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Sparkebeat

Australia's Legal Environment – Health Law Update

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IN THIS ISSUE

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INTRODUCTION

Welcome to the thirteenth 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.

PARENT OF THE NATION: COURT AUTHORISED MEDICAL TREATMENTS AGAINST THE WISHES AND CONSENT OF A CHILD

Authors: Partner Marie-Clare Elder
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Introduction

The recent ex tempore decision of the Supreme Court of NSW (the **Court**) in *H v RJ*[1] explored the Court's approach to its parens patriae jurisdiction and the balancing of competing interests between a medical practitioner and a minor who refused consent for potentially life-saving treatment, in the unlikely event that it was required during surgery.

This article provides a summary of the facts of the case, reasoning of the Court, and considers the ethical dilemmas relating to the court's approach to such matters.

Issue

In this case, RJ, the minor, withheld his consent to any blood transfusion during surgery due to religious reasons. The Court was required to evaluate the proposed surgical plan of RJ's treating clinician and the potential complications which might arise within. The Court also considered the religious wishes of RJ, who would not provide consent to a blood transfusion should it be required. RJ was at the time 16 years old, and his parents were also in opposition to a blood transfusion due to their faith.

Background

RJ suffered from a congenital arrhythmogenic right ventricular cardiomyopathy for which treatment required insertion of an implantable cardioverter defibrillator to assist with normal heart rhythm function. The performance of such a procedure carried a rare, but very real risk of an internal bleed. Should the complication arise, a blood transfusion would be indicated in order to prevent serious injury or death. The performance of the blood transfusion itself would carry very little risk to the patient but would be lifesaving in the event that it was needed.

It should be noted that this case is slightly different from some cases found within this jurisdiction where a blood transfusion may be required immediately during emergency surgery, as the patient is bleeding out in the operating theatre and consent has been withheld by a parent. Here, the surgery was planned but nonetheless urgent, as such there was more time for consideration (and for an application to be made in advance of the surgery occurring). As such, the Hospital where the surgery was to be performed (the **Hospital**), sought a declaration from the Court that they may continue with the surgical plan, and provide treatment as and when required, i.e., regardless of RJ's refusal and that of his parents to consent to a blood transfusion if needed.

The Hospital sought a declaration and orders from the Court that:

- in the absence of RJ's consent, the Hospital was authorised to order that any qualified member of Hospital staff, nursing or medical (employed or contracted), administer blood transfusion treatment to RJ during surgery if in the opinion of the authorised clinician, the transfusion was necessary, and that in forming such an opinion, the clinician avoid unnecessary use of, and minimises where possible the use of, the transfusion procedure
- if the authorised clinician was not available, the authorised clinician should instead be a medical practitioner from the Hospital, provided that the replacement clinician had read the Court's orders, and

[1] *H v RJ* [2024] NSWSC 1404; BC202415813.

- for completeness, it be recorded that, transfusion of blood, or blood products, and a reinfusion of RJ's own blood, and treatment ancillary to this, be referred to as the "blood transfusion procedures".[2]

Evidence

RJ's treating practitioner, a paediatric congenital heart surgeon, gave evidence in cross examination that the risk of suffering a bleed was low, but that it can, and does, happen from time to time. Further, not every situation where a bleed occurs would require a transfusion, but in some instances, it would be required. Finally, whether a blood transfusion was required was a matter of clinical judgement and the risks associated with performing a transfusion were low.[3]

His Honour Hammerschlag CJ considered the affidavit of RJ and his parents (who provided written submissions by way of affidavit) in determining the application. RJ was considered to be of an intelligence and understanding commensurate with his age with respect to the surgery and its consequences.[4] Hammerschlag CJ also considered the comprehensive clinical psychology report served in the proceedings which set out that RJ was not yet at a level where he could function autonomously or independently specifically within the area of medical decision-making, albeit that he was otherwise regarded as being of a "good age appropriate maturity".[5]

Case law

The role of the Court in such an application, where it is determined that the young person does not have the necessary decision-making capacity, is to exercise an independent and objective judgment in its parens patriae jurisdiction, to balance the advantages or disadvantages of the medical procedure under consideration: *Department of Health and Community Services (NT) v JWB and SMB (Marion's case);*[6] *Director-General, Department of Community Services; Re Jules;*[7] *and Sydney Children's Hospital Network v X*.[8]

Hammerschlag CJ, with reference to the relevant authorities dealing with the exercise of the parens patriae jurisdiction, such as X v *the Sydney Children's Hospital Network*[9] (**X**) and *H v AC*,[10] considered that the overriding consideration was the safety and wellbeing of the minor. Whilst giving "due weight" to the beliefs of RJ's parents as well as RJ's "own level of autonomy",[11] the Court was persuaded to exercise its jurisdiction to override the religious wishes of RJ and his parents.

His Honour observed that there was a real likelihood that a transfusion would not be required in the course of surgery (as the risk of a complication requiring blood was low), and as a result, it was "unlikely that there will be non-observance of the tenets of their faith".[12] However, in the event that there was a complication "those wishes . . . must be overridden, his safety and wellbeing are paramount".[13]

In the case of X, his Honour Gzell J ordered the hospital to be allowed to carry out a blood transfusion on X, a 17-year-old suffering from Hodgkin's disease who had refused the transfusion on religious grounds. His treating practitioners believed there was an 80% chance of X dying from anaemia in the absence of the treatment. Justice Gzell stated: "The sanctity of life in the end is a more powerful reason for me to make the orders than is respect for the dignity of the individual."[14]

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2 Above, at [9].

3 Above n 1, at [10].

4 Above n 1, at [12].

5 Above n 1, at [13].

6 *Department of Health and Community Services* (NT) v *JWB and SMB* (Marion's case) (1992) 175 CLR 218 at 240.

7 *Re Director-General, Department of Community Services; Jules* (2008) 40 Fam LR 122; [2008] NSWSC 1193; BC200809861.

8 *Sydney Children's Hospital Network v X* (2013) 49 Fam LR 330; [2013] NSWSC 368; BC201301868.

9 *X v Sydney Children's Hospital Network* (2013) 85 NSWLR 294; 304 ALR 517; [2013] NSWCA 320; BC201313311.

10 *H v AC* [2024] NSWSC 40; BC202400791 per Meek J.

11 Above n 1, at [15].

12 Above n 1, at [16].

13 Above n 1, at [17].

14 Above n 9, at [54].

Whilst X appealed the decision, the Court of Appeal upheld the Supreme Court's assessment of the situation, in that exercising the parens patriae jurisdiction "the court must act cautiously"[15] and be "judicially satisfied that the welfare of the child requires that the parental right should suspended or superseded".[16]

In the more recent case of *H v AC*, Meek J authorised the resumption of AC's chemotherapy treatment for her Ewing sarcoma on 2 February 2024, about four months after AC had declined further treatment, as AC had believed that God had healed her, and she no longer had cancer.[17] In this matter, Meek J considered AC's competence, including her maturity and ability to reflect on her medical treatment as well as consider her prospects. It was held that for her ability to make decisions regarding refusal to consent to the recommended treatment, or the continuation of that treatment, that she was "*Gillick competent*".[18]

In the case of RJ, whilst assessing the competency of RJ, his Honour did not do so with explicit reference to the *Gillick* competence of RJ. Rather, his Honour relied on the decision of Parker J in *Hunter New England Local District v C*[19] where the interplay between the exercise of the parens patriae jurisdiction and the *Children and Young Persons (Care and Protection) Act* 1998 (NSW) (the **Act**) was considered.

> *Section 174 of the Act states:*
>
> *174 Emergency medical treatment*
>
> 1. *A medical practitioner may carry out medical treatment on a child or young person without the consent of—*
>   a. *the child or young person, or*
>   b. *a parent of the child or young person, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health.*

Section 174 operates so that a medical practitioner may carry out medical treatment on an adolescent without their consent, or the consent of their parents, when the medical practitioner is of the opinion that treatment is necessary, as a matter of urgency required to save their life or prevent serious damage to their health. His Honour, agreeing with the decision of Parker J in C, concluded that s 174 of that Act did not limit the Court's powers under the parens patriae jurisdiction. Rather, s 174 could be taken into account whenever a Court is asked to make an order under its parens patriae jurisdiction, and that an order was to give "complete certainty" to a practitioner to proceed in administering medical treatment to a minor without any concern that action might be taken against them, albeit that the making of an application imposes costs on all parties and might prove to be a distraction if it is sought on the basis of a contingency which may not eventuate.[20]

His Honour commented that s 174 of the Act provided a defence to a doctor who acts when they believe it is necessary to do so as a matter of urgency. Whilst reliance may be had on s 174 of the Act, Hammerschlag CJ stated such reliance was irrelevant in the circumstances of the present case. On a pragmatic view, a practitioner should not have to wait to be sued to advance a defence under s 174, and then await the subsequent outcome. Rather a trustee, or Hospital, may seek the opinion of the Court in advance without having to wait and see whether legal proceedings will commence. As such, the Court's parens patriae jurisdiction was not considered to be limited by the operation of s 174.

Another practical issue that arose during the evidentiary process was that it would be uncommon and unnecessarily risky for a surgeon to wait for the moment until a patient requires blood to save them from harm before administering a transfusion. This issue was supported by unchallenged evidence from the Hospital, from a specialist in paediatric surgery, oncology and thoracic surgery.[21] Hammerschlag CJ held that it was not in a patient's best interests to allow their condition to deteriorate to a point of urgency before the administration of blood products, and to then rely on the s 174 defence under the Act.

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15 Above n 9, at [2].

16 Above n 9, at [2].

17 Above n 10, at [118] and [122]–[23].

18 Above n 10, at [228].

19 *Hunter New England Local District v C [2024] NSWSC 929; BC202410342*.

20 Above n 1, at [20].

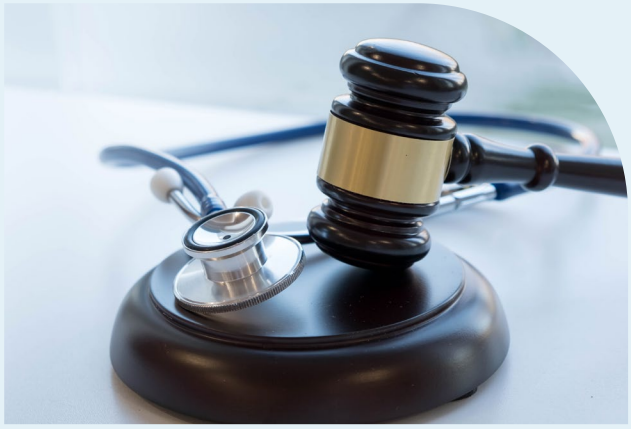
21 Above n 1, at [24].

Whilst Hammerschlag CJ did not canvas that full extent of the case law due to the urgency of the matters before him; relying on precedent, he assessed and considered the available clinical psychology report, the "compelling observations" of RJ's treating practitioner, the wishes of RJ and his parents, and then exercised jurisdiction to override the wishes of RJ and his parents.

The case law indicates that capacity and competence are relevant determiners in assessing whether a minor can refuse treatment but more importantly is the consideration of the outcome to the minor if treatment is not provided when required. Factors such as the probability of the treatment being required, the impact which it will have (such as being lifesaving) are also factors weighed by the Court in its determination. Naturally, where death is assured without medical intervention the Court will be persuaded to making a decision consistent with the preservation of life.

This is what seems to be clear from the decision in *H v RJ*. Hammerschlag CJ explained that the risk of an adverse event would be low, and the need for blood only arises if that risk eventuates, and even then, RJ may not require a transfusion. It is then unlikely that the wishes of RJ and his parents would need to be overridden. That said, should that situation arise, then those wishes must be overridden as the safety and wellbeing of RJ was the most "paramount" concern. Similarly, whilst blood transfusion may have been unlikely, the upside of the treatment would be that RJ's life would be saved.[22]

Ultimately, his Honour found in favour of the Hospital and issued a declaration that: "The medical practitioners may administer a blood transfusion to RJ if they are of the opinion that a blood transfusion is necessary".



[22] Above.

Balancing consent

This case displays the tendency of courts, when exercising their parens patriae jurisdiction, to permit clinicians to be authorised in their use of lifesaving treatment against the wishes of a patient who is a minor (or those of their parents). Whilst there is due consideration to those wishes, the fundamental consideration will be the minor's competency. This competency assessment is based on the minor's understanding of the medical information before them and the potential consequences. Given the often-complex nature of surgical treatments, and the stark knowledge gap between a minor and medical practitioner, the minor is foreseeably unlikely to display a level of competency allowing them to refuse treatment at risk to themselves.

The practical effect is that, despite refusing treatment, the Court may make a determination allowing for treatment despite that refusal. The parens patriae jurisdiction is solely concerned with the Court's determination as to the best interests of the minor. This determination is logically guided by the expert health care providers and arguably, the expectations of society.

As in the case of RJ, religious belief, and potential shunning by their entire community, was not enough to sway the courts. RJ was determined by the Court to present as intelligent, possessing understanding commensurate with his age. Despite this, the unchallenged medical evidence available to the Court from the Hospital (i.e., the findings of the clinical psychology report and the subject nature of the surgical material to be considered in this instant case) set out that RJ did not have the requisite competency to make life or death decisions relating to the proposed surgery. That is, he was not *Gillick* competent.

If RJ's wishes were to be accepted, RJ would be required to make a reasonable assessment of the advantages and disadvantages of the treatment proposal, and the potential consequences of refusal, which it was determined he could not.

The position becomes ever more complex as the adolescent approaches the age of majority and their competency increases commensurate with age. For a young child, or a child with limited capacity for decision-making, the conversation more readily turns to a decision being made in the minor's best interests. However, hypothetically, an interesting problem emerges when a highly competent minor, close to the age of maturity, presents and refuses treatment.

The unanswered question remains as to what level of understanding and competency is required for a minor to meet the threshold allowing them to refuse treatment.

The general presumption of the courts seems to be that minors are not competent to refuse medical treatment, especially in the context when refusing treatment could result in death. Interestingly, in many matters where a minor seeks, or consents to treatment, where risks may be associated albeit unlikely, then the minor will not face push-back from the courts or clinical staff (say by a parent such as the case was in *Gillick*). The result is that where treatment is sought, competency is seemingly not assessed to such a stringent degree, as opposed to a refusal of consent to treatment where a minor's competency is scrutinised. This creates an interesting jurisprudential problem in that a minor may easily seek, but not so easily refuse treatment. It would be interesting to consider this in the reverse in the determination of a case whereby a minor consents to a moderate to high-risk, lifesaving treatment, when a parent or similar were in opposition.

Conclusion

The decision in *H v RJ* highlights the tendency of the Court to favour the maintenance of the minor's life over the minor's own wishes. Whilst there is consideration of the competence and maturity of the minor, set against the context of complex medicine, the minor's competency for decision-making is almost by default reduced to the court exercising its jurisdiction to make the determination for the minor.

Even if a minor were *Gillick* competent to consent in one area of medicine, they may not be competent in a more complex area of medicine. It appears that the greater and more complex the proposed medical treatment, and the greater the risks associated with that treatment, or refusal of treatment, the greater the competency expected by the Court to be demonstrated by the minor—that is, to meet the threshold of *Gillick* competence.

Ultimately in these cases, a minor's right to refuse medical treatment is displaced by an assessment of their competency as framed in the context of their understanding complex medical issues. Whilst jurisprudentially on one view this position can be viewed as limiting toward a minor. It would seem many adults would not meet the same bar, but would by virtue of their age and capacity, be able to refuse treatment. Pragmatically, enabling a minor to allow a risk of harm to arise on account of their own decision-making (in the context of the provision of healthcare) would be unlikely to fit within the moral expectations of society. Especially when, as in *H v RJ*, the basis for refusal relies on the specific beliefs of one subsect of the community. As such, in the absence of genuine and a medically supported reason to refuse treatment, a court is likely to be persuaded toward allowing treatment to proceed.

In an application concerning treatment of a minor, the Court's focus is on the party prosecuting such an application being able to establish that the treatment must be carried out as a matter of urgency to save a patient's life or prevent serious damage to their health. After all, health is a matter of public policy; and public policy has an impact on the law.

Note: This article was first published in Lexis Nexis Australian Health Law Bulletin, 2025. Vol 33 No 1 (February 2025)

COSMETIC INJECTABLES: QUEENSLAND REGULATIONS

Author: Partner Mark Sainsbury

The cosmetic injectables and beauty therapy industry has come under increasing scrutiny from both the media and regulators in recent years.

The primary aim of increased regulatory oversight is to provide greater confidence to the public and to ensure an increased level of safety for consumers.

Along those lines, Queensland Health recently issued a factsheet (**factsheet**) entitled "Medicines in beauty treatment/cosmetic businesses (*Medicine and Poisons Act* 2019 – December 2024)".

The factsheet is intended to provide clarification and guidance to businesses performing treatment involving cosmetic injectables. It also outlines some of the requirements under the *Medicine and Poisons Act* 2019 (**Act**) and *Poisons (Medicines) Regulation* 2021 (**Regulations**) with respect to the following categories:

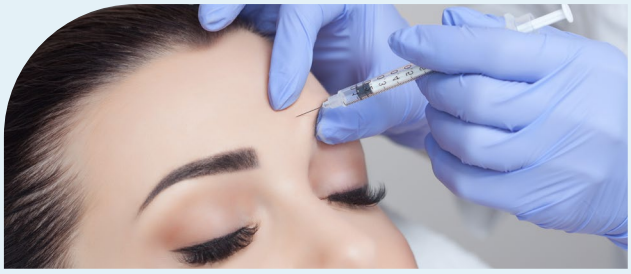
- Authorisation for prescribing and administering S4 cosmetic injectables
- Standing orders for the administration of cosmetic injectables
- Buying S4 cosmetic injectables
- Supplying S4 cosmetic injectables
- Storage of S4 medicines including cosmetic injectables
- Advertising of S4 cosmetic injectables
- Buying and administering S2 and S3 medicines
- Infection control requirements.

The factsheet has caused discussion as well as some concern within the cosmetic injectables industry because the commentary arguably provides a strict interpretation of certain sections in the Act and Regulations and perhaps (by implication) indicates that an increased level of auditing and/or enforcement may follow.

Of particular concern to the industry is the comments surrounding the buying of S4 cosmetic injectables, which states that it is unlawful for registered nurses, enrolled nurses, admin staff or other unauthorised persons to buy cosmetic injectables for a beauty treatment/cosmetic business, even "on behalf of" or "with the approval of" a doctor or nurse practitioner.

This means that the type of persons listed above cannot simply place a purchase order with a medicine wholesaler or pharmacist for the supply of S4 medicines. Further, doctors and nurse practitioners that are able to purchase such medicines cannot do so if they do not work for the beauty treatment or cosmetic business. Therefore, the S4 medicines can only be purchased on behalf of the business by a medical practitioner or nurse practitioner **working for the business**.

Further, the medicines purchased on behalf of the business must then be delivered to a place where the authorised buyer is physically practising from. This means doctors and nurse practitioners who are authorised to buy S4 cosmetic injectables cannot buy stock for a place that they do not practice from, including locations for which telehealth services are provided.



In practical terms, this may have a significant impact upon cosmetic injectable businesses and practitioners who rely on telehealth services from doctors for the prescription of such medication.

The factsheet also confirms that Standing Orders for prescription and administration of S4 medications cannot be provided by medical or nurse practitioners, for the administration of cosmetic injectables to patients by registered nurses in a beauty treatment or cosmetic business. Again, this may add further logistical burdens and costs to businesses.

The factsheet reiterates the strict requirements around the prescription or such medicines and confirm that the prescribing person such as a doctor must assess the intended medicine to be reasonably necessary for the therapeutic treatment of the patient. This means that the practitioner must assess each individual patient to determine therapeutic medicine requirements for that patient.

Finally, the factsheet reminds practitioners about their obligations in relation to infection control and in particular, practitioners undertaking personal appearance service (i.e., in-home treatments) are referred to the Queensland Health guidelines for these services. This separate factsheet confirms that all personal appearance service providers must meet the following obligations:

- business owners must meet the licensing requirements set out in the P*ublic Health (Infection Control for Personal Appearance Services) Act* 2003 (Qld).
- The person providing the service must hold the infection control qualification specified in the *Public Health (Infection Control for Personal Appearance Services) Regulation* 2003.

Some cosmetic businesses have expressed significant concerns around the commentary in the factsheet and what it will mean for businesses in a practical sense. Further, they have concerns of how the requirements will be assessed, audited, and enforced.

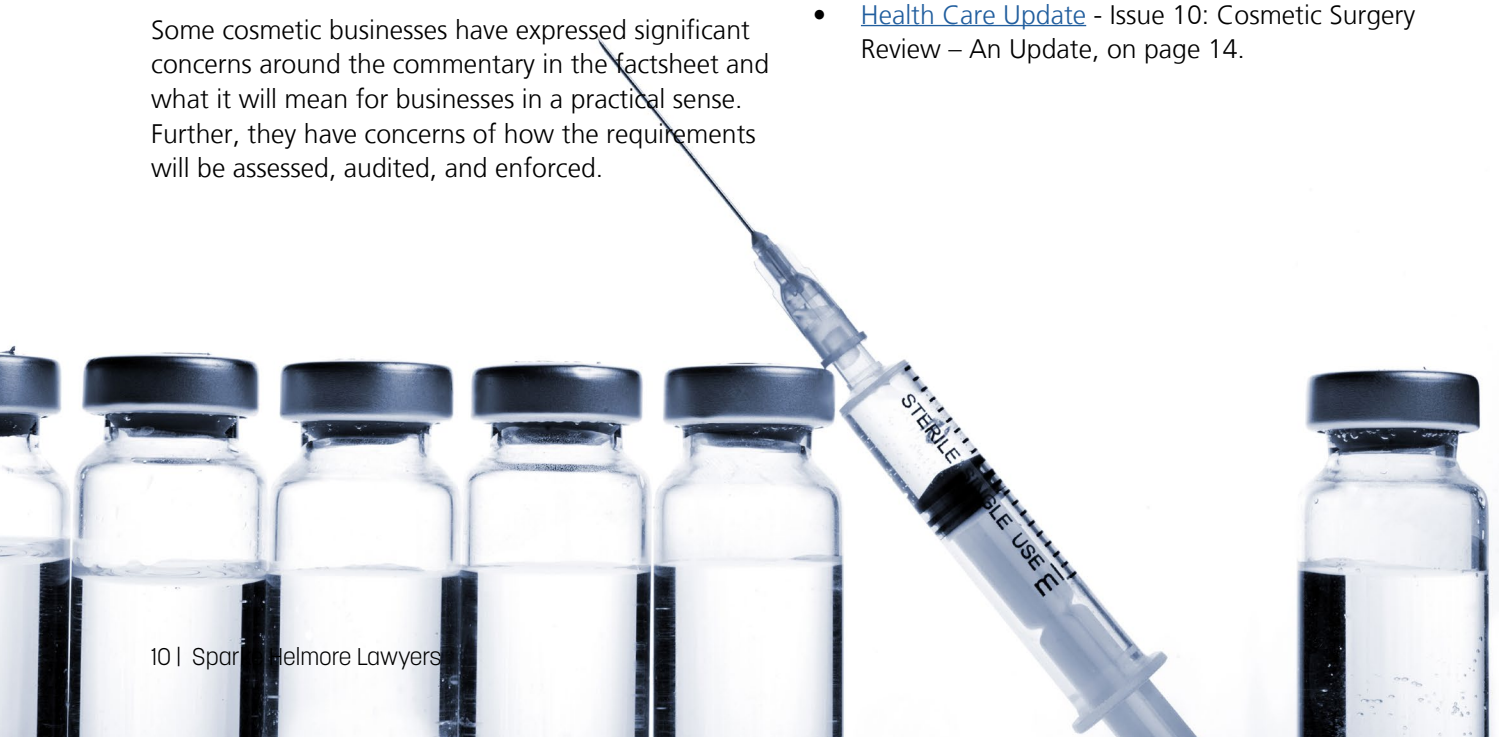
We note that the Cosmetic Physicians College Australia (**CPCA**) issued a release in response to the factsheet welcoming the clarification of the Regulations in Queensland. The CPCA media release also refers to a recent tragic event of three individuals being hospitalised with botulism allegedly due to the use of an unregulated product. The CPCA appears to be using this adverse event as an example of an outcome that can occur when S4 medications are not properly prescribed, purchased, administered, and/or stored, which is the main topic of focus in the factsheet.

The CPCA confirms that it welcomes such statements from regulators that provide clarity on guidelines, regulations and laws and it urges all members to review the Queensland Health factsheet and applicable Regulations to ensure they are complying with them.

It remains to be seen exactly how businesses and other regulators might respond to the guidelines set out in the factsheet and whether Queensland Health seeks to implement any kind of auditing and enforcement regime for these guidelines. However, this is clearly an area of practice that will continue to be scrutinised and regulated and therefore all operators within the industry (including their insurers) need to keep abreast of these changes and the implications for them.

Please see Sparke Helmore's articles from a past Health Care issue covering the increased scrutiny that the cosmetics and beauty therapy industry have come under from the media and from regulators.

- Health Care Update - Issue 10: Cosmetic Procedures: Influencers, Trends and A Snapshot of The Latest Developments in Australia and Abroad, on page 4.
- Health Care Update - Issue 10: Cosmetic Surgery Review – An Update, on page 14.



INTERVIEW WITH A CORONER: HMC NADIA PERSAUD

Author: Partner Marie-Clare Elder

During her recent visit to the United Kingdom, Marie-Clare Elder (MCE) was fortunate to have the opportunity to interview His Majesty's Coroner, Nadia Persaud (HMC), who serves as the Area Coroner for East London.

HMC Persaud has been a qualified solicitor since 1995 and holds a Master's degree in Medical Law and Ethics from King's College London. She was initially appointed as a part-time assistant coroner in 2009 and transitioned to a full-time coroner in Jan 2014.

Australia's coronial system was received from English law when the Colony was established in New South Wales. Each Australian state and territory has its own legislation governing the powers and duties of coroners, with minor variations in powers and procedures.

While the Australian Acts are based on UK legislation, there are notable differences, which we explore with Nadia below.

MCE: Can you tell us about your health law experience prior to being appointed as a Coroner?

HMC: I qualified as a solicitor in 1995. From the outset, I practised healthcare law for NHS trusts and other health/social care related organisations. For the first seven years, I had a mixed caseload of medical negligence claims and inquest cases. I then moved over to pure medical law, with a caseload of court of protection (primarily related to best interest decisions); judicial review (allocation of healthcare resources and human rights challenges), and inquest cases. My last few years in private practice were spent heading up the inquest advocacy team.

Can you tell us what types of deaths you are investigating in the health space?

As a coroner, sadly a large proportion of my work relates to the delivery of healthcare. There are a wide range of cases, but the most common are:

- Secondary care[1]
- Deep Vein Thrombosis (**DVT**) and Pulmonary Embolisms – whether the Venous thromboembolism (**VTE**)[2] risk was adequately assessed and adequately managed
- Delay in diagnosing and treating sepsis
- Surgery related or post operative management
- Medication prescribing and administration errors
- Failure to diagnose conditions, such as aortic aneurysms[3]

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1 Secondary care occurs when your primary care provider, such as a General Practitioner, refers you to a specialist practitioner for further management or treatment.

2 VTE is a condition that occurs when a blood clot forms in a vein, and includes DVT (occurring in the leg) and PE (occurring in the lung).

3 An enlargement or bulges that occur in the aorta, which dissects or ruptures and causes sudden and severe pain

In primary care, we often hear cases relating to failure to diagnose, or adequately consider red flags and signpost, or set robust safety nets.

Failures to adequately address physical healthcare whilst patients are detained in mental health hospitals including suicides whilst an in-patient or under community mental healthcare teams are also commonly seen.

In the care home setting, falls and choking are the most common.

Alarmingly, suicide is the leading cause of death among Australians aged 15-24 years[i] Is this mirrored in the UK? If so, what have been your recommendations?

I believe that accidents may be responsible for the highest percentage of deaths in that age range in the UK. However, suicide is the second highest cause.

Coroners in the UK are not permitted to make recommendations, but we have a duty to raise concerns if the evidence at an inquest raises a risk of future deaths and the coroner believes that action can be taken to reduce the risk.

The sorts of concerns that I have raised relating to suicides in this age group are:

Lack of resources within the child and adolescent mental health setting. The number of children and adolescents presenting to mental health services has hugely increased over the last 10 years. As you can imagine, the level of staffing has not similarly risen to address the need.

Concerns relating to the quality of mental health risk assessment and risk management.

Concerns about the communication between agencies about risk – and also communication with families/carers.

Concerns about the ease of access to harmful substances by young people, such as dinitrophenol (DNP).

What was your experience during COVID-19, and have you seen any emerging trends following the pandemic?

The greatest impact that COVID-19 had on inquests for my coroner area is the introduction of remote hearings. When we started these hearings in March 2020, I thought that families would object to this on the basis that they are not having their "day in court". To the contrary, my experience has been that families often request attendance by video link. It is a more comfortable setting for them. I believe that families participate more effectively when they are in their own surroundings rather than within an austere court room filled with lawyers who are familiar with the process. We continue to hear some inquests by video link. The decision is made on a case-by-case basis. It can sometimes be difficult to maintain the necessary gravitas of the court when hearings are held remotely. Inquests with a jury always require key witnesses to attend court in person.

In my experience, I have heard relatively few COVID-19 healthcare inquests. I thought that we might have inquests where staff or patients developed COVID-19 in hospital, with concerns raised about the standards of hospital infection control. These did not materialise in my area.

I have heard an inquest relating to the rare VTE risk associated with a certain COVID-19 vaccine. I believe the particular vaccine has been withdrawn globally.

Unlike Australia, in the United Kingdom, coroners must hold an inquest before a jury in certain circumstances but equally, if the senior coroner thinks that there is sufficient reason for doing so.[4] What is your experience of juries in an inquest, and can you recall a health/hospital matter which was before a jury?

Since the *Coroners and Justice Act 2009* (UK) came into force (from July 2013), a significant change relating to the need for juries in healthcare related cases occurred. Subject to the senior coroner, there is a need for an inquest to be held with a jury when a person dies an unnatural cause of death, whilst detained under the *Mental Health Act 1983* (UK) (**MH Act**). The definition of state detention was expanded to include detention under the MH Act. So, now, all in-patient suicide deaths are heard with a jury.

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4 *Coroners and Justice Act* 2009, section 7

Other than where a patient is detained under the MH Act, it is now rare to have a hospital death inquest with a jury. Coroners can apply their discretion to call a jury if there is "*sufficient reason*" to do so. In my experience, discretion to call a jury is rarely used in a general hospital case.

The previous legislation contained a provision to hold an inquest with a jury where the death could affect public safety. This was often used to argue for a jury in hospital cases. This provision was not repeated in the *Coroners and Justice Act 2009*.

In the United Kingdom, coroners may deliver short form 'determinations' of accident/ misadventure, unlawful killing, or natural causes. It may be alarming to our readers that coroners in the past, have determined that a hospital death be recorded as 'unlawful killing'. Can you give us some examples?

There was a very well-known case of Mayra Cabrera who died as a result of a medication administration error following delivery of her baby. Bupivacaine was attached to her drip instead of the correct intravenous fluids. This inquest was pre-reform (of the *Coroners and Justice Act 2009*) and took place with a jury in 2008. This was a rare case indeed, and I am not personally aware of any other unlawful killing verdicts before the Supreme Court decision in the case of *Maughan*.[5]

The Supreme Court decision in *Maughan* (November 2020), reduced the standard of proof for every inquest conclusion to the balance of probabilities. Before the Supreme Court decision, it was necessary for the coroner or jury to be satisfied beyond reasonable doubt before returning a conclusion of suicide or unlawful killing. Since *Maughan*, a coroner or jury only had to be satisfied on the balance of probabilities that the criteria for either manslaughter or murder were met, before reaching an unlawful killing conclusion.

This resulted in an increase in the number of unlawful killings conclusions, but they are still rare. The cases that I am aware of involve the use of restraints in a hospital setting and again, one case of incorrect medicine administration.

To end on a positive note, can you give an example or examples, where Coronial concerns have made substantial improvements in the NHS or other health settings such as aged/disability care?

Off the top of my head, the most significant Preventing Future Death Report that I can recall is a report following the death of Molly Russell by suicide,[6] where the coroner raised significant concerns about the exposure young children can have to disturbing social media content and the way in which the algorithms work to push more disturbing content. I understand that this report was significant in the development of the *Online Safety Act 2023* (UK).[7]

More generally, in the healthcare setting, I believe that coroner reports have led to improved safety protocols, improved risk assessments and improved training for staff.

[5] R (on the application of Maughan) (AP) v Her Majesty's Senior Coroner for Oxfordshire [2020] UKSC 46

[6] Regulation 28 Report to Prevent Future Deaths, HMC Mr Andrew Walker dated 13 October 2022, which can be accessed at: https://www.judiciary.uk › uploads › 2022/10

[7] Australia has a similar act – *Online Safety Act 2021* (Cth), which is intended to improve and promote online safety for Australians, and regulate online content.

[i] Australian Institute of Health and Welfare: Suicide among young people - Australian Institute of Health and Welfare

READY OR NOT: THE FINDINGS OF AUSTRALIA'S COVID-19 RESPONSE INQUIRY

Authors: Partner Marie-Clare Elder and Law Graduate George Bozikis

On 29 October 2024, the Australian Government released the findings of the independent inquiry into Australia's response to the COVID-19 pandemic (the **Report**).

Led by Robyn Kruk AO, the inquiry was concerned with examining the responses undertaken either unilaterally by the Commonwealth Government or those undertaken in conjunction with the states and territories.[1] Actions undertaken by only the states, such as lockdowns, curfews, school closures and mask mandates, were outside the scope of the inquiry.

The Report broke down Australia's response into five aspects:


Preparedness, Governance and Leadership


International Border Closures and Quarantine


Health Response


Equity


Economic and Industry Response

Although emphasising the relative success of Australia in dealing with the pandemic when compared to the rest of the world, the underlying message of the Report was clear: '*Australia was not prepared for a crisis like COVID-19*.'[2]

Key findings

One of the most common phrases that emerged in the submissions made to the Inquiry was that of '*building the plane while it was flying*'.[3] Despite having many factors that played to its advantage, such as a strong health system, established institutional settings and a number of emergency health plans, the Report concluded that Australia lacked the necessary structures or plans to be ready for '*a pandemic of the severity, complexity or duration of the COVID-19 pandemic*.'[4]

Another prominent finding amongst the submissions made to the inquiry were the issues that emerged as a result of a lack of clarity and information with and between different levels of government. This gap in effective communication was deemed to have caused significant delays, increased risk of harm and distress in pivotal areas, such as quarantine, border closures and aged care.[5]

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1 COVID-19 Response Inquiry Report (Commonwealth of Australia, 2024), 48.
2 Ibid 75.
3 Ibid.
4 Ibid 100.
5 Ibid 89.
6 Ibid 275.
7 Ibid 276.

It was also highlighted that while the Australian government made a conscious effort to protect those more susceptible to the virus, such as the elderly and those with disabilities, restrictive non-pharmaceutical measures also had detrimental effects.[6] Social isolation was identified as a major issue amongst all walks of life from young children to those in nursing homes. With the latter, the effects of this isolation were starker as many were deprived of support networks, which led to a greater risk of neglect and deteriorating mental health.[7]

Moving forward: recommendations and actions

The inquiry identified and put forward nine guiding recommendations and 26 actions for implementation to ensure Australia is in the best position possible to respond to future public health emergencies.

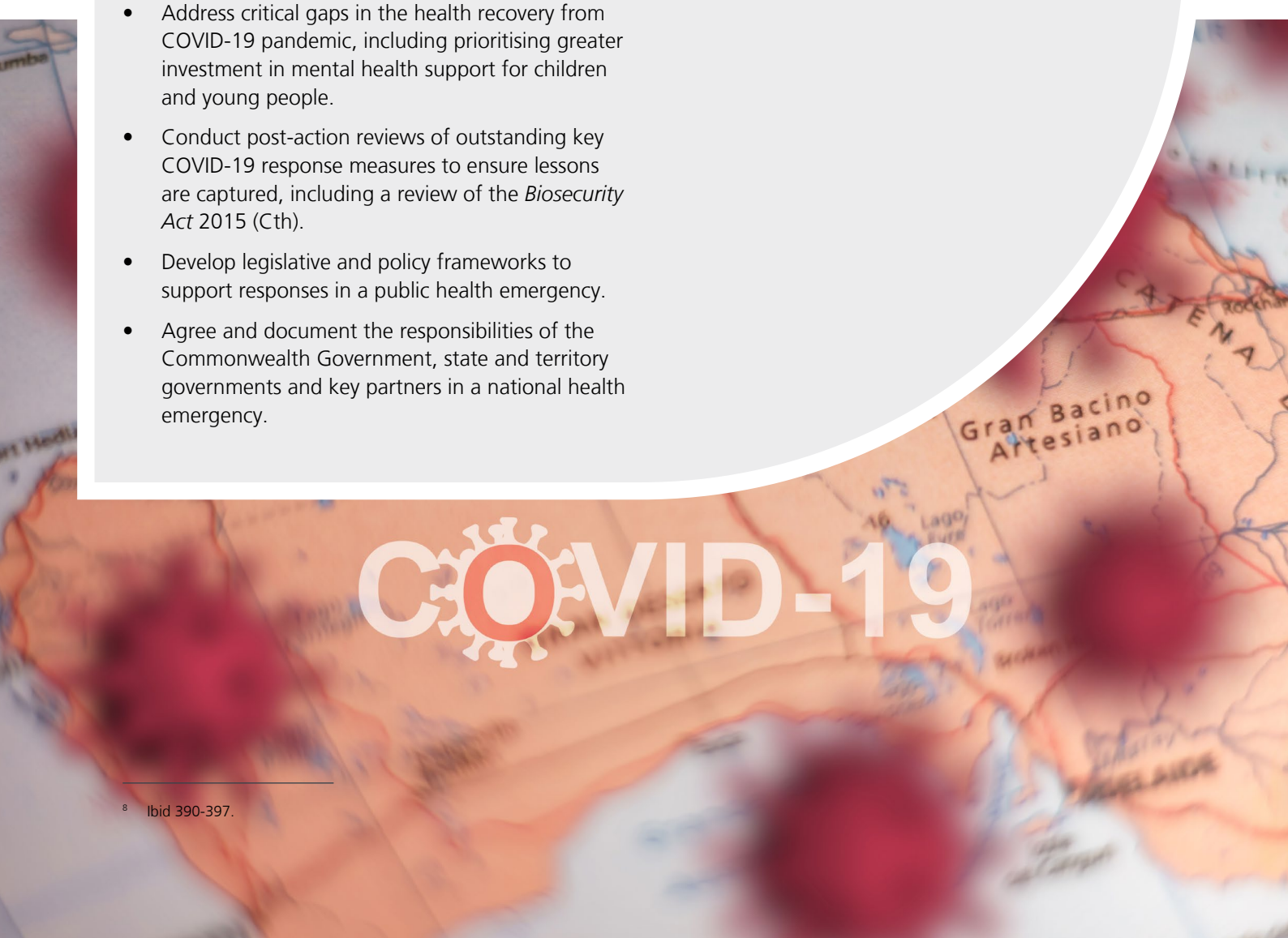
Within these recommendations were several '*immediate actions*' for implementation within the next 18 months. Some notable actions included:[8]

- Address critical gaps in the health recovery from COVID-19 pandemic, including prioritising greater investment in mental health support for children and young people.
- Conduct post-action reviews of outstanding key COVID-19 response measures to ensure lessons are captured, including a review of the *Biosecurity Act* 2015 (Cth).
- Develop legislative and policy frameworks to support responses in a public health emergency.
- Agree and document the responsibilities of the Commonwealth Government, state and territory governments and key partners in a national health emergency.

Ultimately, the COVID-19 inquiry represents a valuable opportunity to diagnose the strengths and shortcomings of Australia's efforts in dealing with the pandemic. However, it must be kept in mind that the Report is limited by its scope and is primarily concerned with examining the actions of the Commonwealth Government.

Several states have taken the initiative of conducting their own inquiries into their COVID response measures, including New South Wales, Victoria, Western Australia, and South Australia. Though there are certainly questions that can be asked over the efficacy of such reports, with both Victoria and New South Wales conducting their inquiries while COVID was still prevalent. In the case of the former, the final report was tabled in February 2021, which was seven months before the State's last lockdown ended.

Whatever the case, the takeaway is clear: there is more to be done.



[8] Ibid 390-397.

WHATSAPP WOES: PRESERVING PATIENT PRIVACY

Author: Partner Mark Sainsbury and Lawyer Emma Frylink

Health Ombudsman v KGY **[2024] QCAT 337 related to the investigation by the Queensland Health Ombudsman into a junior practitioner's conduct, with the main issue before the Queensland Civil and Administrative Tribunal (QCAT) being the appropriate sanction to be imposed on the practitioner (KGY).**

KGY was a trainee orthopaedic surgeon working as a Principal Health Officer in a major Queensland public hospital. On 12 occasions in 2019, he sent various photos and videos of patients' injuries to two women whom he was in relationships with. The images were sent by text or WhatsApp, usually provided with commentary and without the patients' (or his employer's) consent.

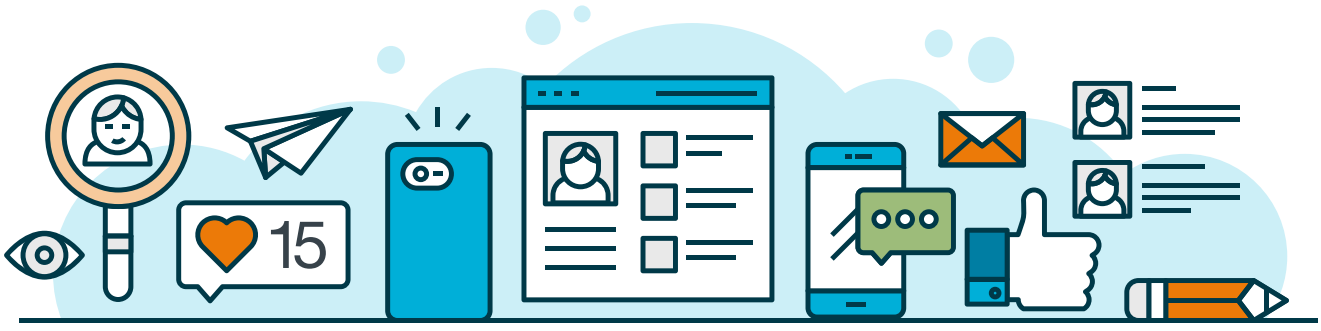
Examples of KGY's conduct described in the decision included:

- an image of a severe trauma injury to a patient's hand, leaving two remaining fingers with bony protrusion and blood, accompanied by messages: "*Clap clap*"; "*Haha. Another day. It's like chopsticks*"; "*Haha. I have more… But am about to go do something to it*", and
- an image of a patient's foot with trauma and necrosis accompanied by the message: "*that's my night. A foot that looks like pizza haha*".[1]

The photographs were taken by KGY in the course of his work and not sourced from patient records. The images did not identify any of the patients and the images were not shared with the wider public.

The QCAT characterised KGY's behaviour as "*a juvenile interaction between KGY and two women who, apparently, he sought to impress by that conduct*". There was one instance where the image showed part of the patient's name; however, his employer's investigations concluded that no patient was capable of being identified in the images.

Importantly, QCAT recognised that KGY was aware of his behaviour and was remorseful regarding his conduct.



[1] *Health Ombudsman v KGY* [2024] QCAT 337 at [8]

Nonetheless, KGY's conduct was considered to exhibit a flippant disregard for the patient's pain and suffering, that the conduct offended the standards of professional behaviour set by the relevant Codes of Conduct and the obligations of doctors to practice with integrity and compassion in particular.

Ultimately, QCAT concluded that KGY's unprofessional conduct constituted professional misconduct as defined in the National Law. QCAT considered imposing a sanction on KGY but decided a reprimand (without publication) and a fine of $5,000 were appropriate in the circumstances.

The QCAT considered that this outcome would underscore the seriousness of the conduct and send a general deterrent message to practitioners and the wider community to maintain standards.

With respect to the response by KGY and his legal representatives, it was evident from the decision that KGY was remorseful and his insight into his behaviour was communicated to QCAT, who largely accepted these submissions. This accords with the appreciation of practitioner insight and cooperation that is common within OHO, AHPRA and QCAT when managing professional conduct and disciplinary matters.

This case serves as a reminder to all practitioners, particularly those new to the profession, to maintain patient confidentiality and professionalism at all times despite the ever-present influence of social media and the ability to instantly communicate with friends and followers.

Finally, it is also worth considering any policy exclusions that might apply to an insured engaged in this type of behaviour who then seeks cover in response to an inquiry by a regulating body. It would be a double blow for an insured facing disciplinary action if defence/inquiry costs coverage was denied by an insurer (for example, if the behaviour was considered deliberate and reckless).

INQUIRY INTO BIRTH TRAUMA: IMPORTANCE OF EDUCATION AND CONSENT

Author: Partner Marie-Clare Elder and Lawyer Julia Kowald

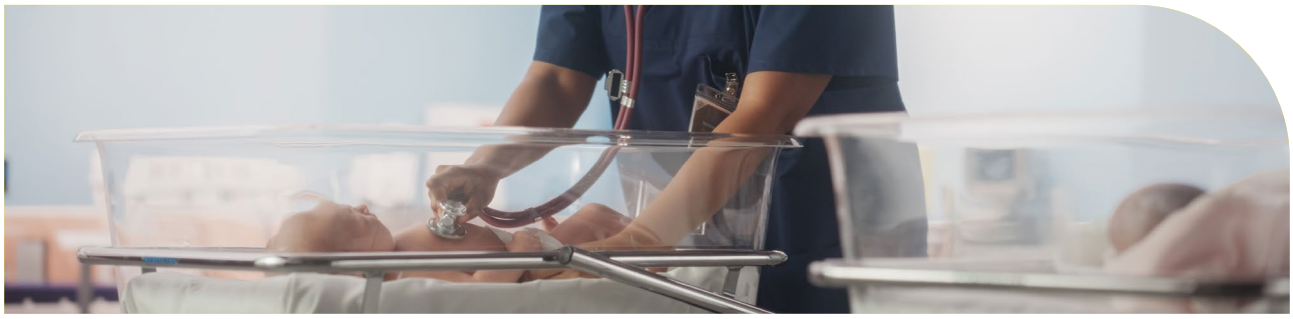
On 29 May 2024, the Select Committee on Birth Trauma (the Committee) published its Report on the Inquiry into Birth Trauma, detailing five findings and 43 recommendations. In the NSW Government response published 29 August 2024, they indicated support for all recommendations (noting one recommendation is an action for the Chair of the Committee).

Through the Inquiry, the Committee found that many instances of birth trauma are preventable and identified key contributing factors that can be addressed to minimise traumatising birth experiences. Multiple recommendations specifically focused on the positive impact that education in the antenatal stage and obtaining fully informed consent, can have on the birthing experience.

Antenatal education

Resources including classes for pregnant people are available for parents however many submissions critiqued the limited accessibility of these resources across varying demographics. The Report heard that less than 50% of first-time parents had attended formal antenatal education programs and 90% of members of the NSW Nurses and Midwives' Association have concerns regarding barriers to these programs. Generic information and pamphlets provided to expectant parents do not adequately educate parents on potential childbirth complications as well as the parenting journey. Where a pregnant woman has not accessed formal antenatal education programs, it is more likely that they will be uninformed or may have received biased information from clinicians, leaving them unprepared and uneducated for childbirth.

When a woman is inadequately educated, particularly regarding potential interventions in the event of a complication, the Report found that it can be harder to obtain informed consent when in the birthing suite, compared to if they had received appropriate education ahead of the birth. This can lead to women feeling forced into decisions about their childbirth and a sense of disempowerment, and both factors could lead to traumatising experiences.



Informed consent

Throughout the submissions of mothers who experienced birth trauma, there were themes of poor consenting practices including feeling forced into procedures with little explanation or time and space to consider their options, and no involvement in the decision-making. The Report highlighted that fully informed consent and empowered decision-making requires an ongoing dialogue between patients and their healthcare providers, to explore all available options and adequate information-sharing from as early as possible in the pregnancy.

While many of the submissions related to emergency situations requiring intervention during birth, the Report also drew attention to submissions that questioned the routine interventions and 'invasive procedures' that are sometimes mandated by hospital policies and protocols. Compliance with these policies and protocols is expected, but women are sometimes uninformed of these until they are already in the process of labour. The Committee specifically addressed this concern and the issues with consent these policies can raise by recommending a review of maternity policies and guidelines around birthing interventions, to ensure that they contain processes for seeking informed consent, that interventions are evidence-based and that these guidelines are made publicly available.

The Committee also recommended that the NSW Health 'Consent to Medical and Healthcare Treatment Manual' is implemented and that maternity health practitioners undertake informed consent training. One submission remarked that many practitioners were unaware of this existing resource.

Another recommendation to address education before birth and consent is to have freely available evidence-based birth plans for use as a guide. Birth plans are an important tool to encourage women to be well-informed from early stages of pregnancy about the birthing process to allow them able to consider and communicate their preferences if interventions are recommended.

The Inquiry found that rates of birth trauma in the modern day are unacceptable, and whilst there is a recommended overhaul of the health system to achieve more clarity in education and consent procedures, the ultimate goal is to ensure that these women no longer suffer in silence.

EXPLORING THE EPIDEMIC: THE INQUEST INTO DOMESTIC VIOLENCE IN THE NORTHERN TERRITORY

Authors: Special Counsel Lani Carter and Law Graduate George Bozikis

***Warning:** Aboriginal and Torres Strait Islander readers are advised that this article contains the names of Indigenous people who have died. This article contains content that readers may find distressing.*

On 25 November 2024, the Coroners Court of the Northern Territory delivered the findings of the inquest into the deaths of four Indigenous women: Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kamanjayi Haywood (the Inquest).

Whilst these four cases were the focus of the Inquest, they are merely the tip of the iceberg and provide only a glimpse into '*the horrifying reality of domestic violence killings in the Northern Territory*.'[1]

The facts

With the utmost respect, we summarise the facts regarding two of the deceased that were the focus of the Inquest.

Miss Yunupiŋu

In 2005, Miss Yunupiŋu, who was 15-years old, entered into a relationship with Gayurruy Neil Marika, who was 'about' 21. The following year, when Miss Yunupiŋu was 16 years-old, in a fit of jealousy, Mr Marika beat her with a large aluminium garbage bin, causing critical injuries including a collapsed lung.[2] While Mr Marika was incarcerated for this incident, both he and his family maintained that Miss Yunupiŋu was at fault.[3] What followed over the next twelve years was a cycle of intoxication, domestic violence and abuse.

On 8 September 2018, Miss Yunupiŋu attended the Crisis Accommodation Gove, telling the service providers that she was suicidal due to pressure from Mr Marika's family and asked for assistance to be moved elsewhere.[4] Without conducting checks or risk assessments about her situation, Miss Yunupiŋu was transported to the Darwin Aboriginal and Torres Strait Islander Women's Shelter. Within a day of being moved to Darwin, she met up with Mr Marika in Palmerston.[5]

On the evening of 4 October 2018, after having consumed alcohol throughout the day, Miss Yunupiŋu and Mr Marika engaged in a heated argument after he wanted her to get more alcohol.[6] He punched Miss Yunupiŋu in the face, told her 'I will stab you before

[1] Inquests into the deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood [2024] NTLC 14, [9].

[2] Ibid [156].

[3] Ibid.

[4] Ibid [176].

[5] Ibid.

I go to gaol' and, with a kitchen knife, stabbed her three times.[7] The third stab wound was to her chest and perforated her left lung. Miss Yunupiŋu died within minutes.

Ngeygo Ragurrk

In late 2016, Ngeygo Ragurrk, who was then 37, met Garsek Nawirridj, who was 35 and had a extensive history of domestic violence and substance abuse.[8] Over the next two years, although altercations were common, Miss Ragurrk never personally called the police except for one instance on 13 July 2019. In that instance, it was found that the police failed to properly understand her complaint or take the time to appropriately engage with her.[9]

On 23 December 2019, Mr Nawirridj was intoxicated and extremely aggravated. Within the early hours of the morning, he had set fire to her car, been cautioned several times by the police and engaged in brawls with a number of people.[10] He was admitted to the Royal Darwin Hospital after the police noticed a large cut on his head. At the hospital, his blood alcohol level was determined to be 0.15. After being discharged later that afternoon, he continued to drink and move about the city.[11]

At about 6:50pm, Mr Nawirridj drove past Miss Ragurrk, who was with other family members, in a taxi. He ran out of the taxi and punched her and her cousin, before dragging Miss Ragurrk away. There were many witnesses, yet no one called the police.[12] For the next two and a half hours, Mr Nawirridj viciously assaulted Ms Ragurrk. He then dragged her unconscious body down to the beach, brought her into the shallow water and strangled her with her own clothes. At 9:40 pm, he called for help, saying his wife had drowned.[13]

Mr Nawirridj was subsequently arrested, charged, and sentenced to thirteen years imprisonment.[14]

The findings

Judge Armitage, the NT Coroner, handed down a number of findings, addressing key elements and stakeholders that both contribute to or are affected by the epidemic of domestic violence against Indigenous women.

Police responses

The findings acknowledged the substantial efforts of the police to deal with domestic violence and the difficulty of having to intervene in so many traumatic situations. However, it was also stated the failings of the Police response must also be confronted.

The main issues emerged as follows:

Lack of sufficient resourcing – amongst the vast majority of cases, there are significant delays in the police response times to reports of domestic violence. This can have a number of consequences, such as further harm being inflicted in the meantime, erosion of trust with the community or decrease the likelihood of the victim actually disclosing what happened.[15]

Deficient training – throughout the Inquest, several deficits in domestic violence response training were identified. These deficits were identified in relation to the general approach and investigation of incidents, failures to check or reflect on the perpetrator's history, evidence gathering and the use of body cameras, and not seeing domestic violence as an isolated incident but as part of a larger picture.[16]

Rapport building – it was clear in the facts of the cases, that several times the women did not disclose the reality of the situation to the police officers involved because they were approached in a way that was unsympathetic, distrusting, or blunt. It was also identified that in certain instances, the attending officers appeared to exhibit sympathy for and prejudgment in favour of the accused perpetrator. The Inquest found, '*effective communication is far more likely to result in a complaint being made*.'[17]

6 Ibid [178].
7 Ibid.
8 Ibid [185].
9 Ibid [196].
10 Ibid [200].
11 Ibid.
12 Ibid [207].
13 Ibid [208].
14 Ibid.
15 Ibid [209].
16 Ibid [466].
17 Ibid [479].

Health Services

The Inquest also turned its attention to the role of health services within these issues. As stated by NT Health, "*the prevalence of domestic violence within families and communities in the Northern Territory is inseparable from the complex structural disadvantage experienced by many, including the poor health and health outcomes experienced by many Aboriginal people*."[18] Within this context, Judge Armitage focused on two issues:

1. **Hospital based social workers** - In many of the cases that were brought before the Inquest it was found that, on numerous occasions, women who presented to hospital for domestic violence were not offered a social worker referral.[19] Not only can this be a result of failure in procedure but also a lack of resourcing. For example, Alice Springs Hospital had a social worker available between the hours of 8am to 4:30pm, but at no other times.[20] With so many instances of domestic violence occurring either late at night or early in the morning, these women are obstructed from receiving the proper support or referral avenues that may be necessary to ensure their safety.
2. **Reports to Police** – Within this issue, the Inquest explored the potential for hospital staff to support the work done by the police through vigilant and proactive reporting. In examples brought before the Inquest, there were times were the actual police response at the scene of the domestic violence incident was lacking or uninformed. In these same incidents, there were victims who had already contacted medical centres for advice and assistance. In these situations, the Inquest promoted the proactive alerting of the situation by health services in order to provide a better understanding to the attending police officers of what had happened.

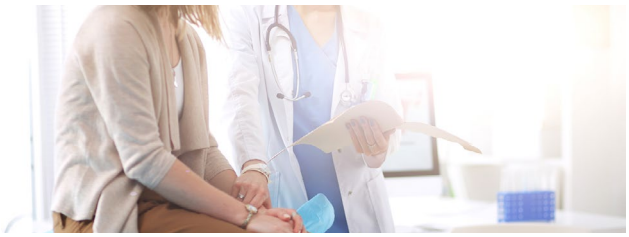
18 Ibid [640].

19 Ibid [650].

20 Ibid [652].

Examining the burden on the health system

The Inquest explored numerous issues, each with its own intricacies and nuances, however, what was clear is that there existed a definitive resourcing issue. This was exemplified when examining the impact that this epidemic of domestic violence has had on emergency services.



Trauma

Although it is acknowledged at a few points throughout the Inquest, one of the often glossed over aspects when it comes to critiquing responses to domestic violence was the fact that health workers were confronted with the aftermath of the violence, which can be traumatising. The Inquest highlighted a number of incidents of violence where these women were taken to the hospital with often horrific injuries. The compounding effect of being confronted with these victims for health workers already working in a high pressure environment was not something to be understated.

Not enough manpower

Another theme in the Inquest was a lack of resourcing. Health services are continuously spread thin. Despite best intentions, certain mistakes emerge or procedural steps are skipped. As highlighted in the Inquest, this can clearly result in women not receiving the support they require. However, it also raises questions over liability and accountability. After all, how much blame or culpability can you place on hospital staff who fail to correctly deal with a domestic violence victim because there simply are not enough hands to go around? Yes, in an ideal world, all patients receive highly attentive and proactive care. However, the reality is that this is not always possible, especially when the system is overburdened.

Conclusion

The Inquest made 35 recommendations to be implemented amongst the key stakeholders including government agencies, police departments, health services, social services. Despite the grim and tragic contents of the cases examined during the course of the proceedings, Judge Armitage concluded her findings with words of hope, where she stated: '*If the task seems too big or overwhelming and this all sounds impossible, if anyone is feeling defeated, there is some good news. With all this combined input we know what needs to be done and there is no reason for any further delay before action is taken*.'

It may be a long road ahead to implement the appropriate remedies to fix this epidemic, however, it must begin with small steps.

WATCH THIS SPACE - GENETIC DISCRIMINATION IN LIFE INSURANCE BAN REMAINS UNCERTAIN AS FEDERAL ELECTION APPROACHES

Authors: Partner Aimee Dash
and Law Graduate Oscar Bailey

The imminency of the Federal election and recent retirement of Assistant Treasurer and Minister for Financial Services, Stephen Jones, has prompted growing concerns that a ban on genetic discrimination in life insurance will not be implemented as promised in September last year.

Mr Jones' promise to implement a ban that would "*give Australians the confidence to undertake genetic testing without fear it will impact their ability to access financial security through life insurance*,"[1] is now running out of time to be fulfilled.

Genetic testing is capable of detecting a range of conditions including Huntington's disease, certain forms of cancer, and cystic fibrosis, and allows for greater knowledge with respect to early detection, prevention, and decisions for treatment.

However, Monash University's public health and genomics researcher, Dr Jane Tiller, recently cast doubt on the transition from industry self-regulation to a Federal mandate, offering the critique that "*making an announcement doesn't actually equate to putting the policy change in place*."[2]

The basis for the ban

The current model for protection is the Financial Services Council's (**FSC**) moratorium to prevent genetic discrimination, introduced in 2019. Under the FSC's guidelines, genetic testing results could not be collected by insurers for policies up to $500,000.

However, beyond concerns over the inherent risk of conflict of interests being encountered by self-regulation, the moratorium is also undermined by legislation as s 46 of the *Disability Discrimination Act* 1992 (Cth) openly permits life insurers to discriminate on the basis of genetic testing. That section provides that its operation "*does not render it unlawful for a person to discriminate, on the ground of the other person's disability, by refusing to offer the person*[3] *life insurance, if it is based on actuarial or statistical data*," and "*is reasonable having regard to the matter of the data and other relevant factors.*"[4]

Further, under s 20B of the *Insurance Contracts Act* 1984 (Cth), applicants for life insurance may be required to declare genetic testing results to life insurers, with a failure to disclose "explanatory material" amounting to a breach of an insured's duty of disclosure.[5]

Despite genetic testing results being incapable of affecting private health insurance premiums in Australia, which are community-rated under the *Private Health Insurance Act* 2007 (Cth), the FSC's moratorium is not legally binding and does not provide adequate protection given the financial limits.

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1 Life insurers banned from using genetic tests to deny cover or hike premiums | ABC News

2 Health groups demand urgent ban on genetic discrimination in life insurance - ABC News

3 *Disability Discrimination Act 1992* (Cth), s 46(1)(b).

4 *Disability Discrimination Act 1992* (Cth), s 46(1)(f)(i)-(ii).

5 *Insurance Contracts Act 1984* (Cth), s 20B(3)(b).

The response of stakeholders and commentators

Following the announcement in September 2024, Australian Medical Association President Steven Robson believed it would incentivise Australians to undergo genetic testing, as there had previously been "*a huge financial penalty for having potentially life-saving medical testing*."[6]

Insurers have raised a view that if genetic testing results cannot be used by life insurers, adverse selection by gene-positive applicants will lead to increased premiums for consumers and incapacitate the operation of insurance markets.

However, concerns over the operation of a reasonably sized life insurance market should be quelled by the success of Canada's introduction of the *Genetic Non-discrimination Act* (2017), which prohibits insurers (and all other entities offering goods and services) from using genetic test results without an individual's express consent.[7] The US has adopted a similar model through implementing the *Genetic Information Non-discrimination Act* (2008), which limits the use of genetic information only in health insurance underwriting.[8]

In general terms, the current approach, according to Dr Tiller, produces an environment wherein there is a "*deterred uptake of genetic testing by at risk individuals and deterred participation in medical research,*" of which is intrinsically inclined toward counter-productive effects on insurance premiums and public health. Furthermore, fears of insurers as to how genetic testing effects the synchronicity with which community-rated policies can be offered should be mitigated by the fact that genetic testing differs from other screening tests on the basis that "*they only need to be done once, since a persons' genome does not change over time.*"[9]

Breast Cancer Network Australia's Director of Policy, Advocacy, and Support Services, Vicki Durston, recently underlined the position of health groups in respect of the Federal Government's inaction, saying to ABC that "*Our message to the government is clear: deliver on what was promised and introduce legislation to ban genetic discrimination as a matter of urgency.*"[10]

Unfortunately, despite a groundswell of support for the ban amongst health groups and insurers alike, and the international examples of effective similarly natured policy, the election cycle may cause the stagnation of the ban's implementation to continue.

6 Health groups demand urgent ban on genetic discrimination in life insurance - ABC News

7 Study protocol: the Australian genetics and life insurance moratorium—monitoring the effectiveness and response (A-GLIMMER) project | BMC Medical Ethics | Dr Jane Tiller et al

8 Study protocol: the Australian genetics and life insurance moratorium—monitoring the effectiveness and response (A-GLIMMER) project | BMC Medical Ethics | Dr Jane Tiller et al

9 Thinking about life insurance through a genetic lens | Actuaries Institute | Dr Damjan Vukcevic and Jessica Chen

10 Health groups demand urgent ban on genetic discrimination in life insurance - ABC News

GENETIC TESTING WOES: BOPPING V MONASH IVF PTY LTD & ORS

Authors: Partner Kerri Thomas and Partner Marie-Clare Elder

Group proceedings were brought by and on behalf of individuals who received cell-free non-invasive pre-implantation testing (nIPGT-A testing) on their live embryos between May 2019 and October 2020. The claim alleged breach of contract, breach of Australian Consumer Law and negligence on the part of the Defendants, allegedly causing financial loss and psychiatric injury to group members. Settlement occurred prior to any trial and was approved by the Supreme Court of Victoria in a judgment dated 19 December 2024.

Background

The Plaintiffs claim niPGT-A testing was used by the Defendant IVF clinics to screen patient embryos to identify those that had abnormalities and were unsuitable for transfer. The claim alleged that there was a substantial risk that the nIPGT-A testing could yield false positive results, leading to embryos having potentially been erroneously classified as non-suitable for transfer and discarded. The Plaintiffs claim that the Defendants knew of or ought to have been aware of those risks, and that the testing ought not to have been relied upon for such classification.

The claim was initially brought against two fertility clinics, Monash IVF Pty Ltd, Adelaide Fertility Centre Pty Ltd and their parent company, Monash IVF Group Ltd. The pleadings were subsequently amended to add other subsidiaries of Monash IVF Group Ltd, which provided fertility services, including IVF, in other parts of Australia.

The claim alleged liability on the part of Monash IVF Group Ltd, the parent company, for the development, clinical trials, and commercial offering of niPGT-A testing by its employees and subsidiaries. It also alleged liability on the part of the Defendant IVF clinics that provided the commercial service of niPGT-A testing to customers, allegedly on an improper basis and without obtaining proper informed consent.

What was niPGT-A testing used for?

It was claimed that group members who received IVF treatments from any of the Defendants in the relevant period were provided niPGT-A testing of their live embryos for aneuploidy.

Aneuploidy refers to a chromosomal abnormality involving an extra or missing chromosome. In most cases, embryos with these chromosomal abnormalities are not compatible with life due to abnormal early development.

The claim states that the Defendant IVF clinics' pre-implantation genetic testing had initially involved analysis of a biopsy sample of embryo DNA (**biopsy testing**) with the subsequent addition of niPGT-A testing, which uses DNA from the culture media that the embryo was growing in while in the laboratory. Only embryos found to be chromosomally normal for the tested chromosomes were considered suitable for transfer.

It was alleged that from May 2019, the Defendant IVF clinics offered niPGT-As testing as a commercial service for the identification of aneuploidy and classification of embryos up until October 2020, when a notice was sent to patients advising that niPGT-A testing was being suspended. This was said to be because the proportion of abnormal embryos classified aneuploid by niPGT-A testing was higher than had been observed in the clinical trial. From October 2020, the Defendants reverted to biopsy testing for genetic assessment of the aneuploid status of embryos.

The amended pleadings

Following discovery, the Plaintiffs amended their pleadings and introduced new allegations regarding the clinical trials and validation processes relating to the rollout and reliability of niPGT-A testing. The new pleadings also raised allegations of evidence held by the Defendants being fabricated or destroyed.

The allegations in the amended pleadings placed in sharp focus the issue of the suitability of niPGT-A testing as a substitute (rather than an adjunct) to biopsy testing.

The outcome

A settlement has been reached by which the Defendants collectively will pay $40,000,000 in damages and a contribution of up to $16,000,000 for the Plaintiffs' legal costs.

Although the settlement involved no admission of liability on the part of the Defendants, the outcome speaks to the serious commercial risks in rapidly growing industries. It highlights the imperative of strict adherence to regulatory requirements and best clinical practice when bringing emergent scientific and technological advancements into the market.

BALANCING THE HIPPOCRATIC OATH AND THE CLIMATE CRISIS: DISCIPLINARY ACTION AGAINST PHYSICIANS

Authors: Special Counsel Lani Carter and Paralegal Anthony Tsecagias

According to the Lancet Commission Report on *Climate Change and Health*:

> *"Climate change is the greatest global health threat facing the world in the 21st century, but it is also the greatest opportunity to redefine the social and environmental determinants of health."*

Given the public health implications of a warming planet, some medical professionals have felt compelled to participate in climate protests.

In October 2024, Dr Patrick Hart, a general practitioner in the UK was found guilty of criminal damage and later sentenced to one year imprisonment following a non-violent protest in which he damaged and disabled petrol pump screens at an Esso petrol station as part of a coordinated protest.[1]

Dr Hart was referred to a medical tribunal by the General Medical Council (the professional regulator) (**GMC**) to consider disciplinary action, which may include suspending his registration. In the UK, the GMC has a duty to refer doctors to a medical tribunal when they receive a custodial sentence.[2]

The British Medical Association argued that in Dr Hart's case, the custodial sentence '*[has] no bearing on [the practitioner's] ability to practise medicine nor [does it] pose any risk to their patients*.'

Medical practitioners being involved in protests or petitions for climate action are not foreign in Australia. In June 2024, some 400 plus medical practitioners signed a petition urging the Federal Government to ban all new coal, gas, and oil projects in Australia. The petition focused on the consequential effects of climate change on patients, particularly those presenting with pollution-related issues "*increasing the rates of asthma, heart disease, cancer, learning delays and poor pregnancy outcomes.*"

Double punishment?

Dr Hart's treatment by the regulator has been criticised by the UN special rapporteur on environmental defenders, Mr Michel Forst, who has demanded that the UK government investigate the alleged penalising, persecution, or harassment of Dr Hart for peaceful civil disobedience, which has been previously used by women's rights, anti-apartheid, anti-poll tax, LGBTQ+ and black civil rights activists. He said the GMC appears to be "*subjecting Dr Hart to double punishment for his peaceful climate activism.*"[3]

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1 https://www.bbc.com/news/articles/cg525d9jlvlo

2 *The General Medical Council (Fitness to Practise) Rules Order of Council 2004* No 2608 provides:
Rule 5.

(1) Subject to rule 4(5), the Registrar shall refer an allegation falling within section 35C(2)(c) of the Act relating to a conviction resulting in the imposition of a custodial sentence, whether immediate or suspended, directly to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal.

Section 35C(2)(c) states that fitness to practice is impaired by reason of a conviction for a criminal offence.

3 https://www.theguardian.com/environment/2024/oct/27/stop-punishing-doctors-climate-protests-general-medical-council

Dr Hart also faced civil charges and was fined in relation to a private injunction obtained by Esso and said that he has also been penalised at work.[4]

In Australia, under the *National Law*, a National Board must refer a matter about a registered health practitioner or student to a tribunal if the National Board reasonably believes that the practitioner has behaved in a way that constitutes '*professional misconduct*'. The National Board must also refer the matter to a tribunal if a panel established by the National Board requires it to do so. There is no automatic referral for criminal conviction, meaning that there is a discretion to determine whether an act giving rise to a criminal conviction amounts to '*professional misconduct*' or whether the act leading to the conviction is unconnected to the practice of medicine.

Professional misconduct is defined in the *National Law* to mean one or more instances of unprofessional conduct that amounts to conduct substantially below the standard reasonably expected of a registered health practitioner (of an equivalent level of training or experience) and conduct inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

Arguments suggesting that referral to a board amount to double punishment have been rejected by Australian Courts – and it has been made clear that the intention of disciplinary action by the regulator is not punitive but rather, for the protection of the public.[5]

The *National Law* in Australia also specifically deals with the 'double punishment' argument—under s 70 of the *National Law* where conduct constituting an offence is also a ground for disciplinary action, conviction is not a bar to disciplinary action and disciplinary action is not a bar to conviction.[6]

Anti-vax and lock-down protests in Australia

A number of practitioners in Australia have been the subject of disciplinary action for protests involving the expression of negative views about COVID-19 vaccinations, participating in anti-lock down protests, and otherwise breaching public health directives.

Conditions were imposed upon the registration of psychologist, Mr Mohammad Attai, for example, when complaints were made that he attended an unlawful anti-lockdown protest rally in defiance of public health directives, that he saw clients during lock-down and was said to be spreading misinformation via social media.[7]

Ms John, a paramedic had her registration suspended as a result of failing to self-isolate after contracting COVID-19 and participation in an anti-lockdown rally, contrary to public health orders.[8]

Finally, general practitioner, Dr William Anicha Bay had his registration suspended after posting on social media and attending an anti-vax protest (although this was overturned on appeal).[9]

Whilst the anti-lockdown protests may have been non-violent, the connection with the practice of medicine (and the potential for each of the practitioners' actions to bring their profession into disrepute) is clear in these cases.

In the case of Dr Hart, whilst his action may not have had any connection to the practice of medicine (or risk the health and safety of the public in his practice of medicine), his action did cause property damage, which is a criminal offence.

Takeaways for medical practitioners

Medical practitioners are entitled to engage in civil discourse—including protest—and should not feel restricted from expressing views and engaging in civil society. There is no doubt that the advocacy path is challenging, however, it is when the acts of protest break the law or otherwise put the public at risk that doing so may risk disciplinary action being taken by the regulator.

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4 In his closing statement at Chelmsford Crown Court during his trial, Dr Hart said:

"I disrupted people as an act of care. I damaged the petrol pump screens as an act of care, because in times of great peril, a caring person has to stand up for what is right. My actions have already cost me greatly. I have been handed a suspended prison sentence, and thousands of pounds in costs through a civil injunction for this exact same action. I have been penalised at work and stand to be suspended or lose my licence to practise as a doctor. But I regret nothing. Because to not do it, would have been to give up on caring, and that would be worse. In the face of the permanent collapse of our climate, our economy, our society and life on Earth, the only thing that keeps me going is our continued capacity as people to care, regardless of what happens. Yes, I fear prison, but I am ready to go if I must."

5 See for example, *Psychology Board of Australia v Idiri* (Occupational and Business Regulation) [2011] VCAT 1036

6 See also section 243 of the National Law.

7 *Attai v Psychology Council of New South Wales* [2022] NSWCATOD 136

8 *Health Care Complaints Commission (NSW) v John* [2023] NSWCATOD 45

9 *Bay v Australian Health Practitioner Regulation Agency* [2024] QSC 315

CURRENT NATIONAL MAXIMUM AWARDS FOR NON-ECONOMIC LOSS/ GENERAL DAMAGES IN PERSONAL INJURY CLAIMS

Legislation	Threshold
Victoria *Wrongs Act* 1958	The current statutory maximum award of damages is $741,000. This amount will be indexed on 1 July 2025.
New South Wales *Civil Liability Act* 2002	As of 1 October 2024, the maximum award of damages for non-economic loss is $761,500. This amount will be indexed again on 1 October 2025.
Queensland *Civil Liability Act* 2003	The maximum award for general damages is $456,950, 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).
ACT *Civil Law (Wrongs) Act* 2002	No threshold for awards of general damages/non-economic loss in personal injury claims.
South Australia *Civil Liability Act* 1936	Assesses personal injury general damages by reference to a points system from 1 to 60 based on the year of the incident. As of January 2025, the maximum award of 60 points was valued at $444,340.
Western Australia *Civil Liability Act* 2002	No maximum threshold. General damages will only be awarded by the court if they are assessed to be greater than $25,500. If general damages are assessed over the minimum threshold, various formulas are then used to calculate the amount awarded to the plaintiff. The minimum threshold is indexed on 1 July every year.
Tasmania *Civil Liability Act* 2002	There is no cap on general damages. However, if general damages are assessed at or less than $7,000 (Amount A), there is no award. If assessed to be more than Amount A but not more than $35,000 (Amount B), damages are awarded according to a formula. If general damages exceed Amount B, the assessed amount becomes the award.
Northern Territory *Personal Injuries (Liabilities and Damages) Act* 2003	The maximum amount of damages for non-pecuniary loss is $809,200 (85% + PI = 680,000 monetary units @ $1.19 per unit until 30 June 2025), provided the degree of permanent impairment exceeds 5%, pursuant to section 27 of the Act.

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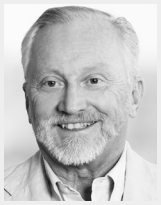

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