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Sparkebeat

Australia's Legal Environment – Health Law Update

JUN 2024 ISSUE 12

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INTRODUCTION

Welcome to the twelfth issue of the Health Update – Sparkebeat, where Sparke Helmore's market leading national Health team brings you the latest in local news and knowledge across Australia and abroad.

We advise medical defence organisations, insureds (including hospitals, clinics, practitioners and other medical and allied health service providers), insurers, underwriting agencies cover holders and brokers, both locally and internationally including in the Lloyd's market.

Our team specialises in clinical negligence litigation, investigations, professional conduct hearings, and coronial inquiries. We also advise on matters related to regulatory compliance, policy drafting, coverage and indemnity issues.

This unique experience allows us to meet the needs of our clients regardless of jurisdiction, volume or complexity.

We hope you find this issue informative and useful. If there are any topics you would like us to cover in the future, please contact a member of our national Health team.

There is nothing in health that we cannot do.

"THE LAW CANNOT … IMPOSE DUTIES AND LIABILITY ON THE BASIS OF SYMPATHY"

Paul and another (Appellants) v Royal Wolverhampton NHS Trust (Respondent); Polmear and another (Appellants) v Royal Cornwall Hospitals NHS Trust (Respondent); Purchase (Appellant) v Ahmed (Respondent) [2024] UKSC 1

Authors: Partner Marie-Clare Elder and Special Counsel Marie Panuccio

In January 2024, the Supreme Court of the United Kingdom (the **Supreme Court**) delivered a landmark judgment in a conjoined clinical negligence appeal concerning psychiatric injuries suffered by secondary victims.

The brief facts of each case were as follows:

1. *Paul and another v Royal Wolverhampton NHS Trust* – Mr Paul was treated for coronary symptoms at the Trust in November 2012. Subsequently, Mr Paul collapsed and died from a heart attack in January 2014 whilst shopping with his daughters. His daughters claimed that they suffered psychiatric trauma as a result of witnessing their father's collapse and his death, which could have been avoided had a coronary angiogram been performed by the Trust, which would have revealed coronary artery disease.

2. *Polmear and Anor v Royal Cornwall Hospitals NHS Trust* – Ms Polmear, aged seven, was treated by a Paediatrician at the Trust in December 2014 following respiratory issues which were caused by an underlying pulmonary veno-occlusive disease. The Trust admitted that her pulmonary disease ought to have been diagnosed by mid-January 2015. Approximately five months later, Ms Polmear collapsed and died in July 2015 after a school trip. The events, including her resuscitation and death were witnessed by her parents, who both claimed to have suffered PTSD and Major Depression as a result.

3. *Purchase v Ahmed* – This matter involved the death of 20-year-old Ms Purchase after out-of-hours GP, Dr Ahmed, failed to diagnose extensive bilateral pneumonia three days prior. Subsequently, her mother found her motionless, and CPR was performed without success. The mother sought compensation for PTSD, severe chronic anxiety and depression caused by events.

In the proceedings, the claimants contended that the deaths of their respective relatives, (the defendant's patient) were caused by the negligent failure of the defendant doctor or health authority to diagnose and treat a life-threatening medical condition from which each deceased was suffering. The claimants' cases were based on the assertion that the respective defendants were not only responsible for the death of their close relative but were also liable to compensate them for psychiatric illness caused by their experience of witnessing the death (or its immediate aftermath).

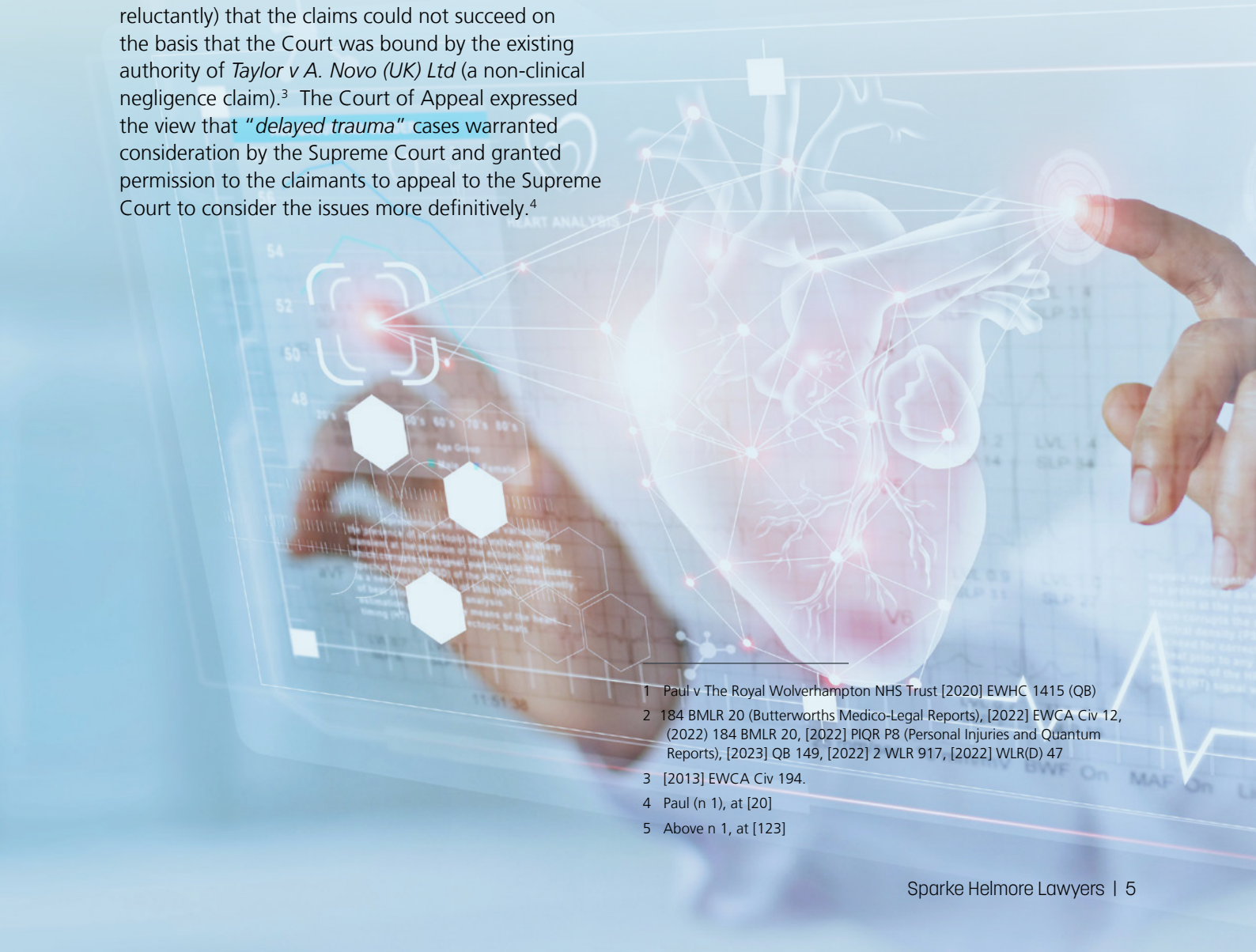
In each case, the respective defendants had applied to strike out the claim on the basis that, as a matter of law, the claimants' cases could not succeed. Initially, the cases of *Paul* and *Purchase* were dismissed by the High Court[1] and County Court[2] respectively, with permission given to appeal. Following the case brought by *Paul*, an application to dismiss the claim in *Polmear* was also rejected, with permission given to appeal.

The Court of Appeal subsequently heard and decided appeals in all three cases together, finding for the defendants in each case, and concluded (somewhat reluctantly) that the claims could not succeed on the basis that the Court was bound by the existing authority of *Taylor v A. Novo (UK) Ltd* (a non-clinical negligence claim).[3] The Court of Appeal expressed the view that "*delayed trauma*" cases warranted consideration by the Supreme Court and granted permission to the claimants to appeal to the Supreme Court to consider the issues more definitively.[4]

The primary issue before the Supreme Court was whether secondary victims (or close relatives of a patient) could, as a result of earlier clinical negligence, make a claim for psychiatric harm caused by witnessing the death of the patient, or its immediate aftermath. That is, whether the necessary legal proximity existed between the clinician/defendant and the secondary victim.

The decision reaffirmed that UK common law claims for compensation for pure mental harm, or "*nervous shock*" have no place in clinical negligence cases (subject to exceptions that may arise on the individual facts of each matter).[5] The Supreme Court held that a secondary victim must be present at the scene of an *accident* or its immediate aftermath to be entitled to damages for nervous shock.

For the full article and a comparison on Australian case law regarding nervous shock, please see Sparke Helmore's complete article published in the *Health Law Bulletin, April 2024 Volume 32 No 3* in **Annexure 1**.



1 Paul v The Royal Wolverhampton NHS Trust [2020] EWHC 1415 (QB)

2 184 BMLR 20 (Butterworths Medico-Legal Reports), [2022] EWCA Civ 12, (2022) 184 BMLR 20, [2022] PIQR P8 (Personal Injuries and Quantum Reports), [2023] QB 149, [2022] 2 WLR 917, [2022] WLR(D) 47

3 [2013] EWCA Civ 194.

4 Paul (n 1), at [20]

5 Above n 1, at [123]

THE NATIONAL LAW: THE COST OF A CRIMINAL OFFENCE

Authors: Special Counsels Marie Panuccio and Lani Carter
Acknowledgment: Lawyer Hanna Kozik

As a health practitioner grapples with the personal and professional implications of being charged with a criminal offence, the far-reaching effects of the criminal proceedings are not often at the forefront of a practitioner's mind.

Unfortunately for a practitioner, whether they are *guilty* of the offence they are charged with, a criminal charge is often followed by a volley of disciplinary issues.

The relevant council or Board will consider whether the criminal charge has any bearing on the practitioner's fitness and suitability to practice, including charges unrelated to a practitioner's work. Courts and Tribunals will determine whether a practitioner is fit in the public interest to practise medicine or health-related services based on criminal charges or convictions that arise from conduct in their personal life even if the offences do not relate to their professional responsibilities and particularly if the offence is serious in nature. A practitioner's employment with respect to their suitability to continue practicing may also be called into question depending on the circumstances of the offence. This may also result in a suspension from their employment by their employer whilst the matter is investigated, and these investigations can occur both internally and externally.

It must be remembered that the guiding principles of the National Law are to protect the public and maintain public confidence in the safety of services provided by registered health practitioners and students, by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

This means that although a practitioner is 'innocent until proven guilty', they may be subject to restrictions on their practice pending the outcome of any criminal charges.

Health Practitioner Regulation National Law Act 2009 (Qld)

The *Health Practitioner Regulation National Law* was implemented by each state and territory in 2009 and 2010. Queensland is the host jurisdiction, and the National Law governing medical and health practitioners alike is set out in a schedule to the *Health Practitioner Regulation National Law Act* 2009 (Qld) (the **National Law**). This framework has enabled nationally consistent legislation.

Some states and territories have adopted the Queensland legislation in their jurisdiction, including the Northern Territory and Victoria, for example, pursuant to s 4 of the *Health Practitioner Regulation (National Uniform Legislation) Act* 2010 (NT) and *Health Practitioner Regulation National Law (Victoria) Act 2009*.

Other jurisdictions enacted corresponding legislation such as New South Wales with the *Health Practitioner Regulation National Law (NSW) 2009*.

Under the National Law, when a practitioner is charged with a criminal offence punishable by 12 months imprisonment or more, a scheduled medicine offence, or if they have been convicted or found guilty of an offence punishable by imprisonment in Australia and/or overseas, they must notify the National Board of their profession (and AHPRA) within seven days of this "*event*".

Disciplinary action by the relevant regulator is often the most serious as a medical or health practitioners' ability to practice is often heavily scrutinised in the face of the criminal charges, particularly when the offence is connected to/occurred during the course of their practice.

Not only will a practitioner need to deal with the stress and uncertainty of the criminal process, but they will also most likely have to respond to any investigations the relevant National Board may wish to take in order to assess and manage the risk of the practitioner's actions with respect to the health and safety of the public.

Recent cases

Northern Territory - Nursing and Midwifery Board of Australia v Williams[1]

On or about 24 December 2020, Ms Williams, a nurse, pleaded guilty to and was convicted of two charges of dishonestly causing loss to a Commonwealth entity and obtaining a financial advantage from a Commonwealth entity by deception contrary to ss135.1(5) and 134.2(1) of the *Criminal Code Act* 1995 (Cth). She was sentenced to a period of home detention.

The criminal offending consisted of a failure to report income and false declarations of income, which resulted in an overpayment of Commonwealth benefits in the order of $80,000.

The charges were laid in August 2019, and formally served in January 2020. Ms Williams also failed to provide the Midwifery Board with written notice of these criminal charges within seven days in accordance with s 130 of the National Law.

In May 2020, Ms Williams attempted to renew her registration and falsely declared that there had not been any change to her criminal history since her last declaration. She initially claimed that she had not been formally charged until later, in August 2020, but at the hearing she did not contest the allegation that she failed to report the criminal charges to the Midwifery Board.

The Midwifery Board alleged that the criminal offences themselves and the failure to report them to the Board, the false declaration in Ms William's application renewal and the false information provided to the Board during the investigation into her declaration, amounted to professional misconduct.

Ms Williams did not dispute any of the actions or allegations of the Midwifery Board. Ultimately, the Northern Territory Civil and Administrative Tribunal found that her conduct cumulatively established a pattern of dishonest behaviour and that conduct fell substantially below the standard reasonably expected of a registered nurse. Ms Williams was reprimanded, and her registration was cancelled with a non-review period of two years.

New South Wales – Health Care Complaints Commission v GGO[2]

The respondent, GCO, was a paramedic who had been convicted of criminal offences for three counts of sexual intercourse without consent on 5 May 2019 and contravening a restriction of an apprehended domestic violence order on 8 April 2022.

The HCCC commenced proceedings against the respondent seeking cancellation of his registration for a period of 1-2 years.

The main issue for the Tribunal to consider was whether it should exercise its disciplinary powers under the National Law. The Tribunal set out the applicable legal principles, noting that their task is centred on the protection of the public and the maintenance of professional standards, rather than on punishment. The Tribunal weighed the nature and gravity of the offence, the period of time since the offence was committed, the conviction and sentence imposed, and the respondent's behaviour after committing the offences.

Ultimately, the Tribunal found both offences to have rendered him unfit in the public interest to practice as a paramedic and found it appropriate to cancel the respondent's registration and to fix a non-renewal period of one year.

South Australia – Spark v Medical Board of Australia

Dr Ian James Spark, a South Australian vascular surgeon, pleaded guilty to seven counts of deception and one count of attempted deception relating to falsified timesheets submitted to SA Health defrauding the state of $50,694.15.

Dr Spark was originally charged with 56 counts of deceiving another to benefit himself following an ICAC investigation.

The charges involved claims for surgeries at which Dr Spark was not present, call backs that did not occur, and claims for private patients. In one instance, a claim was made for a patient who did not exist.

Dr Spark had previously had conditions imposed on his registration preventing him from performing any surgery for the treatment of the condition known as Nutcracker Syndrome and otherwise requiring supervision by a specialist vascular surgeon and auditing of his practice.[3] Dr Spark continues to practice under these conditions.

Dr Spark is scheduled to appear in the Adelaide Magistrates Court next month.

Given the gravity of the conduct, we anticipate that following resolution of the criminal matter, further disciplinary action will be considered by the Medical Board.

Australian Capital Territory – Nursing and Midwifery Board of Australia v Morrison[4]

Mr Morrison, a registered nurse in the Australian Capital Territory, pleaded guilty and was originally sentenced to 31 charges of family violence offences against his former wife in the ACT Magistrate's Court. The charges spanned a nine-year period and included assault occasioning bodily harm, stalking, and possessing an offensive weapon with intent. Upon notification of the charges, in 2019 the Nursing and Midwifery Board of Australia (the **Nursing Board**) immediately suspended Mr Morrison's registration and commenced disciplinary action against him.

A single charge of stalking was later dismissed against Mr Morrison, and he was re-sentenced to a lesser period of imprisonment. Subsequently, the Nursing Board filed an amended application for disciplinary action to reflect the new decision and the procedural orders made by the Tribunal on the original application.

The Nursing Board submitted in its application that the subject of Mr Morrison's convictions, as well as the convictions themselves, constituted "professional misconduct." The Tribunal rejected Mr Morrison's submission that the conduct fell within the context of his personal relationship with his wife and therefore did not affect his professional work. It noted that the definition of "*professional misconduct*" expressly includes conduct whether occurring in connection with the practitioner's profession or not. Moreover, the Tribunal was alive to the authorities which recognised significant harm done to public confidence in health services when individual providers perpetrate family violence and, in this regard, noted the gravity and significant time span of the conduct in question.

The Tribunal ordered that Mr Morrison be reprimanded, his registration be cancelled, and that he be disqualified from applying for registration as a registered health practitioner until 2029 (being ten years from the date of his suspension). He was also prohibited from providing any health services until such time as he was registered.

Victoria – Pharmacy Board of Australia v VGV[5]

The respondent, **VGV**, was a registered pharmacist in Victoria.

In 2019, VGV was found guilty of a number of criminal offences relating to the improper use of medication, including stealing prescription pads from a hospital, falsifying prescriptions for opioids for his own use and obtaining and possessing a range of regulated medications at his home. He was not convicted of these charges. Between 2018 and 2020, VGV was also charged with various driving offences, of which he was only convicted of one (driving whilst his licence was disqualified).

VGV failed to notify the Pharmacy Board of Australia (the **Pharmacy Board**) of these charges pursuant to s 130 of the National Law and attempted to renew his registration as a pharmacist without disclosing his criminal history.

The Pharmacy Board initially referred VGV to the Tribunal in January 2020. Upon learning of further criminal conduct, it made a second referral to the Tribunal in April 2021.

The Tribunal found that VGV's criminal charges relating to the medication offences, and his charges and conviction arising out of the driving offences, both constituted professional misconduct and that his failure to notify the Board of his criminal history constituted unprofessional conduct. The Tribunal considered medical evidence that VGV had a substance abuse disorder and major depressive syndrome, however, indicated that this was merely a factor to be taken into account and not exculpatory in the circumstances.

Moreover, the severity of the conduct, the findings of guilt against him, the protracted and repeated nature of the offences, and VGV's apparent disregard for the law (particularly in regard to the driving offences), weighed heavily in the Tribunal's findings and ultimate decision.

The Tribunal made orders that VGV be reprimanded, his registration be cancelled, and that he be disqualified for a period of three years from the date of the orders.

What should a practitioner do?

Whilst each case varies, practitioners or insurers should generally advise their insureds of the following:

1. If a practitioner is asked to speak to Police, or is arrested and charged with a criminal offence, their medical indemnity insurer should be notified immediately.
2. A practitioner should not answer any questions asked by Police or give any information unless they have spoken to their medical indemnity insurer and/or their lawyer and obtained legal advice.
3. A practitioner should not discuss the circumstances of the event/s that led to the practitioner being charged with any person unless it is a representative of their medical indemnity insurer and/or their lawyer.
4. Speak to a lawyer to obtain advice regarding what to do if a practitioner have been asked to attend a Police station for questioning/interview or have already been arrested and are in custody.
5. If a practitioner has been charged with an offence that is punishable by 12 months imprisonment or more or a scheduled medicine offence, they must notify the National Board for their profession (and AHPRA) within seven days of this "*event*".

Conclusion

Criminal convictions and other serious misconduct in a practitioner's personal life can have devastating consequences on a practitioner's professional reputation and career as personal misconduct is seen to be linked to professional capacity.

Professional misconduct or unprofessional conduct can have even greater consequences for a practitioner, as the disciplinary oversight is focused on public expectations and safety above all else.

The more serious criminal conduct, the more severe the penalty may be in the professional conduct sphere.

It must be remembered that the interplay between the various proceedings is delicate and can have serious consequences for practitioners in either criminal or disciplinary proceedings, or both, if not carefully managed.

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1 [2022] NTCAT 19
2 [2024] NSWCATOD 50
3 [2022] SACAT 105
4 (Occupational Discipline) [2022] ACAT 92 (7 November 2022)
5 (Review and Regulation) [2022] VCAT 1323 (22 November 2022)

HEALTHCARE PRACTITIONERS: REMINDER ON AHPRA REGULATIONS ON ADVERTISING

Author: Special Counsel Aimee Dash

Whilst health related advertising has been regulated by the Australian Health Practitioner Regulatory Agency (AHPRA) for several years, many practitioners are still unaware of exactly what they are allowed and not allowed to include when advertising their health services.

In the last financial year

AHPRA assessed 380 complaints

about non-compliant advertising by registered health practitioners - some of which resulted in tribunal proceedings and even criminal prosecutions.

The legislation

Pursuant to s 133 of the *Health Practitioner Regulation National Law* (**National Law**) regulated health services must not:

- be advertised in a false, misleading or deceptive way (or in a way that is likely to mislead or deceive)
- offer gifts, discounts or other inducements for health services without stating terms and conditions
- use testimonials about clinical aspects of treatment
- create unreasonable expectation of beneficial treatment, or
- directly or indirectly encourage the indiscriminate or unnecessary use of regulated health services.

The guidelines

AHPRA's guidelines on advertising are designed to safeguard the public from misleading or deceptive information while empowering consumers/patients to make informed decisions about their healthcare providers. These regulations apply to all AHPRA registered healthcare professionals, including doctors, nurses, dentists, pharmacists, and allied health practitioners.

The growing influence of social media and online advertising in the healthcare industry has become a focus area for AHPRA, placing the spotlight on practitioners who are often unaware that they are also expected to comply with the regulations when advertising through websites, social media platforms, email marketing, and all other digital channels.

Failure to comply with AHPRA's advertising regulations can result in serious consequences for practitioners, including fines ($60,000 for individuals and $120,000 for companies), disciplinary action, criminal prosecutions and damage to professional reputation.

Common breaches

A key aspect of AHPRA's regulations is the requirement for practitioners to clearly identify themselves and their professional credentials in all advertisements. The aim is to ensure that consumers are not misled, and to assist them in understanding and verifying the qualifications and expertise of practitioners. For example, if you are a dentist and hold a doctorate you may use the title of 'Dr', but AHPRA requires you to explain on all adverts that you are not a medical practitioner. There are also specific regulations regarding the use of the title 'surgeon'.

AHPRA also aims to prevent the manipulation of public perception by prohibiting the use of testimonials and endorsements in healthcare advertising, as testimonials can be inherently biased and may not accurately reflect the quality of care provided by a practitioner. AHPRA does differentiate testimonials from 'customer reviews' – but there is fine balance to be had and caution should be exercised.

Adverts containing exaggerated claims about the effectiveness of treatments are also a common breach as many providers are not aware that AHPRA regulations also extend to the advertising of health-related products and services, such as medical devices, pharmaceuticals, and complementary therapies. Practitioners must exercise restraint when promoting such products, ensuring that their adverts comply with the regulations and do not make unsubstantiated claims about their efficacy or safety.

Ultimately it is essential for practitioners to familiarise themselves with the regulations and ensure that their advertising practices align with ethical standards and legal requirements. AHPRA's website provides clear and concise guidance and resources to assist practitioners and their businesses with this task.

1 Australian Health Practitioner Regulation Agency - Summary of the advertising requirements (ahpra.gov.au)

HEALTH CARE PROFESSIONALS' SOCIAL MEDIA USAGE AND COMPLAINTS – HERE WE GO AGAIN

Author: Partner Kerri Thomas
Acknowledgment: Paralegal Zara Nazikian

The current Gaza conflict is seeing an upsurge in complaints being made against healthcare practitioners posting their personal opinions and political views on a social media platform.

Individuals have the right to lodge a notification if they are concerned about the social media use of a healthcare practitioner. The issue that is concerning the various practitioner Boards is whether these opinions can be perceived or interpreted to be a professional opinion, even if the account is not associated with the healthcare practitioner's workplace. We saw a spate of similar complaints being lodged during COVID-19 in response to a variety of views being expressed by health practitioners.

As we know, the Australian Health Practitioner Regulation Agency (**AHPRA**) regulates the conduct of specific practitioners who are registered to practise in Australia and their practices; Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Chiropractic, Dental practice, medical practice (doctors), Medical radiation practice, Nursing, Midwifery, Occupational therapy, Optometry, Osteopathy, Paramedicine, Pharmacy, Physiotherapy, Podiatry and Psychology.[1]

It is an accepted principle that within Australia, people will be provided with culturally safe care. When considering cultural safety, it is rare that a healthcare professional will fail to appreciate that they must adopt their practices to respect diversity and bias, discrimination, and racism. However, it may come as a surprise to some that their personal views and opinions may be considered culturally unsafe to some of the general public.

The current Israel and Palestine conflict

While many individuals may feel emotionally compelled to speak out on the Israel and Palestine conflict, healthcare practitioners must be cognisant of their obligations when making public social media posts, even on accounts that are not linked with their workplace.

AHPRA has confirmed that it is currently making inquiries into 39 practitioners following 59 complaints regarding the practitioners' social media posts. Steve Robson, the National President of the Australian Medical Association, has stated that those Health Practitioners who make "*respectful statements on social media advocating for peace and the protection of healthcare workers in war zones should feel confident that they will not be reprimanded by the regulator*"[2] However, Dr Jill Tomlinson, the Victorian President of the Australian Medical Association, has commented about her "*concerns that the complaints process is being weaponised*" against healthcare practitioners for their cultural, religious or political views.[3] While some complaints are being made by patients, in a number of cases we have seen, the complainants are anonymous and/or obviously not known to the healthcare practitioner personally or professionally.

Professional Codes of Conduct and social media

AHPRA may consider regulatory action if a healthcare practitioner's view presents a risk to public safety, provides false or misleading information, risks the public's confidence in their profession, or requires action to maintain professional standards. In short – practitioners need to comply with the principles set out in the Codes. Healthcare practitioners will not be investigated purely for holding or expressing their views on social media.

AHPRA's and the National Boards' Code of Conduct or Code of Ethics describes both the professional behaviour and conduct that is expected from registered health practitioners. Each of the individual professions have an approved Code of Conduct or Code of Ethics. Registered health practitioners have the responsibility to be familiar with and apply the relevant Codes.[4]

The Codes are very similar in form and content. The Medical National Board - good medical practice: a code of conduct for doctors in Australia, for example, relevantly covers the following:

- 4.4.6 - Ensuring that your use of digital communications (e.g. email and text messages) and social media is consistent with your ethical and legal obligations to protect patient confidentiality and privacy and the Board's social media guidance.
- 5.2. Respect for medical colleagues and other healthcare professionals.
- 5.2.3 Behaving professionally and courteously to colleagues and other practitioners including when using social media.

Preventing complaints

To prevent a complaint when posting a personal opinion on social media, healthcare practitioners should as a minimum:

set their profile to private or locked

review their following/followers, friends, and connections list, and

think of who the audience will be before posting.

The current conflict is extremely distressing, and many people feel compelled to speak out, however healthcare practitioners need to be extremely mindful of the forum that they choose to use, noting in particular the ease with which a disgruntled reader can lodge an AHPRA complaint.

1 https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx

2 https://www.smh.com.au/national/dozens-of-doctors-reported-to-watchdog-over-israel-gaza-social-media-posts-20240119-p5eyof.html

3 https://www.smh.com.au/national/dozens-of-doctors-reported-to-watchdog-over-israel-gaza-social-media-posts-20240119-p5eyof.html

4 https://www.ahpra.gov.au/Resources/Code-of-conduct.aspx

SOUTH AUSTRALIA

IMPOSTOR TO INMATE: FAKE NURSE RECEIVES PRISON SENTENCE

Author: Special Counsel Lani Carter

This matter involved Ms Alison Jane Mibus, who had never been registered as a nurse.

When she applied for a role as a practice manager at an Adelaide medical clinic, although the role did not require it, she claimed to have years of experience as a nurse, which put her ahead of other applicants. She also claimed to be a nurse in email communications with SA Health and told colleagues that she worked elsewhere as a nurse to 'maintain her registration'.

As a result of her claimed experience, a colleague at the clinic allowed her to administer vaccines to himself and his parents.

It was only when she resigned from the role that the ruse was uncovered, and her employer reported her conduct to the Australian Health Practitioner Regulation Agency (**AHPRA**).

Ms Mibus was prosecuted for holding herself out to be a nurse in breach of s 116 of the *Health Practitioner Regulation National Law 2009* (the **National Law**). Section 116 of the National Law provides that a person who is not a registered health practitioner must not knowingly or recklessly take or use the title of registered health practitioner or use a description indicating that they are a health practitioner, or a person qualified to practice in a health profession. Section 116 carries at $60,000 maximum fine for individuals, or three years imprisonment (or both), with $120,000 maximum fine for body corporates.

This was the second time that Ms Mibus had been caught out claiming to be a registered nurse and the second time she had been prosecuted by AHPRA. She had been fined $10,500 in 2020 on the first occasion.

Ms Mibus received a sentence of four months and 28 days (reduced from seven months to recognise a guilty plea). Ms Magistrate Dixon ordered Ms Mibus be released after one month.

This is the most serious sentence ever imposed under the National Law and the first sentence to have led to incarceration.

Magistrate Dixon noted that home detention would not be an appropriate outcome in circumstances where this was a repeat offence and the previous fine had not had the intended deterrent effect.

Nursing and Midwifery Board of Australia Chair Adjunct Professor Veronica Casey AM, commenting on the decision said:

> *'Being able to call yourself a nurse in Australia means something, and for someone to knowingly represent themselves as one to secure a job not only discredits the hard work and commitment of the profession, but is a criminal offence'.*

NEW SOUTH WALES

THE TRUE COST OF AN ONLINE REVIEW

Author: Partner Jehan Mata
Acknowledgment: Law Graduate Georgie Aidonopoulos and Paralegal Zara Nazikian

In our September 2022 Health Care Update, we referred to doctor rating websites as the 'wild west'. These rating websites have continued to attract negative attention as they now seem to be more of an avenue for disgruntled patients (or even competitors) to voice their grievances. The fundamental issue with doctor rating websites is that it is incredibly difficult for medical practitioners to have reviews taken down and nearly impossible to control what is being posted.

Chawk v Callan [2023] FCA 898 is a recent defamation case concerning a rhinoplasty procedure performed on 27 August 2020. The case had been the subject of a contested proceeding within the Federal Court before his Honour Halley J.

Background

On 27 August 2020, plastic surgeon Dr Peter Callan performed a rhinoplasty procedure on his patient Mr Zachariah Chawk. Following the procedure, Mr Chawk attended two post-operative consultations with Dr Callan.

At the first post-operative consultation, Dr Callan recalled Mr Chawk as "*being happy*" and observed that Mr Chawk "*looked good*".[1] Mr Chawk's breathing was also assessed as "*excellent*".[2] At the second post-operative consultation, it was Dr Callan's evidence that Mr Chawk was concerned that his right nostril had collapsed slightly when he inhaled. Dr Callan advised Mr Chawk that a "*wait and see*" approach was appropriate as his nostril may stiffen with time.[3] Photographic evidence given to the Court demonstrated that it was the right nostril, not the left nostril that partially collapsed on forced inspiration, with the right side of the nostril collapsing significantly less than it did pre-operatively.[4] On 16 October 2020, Mr Chawk published a negative review of Dr Callan on the online platform *RealSelf*, a website with the purpose to provide online ratings for medical practitioners. Mr Chawk's review remained on the website for a year as the review was not taken down until around the time of the mediation on November 2021.[5] In response to Mr Chawk's publishing of the negative review on *RealSelf*, Dr Callan attempted to contact Mr Chawk on three separate occasions by phone, email and Dr Callen even resorted to posting on Mr Chawk's profile on '*RealSelf*'. Dr Callan did not receive a response from Mr Chawk. Dr Callan's solicitors sent correspondence to Mr Chawk on the 24 October and 25 November 2020, which also went unanswered. Dr Callan contended that the review conveyed imputations to the effect that he had:

a. performed the rhinoplasty procedure negligently
b. negligently failed to correct Mr Chawk's deviated septum
c. performed the procedure so incompetently that Mr Chawk suffered a debilitating nasal valve collapse, and
d. ruined Mr Chawk's self-esteem and self-confidence by "*botching*" a rhinoplasty procedure.[6]

On 3 August 2023, Halley J gave judgment in favour of Dr Callan including damages for non-economic loss assessed at $50,000 plus costs, acknowledging that Mr Chawk had defamed Dr Callan by publishing of the negative review on the online platform *RealSelf*.

Halley J gave five reasons for the judgement:

1. The publication of review on a ratings website… has the potential to cause distress and hurt to the plastic surgeon.[7]
2. That a negligent failure to correct a deviated septum is materially less serious than a failure to correct causing a debilitating nasal valve collapse.[8]
3. Imputations were limited to allegations of negligence and incompetence with respect to a single rhinoplasty procedure. There were no imputations that Dr Callan was an incompetent or negligent plastic surgeon.[9]
4. Only registered users with a log in could access Dr Callan's profile on the *RealSelf* website and read the review, and therefore the potential for wider dissemination of the defamatory matter was significantly reduced.[10]
5. The allegations against Dr Callan were less serious as they did not involve a level of malpractice, fraud, cruelty, sexual abuse of children, participation in a criminal network or perversion of the course of justice.[11]

It was held that Mr Chawk could not rely on the defence of honest opinion (pursuant to s 31 of the *Defamation Act 2005* (NSW) (the **Act**) or qualified privilege (pursuant to s 30 of the Act).

Interestingly, Dr Callan was noted to have presented to the Court as a "*careful, responsive and objective witness*" who gave "*no reason to doubt evidence that he gave*".[12] Importantly, Dr Callan's evidence was consistent with both "*contemporaneous written records and the apparent logic of events. It was also largely corroborated by other witnesses who gave evidence*".[13] On the other hand, Mr Chawk's evidence in chief "*appeared cogent and reliable, his evidence in cross-examination was at times internally inconsistent and also inconsistent with the apparent logic of events and contemporaneous documents*".[14]

The dispute continues

Subsequently on 10 October 2023, within *Calan v Chawk* (Costs),[15] Halley J ordered Mr Chawk pay Dr Callan's costs of the proceedings on an ordinary basis up to 6 October 2022 and on an indemnity basis thereafter.

In 2024, Mr Chawk appealed Halley J's judgment in *Chawk v Callan*,[16] seeking to set aside both the primary and the costs judgment. In response to the appeal, Dr Callan filed an application seeking security for the costs of the appeal. Ultimately, Dr Callan's application was granted and Mr Chawk's application to stay the orders in the primary and costs judgment was dismissed.

In arriving at this decision, Mr Chawk's impecuniosity weighed heavily in favour of granting Dr Callan's application for security for costs. It was determined that "*there is almost no possibility that Mr Chawk can satisfy any of the damages and costs orders below, or any potential costs orders of the appeal*".[17] Rofe J considered it probable that if security was not ordered, and if Mr Chawk's appeal failed, Dr Callan would be not only "*denied the fruits*" from the primary and costs judgment "*but he will be unable to recover his costs of the appeal*".[18]

Further, Rofe J considered that Mr Chawk had already had his "'*day in court' and his prospects of success on the appeal are limited given that it will largely turn on questions of fact and does not obviously raise any important questions of law*".[19]

Due to these considerations, Rofe J considered that the discretionary factors favoured granting a security for costs order in the sum of $50,000.[20]

Takeaway

The dispute between Dr Callan and Mr Chawk reflects a major problem currently being faced by medical practitioners arising from doctor rating websites. These websites are often poorly regulated and do not allow medical practitioners to abstain from creating a profile. For example, RateMD allows patients to create a page for any practitioner. Once a review has been posted, it is nearly impossible to get it taken down.

To further complicate matters, defamation proceedings are costly and time consuming. They are also time constrained and must be commenced within 12 months from the date of the publication.

The first decision of *Chawk v Callan*[21] reinforces the importance of medical practitioners providing clear advice and taking contemporaneous notes detailing that they have informed the patient of the risks associated with the medical procedure and what an expectable and realistic outcome would be.

One of the ways to regulate this area may be for new legislation to be introduced that holds the websites accountable for any reviews, placing more of a burden on the platform to fact check and scrutinise any reviews posted. In the absence of this, medical practitioners need to be cognisant that their entire practice is susceptible to online commentary with no oversight into whether these reviews are well-founded.

In terms of advice to medical practitioners, we firstly recommend ensuring that medical practitioners provide cogent and comprehensible advice to patients, and ensure that discussions with patients, particularly those undergoing cosmetic procedures, are focused on the risks and possible outcomes of the procedure in order to manage and maintain realistic patient expectations. Secondly, we recommend that medical practitioners ensure they are taking accurate, detailed and contemporaneous notes for all patients who they interact with. This is a proactive way to mitigate the risk of being subject to negative online reviews. If a negative review is made, then a cease-and-desist letter should be considered.

1 [2023] FCA 898 at [49]
2 Above n1, at [40]
3 Above n1, at [51]
4 Above n1, at [142] and [143(d)]
5 Above n1, at [69]
6 Above n1, at [3]
7 Above n1, at [209]
8 Above n1, at [210]
9 Above n1, at [211]
10 Above n1, at [212]
11 Above n1, at [213]
12 Above n1, at [9]
13 Ibid
14 Above n1, at [12]
15 [2023] FCA 1198
16 [2024] FCA 92
17 Above n16, at [25]
18 Ibid
19 Above n16, at [34]
20 Above n16, the [35]
21 Above n1.

-- SNAPSHOT

HOLDING HEALTHCARE TO RANSOM

Author: Partner Jehan Mata
Acknowledgment: Lawyer Georgia Mineo

The healthcare sector remains Australia's hardest hit industry, reporting 22% of all data breaches from July – December 2023 (this is staggering when you consider that the financial industry reported 10% of the total data breaches). As the recent hack of MediSecure shows, the fixation on this industry by hackers is not predicted to die down anytime soon.

On 16 May 2024, former prescription delivery service provider, MediSecure fell victim to a large-scale ransomware data breach. While it is currently unknown what data has been stolen, the Department of Home Affairs has said the affected data relates to prescriptions distributed by MediSecure' s systems up until November 2023. Given MediSecure was founded in 2009 and managed millions of digital scripts each year, the breach has all the hallmarks of being significant.

In a statement released by MediSecure on 18 May 2024, it confirmed that the breach impacts personal information (including healthcare providers) and limited health information relating to prescriptions. As has been reported in our previous Cyber updates, despite the Australian Government's investment in cyber security, this recent hack shows that the health sector remains a valuable and vulnerable target. Unfortunately, we do not predict that malicious attacks on this sector will slow down any time soon, particularly given the volume of sensitive data held and increased reliance on telehealth and internet-enabled services. It is for this reason that health care providers now more than ever need to be cyber ready.

QUEENSLAND

RECENT QUEENSLAND OFFICE OF THE HEALTH OMBUDSMAN TRENDS AND UPDATES

Author: Partner Mark Sainsbury
Acknowledgment: Lawyer Emma Frylink

The 2022-2023 annual report of the Office of the Health Ombudsman (OHO) revealed that in the past year, OHO had a decrease in the number of complaints but an increase in the complexity and seriousness of those complaints.

OHO had 8,615 in the 2022-2023 year, compared with 9,618 in 2021-2022. 20% of matters assessed in 2022-2023 were categorised as high risk or "priority" compared to 14% in the previous year. Examples of complaints classified as a "priority" are adverse treatment outcome including serious harm or death.

In the last year, OHO issued 22 permanent prohibition orders to address serious risks posed by unregistered health practitioners. This was an increase from 14 such orders made in 2021-2022.

The health practitioners who received the most complaints were medical practitioners (56%), followed by nurses (16%), and psychologists (6%). Complaints regarding health service organisations were mostly relating to public hospitals (36%), followed by correctional facilities (23%), and medical centres (10%).

Recent OHO investigation

Last year, OHO launched an investigation into 24 licensed assistive reproductive technology (**ART**) providers. OHO is investigating various systemic issues in ART practice including:

- Handling of gametes and embryos, including concerns raised by consumers about delays in the disposal of genetic material.
- Screening techniques used in Queensland for gametes and embryos. For example, whether donated sperm is of good quality and in accordance with World Health Organisation guidelines for the examination and processing of human semen.
- Record keeping around donor and recipient information.
- Providing adequate information to customers to allow them to provide informed consent when choosing ART treatment.
- The use of gender selection in accordance with National Health and Medical Research Council.

Following this investigation, OHO will recommend improvements to ART procedures, which will complement work by Queensland Health regarding potential changes to the ART regulatory regime.

Practitioners who provide ART should monitor the outcome of OHO's investigation and potential subsequent legislative changes to ensure that they are complying with what is considered best practice.

No doubt insurers of ART clinics and of practitioners will also be interested in the outcome of OHO's investigation and any steps that need to be taken by their insureds to achieve compliance.

Proposed Queensland legislative changes affecting the health sector

The *Health and Other Legislation Amendment Bill (No. 2) 2023* is currently before the Queensland Parliament, which aims to introduce various amendments. The overall rationale for the Bill is to support access to healthcare, promote quality improvement and patient safety in public health facilities as well as to improve the operation of health legislation to support the health of all Queenslanders.

Maternity care

The Bill includes significant proposed changes to maternity care. The Bill will amend the *Hospital and Health Boards Act 2011* to clarify that for the purposes of patient ratios, a newborn baby should be counted as a patient when staying in a room or ward with their parent. Minimum midwife-to-patient ratios have not yet been implemented in Queensland; however, the Bill aims to lay the groundwork for implementing these ratios.

Additionally, the Bill will amend the *Termination of Pregnancy Act 2018* and Queensland *Criminal Code* to allow additional health practitioners (nurses and midwives) to perform early medical terminations of pregnancy using termination drugs.

The rationale for this is to enable equitable access to healthcare particularly for people in rural and regional Queensland. The proposed changes also include the use of more inclusive terminology in relevant provisions, replacing references to "woman" with "person", to permit legal access to termination services for all pregnant people.

Reporting requirements

The Bill also intends to make various changes affecting practitioner reporting requirements. The Bill will amend the *Hospital and Health Boards Act* to require a Quality Assurance Committee (**QAC**) to disclose information about a health professional to a chief executive where the QAC reasonably believes the health professional poses a serious risk of harm to a person because of the health professional's health, conduct or performance.

Currently, members of QACs can only disclose information in limited circumstances. For example, a member of a QAC can notify OHO of a reasonable belief that another registered health practitioner has behaved inappropriately so as to constitute "public risk notifiable conduct". However, this does not capture all kinds of notifiable conduct, nor does it capture unregistered health professionals. Currently, a QAC could not notify a practitioner's clinical supervisor of a report that the practitioner has been treating patients while intoxicated. Therefore, the Bill seeks to facilitate more rapid responses to patient safety risks by allowing further permitted disclosures by QACs.

Another proposed change is to amend the *Public Health Act 2005* to exempt practitioners from duplicate reporting requirements for dust lung diseases. In June 2023, the Australian Government introduced legislation to establish a national occupational respiratory disease registry (**National Registry**). If this legislation is passed, it would require Queensland practitioners to report dust diseases to both the Queensland notifiable dust lung disease register (**Queensland Register**) and the National Registry. This would result in an unnecessary burden for practitioners as the information provided to the National Registry will be shared with state and territory health agencies.

Proposed changes regarding Mental Health Court evidence

The Bill will amend the *Mental Health Act 2016* (**MHA**) with the goal of supporting appropriate release and use of information used in, or related to, Mental Health Court (**MHC**) proceedings. There are two main changes proposed, expanding the admissibility of MHC reports and transcripts, and permit release of expert reports prior to hearings.

The MHA currently permits expert reports received as evidence before the MHC in proceedings for the same offence before a criminal court, for limited purposes, to protect a person's health information and foster participation in MHC proceedings without fear of self-incrimination. Additionally, the MHA does not provide for transcripts of MHC proceedings to be used in the same way that expert reports may be used.

The Bill seeks to allow for the admission of expert reports and MHC transcripts in any offence being determined by a criminal court, but for the existing limited purposes (for example, determining a person's soundness of mind, fitness for trial, or for sentencing considerations). The rationale for these changes is to permit courts to consider all relevant information concerning a matter including details about a person's mental health.

Additionally, the Bill will remove the requirement that an expert report must have been received in evidence by the MHC, instead providing that the court may grant leave to release an expert report that has been filed with the registry for a proceeding. This will permit experts to consider previous expert reports already before the MHC when formulating their opinions and evidence. Also, authorised mental health services will be permitted to access report so to deliver treatment and care prior to a MHC hearing. These changes will assist in the provision of treatment and care and also ensure that meaningful evidence can be advanced in MHC proceedings.

Conclusion

Practitioners should remain informed about whether each of these proposed changes are passed into law and how they may affect their daily practice.

The proposed amendments regarding maternity care seek to improve access to health care; however, appropriate education, support and resources will be required to ensure patient safety and minimise risk.

Practitioners affected by the proposed amendments regarding disclosure and reporting should seek guidance to ensure they do not fall foul of the relevant legislation and the Australian Privacy Principles.

THE GREAT PRETENDER: A GP'S MISADVENTURES IN ALTERNATIVE CANCER TREATMENTS

Author: Special Counsel Aimee Dash
Acknowledgment: Law Graduate Grace Clavey

In *Medical Board of Australia v William Barnes*,[1] the Western Australian State Administrative Tribunal (**SAT**) found that the respondent, Dr Barnes, a general practitioner, had falsely represented to his patients, prospective patients, and members of the public, that "*Non-Toxic Herbal and Nutritional Treatment as an Alternative Treatment for Cancer*" could cure cancer.

The SAT ordered that Dr Barnes be reprimanded, conditions be placed on Dr Barnes' Registration and that Dr Barnes pay a $25,000 fine and the Medical Board's costs of the proceedings. The decision highlights that medical practitioners should avoid advertising and promoting so called "*alternative or complementary therapies*", or if they choose to do so, they should exercise extreme caution and ensure that they are satisfied of the following:

1. the medical service they intend to advertise or promote is recognised by competent medical practitioners and specialists in the relevant field, and
2. there is a sound scientific basis upon which they can rely to support all representations made about the medical service in the advertising and promotional material.

Facts

In 2008 and 2009, Dr Barnes advertised on his website, or caused or permitted to be advertised on his website, "*Non-Toxic Herbal and Nutritional Treatment as an Alternative Treatment for Cancer*", which was described as including the oral and/or intravenous administration of "*green tea polyphenols, genistein from soybeans, curcumin from turmeric, quercetin, vitamin C and selenium, administered orally and intravenously, "mineral replacement" and the adoption of a particular diet*" (collectively the **Treatment**).

On 31 July 2009, the Medical Board received a notification that Dr Barnes falsely represented on his website that the Treatment could cure cancer (**False Representation**).

Following receipt of the notification and pursuant to s 17(1)(a) of the Schedule to the *Health Practitioner Regulation National Law (WA) Act 2010* (**National Law**), the Medical Board commenced proceedings against Dr Barnes pursuant to s 86(1) of the *Medical Practitioners Act 2008* (WA) (repealed) (**MPA**) in relation to the False Representation. The Medical Board alleged that while the advertisement remained on Dr Barnes' website, Dr Barnes caused his patients, prospective patients and members of the public to be misled by the False Representation, which gave rise to the risk that patients diagnosed with cancer would:

delay ongoing or receiving effective treatment for cancer

refuse to undergo or receive effective treatment for cancer, and/or

necessarily incur expense, discomfort and inconvenience in order to obtain the Treatment.

On 2 August 2013, following a mediation between the parties, Dr Barnes admitted to the allegations made against him by the Medical Board. The SAT's decision therefore deals only with the penalties imposed on Dr Barnes.

On 15 October 2013, the SAT made orders that Dr Barnes be reprimanded, conditions be placed on Dr Barnes' Registration and that Dr Barnes pay a $25,000 fine and the Medical Board's costs of the proceedings.

The two conditions that were placed on Dr Barnes' Registration, not to be reviewed within five years of the date of the orders, were:

1. Dr Barnes is prohibited from advertising any unproven (so called alternative or complementary therapies for the treatment of cancer, and
2. before commencing or continuing to provide any patient or advice in relation to the patient's diagnosed cancer, Dr Barnes must provide the patient with a "*consent to alternative or complementary therapy or treatment of diagnosed cancer*" form.

Comments

This decision highlights that if a medical practitioner advertises or promotes a medical service that is not supported by competent medical practitioners or specialists in the relevant medical field, and is not supported by a sound scientific base, there is an increased risk that the advertising and promotional material may be misleading and therefore amount to improper conduct by the medical practitioner.

Medical practitioners who advertise and promote medical services, which fall within the category of '*alternative therapies*', are at greater risk of making false representations.

Further, the decision demonstrates that disciplinary proceedings may be brought against medical practitioners who advertise and promote medical services and that this conduct may result in the imposition of personal fine.

1 *Medical Board of Australia v William Barnes [2013] VR 107.*

LEGAL PROFESSIONAL PRIVILEGE IN THE CONTEXT OF SOLICITOR FILE NOTES OF DISCUSSIONS WITH EXPERTS

Author: Partner Mark Sainsbury

Case Update: *Enkelmann & Ors v Stewart & Anor* [2023] QCA 155

In the case of *Enkelmann & Ors v Stewart & Anor* [2023] QCA 155, the Queensland Court of Appeal examined the nature of legal professional privilege concerning solicitor-prepared file notes, particularly those incorporating an expert's opinions pursuant to rule 212(2) of the *Uniform Civil Procedure Rules 1999* (QLD) (**UCPR**).

The file notes in question were created by the appellants' solicitors during a conference with an expert, Mr Giles, who was requested to provide a "peer review" of two reports prepared by other engineers engaged by both parties throughout the proceedings.

The Court of Appeal concluded that the file notes were protected by legal professional privilege, however, the privilege was deemed to have been implicitly waived when the appellants permitted Mr Giles to openly discuss his viewpoints during cross-examination without raising any objections.

This decision is important given the frequency with which defendant solicitors are required to speak with experts, particularly medical experts, on healthcare claims.

Overview of legislative framework

In Queensland, the disclosure of file notes, especially those involving expert opinions, have historically been subject to much contention. Under the UCPR, legal professional privilege applies to documents produced by solicitors for the dominant purpose of advising a client in litigation. This includes various correspondences between a client and their solicitor, which are considered confidential to safeguard the client's legal interests. However, the UCPR explicitly clarifies that expert reports or statements, regardless of their inclusion in solicitors' file notes, do not benefit from this privilege.

It should be noted this was a property related claim and not a personal injury claim. Therefore, the disclosure provision under the *Personal Injuries Proceedings Act 2002* (Qld) were not considered by the Court.

Case background

The proceedings began in 2016 when the appellants' alleged nuisance and negligence by the respondents, claiming that alterations to the respondents' property caused flooding impact on their land.

Both parties submitted reports by hydrology experts to substantiate their claims. During the trial, Mr Giles, the appellants' retained expert, revealed under cross-examination that he had provided oral opinions of the existing hydrology reports during a conference with the plaintiff's solicitors.

As a consequence of Mr Giles' answers in cross-examination, the respondents called for the production of documents, including any file notes taken by the appellants' solicitors, which could reflect Mr Giles' thoughts or advice during his engagement as an expert.

The appellants argued that the file notes were protected by legal professional privilege because it was created for the primary purpose of providing confidential legal advice or for use in impending legal proceedings.

Supreme Court of Queensland's verdict

Justice Williams held that the file notes between the appellants' solicitors and Mr Giles that encapsulated his reviews of other expert reports, constituted "*a document comprising an expert statement or report,*" which under rule 212(2) of the UCPR, does not benefit from the protection of privilege.

Alternatively, Justice Williams acknowledged that if she was wrong about the application of rule 212(2), it would still be unjust to allow the appellants to invoke legal professional privilege. This is because the oral advice given by Mr Giles regarding the evaluation of reports by the two other experts significantly influenced his methodology and led him to deviate from the approach initially suggested by the first expert. The Court reasoned that since this oral advice effectively shaped Mr Giles' approach and was integral to the development of his expert opinion, concealing this advice under the guise of legal professional privilege could mislead the Court and disadvantage the respondents.

Court of Appeal's finding

The Court of Appeal found that:

a. A proper construction of rule 212(2) of the UCPR is that it applies to "…*a document brought into existence to be a statement or report of an expert*…", including where that statement or report is taken or prepared by a solicitor and where it is in draft form.

b. The phrase "*consisting of*" in rule 212(2) of the UCPR was held not to cover a solicitor's file note documenting an expert opinion.

Accordingly, the Court of Appeal concluded that the file notes prepared by the appellants' solicitors could legitimately be protected under legal professional privilege. Nonetheless, the privilege was considered waived implicitly due to the appellants' conduct during Mr. Giles' cross-examination. The appellants' failure to contest the inquiries about the conference with Mr. Giles signalled an inconsistency with the preservation of legal professional privilege and amounted to implied waiver.

Conclusion

It was with some relief for defendant solicitors that the Court of Appeal confirmed that UCP Rule 212(2) does not revoke legal professional privilege for solicitor-prepared file notes unless they are expressly created as an expert statement or report.

Being able to meet with medical experts and discuss the complexities of medical negligence claims is a vital part of constructing a viable defence for medical practitioners and their insurers and written notes are almost universally produced during such meetings. Those notes are then used to advise clients on the existing or looming litigation. The Court of Appeal has, for the time being at least, provided some security over that process.

However, this case underscores the critical nature of consistent action to uphold confidentiality and privilege. The appellants' acquiescence to Mr Giles' disclosure of the conference content in Court amounted to a waiver of privilege, which serves as a useful reminder for all legal practitioners involved in litigation.

NSW SELECT COMMITTEE ON BIRTH TRAUMA

Author: Partner Marie-Clare Elder

In May 2023, Murrumbidgee Local Health District received a joint complaint by over 30 women in relation to maternity care they had received at Wagga Wagga Base Hospital.[1]

The complaint was referred to the NSW Health Care Complaints Commission (**HCCC**), and the NSW Parliament Select Committee was established in June 2023 to inquire into and report on birth trauma. Over 4000 submissions have been received.

In September 2023 the Terms of Reference were released. There are ten broad terms[2] that range from experience and prevalence of birth trauma to the provision of antenatal care and informed choice when it comes to birthing.

There were six hearings in Sydney, Wagga Wagga and Wollongong. The final was heard on 08 April 2024 and submissions were closed on 15 August 2023.

The evidence by many women who have experienced birth trauma has been harrowing and widely reported in the press.

Numerous thoughtful submissions have been made by health care professionals who report feeling increasingly frustrated with the lack of resources and funding in state hospitals. Most endorse a holistic approach to birthing but describe feeling powerless when there are inadequate support services for women and their partners when a birth does not go according to plan.

Perhaps the most controversial aspect of the inquiry has been Term 1(a):

> *the experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")*[3]

The phrase 'obstetric violence' has understandably caused concern amongst Obstetricians and Midwives given its negative connotation and the suggestion that birthing complications are intentional as opposed to unintended outcomes despite the best efforts of the delivery team.

In its submission to the Inquiry, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**) respond to Term 1(a) by stating:

> *RANZCOG strongly believes that the term 'obstetric violence' is incorrect and in fact may limit opportunities to reduce patient experience of birth trauma. Whilst RANZCOG acknowledges that interventions can cause harm, or psychological stress to the patient, the term 'obstetric violence' implicates that the obstetrician 'intended' the harm – which is unfair and vastly incorrect.*[4]

In our next edition, we will summarise the 5 findings and 43 recommendations that were released on 29 May 2024.

The NSW Government has three months to formally respond to the inquiry's report.

The submissions and transcripts can be found on the Parliament of New South Wales website.

1 *NSW Health Select Committee on Birth Trauma – Questions on Notice, Hearing 12/12/23 pp2-3 https://www.parliament.nsw.gov.au/lcdocs/other/18937/AQON%20-%20Murrumbidgee%20Local%20Health%20District%20-%20Received%2012%20January%202024.pdf*

2 *The NSW Parliament Select Committee on Birth Trauma, Terms of Reference, 12 September 2023 https://www.parliament.nsw.gov.au/lcdocs/inquiries/2965/Terms%20of%20reference%20-%20Birth%20trauma%20-%20Updated%2012%20September%202023.pdf*

3 *Ibid at 1*

4 *Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Submission to the Inquiry into Birth Trauma, 11 August 2023 at 2 https://www.parliament.nsw.gov.au/lcdocs/submissions/80709/0238%20RANZCOG.pdf*

VICTORIA

VICTORIAN GOVERNMENT ANNOUNCES VICTORIAN INFRASTRUCTURE DELIVERY AUTHORITY: WHAT THIS MEANS FOR HEALTH INFRASTRUCTURE

Authors: Partner John Kehoe
Acknowledgment: Lawyer Benjamin Hicks

The Victorian Government announced that Major Transport Infrastructure Authority (**MTIA**) will merge with the Victorian Health Building Authority (**VHBA**) to become a joint Victorian Infrastructure Delivery Authority (**VIDA**), which was subsequently established on 2 April 2024.

The merger of expertise and skills of the transport and health sectors is anticipated to deliver better outcomes and value for money to both transport and health infrastructure, including the $15 billion health infrastructure project pipeline and the crucial health infrastructure program currently underway in Victoria.

Early announcements have indicated that the Minister for Transport and Minister for Health will remain responsible for their respective portfolios, and much of the transitional arrangements relate to staff movements and proposed offices for staff to work from (for example, all rail projects will transition following the completion of the Metro Tunnel project into a single project office focused on delivering Victoria's rail infrastructure).

Further details can be found about VIDA here: https://bigbuild.vic.gov.au/about/vida.

IN THE PUBLIC INTEREST, I NOW PRONOUNCE YOU...

Author: Special Counsel Marie Panuccio
Acknowledgment: Lawyer John Youssef

Health Care Complaints Commission v EAE[1]

The New South Wales Civil and Administrative Tribunal recently granted a nurse's application to terminate the Tribunal's inquiry into a complaint against him made by the Health Care Complaints Commission (**HCCC**) pursuant to Clause 12(1) of Schedule 5D of the *Health Practitioner Regulation National Law (NSW)* 2008 (**National Law**).

Background

In November 2022, the respondent nurse (**EAE**), had been convicted in the District Court of several offences, including sexual intercourse with a child between the ages of 10-14, which were alleged to have been committed when he was 14 years old. The offences were against his younger sister, then 10 years old. As a result of the convictions, EAE was deemed to be a "*registrable person*" under the NSW Child Protection Register. He was also sentenced to a period of 1 year and 3 months imprisonment and had recently been released on parole.

He had also voluntarily surrendered his registration as a nurse.

EAE lodged a statutory declaration admitting conviction of the offences and undertaking not to re-apply for registration as a registered nurse in NSW, or elsewhere, and to pursue a career unrelated to health care or any health care related profession.

The HCCC had commenced proceedings against EAE for the criminal conduct and sought protective orders in the nature of cancellation of EAE's registration with a non-review period of 2-3 years.

EAE filed an application with the Tribunal pursuant to Cl 12(1), Sch 5D of the National Law, which includes the power of the Tribunal or a Professional Standards Committee (**PSC**) to terminate proceedings or decide not to hold an Inquiry into a complaint.

The HCCC opposed EAE's application to terminate the inquiry on the basis of, *inter alia*, it being contrary to the public interest if health practitioners could simply de-register to avoid an inquiry regarding serious allegations.

The National Law

The power to terminate the proceedings arises under Cl 12 of Sch 5D of the National Law. It gives the Tribunal power "*not to conduct*" an inquiry or "*at any time to terminate an inquiry*" in any of the following circumstances:

> *(a) …*
>
> *(i) a complainant fails to comply with a requirement made of the complainant by the Committee or the Tribunal*
>
> *(ii) the person about whom the complaint is made ceases to be a registered health practitioner or student*
>
> *(iii) the complaint before the Committee or the Tribunal is withdrawn, and*
>
> *(b) in the opinion of the Committee or the Tribunal it is not in the public interest for the inquiry or appeal to continue.*

The concept of the public interest fundamentally underpins the health practitioner regulation framework in Australia and are intertwined with the objectives and guiding principles set out in s 3 of the National Law.

Section 3A, which is unique to the NSW version of the National Law, places emphasis upon the protection of the health and safety of the public but does not expand or proscribe the content of s 3.

"*Public interest*" is not defined in the National Law and whilst there is no other statutory definition, establishing what is in the public interest will depend on the particular circumstances of each case and the broader public concerns at the time.

In EAE, the Tribunal set out that when determining whether it was "*not in the public interest*"[2] for the proceedings to continue, that the first step was to identify relevant facets of the public interest based on the subject matter, scope and purpose of the National Law. The second step was to identify the factual matters which will inform the Tribunal's discretionary value judgement as to whether the discretion to terminate the inquiry should be exercised.

The Tribunal commented at that:

> *"In the circumstances of this case, there can be no deterrent effect if the Tribunal continues with the inquiry and makes protective orders. There is no deterrent to a child from committing these kinds of offences. Nor would holding an inquiry, as distinct from terminating the inquiry and providing reasons, deter a person who has engaged in such undetected criminal conduct as a child, from applying for registration as a health practitioner."*[3]

The Tribunal found that it was not in the public interest for the Tribunal to continue the inquiry, and that it would be more efficient to terminate the inquiry as the Tribunal (and EAE) would not incur the costs of holding an inquiry.

Previous treatment

Very rarely do circumstances arise where a respondent health practitioner would seek to terminate an inquiry. However, there are authorities where the HCCC (as the applicant) sought orders that the Tribunal consent to the withdrawal of a complaint against health practitioners.

In *HCCC v BQB*,[4] the HCCC filed a complaint in February 2014 alleging that Ms BQB, a registered nurse (**RN**), had misappropriated supplies of Seroquel (a schedule 4 medication) from her workplace, and had failed to seek medical assistance for her then de-facto partner who was found deceased in August 2011.

She had subsequently been charged with murder by NSW Police in September 2011. In a separate matter, she was also charged with assault occasioning actual bodily harm in relation to a domestic dispute, common assault, and assault of a police officer. The HCCC asserted that she also failed to notify AHPRA of the criminal charges, all of which were dismissed or withdrawn, save for the assault on a police officer and assault occasioning actual bodily harm.

Subsequently, in November 2014, Ms BQB signed a statutory declaration in which she deposed that she would not seek to practice in the future and had provided evidence that she was no longer registered with AHPRA. Expert psychiatric evidence served by Ms BQB indicated that she had a mental illness which rendered her unlikely to be able to work again in the capacity of an RN.

The Tribunal was "*completely satisfied*"[5] that the public was protected by reason of Ms BQB's surrendering of her registration, execution of the statutory declaration and her mental illness which precluded her from working as an RN in the future; and that there would be no deterrent value or public safety served by a hearing of the complaint.

The Tribunal consented to the withdrawal of the HCCC's complaint under Cl 12 of Sch 5D.

In *HCCC v Sharah*,[6] Dr Sharah's application under Sch 5D cl. 12 to terminate the inquiry was dismissed. That application was made by the practitioner and opposed by the HCCC. The original complaints concerned several patients and spanned from inappropriate religious advice/gestures in the context of his treatment as a psychiatrist (such as telling his female patients they needed God and handed them a crucifix as "*treatment*"), boundary violations and the provision of inappropriate treatment which was not supported by conventional psychiatric practice.

Although the medical practitioner was aged 79, admitted all four complaints of unprofessional conduct, misconduct and impairment, and undertook not to re-register in the future, the Tribunal noted:

> *"While the respondent conceded [the complaints], he disputed a number of the particulars relied upon. This was not a case of full and frank admissions of the particulars as seen in some of the cases where the discretion not to proceed has been exercised favourably to the respondent.*
>
> *Further, there was the contest that remained over the allegations [of touching] made by Patient A. The allegations were very serious, and it was in the public interest, in our opinion, for those allegations to be ventilated and dealt with."*[7]

The application was refused on the basis that, *inter alia*, the Tribunal had concerns that by terminating the inquiry formal orders of the kind sought could not be made, and that the inability to do that, in the circumstances of this case, might not serve the public interest. As a prohibition order was being sought, and there was evidence that Dr Sharah remained active in the wider community (which had played heavily in the conduct which was the subject of the complaints), there was "*on the face of it, a risk to the public in this case that needed to be addressed.*"[8]

In *HCCC v Duggan*,[9] the HCCC filed a complaint of unsatisfactory professional conduct and professional misconduct filed by the HCCC on 9 June 2015 in relation to Mr Duggan's practice as an osteopath from 2009 – 2010. Mr Duggan had been criminally charged with a number of counts of indecent and sexual assault relating to three female patients (in the nature of clinically unjustified touching) and was acquitted in 2012.

Mr Duggan sought leave to make an application pursuant to Cl 12 of Sch 5D to terminate the inquiry on the basis that he would not be re-applying for registration as an osteopath or health care professional at any time in the future. The HCCC opposed the application.

Ultimately, the Tribunal found no basis to terminate the inquiry by virtue of s 55 of the *Civil and Administrative Tribunal Act* 2013 (**CAT Act**), nor was it in the public interest to terminate the inquiry under Cl 12 of Sch 5D of the National Law. The Tribunal considered the objects and guiding principles of both the National Law and the CAT Act and considered that the objectives of the National Law were of overriding importance.

Specifically, the Tribunal observed that:

1. *"The Tribunal's role in protecting the health and safety of the public is not limited to consideration of the direct protection of individual members of the public from the incompetent or unethical practice of the relevant practitioner in proceedings, but rather extends to an interest in protecting the public more broadly by maintaining and communicating professional standards, signalling disapproval of unethical and incompetent conduct and thereby enhancing both professional standards and the public's trust in the health professions."*[10]

2. *"It is our view that terminating these proceedings based upon the practitioner's willingness to surrender his registration would fall into ... error. Here the very serious nature of the misconduct alleged, and the factual dispute as to events and their clinical justification, mean that an inquiry is required."* [11]

3. Despite his affidavit asserting that he would not reapply for registration into the future, the allegations against Mr Duggan that were presently before the Tribunal were described as "*extremely serious*" and none of the cases in which an application to terminate had been previously granted involved allegations of unwarranted intimate physical contact in a clinical setting.[12]

4. The practitioner's argument that the public interest in deterrence in this matter has been served by the previous criminal process was not accepted.[13]

5. The alleged "*cost burden being placed on all practicing osteopathy registrants in NSW*" as a result of professional regulation was not a relevant consideration.[14]

6. Assertions with respect to a lack of professional indemnity insurance cover and absence of legal representation were not arguably points that it is in the public interest to dismiss proceedings.[15]

Insights

The public interest is often addressed by the specific protective measures taken for the public's health and safety.

The Tribunal's role in protecting the health and safety of the public is not limited to consideration of the direct protection of individual members of the public from the incompetent or unethical practice of the relevant practitioner in proceedings, but rather extends to an interest in protecting the public more broadly by maintaining and communicating professional standards, signalling disapproval of unethical and incompetent conduct and thereby enhancing both professional standards and the public's trust in the health professions.[16]

It is evident that whilst the conduct in the cases of EAE and Duggan were inherently similar and serious, the dichotomy arose from the timing and circumstances of the conduct, the former of which occurred pre-registration as a health practitioner and when EAE was under 18 years old and the latter, in a clinical setting in the provision of health care and treatment.

Determining what is in the public interest in continuing an inquiry is guided by the objects and guiding principles of the National Law. While the CAT Act and the National Law operate in conjunction in these proceedings, the National Law objectives are overriding.[17]

The power pursuant to Cl12 of Sch 5D is a discretionary power of the Tribunal to determine not to conduct, or at any time terminate an inquiry in certain circumstances, subject to being satisfied that it is "*not in the public interest*" for the matter to be determined at hearing. Decisions against practitioners pursuant to the National Law must. Careful consideration of what is in the "public interest" will involve an analysis of the unique circumstances of each matter being determined, and identifying and acting on a broader understanding of that interest to make a determination that adequately reflects the public's expectations and level of concern relative to the practitioner's conduct.

1 [2024] NSWCATOD 48
2 Above n1, at [26]
3 Above n1, at [54]
4 [2014] NSWCATOD 157
5 Above n4, at [32].
6 [2015] NSWCATOD 99
7 Above n6, at [32-33]
8 Above n6, at [34]
9 [2015] NSWCATOD 142
10 Above n9, at [42]
11 Above n9, at [47]
12 Above n9, at [52]
13 Above n9, at [59]
14 Above n9, at [63]
15 Above n9, at [64]
16 Health Care Complaints Commission v Do [2014] NSWCA 307 at [35]
17 Health Care Complaints Commission v Chester [2017] NSWCATOD 97 at [40]

-- SNAPSHOT

COVID-19 RESPONSE INQUIRY UPDATE

An independent Inquiry into Australia's COVID-19 response was announced by the Prime Minister in September 2023.

Chaired by Robyn Kruk AO, the Inquiry has broad terms of reference, which seek to:

> ". . . review the Commonwealth Government's response to the COVID-19 pandemic and make recommendations to improve response measures in the event of future pandemics. It will consider opportunities for systems to more effectively anticipate, adapt and respond to pandemics in areas of Commonwealth Government responsibility"

Over 2000 responses were received through the public submissions process, which closed in December 2023. Where authors have provided permission, the submissions are publicly available online.

The Independent Panel is due to deliver a Final Report to Government by the end of September 2024.

We will summarise the findings in future editions.

1 Commonwealth Government COVID-19 Response Inquiry terms of reference https://www.pmc.gov.au/resources/commonwealth-government-covid-19-response-inquiry-terms-reference

-- SNAPSHOT

STATUTORY THRESHOLDS – MAXIMUM AWARDS – GENERAL DAMAGES

State	Maximum Awards – General Damages
New South Wales	As of 1 October 2023, the maximum award of damages for non-economic loss under the *Civil Liability Act 2002* (NSW) is $722,000. This amount will be indexed again on 1 October 2024.
Australian Capital Territory	In the Australian Capital Territory, there is no statutory threshold for awards of general damages/non-economic loss in personal injury claims in the *Civil Law (Wrongs) Act 2002* (ACT).
Queensland	The maximum award for general damages in Queensland for a claim regulated by the *Civil Liability Act 2003* (QLD) (i.e. not a common law claim) is $436,100, where a claimant's injuries are assessed against an Injury Scale Value from 0-100, found in Schedule 7 of the *Civil Liability Regulation 2014* (QLD).
Western Australia	In Western Australia, there is no maximum cap on general damages pursuant to the *Civil Liability Act 2002* (WA). However, there is a minimum threshold which is indexed on 1 July every year. As at 1 July 2023, general damages will only be awarded by the court if they are assessed to be more than $24,500. If general damages are assessed over the threshold, various formulas are then used to calculate the amount awarded to the plaintiff.
South Australia	The *Civil Liability Act 1936* (SA) assesses personal injury general damages by reference to a points system from 1 to 60 based on the year of the incident. As of June 2023, the maximum award of 60 points was $443,000.
Tasmania	In Tasmania, there is no cap on the maximum compensation for non-economic loss pursuant to the *Civil Liability Act 2002* (Tas). As of June 2023, the threshold requirement was that claims must be worth more than $6,000. The minimum value increases each year.
Victoria	The current statutory maximum award of damages in Victoria under the *Wrongs Act 1958* (VIC) is $713,780. This amount will be indexed on 1 July 2024.
Northern Territory	In the Northern Territory, the maximum amount of damages for non-pecuniary loss pursuant to s27(1) of the *Personal Injuries (Liabilities and Damages) Act 2003* (NT), is $775,200 (85% + PI = 680,000 monetary units @ $1.14 per unit until 30 June 2024) provided the degree of permanent impairment exceeds 5%, pursuant to section 27 of the Act.

ANNEXURE

PAUL v ROYAL WOLVERHAMPTON NHS TRUST; POLMEAR v ROYAL CORNWALL HOSPITALS NHS TRUST; PURCHASE v AHMED

Authors: Partner Marie-Clare Elder and Special Counsel Marie Panuccio

"The law cannot, however, impose duties and liability on the basis of sympathy."[1]

The Supreme Court of the United Kingdom (the Supreme Court) recently delivered a landmark judgment in a conjoined clinical negligence appeal concerning psychiatric injuries suffered by secondary victims. In the proceedings, the claimants contended that the deaths of their respective relatives, (the defendant's patient) were caused by the negligent failure of the defendant doctor or health authority to diagnose and treat a life-threatening medical condition from which each deceased was suffering. The claimants' cases were based on the assertion that the respective defendants were not only responsible for the death of their close relative but were also liable to compensate them for psychiatric illness caused by their experience of witnessing the death (or its immediate aftermath).

In each case, the respective defendants had applied to strike out the claim on the basis that, as a matter of law, the claimants' cases could not succeed. Initially, the cases of *Paul v Royal Wolverhampton NHS Trust*[2] (**Paul**) and *Purchase v Ahmed*[3] (**Purchase**) were dismissed by the High Court[4] and County Court[5] respectively, with permission given to appeal. Following the case brought by *Paul*, an application to dismiss the claim in *Polmear v Royal Cornwall Hospitals NHS Trust*[6] (**Polmear**) was also rejected, with permission given to appeal.

The Court of Appeal subsequently heard and decided appeals in all three cases together, finding for the defendants in each case, and concluded (somewhat reluctantly) that the claims could not succeed on the basis that the Court was bound by the existing authority of *Taylor v A Novo (UK) Ltd*[7] (a non-clinical negligence claim). The Court of Appeal expressed the view that "delayed trauma" cases warranted consideration by the Supreme Court and granted permission to the claimants to appeal to the Supreme Court to consider the issues more definitively.[8]

The primary issue before the Supreme Court was whether secondary victims (or close relatives of a patient) could, as a result of earlier clinical negligence,make a claim for psychiatric harm caused by witnessing the death of the patient, or its immediate aftermath. That is, whether the necessary legal proximity existed between the clinician/ defendant and the secondary victim.

Background

The brief facts of the cases are as follows:

Paul v Royal Wolverhampton NHS Trust

Mr Harminder Singh Paul, who suffered from Type 2 Diabetes, was admitted to the Royal Wolverhampton NHS Trust in November 2012 complaining of chest and jaw pain. He was treated for coronary symptoms and subsequently discharged. The Trust did not perform a coronary angiography which would have revealed Mr Paul's coronary artery disease. Some 14 months later, Mr Paul collapsed and died from a heart attack on 26 Janu-ary 2014 whilst shopping with his daughters. His daugh-ters claimed that they suffered psychiatric trauma as a result of witnessing their father's collapse, its traumatic aftermath, and his death.

Polmear v Royal Cornwall Hospitals NHS Trust

Ms Esmee Polmear, aged 7, was seen by a paediatrician at the Royal Cornwall Hospitals NHS Trust on 1 December 2014 following episodes where she could not breathe, appeared pale and turned blue. A cardiac cause for these symptoms was ruled out, however, the Trust did not diagnose that Ms Polmear was suffering from pulmonary veno-occlusive disease. The Trust admit-ted that that condition ought to have been diagnosed by mid-January 2015. Ms Polmear subsequently collapsed and died on 1 July 2015 after a school trip to the beach. Ms Polmear's collapse, unsuccessful resuscitation, and death, some 5.5 months after the admitted failure by the Trust, were witnessed by her mother and father, both of whom claimed to have suffered post-traumatic stress disorder (PTSD) and major depression as a result.

Purchase v Ahmed

Ms Evelyn Purchase, aged 20, presented to her general practitioner (GP) on 4 April 2013 with symptoms of severe pneumonia. At the time, Ms Purchase was suffering from extensive bilateral pneumonia with pulmonary abscesses (which was ultimately determined as the cause of her death). Three days later, on 7 April 2013, Ms Purchase was found by her mother (the claimant) lying motionless in bed with the house telephone in her hand. Ms Purchase's mother attempted CPR; however, it was determined that Ms Purchase had sadly died approxi-mately 5 minutes before being found by her mother. Her final moments were recorded in a voicemail left on her mother's mobile phone. The claimant alleged that there was a negligent failure by the GP to assess and treat Ms Purchase, and as a result of which, she died. Consequently, her mother claimed that she developed PTSD, severe chronic anxiety and depression.

Each of the claimants in *Paul*, *Polmear* and *Purchase* brought claims for damages for psychiatric injury as secondary victims.

Supreme Court decision

Each claim before the Supreme Court had two common denominators, a patient who subsequently died from manifestation of their untreated disease, and sec-ondary victims who witnessed the death or immediate aftermath at a point that was removed in time from the act of clinical negligence.

The Supreme Court's analysis focused on whether this category of case included, or could and should be extended to include, claims where the injury suffered by the secondary victim was caused by witnessing the death or injury of a close relative, not in an "accident",[9] but from a medical condition which the defendant had previously negligently failed to diagnose and treat.

The Supreme Court discussed both the application and dichotomy between the occurrence or manifestation of injury and the witnessing of an accident, with the latter being a legally significant requirement and a necessary condition for a secondary victim claim. However, a secondary victim who witnessed the suffering or death of a relative from illness[10] or its consequences was not sufficient for the cases to succeed.[11]

The Supreme Court also made specific reference to the scope of the duty owed by a medical practitioner, and whether a doctor owes an extended duty to the family of a patient:

> *We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. To impose such a responsibility on hospitals and doctors would go beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role.*[12]

The conclusion was that claims for compensation for pure mental harm, or "nervous shock" claims have no place in clinical negligence cases (subject to exceptions that may arise on the individual facts of each matter).[13] The Supreme Court held that a secondary victim must be present at the scene of an accident or its immediate aftermath to be entitled to damages for nervous shock.

The UK perspective

The UK's position on claims for psychiatric illness has evolved through the common law through three primary cases. There is no specific statute.

In the case of *McLoughlin v O'Brian*,[14] the claimant witnessed the injuries caused to her family members shortly after a road accident. The claimant immediately went to the hospital upon learning about the accident to discover that her daughter was dead, and her husband and other children were injured and in distress. As a result of shock, the claimant suffered physical and psychological injuries that included but not limied to loss of voice, depression and lapse of memory. The House of Lords held that she was entitled to recover damages while acknowledging

the potential counter policy arguments that may exist, including the profilitera-tion of claims (including fraudulent claims), greater evidentiary burdens thereby extending litigation and the extension of defendants' liabilities that ought to be made by the legislature. Lord Wilberforce set out control mechanisms to be considered to mitigate those risks.[15] These are the following:[16]

- The class of persons whose claims should be recognised (those involving less close relation-ships than family ties should be carefully scrutinised because the defendant cannot be expected to compensate the world at large).
- The promiximity of such persons (it is reasonably foreseeable that shock can be caused not only through sight or hearing of the event, but of its immediate aftermath).
- The means by which their injury was caused (must come through sight or hearing of the event and not communication by a third party).

These elements were considered in depth in *Alcock v Chief Constable of South Yorkshire Police*[17] (**Alcock**), where 95 people died and 400 more injured as a result of overcrowding in the Hillsborough Football Stadium. All claimants had relatives who were killed in the accident, and were either present at the ground, saw the accident unfold on television, or went to the mortuary to identify the body of their relative. The claimants were mostly secondary victims who were "no more than the passive and unwilling witness of injury caused to others", in contrast to primary victims who were directly affected.[18] The House of Lords expanded on the control mecha-nisms set out above by Lord Wilberforce, namely that for a plaintiff to claim damages for nervous shock resulting in psychatric illness:[19]

- it must be reasonably foreseeable that a person of "normal fortitude" or "ordinary phlegm" might suffer psychiatric injury by shock. There must also be a recognised psychiatric injury suffered;
- there must be a close tie of love and affection between the plaintiff and the victim (the case of a bystander unconnected with the victim would be difficult to establish. Family ties would also not automatically satisfy this condition (eg, "brotherly love is well known to differ widely — from Cain and Abel to David and Jonathan");
- the plaintiff must have been present at the accident or its immediate aftermath (proximity cannot exist where immediacy, closeness of time and space, and direct visual or aural perception are absent —eg, viewing the television scenes did not create the necessary degree of proximity); and
- the psychiatric injury must have been caused by direct perception of the accident or its immediate aftermath and not by hearing about it from some-body else.

In *White v Chief Constable of South Yorkshire*,[20] a claim where police officers sued their employer for psychiatric illness for their involvement in the aftermath of the Hillsborough disaster, the requirements set out in *Alcock* were applied, and as none of the police officers had a close tie of love and affection with the victims injured or killed.[21]

The House of Lords rejected their argument that they were "primary" victims because they were first respond-ers trained to deal with catastrophic incidents, reinforc-ing the position that was set out in *Paul* that:

> *. . . the inability of bystanders to recover damages even where they suffer foreseeable harm (of any kind) is a consequence of the general rule that the law does not grant remedies for the effects — whether psychological, physical or financial — of the death or injury of another person.*[22]

The Australian perspective

In 2002, there was considerable concern in relation to personal injury damages and the subsequent effect on insurance premiums, particularly in the medical indem-nity sphere. The federal, state and territory governments commissioned the Negligence Review Panel, Chaired by the Hon Justice David Andrew Ipp.[23]

At the time the reforms were being considered, two pure mental harm cases were before the High Court.

Western Australia — Tame v New South Wales; Annetts v Australian Stations Pty Ltd

The High Court of Australia held that a plaintiff claiming for pure psychiatric injury does not need to prove that they were a person of normal fortitude. However, their mental fortitude is still relevant to whether it was reasonably foreseeable that the distress-ing event would cause a psychiatric illness.[24]

Ms Tame suffered a psychiatric injury from discov-ering a police officer had recorded her blood alcohol level as 0.14 when that was actually the other driver's

result. The error was quickly corrected and never acted on. The court held that it was not reasonably foreseeable and her claim was dismissed.

In contrast, Mr and Mrs Annetts risk of psychiatric injury was held to be foreseeable. Their 16-year-old son, James, travelled to Western Australia to work as a jackeroo on the defendant's sheep station. Despite assur-ances to Mrs Annett, from the wife of the station manager that her son would not be unsupervised, James was sent to work alone on an outlying part of the property. This continued for some weeks until James and another teenager from a neighbouring station disap-peared. Nearly 5 months later, Mr Annetts was informed via telephone that the bodies of the two boys had been discovered in the desert. Mr Annetts identified his son's skeleton from a photograph.

The Annetts commenced proceedings in the Supreme Court of Western Australia. Hennan J held that psychi-atric injury was foreseeable but other duty requirements in psychiatric cases were not satisfied.[25] The Full Court dismissed the appeal disagreeing with Hennan J holding that such an injury was not foreseeable.[26]

When the plaintiffs sought special leave to appeal to the High Court, it was ordered that the application be heard by the Full Court at the same time as the hearing in *Tame v New South Wales; Annetts v Australian Stations Pty Ltd* (**Tame**).[27]

Five of the seven judges in the High Court held that neither direct perception nor sudden shock could be supported as limitations on the scope of reasonale foreseeability. This effectively opened the door to the defendants owing a duty of care to Mr and Mrs Annetts because there was a sufficient relationship between the parties, especially in light of the assurances given to Mrs Annetts, and because in the circumstances, psychi-atric injury was reasonably foreseeable.[28]

On sudden shock, Gleeson CJ said:

> *The process by which the applicants became aware of their son's disappearance, and then his death, was agonizingly protracted, rather than sudden. And the death by exhaustion and starvation of someone lost in the desert is not an "event" or "phenomenon" likely to have many witnesses. But a rigid distinction between psychiatric injury suffered by parents in those circumstances, and similar injury suffered by parents who see their son being run down by a motor car, is indefensible.*[29]

In relation to direct perception, Gaudron J said:

To treat those who directly perceive some distressing phenomenon or its aftermath and those identified in *Jaensch v Coffey* as the only persons who may recover for negligently caused psychiatric harm is, as Gummow and Kirby JJ point out, productive of anomalous and illogical consequences. More fundamentally, it is to limit the categories of possible claimants other than in conformity with the principle recognised in *Donoghue v Stevenson*, namely, that a duty of care is owed to those who should be in the contemplation of the person whose acts or omissions are in question as persons closely and directly affected by his or her acts.

Accordingly, the "direct perception rule" is not and cannot be determinative of those who may claim in negligence for pure psychiatric injury.[30]

Three weeks following the decision in *Tame*, the final Ipp report was submitted. The 2002 Civil Liability reforms did not alter the *Annette* principles in Western Australia, in that no restriction is placed on the nature of the relationship between the plaintiff and any person killed, injured or put in peril.[31]

Applicable state and territory statutes governing claims for pure mental harm are tabled below:

Elements	NSW	ACT	SA	TAS	VIC	WA
Applicable Legislation	Civil Liability Act 2002	Civil Law (Wrongs) Act 2002	Civil Liability Act 1936	Civil Liability Act 2002	Wrongs Act 1958	Civil Liability Act 2002
Claim for Pure Mental Harm	s 31	s 33	s 53(2)	s 31	s 23	s 5S(1)
Duty (Subject to tests of Foreseeability and Normal Fortitude)	s 32(1)	s 34(1)	s 33(1)	s 34(1)	s 72(1)	s 5S(1)
Requisite Relationship	s 30(2)(a): claimant witnessed the victim's harm or death; or (b) is a close family member of the victim	s 36(1)(a) a parent; or (b) a spouse; or (c) a person who is living in a de facto marriage relationship with; or (d) family member of, the victim, if the harm occurred within the sight or hearing of the family member	s 53(1)(a): claimant was physically injured; or witnessed the event (b) is a parent, spouse or child of the victim	s 32(2)(a): claimant witnessed the victim's harm or death or immediate aftermath; or (b) is a close family member of the victim.	s 73(2)(a): claimant witnessed the victim's harm or death; or (b) the claimant is or was in a close relationship (not defined) with the victim	No restrictions on the basis of relationship.
Element of "sudden shock"	s 32(2)(a)	s 34(2)(a)	s 33(2)(i)	s 34(2)(a)	s 72(2)(a)	s 5S(2)(a)
Witness at Scene or Aftermath	s 32(2)(b) NB: aftermath not included	s 34(2)(b) NB: aftermath not included	s 33(2)(ii) NB: aftermath not included	s 32(2)	s 72(2)(b) NB: aftermath not included	s 5S(2)(b) NB: aftermath not included
Pre-existing relationship and nature of same	ss 32(2)(d) and (c)	ss 34(2)(d) and (c)	ss 33(2)(iii) and (iv)	ss 34(2)(b) and 32(3)	ss 72(2)(c) and (d)	ss 5S(2)(c) and (d)

Queensland and the Northern Territory have not codified specific provisions relating to mental harm in their respective civil liability statutes.

Australian Capital Territory — Skea v NRMA Insurance Ltd

In 2005, Ms Skea advanced a pure mental harm case after she attended the scene of a motor vehicle accident in which her husband and her two children were seriously injured. She suffered PTSD amongst other psychiatric conditions. Subsequent to the accident, Ms Skea claimed damages arising out of her perception of the aftermath of the accident, which included subsequent are for her tortiously injured husband and daughter, claim-ing that her role as a carer had aggravated her initial injury.[32]

The ACT Court of Appeal held that:

> *A person is not entitled to damages from a tortfeasor if that person suffers a psychiatric illness by reason of that person caring for a person who has been injured by reason of the tortfeasor's negligence.*[33]

However, where the distressing experience causes a psychiatric injury, and that injury is then exacerbated by having to care for an injured family member, the additional exacerbation will be compensable if:[34]

- it was a reasonably foreseeable consequence of the original injury and not a novus actus interveniens (meaning independent, or not caused by, interven-ing act); or
- the extent of the injury caused by the initial distressing experience and the caring for the injured family member cannot be disentangled (the defen-dant bears the onus of proof to disentangle the damage).

The Court stated that, whilst it was clear that the accident and its aftermath had a devastating effect on Ms Skea, her compensable injury must be limited to the direct consequence of observing the scene of the acci-dent and its immediate consequences, and not the ongoing impact of the care provided to her family.

In NSW, the position is that damages cannot be recovered for pure mental harm, arising from pure mental or nervous shock in connection with another person's death or injury, unless:

- the plaintiff witnessed, at the scene, the victim being killed, injured or put in peril, or the plaintiff is a close member of the family of the victim;[35]
- the plaintiff proves that they suffered a "recognised psychiatric illness";[36] and
- the defendant should have foreseen that a person of normal fortitude might, in the circumstances, suffer a recognised psychiatric illness if reason-able care was not taken.[37]

In NSW, witnessing the aftermath of an accident is in most circumstances insufficient for a claimant to recover damages for pure mental harm. However, the High Court of Australia found in *Wicks v State Rail Authority of New South Wales; Sheehan v State Rail Authority of New South Wales*[38] (**Wicks**) that "there are cases where death, or injury, or being put in peril takes place over an extended period, and this was such a case".[39]

Wicks is distinguishable from *Paul* on the facts, as *Wicks* involved a claimant witnessing the aftermath of an accident (which is consistent with the UK Supreme Court's reasoning above), as opposed to in *Paul*, where the claimants witnessed the aftermath or death of a person following the manifestation of an illness or disease, as a result of earlier clinical negligence.

In *Wicks*, two police officers sued the State Rail Authority alleging that as a result of their attendance at a train derailment in which seven passengers were killed. On their arrival, in the immediate aftermath of the incident, they were confronted with injured passengers, death and the wreckage of the train. They advanced through the wreckage to search and retrieve survivors—it is here that the Court found, inter alia, the survivors were "in peril" until they were rescued from the derailed carriages and removed from the danger that presented (therefore this occurred over an extended period of time).[40] Ultimately, the High Court unanimously held that Wicks and Sheehan were not prevented from pursuing damages for mental harm by the proximity limitations set out in s 30(2) of the Civil Liability Act 2002 (NSW) (CLA NSW), for their attendance at the effective aftermath of an accident. This is consistent with the UK perspective set out in *Paul*.

Frangie v South Western Sydney Local Health District t/as Liverpool Hospital

In the more recent case of *Frangie v South Western Sydney Local Health District t/as Liverpool Hospital*[41] (**Frangie**), Mr Frangie presented to Liverpool Hospital,(the Hospital) on 13 November 2016 with a severe heart attack. He was treated and managed, and subsequently discharged on 18 November. Three days later, Mr Frangie suffered another heart attack and died on 21 November. Dr Leung, staff specialist Hospital's Cardiology ward who treated Mr Frangie, accepted that, at the point of discharge, he had sustained significant damage to the heart muscle and had a high risk of mortality. The expert cardiologists were unable to definitively identify the reason as to why Mr Frangie experienced a sudden cardiac death on 3 days after discharge.

Four of Mr Frangie's family members commenced proceedings for nervous shock, including his former

wife, Jane, who found Mr Frangie sitting dead in the bathroom in the aftermath of his hospital treatment. The defendant submitted, amongst other things, that the plaintiffs were not entitled to damages as none of them actually saw Mr Frangie die, relying on the High Court's decision in *King v Philcox*.[42] That is, none of the plaintiffs had "witnessed" Mr Frangie being killed, but only saw the aftermath of the alleged negligence by the Hospital. His Honour, Abadee DCJ stated that there was no implicit requirement in NSW law that the plaintiffs were required to be witnesses at the scene of the Mr Frangie's death and it was sufficient that, as his close family members, they only saw the aftermath of his death.[43]

His Honour found that the plaintiffs were unable to establish that the Hospital breached its duty of care to Mr Frangie to avoid the risk of dying from Ventricular Fibrillation or Ventricular Tachycardia. With respect to causation, with respect to the three precautions the plaintiffs alleged the Hospital ought to have taken (use of a defibrillator vest, prescription of Eplerenone and performance of a cardiac MRI), his Honour found that none of these precautions, had they been pursued by the Hospital, would have altered Mr Frangie's outcome.

Despite Abadee DCJ finding that breach and causation were not established by the plaintiffs against the Hospital, he otherwise found that the Hospital would have owed a duty of care to all plaintiffs and that they each suffered a recognised psychiatric illness in accor-dance with ss 31 and 32 of the CLA NSW, had they been successful. His Honour was satisfied that it was reason-ably foreseeable that Mr Frangie's family members (persons of normal fortitude) in the circumstances of the Hospital treating Mr Frangie for a heart attack, then discharging him without clear prognosis being disclosed to his family members might suffer a recognised psy-chiatric illness if it did not apply reasonable care.[44] This reasoning suggests that nervous shock law could have taken a different path to what was determined in *Paul*.

In contrast with the conclusions in *Paul*, his Honour also provided the following commentary which is useful in relation to the application of s 32 in CLA NSW, and other similar provisions in other states and territories, for mental harm/nervous shock:

> . . . I note, for completeness, *that the circumstance that a close family member did not see the victim's death (or its aftermath) but was only told about it later did not bar liability for psychiatric illness in Gifford v Strang Patrick Stevedoring Pty Ltd (2003) 214 CLR 269* (especially per McHugh J at [46]–[51], 288–[89]); and see also *Kemp v Lyell McEwin Health Service* (2006) 96 SASR 192 at [18] [emphasis added].[45]
>
> Notwithstanding these features, I am satisfied that discov-ery of her late husband appearing dead in the bathroom was such as to be likely to have caused "sudden shock". This discovery was significant. She was not just informed about it. *It was the hospital's discharge of Mr Frangie which led to the situation where he was left in a position of vulner-ability if it had not acted with due care — the foreseeable and not insignificant risk of dying from VT or VF*. Those, like Jane and other close family members in close temporal proximity to the deceased, were themselves exposed to mental harm if that risk to Mr Frangie materialised. In that sense, Jane was exposed to direct perception of his death [emphasis added].[46]
>
> Section 32(2)(b) is not, by its terms, applicable to this case. That said, *for a close family member to see Mr Frangie dead in the bathroom (in the aftermath of hospital treat-ment) does not, in my view, materially mitigate against the risk of shock* [emphasis added].[47]
>
> Also, in relation to s 32(2)(c), although divorced for a long period, I am satisfied that Jane retained a very close and affectionate relationship to Mr Frangie. This consideration (applicable also to the other plaintiffs) is, as noted in *Gifford, a powerful indicia of a duty of care* [emphasis added].[48]

Had the plaintiffs in *Frangie* been successful in establishing breach and causation, it would seem that the door for secondary victims to recover damages where the negligence to the primary victim has occurred in a clinical context may have been wide open.

Conclusion

While the decision of the UK Supreme Court gives certainty to secondary victims in the UK in nervous shock claims, given the recency of the decision, it remains to be seen what influence, if any, the ruling may have on the spectrum of nervous shock provisions and future claims in Australian states and territories.

Nonetheless, the case of *Paul* may become relevant to legal practitioners and professionals alike in Australia when considering the scope of duties to secondary victims and questions of foreseeability in nervous shock claims. The question that remains in NSW and other jurisdictions with similar provisions, is one of foresight; not hindsight. Like all questions of reasonable foresee-ability it must be decided without the benefit of hind-sight, looking forward without knowledge of the precise circumstances in which the harm was inflicted, and as though the harm had not occurred.

1. *Paul v Royal Wolverhampton NHS Trust; Polmear v Royal Cornwall Hospitals NHS Trust; Purchase v Ahmed* [2024] UKSC 1 at [143].
2. Above.
3. Above n 1.
4. *P (a child, by her mother and litigation friend) v Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB).
5. *Paul v Royal Wolverhampton NHS Trust and other cases* (2022) 184 BMLR 20; [2022] EWCA Civ 12; [2022] PIQR P8;[2022] 2 WLR 917; [2022] WLR(D) 47; [2023] QB 149.
6. Above n 1.
7. *Taylor v A Novo (UK) Ltd* [2013] EWCA Civ 194.
8. Above n 1, at [20].
9. Above n 1, at [52].
10. Above n 1, at [53].
11. Above n 1, at [105].
12. Above n 1, at [138].
13. Above n 1, at [123].
14. *McLoughlin v O'Brian* [1983] 1 AC 410.
15. Above, at [419G] and [421H]–[422A].
16. Above n 15, at [421]–[423].
17. *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310.
18. Above, at [407].
19. Above n 17, at [411F–H]
20. *White v Chief Constable of South Yorkshire* [1999] 2 AC 455.
21. Above, at [496D–E].
22. Above n 1, at [48].
23. Treasury *Final Report of the Review of the Law of Negligence* Report (2002) https://treasury.gov.au/sites/default/files/2019-03/R2002-001_Law_Neg_Final.pdf.
24. *Tame v New South Wales; Annetts v Australian Stations Pty Ltd* (2002) 211 CLR 317; 76 ALJR 1348; [2002] HCA 35; BC200205111.
25. *Annetts v Australian Stations Pty Ltd* [2000] WASC 104; BC200002046.
26. *Annetts v Australian Stations Pty Ltd* [2000] WASCA 357; BC200007089.
27. Above n 24; *Annetts v Australian Stations Pty Ltd* P97/2000 [2001] HCATrans 223 (1 June 2001).
28. Above n 24, at 1355–56 per Gleeson CJ; at 1359–60 per Gaudron J; at 1390–91 per Gummow and Kirby JJ; and at 1403–04 per Hayne J.
29. Above n 24, at [36].
30. Above n 24, at [51].
31. Civil Liability Act 2002 (WA), s 5S(2)(c).
32. *Skea v NRMA Insurance Ltd* (2005) 43 MVR 495; [2005] ACTCA 9; BC200501425.
33. Above, at [111].
34. Above n 28, at [121]–[24].
35. Civil Liability Act 2002 (NSW) (NSW CLA), s 30.
36. Above, s 31.
37. Above n 34, s 32(1).
38. *Wicks v State Rail Authority of New South Wales; Sheehan v State Rail Authority of New South Wales* (2010) 241 CLR 60; 84 ALJR 497; [2010] HCA 22; BC201004005.
39. Above, at [44].
40. Above n 38, at [51].
41. *Frangie v South Western Sydney Local Health District t/as Liverpool Hospital* [2019] NSWDC 42; BC201940075.
42. *King v Philcox* (2015) 255 CLR 304; 320 ALR 398; [2015] HCA 19; BC201504903. This decision centred on the mental harm requirements of s 53(1)(a) of the Civil Liability Act 1936 (SA), which, as the High Court noted (at [25]) was analogous to but significantly different from s 30 of the NSW CLA.
43. Above n 41, at [113].
44. Above n 41, at [137].
45. Above n 41, at [101].
46. Above n 41, at [129].
47. Above n 41, at [130].
48. Above n 41, at [131].

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