberate and apparently rational fashion.

The totality of the evidence left the court in no doubt that JS had the capacity to make the decision and the orders were made, provided that the request was not revoked or modified. ■



## Electronic Health Records and Healthcare Identifiers Update

By Alison Choy Flannigan, Partner

In May 2015, the Commonwealth Department of Health published a legislation discussion paper – “*Electronic Health records and Healthcare Identifiers*”.

The Australian Government is proposing changes to the Personally Controlled Electronic Health Record (**PCEHR**), now renamed “My Health Record” to increase the number of individuals and healthcare providers participating in the PCEHR system, increase the clinical utility and usability of the PCEHR system to support meaningful use by healthcare providers, and improve the overall operation of the PCEHR system and Healthcare Identifiers (**HI**) Service, and eHealth more generally.

The primary change being considered is the move to change to an “opt-out” basis. From 2016, trials of different participation arrangements for individuals will be undertaken. An opt-out model of participation will be included as part of these trials. If the opt-out model is adopted, every Australian entitled to Medicare will have an electronic health record unless they opt out.

The system will still offer the same level of personal control over the information in the PCEHR and will continue to give information the same level of privacy and security protection.

Proposed changes to eHealth governance arrangements aim to streamline the existing mechanisms across eHealth development and implementation, and improve key stakeholder involvement with the establishment of the Australian Commission for eHealth.

Other proposed changes would:

- clarify the data breach notification requirements to remove ambiguities of what constitutes a data breach and when parties need to provide notification;
- clarify how healthcare providers and other entities can handle healthcare identifiers and other information, ensuring information can be obtained and used as is required to support safe and effective information sharing and recording; and
- provide alignment with Government measures to standardise regulatory powers and better reflect the rights of people with disabilities.

The Government is also considering whether changes to the PCEHR’s system’s penalty framework are necessary. ■





## Assisted Reproductive Technology Update

By Alison Choy Flannigan, Partner and Irene Maragiannis, Special Counsel

On 23 July 2015, the National Health and Medical Research Council (NHMRC), issued a Media Release opening public consultation on proposed draft revisions to the clinical practice section of: *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research, 2007* ('ART Guideline').<sup>11</sup>

Assisted Reproductive Technology (ART) is the application of laboratory or clinical techniques to human eggs, sperm or embryos for the purposes of reproduction. Compliance with these guidelines is a key part of accreditation for all Australian ART clinics.

Part B of the ART Guideline (Ethical Guidelines for the Clinical Practice of ART) is the main section under review by the NHMRC, with some amendments to Part A (Introduction), however Part C (Ethical Guidelines for Research involving ART and other practices) is not part of the current review.

The main purpose of the ART Guideline is to assist clinicians with developing appropriate operating procedures in ART clinics utilising the ethical principles which are illustrated. "The Ethical Guidelines provide an overarching framework for the conduct of ART in both clinical practice and research".

In essence, the ART Guidelines should be adhered to "unless there is an effective alternative option that is consistent with the relevant ethical principle."

It is the expectation of the NHMRC that the ART Guidelines will form part of the standard operating procedures utilised by ART clinicians and researchers.



<sup>11</sup> Australian Government – National Health and Medical Research Council Media Release "Feedback Sought on Draft Revisions to Ethical Guidelines for Assisted Technology" (23 July 2015).  
Australian Government – National Health and Medical Research Council - Public Consultation Paper: Draft Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research" (15 July 2015)

The review process will be coordinated by the Australian Health Ethics Committee ('AHEC') and assisted by the Assisted Reproductive Technology Working Committee. Public submissions close on Thursday 17th September 2015 at 5.00pm AEST. The ART Working Committee includes experts in the field of ethics, law, religion, reproductive technology and consumer issues.

The revised ART Guideline is to operate within a framework of existing Australian State and Territory legislation, covering certain quality assurance and accreditation standards.

Some of the proposed changes to the draft ART Guidelines cover topic areas concerning the following issues:

- The use and storage of human eggs, sperm and embryos;
- Specific situations such as fertility preservation, surrogacy, preimplantation genetic testing, the collection and use of eggs and sperm from persons who are deceased or dying, and the use of stored eggs, sperm and embryos after the death of the person;
- The provision of counselling, information, and consent requirements.

Some of the other considerations factored into the draft ART Guidelines include:

- A clearer identification of ethical principles which are relevant to ART clinical practice (and associated guidance to apply these principles);
- Changes in technology and community sentiment to be reflected; and
- Making the document more "user friendly".

The Ethical Principles in the Clinical Practice of ART adopts a 'rights-based' framework, and in particular, respect for human rights is relevant to the development and implementation of health policies, laws and practices, including those that relate to assisted reproduction.

The principles and values are defined as follows:

**Respect** – the right for individuals to be treated with dignity and to have their autonomy respected;

**Justice** – which is concerned with equality and fairness;

**Solidarity** – 'standing together' as a group, community or nation;

**Altruism** – seeking the welfare of others, with no expectation of personal reward or gain;

**Transparency** – the disclosure of clear and accurate information about activities and decision-making processes; and

**Effectiveness and Efficiency** of practices and resources.

The draft ethical principles include:

- ART activities must be conducted in a way that shows respect to all involved;

- Decision-making in the clinical practice of ART must be undertaken in a manner that protects from harm each individual or couple involved in ART activities and any persons who would be born;
- Decision-making in the clinical practice of ART must recognise and take into account the biological connections and social relationships that exist or may be formed;
- Decision-making about ART activities must recognise and respect the autonomy of each individual or couple involved;
- Processes and policies for determining an individual's or couple's eligibility to access ART services must be just, equitable and respectful of the inherent dignity and of the equal and inalienable rights of all persons;
- Donation of gametes or embryos or the provision of surrogacy services is an act of altruism and solidarity that provides significant benefits to those requiring assisted conception; and
- The provision of ART must be transparent and open to scrutiny, while ensuring the protection of the privacy of all individuals or couples involved in ART and persons born.

The NHMRC has stated that it is extremely interested in receiving comments in connection with the following subject areas:

- The establishment of an Australian donor egg bank;
- Sex-selection for non-medical purposes; and
- Monetary compensation for the reproductive effort/risks in connection with egg donation for Australian women. ■

## New Cosmetic Surgery Guidelines

By Alison Choy Flannigan, Partner and Joann Yap, Solicitor

Currently information available to consumers having cosmetic medical and surgical procedures (including botox injections) can be of variable accuracy and quality. Patients may be unaware of the various levels of qualifications and training required for different procedures.

To address this issue, the Medical Board of Australia (**the Board**) released a Public Consultation Paper and Regulation Impact Statement<sup>12</sup> (**the Paper**) in March 2015 on registered medical practitioners who provide cosmetic medical and surgical procedures, with a key focus on identifying whether additional safeguards are needed. The Paper outlined the following four options to create a consistent national approach:

- Retaining the status quo of providing general guidance about the Board's expectations of medical practitioners providing the procedures via the Board's approved code of conduct;
- Providing consumer education material about the provision of cosmetic medical and surgical procedures by medical practitioners;
- Strengthening current guidance for medical practitioners providing cosmetic medical and surgical procedures through new, practice-specific guidelines that clearly articulate the Board's expectations of medical practitioners; and
- Strengthening current guidance for medical practitioners providing cosmetic medical and surgical procedures through practice-specific guidelines as per option three but providing less explicit guidance to medical practitioners.



<sup>12</sup> The Medical Board of Australia, June 2015 update [www.medicalboard.gov.au](http://www.medicalboard.gov.au)



Based upon the available data and evidence to date, and subject to the outcome of consultation with stakeholders, the preferred option of the Board was option 3.

The Board sought feedback on a range of proposals for draft guidelines in relation to option three, including:

- a seven-day cooling off period for all adults before procedures;
- a three-month cooling off period before procedures can be undertaken for all individuals under the age of 18, along with mandatory assessment by a registered psychologist or psychiatrist;
- explicit guidance on informed patient consent, including clear information about risks and possible complications;
- explicit responsibility for post-operative care by the treating practitioner, including emergency facilities when sedation or analgesia is involved;
- mandatory face-to-face consultations before prescribing Schedule 4 (prescription only) cosmetic injectables;
- transparency and detailed written information about the costs of cosmetic medical procedures; and
- limits on where cosmetic procedures can be performed, in order to manage the risk to patients.

The consultation period closed on 29 May 2015 and the Board received hundreds of submissions from a wide range of stakeholders including medical colleges, professional associations, medical insurers, medical practitioners, nurses working in the cosmetic field and patients. The Board is now analysing the submissions, which are expected to be published in due course. At the time of writing of this article, there has been no indication as to when a final decision will be made. The review is likely to result in stronger regulation of the cosmetic surgery industry in Australia. Some patients will still choose to travel overseas for cosmetic surgery. ■

## How is the Royal Commission into Institutional Responses to Child Sex Abuse Relevant to Health Care Providers?

*By John Wakefield, Partner*

There has been recent media coverage in relation institutional responses to child sexual abuse in schools, however, hospitals and other health care providers who provide children's health services should also implement risk minimisation strategies.

Child safety strategies include:<sup>13</sup>

- A statement of commitment to the safety and wellbeing of children and the protection of children from harm;
- A code of conduct for interacting with children and young people;
- Recruitment, selection, training and management procedures for paid employees and volunteers (including working with children checks);
- Policies and procedures for handling disclosures and suspicions of harm, including reporting guidelines;
- A plan for managing breaches of the risk management strategy;
- Risk management plans for high risk activities and special events;
- Policies and procedures for compliance with legislation, including regular reviews of the operation and effectiveness of the organisation's child safe policies and practices; and
- Strategies for communication and support including:
  - a) written information for parents/carers, paid employees and volunteers outlining the organisational child safe policies; and
  - b) training material for paid employees and volunteers to help them identify risks of harm and handle disclosures.

The laws regarding working with children checks differ from state to state. In some States, such as New South Wales, you are required to have a working with children check if you have face to face contact with children and work in children's health services.<sup>14</sup> However, this is not the case in all States, for example Victoria, where, if you are supervised you do not need the working with children check.<sup>15</sup>

<sup>13</sup> Queensland Commission for Children and Young People and Child Guardian "Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse", October 2103.

<sup>14</sup> Section 6 of the *Child Protection (Working with Children) Act 2012 (NSW)*.

<sup>15</sup> Section 9 of the *Working with Children Act 2005 (Vic)*.

The Royal Commission released its report on Working With Children Checks on 17 August 2015, recommending a national approach.

The Royal Commission into Institutional Responses to Child Sexual Abuse commenced its public hearings in Sydney on 6 May 2015 to inquire into a number of matters including:

- 1) The experience of a number of people who were sexually abused as children in:
  - a) private medical practices; and
  - b) private hospitals;
- 2) The experience of a number of complainants who made complaints against a medical practitioner to the New South Wales Health Care Complaints Commission (HCCC) and the then New South Wales Medical Board;
- 3) The systems, policies, practices and procedures for receiving, investigating and responding to complaints against medical practitioners of child sexual abuse of:
  - a) the HCCC;
  - b) the Medical Council of New South Wales; and
  - c) the Royal North Shore Hospital;
- 4) The experience of an out-patient who alleged child sexual abuse by a psychologist at the Royal North Shore Hospital, in the late 1960s;
- 5) The systems, policies and procedures of the Northern Sydney Local Health District and the NSW Ministry of Health for preventing, detecting and responding to child sexual abuse;
- 6) The experience of an in-patient who was allegedly abused by a volunteer at Royal Children's Hospital, Melbourne in the early 1980s;
- 7) The response of the Royal Children's Hospital, Melbourne, to an allegation of child sexual abuse made against a hospital volunteer; and
- 8) The systems, policies and procedures of the Royal Children's Hospital, Melbourne, for preventing, detecting and responding to child sexual abuse.

Persons believing they have a direct or substantial interest in the scope and purpose of the public hearing were invited to lodge written applications for leave to appear at the public hearing by 22 April 2015. The hearings have for the moment concluded.

One aspect of institutional response is the way in which claims are dealt with by the institutions. Many civil claims are being made well past the limitation period for claims for damages for personal injury under statute. Respondents are regularly requested not to rely on technical defences and to agree on a process to allow such claims to be dealt with on their merit. Claimants also regularly seek suspension of limitation periods during the conduct of an agreed claims process. Such process is aimed at resolving claims without recourse to litigation.

In appropriate circumstances, an agreed resolution process might enable the parties to resolve abuse claims in ways which are respectful and dignified and minimise the risk of re-traumatization otherwise inherent in the adversarial process.

Insurance issues may also arise in respect of the acts of employees or others for whom the principal might be vicariously liable by reason of a non-delegable duty of care or otherwise or the costs involved in directors and officers managing the claims process.

If a complaint or claim arises in relation to child sexual abuse, consideration should be given to:

- The question of any insurance cover and, if so, notification of the claim;
- Consideration of liability as a principal, vicariously or otherwise;
- Consideration of limitation or permanent stay issues; and
- Subject to the above, consideration of a non-adversarial resolution of the claim.

Holman Webb Lawyers has recently acted for a number of religious organisations and schools in relation to claims in connection with child sexual abuse. ■



## Privacy Update – Proposed Mandatory Reporting of Data Breaches

*By Alison Choy Flannigan, Partner*

In a Joint Media Release between the Attorney-General for Australia and the Minister for Arts on 3 March 2015, in relation to the Australian Government's Response to the *Inquiry of the Parliamentary Joint Committee on Intelligence and Security (PJCIS) into the Telecommunications (Interception and Access) Amendment (Data Retention) Bill 2014*, the Government has agreed to introduce a mandatory data breach notification scheme by the end of 2015, and will consult on draft legislation. The draft legislation is yet to be released. When passed, organisations will be required to notify people if their personal information has been incorrectly disclosed.



## Real Property Update – What are Easements and Rights of Way and why do Hospital and Aged Care Providers Need to Know about Them?

By Robyn Chamberlain, Senior Associate

Many properties are either burdened or benefited by easements.

But what is an easement, and what does it mean if your property is the subject of an easement?

### What is an easement?

An easement gives someone the right to use a section of land for a specific purpose even though they are not the owner of that land. Typically this could be an easement for access or an easement for drainage.

The land with the benefit of the easement is called the dominant or benefited land.

The land burdened by the easement is called the servient or burdened land.

The owner of the burdened property continues to own the land, but the owner of the benefited lot holds certain rights over the area of the easement.

### How do I know if my property is the subject of an Easement?

Easements may be created in various ways, but commonly they are registered on the title of the property and are discoverable by conducting a title search of your property.

The nature, location and terms of the easement will be set out in the dealing which is registered on the title.

### What does it mean?

If your property is benefited by an easement, then you will have the rights set out in the easement over the burdened property.

If you have an easement burdening your land, you may not be able to build any structure on or over the easement land or use the easement land in any way which interferes with the rights of the benefited party.

Otherwise, the owner of the land benefited by the easement may have the right to sue you, or to destroy the structure to gain access to the easement without being liable to compensate you for the damage.

### Creation of an Easement

We recently acted for a hospital which proposed to sub-divide its property into two lots.

Our client's property was located on a creek which may flood during heavy rain. However, if the creek flooded, the new lot would be completely cut off, as the only road access to the subdivision could be submerged under the flood water.

The council consented to the sub-division, subject to a number of conditions.

The conditions included granting an easement for access and egress in the case of emergency. There were also discussions about raising the roadway, however, this could potentially result in flooding sections of the neighbouring property.

Luckily our client was able to come to a mutually satisfactory agreement, however, not all adjoining neighbours are so 'neighbourly'.

The enactment of section 88K of the Conveyancing Act 1919 (NSW) in 1995 granted the Court power to impose easements over servient land where necessary for the effective use of the dominant land.

The operation of section 88K is of obvious benefit to builders and developers.

### Lesson

The concept of an easement is simple. However, the law relating to easements is quite complex and is frequently litigated, particularly in relation to the maintenance of land subject to the easement.

It is best to take time to understand the terms of any easement which may benefit or burden your property and to take effort to ensure that all rights are expressly provided for in any instrument creating an easement, particularly if you are purchasing real property or planning construction.



## Background Checks/Pre-employment Screening in Health and Aged Care—What is involved?

By Rachael Sutton, Partner and Alison Choy Flannigan, Partner

A critical lesson from the Quakers Hill Nursing Home disaster is to conduct adequate pre-employment screening and check references on new employees.

These principles may also be applied to conducting adequate background checks and checking references on independent contractors such as agency staff, volunteers and potential residents.

Pre-employment screening can include any, or all, of the following:

- Applicant interviews;
- Tests to confirm general ability, aptitude and personality;
- Medical checks; and
- Reference and background checks.

A range of pre-employment screening processes should be adopted as part of any comprehensive recruitment procedure and ideally should include the following steps:

- An initial interview between the recruiter (internal and external) and the line manager to understand the role and capabilities required;
- Short listing of candidates by the recruiter and the line manager – based on the resumes received;
- Reference checks – this should be done once the candidate is chosen, but prior to any offer being made;
- Qualification check – documentary evidence can be used to verify qualifications and accreditations quickly;
- Phone screening to assess basic capabilities, propensity to move, salary expectations, etc;
- One (possibly two) competency based interviews by the line manager and HR;
- Group assessment centre, if appropriate (eg using case studies, presentations etc);
- Online testing, if appropriate (for example verbal reasoning, analytical skills, etc);
- Medical assessment;

- Background checks such as police/criminal checks, credit history and litigious conduct and working with children checks if direct contact with children is involved;
- Mandatory requirements - some jobs require mandatory checks specific to that role. However, nearly all jobs will require an employer to ensure that a job applicant has a legal right to work in Australia; and
- ASIC Register - a quick search of the ASIC Register will disclose whether someone has been deemed a banned/disqualified person in terms of Board appointments.

There are a range of benefits arising from pre-employment screening, for example:

- A better informed employer is more likely to select a candidate who is a good fit for the role and the organisation;
- Unfortunately dishonesty in job applications is rife, therefore screening increases the likelihood that this will be uncovered;
- The overall cost of hiring may be reduced, despite the costs involved in the screening process, because the chances of a (costly) incorrect hiring decision are minimised; and
- Any restrictions on a candidate's ability to perform his or her role, whether due to insufficient skills or other limitations, are more likely to be made known to the employer before the decision is made.

Importantly the screening process must comply with Australian Privacy Principles, anti-discrimination legislation and other laws.

### Complying with anti-discrimination laws

Legislation at both the federal and state level offers protection to applicants for employment who are treated less favourably than other applicants because of a ground or attribute protected under anti-discrimination legislation. The grounds on which it is unlawful to discriminate against a person vary across jurisdictions, but include race, sex, marital status, age, transgender, non-specific gender and disability.

By revealing information in relation to attributes protected under anti-discrimination laws, the screening of job applicants can expose an employer to a claim alleging breach of those laws. To avoid such a claim employers should not conduct any screening which would reveal information concerning protected attributes. If employers regard the screening process information as essential to their recruitment decision-making, they should ensure that such information has a clear connection to the inherent requirements of the position.

Where the discovery of a criminal record results in a person being discriminated against because of that record (including circumstances where a job applicant is refused employment where a criminal record is revealed), an employer may leave itself open to discrimination claims.



An exception arises where the conviction in question would impact directly on the job. However, it must be noted that some state-specific variations do arise in state anti-discrimination statutes such as in Tasmania and the Northern Territory.

The Australian Human Rights Commission has developed a set of guidelines that can provide assistance to employers in navigating their way around this issue.

The same applies to a dismissal for discovery of a conviction. However, where an employee has misrepresented himself or herself during the recruitment process, there may be cause for termination.

## Obtaining consent from the applicant prior to conducting inquiries

Consent from the candidate should be obtained prior to conducting any searches. This might be included on an application form or requested following an interview.

## Complying with privacy laws

The Commonwealth *Privacy Act 1988 (Cth)* (the **Privacy Act**) (which applies to the private sector and the Commonwealth public sector) and relevant State privacy legislation, such as the *Privacy and Personal Information Protection Act 1988 (NSW)* and the *Health Records and Information Privacy Act 2002 (NSW)* (which applies to the public and private sector in NSW) regulate the collection, use and disclosure of personal information.

Currently, under the Privacy Act, “personal information” excludes an “employee record”, however, there are some proposals to change this in the future.

An “employee record”, in relation to an employee, is defined to mean “a record of personal information relating to the employment of the employee. Examples of personal information relating to the employment of the employee are health information about the employee and personal information about all or any of the following:

- a) the engagement, training, disciplining or resignation of the employee;
- b) the termination of the employment of the employee;
- c) the terms and conditions of the employment of the employee;
- d) the employee’s personal and emergency contact details;
- e) the employee’s performance or conduct;
- f) the Employee’s hours of employment;
- g) the employee’s salary or wages;
- h) the employee’s membership of a professional or trade association;
- i) the employee’s trade union membership;
- j) the employee’s recreation, long service, sick, personal, maternity, paternity or other leave;
- k) the employee’s taxation, banking or superannuation affairs.”

It is important to note that information concerning pre-employment discussions and screening will be excluded from the above definition if the candidate is unsuccessful in their employment application.

There may also be obligations of confidentiality of employment-related records.

An obligation of confidence can arise in contract or in equity. An equitable obligation of confidence can arise where information with the necessary quality of confidence is imparted in circumstances importing an obligation of confidence.<sup>16</sup>

To enable you to obtain the background information from third parties, we recommend that you request the consent of the applicant for the disclosure of their personal information as part of the application process.

If you receive a request for information about a current or former employee, you should request the consent of that employee to make the disclosure before disclosing the material.

## What do you do if you receive unfavourable information?

In the event that you receive information that gives you any reason for concern, it is advisable to discuss its relevance to that role and/or if necessary, your potential liability in the event that you need to refuse an applicant for employment based on same with your lawyer.

It is clear from the above that although pre-employment screening has a worthwhile role to play, it also exposes employers to potential risks. These risks need to be understood and managed if an employer is to minimise the likelihood of a claim.

## Dealing with criminal convictions

Some criminal convictions are relevant to the terms of employment (such as fraud or assault) and some aren’t. Some convictions are “spent”, for example if they are quashed (set aside by a court) or pardoned or when the relevant crime free period has expired. In New South Wales, minor convictions can be spent after 10 years, subject to certain conditions being met.<sup>17</sup> Individuals are not required to disclose spent convictions.

## Risks with giving a reference and defamation

There is no obligation to agree to provide a reference. In giving a reference you need to ensure that the reference is accurate and not misleading or deceptive. Care should also be taken to ensure that the reference is not defamatory.

A publication is defamatory of a person if it tends, in the minds of ordinary reasonable people, to injure his or her reputation either by:

- a) disparaging him or her;
- b) causing others to shun or avoid him or her; or

<sup>16</sup> *Corrs Pavey Whiting & Byrne v Collector of Customs (1987) 14 FCR 443; Smith Kline & Freich Laboratories (Aust) Ltd v Secretary, Department of Community Services and Health (1990) 22 FCR 73, 86-87.*

<sup>17</sup> *Criminal Record Act 1991, Part 2.*

- c) subjecting him or her to hatred, ridicule or contempt.<sup>18</sup>

There is a defence of qualified privilege (under State Defamation Acts, for example, section 30 of the *Defamation Act 2005 (NSW)*) if there is no malice and:

- a) the recipient has an interest or apparent interest in having information on some subject, and
- b) the matter is published to the recipient in the course of giving to the recipient information on that subject, and
- c) the conduct of the defendant in publishing that matter is reasonable in the circumstances.

### Australian Health Practitioner Regulation Agency

The registration of clinicians such as medical practitioners and nurses can be checked against the register operated by the Australian Health Practitioner Regulation Agency (**AHPRA**). In addition, inquiries can be made of AHPRA as to whether or not a registered health practitioner has conditions on their registration or is suffering from an impairment.

### What is the NSW Service Check Register?

NSW Health maintains a Service Check Register (SCR) under NSW Health Policy Directive PD2013\_036. There are mandatory requirements in relation to the creation, maintenance and deletion of records on the SCR for NSW Health. Only staff authorised by the Chief Executive or delegate may be given access to the SCR.

Under section 115 of the *Health Services Act 1997 (NSW) (the Health services Act)* the NSW Health Service consists of those persons who are employed under the relevant Part of that Act by the Government of New South Wales in the service of the Crown. As there is the one employer, the information may be shared.

In 2014, the *Health Services Act* was amended by the *Health Practitioner Regulation Legislation Amendment Act 2014 (NSW)* to include sections 58A and 133C although these amendments have not yet been proclaimed to commence at the time of writing this article.

Section 133C of the *Health Services Act* allows a public health organisation to share or exchange appointment information about a health practitioner with a private health facility licensee (registered under the *Private Health Facilities Act 2007 (NSW)*) if the public health organisation:

- a) reasonably believes that the health practitioner practises at the private health facility; and
- b) reasonably considers that the disclosure of that information to the licensee is necessary because it raises serious concerns about the safety of patients.

Information is “appointment information” about a health practitioner for the purposes of this section if:

- a) the health practitioner practises (or formerly practised) at a hospital or health institution of the public health organisation (whether under a service contract or otherwise); and
- b) the information relates to the variation, suspension or termination by the public health organisation of clinical privileges of the health practitioner.

The disclosure of appointment information about a health practitioner by a public health organisation (or a person acting at the direction of the organisation) to a private health facility licensee does not, if the disclosure was made in good faith, subject the organisation or person personally to any action, liability, claim or demand.

Section 58A enables a private health facility licensee to share or exchange appointment information about a health practitioner with another licensee or a public health organisation if the licensee:

- a) reasonably believes that the health practitioner practises at the private health facility of the other licensee or at a hospital or health institution of the public health organisation; and
- b) reasonably considers that the disclosure of that information to the other licensee or public health organisation is necessary because it raises serious concerns about the safety of patients.

Information is “appointment information” about a health practitioner for the purposes of this section if:

- a) the health practitioner practises (or formerly practised) at the private health facility of the licensee (whether under a service contract or otherwise); and
- b) the information relates to the variation, suspension or termination by the licensee of clinical privileges of the health practitioner.

The disclosure of appointment information about a health practitioner by a licensee (or a person acting at the direction of the organisation) to another licensee or a public health organisation does not, if the disclosure was made in good faith, subject the licensee or person personally to any action, liability, claim or demand.

It would be preferable if these provisions were extended to disclosure to other health care employers, including interstate hospitals, aged care, community care and primary health care.

### Ongoing Disclosure

It is important to include in contracts an obligation upon the employee to disclose certain matters during the course of employment, including loss of registration, conditions upon registration and criminal investigations and convictions.

Section 176BA of the *Health Practitioner Regulation National Law (NSW)* introduced by the *Health Practitioner Regulation Legislation Amendment Act 2014*, will, upon its commencement, enable the Council to notify employers and accreditors about conditions concerning the health, conduct or performance of health practitioners in New South Wales.

<sup>18</sup> Halbury's Laws of Australia, Lexis Nexis Defamation cause of action [145-15] Dr David Rolph.

# MEET THE TEAM



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