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Recent Developments

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Euthanasia on the Agenda … Again

Bills in support of euthanasia represent a recurring legislative theme. Within Australia there have been at least 17 different Bills before different State and Territory legislatures since 1997, all of which have failed. The most prolific States have been Western Australia and South Australia, and 2010 saw the trend continue with a Voluntary Euthanasia Bill failing in September in the West and November in the South. With members in both States clearly stating their intent to table similar Bills in the future, it is worth taking the time to gain some insight into the proposed move to legitimise euthanasia as an end-of-life decision.

The November Bill in South Australia was a reinvention of a 2008 attempt to nest euthanasia within the *Consent to Medical Treatment and Palliative Care Act* 1995 (SA) through the Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA). This proposal was perhaps flawed from the outset as many would challenge the facilitation of voluntary euthanasia as either a form of medical or palliative care. An altered Bill (Voluntary Euthanasia Bill 2010) "failed on the voices" (i.e., was not even put to the vote when it became clear after lengthy debate that it lacked sufficient support to proceed).

The Bill was aimed at allowing those in either the "terminal phase of a terminal illness" or who have a medical condition that results in "permanent deprivation of consciousness" or "irreversibly impairs the person's quality of life so that life has become intolerable" to "end their suffering" by voluntary euthanasia (s3). This perhaps begs the question that always troubles those who critique euthanasia legislation: Who is to determine what qualifies as "intolerable"? Indeed, what level of "intolerable" allows someone to qualify? How is it measured? In short, what level of suffering justifies euthanasia? The Bill did attempt to include safeguards to help in this process and, whilst stopping short of defining "intolerable," it did include provisions aimed at establishing a careful regime of oversight and monitoring (though some could argue that this regime runs the risk of being overly bureaucratic).

The Bill clearly defined who could request the administration of voluntary euthanasia. Only a person who is of sound mind and terminally ill qualifies under the Bill (s5), and before one is permitted to make the request, his or her medical practitioner must have carefully and fully informed the patient of a number of things. These include the patient's diagnosis and

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prognosis, possible treatments, risks, and side-effects, and likely outcomes. There is also an expectation that palliative care is discussed and, of course, the proposed voluntary euthanasia procedure and risks. There is nothing unexpected or unusual in these requirements as they represent the normal pre-treatment discussion that would be required before any medical intervention. Of note is the "sound mind" requirement, which clearly precludes those who may be suffering from a condition that potentially affects their capacity and also those who wish to make advanced requests, foreseeing a time when they may be in a "terminal phase of a terminal illness" and lacking capacity.

The Bill also included specific formal requirements such as procedures to be observed in the making and witnessing of the request (s6), the specific form of the request (s7), and the maintenance of a Register of requests and the appointment of a Registrar (s9). Importantly, there was clear recognition that patients may change their mind as they progress through an illness, and s8 of the Bill specifically provided for the revocation of a request and stipulated that the revocation need not be in writing. Significantly, the competency requirement did not exist for revocation, and any indication that the individual no longer wished to proceed with voluntary euthanasia would suffice.

There are three provisions aimed at protecting the medical profession: firstly, there was to be no mandate on a medical practitioner to administer voluntary euthanasia when requested (s12); secondly, the Bill provided clear protection from civil or criminal liability (s13); and thirdly, it also contained a clear prohibition of publication of any identifying information of those involved in the administration of euthanasia, unless they granted permission for such information (s14).

The South Australian Bill represented a simple and clear attempt to introduce voluntary euthanasia into the law. A similar Bill failed in Western Australia that, whilst similar in effect, contained some tighter provisions. The age limit was lifted to 21, and in Western Australia a patient must, in order to qualify, have a terminal illness with the prognosis of death within 2 years. In addition, the patient must be experiencing pain, suffering, or debilitation that is considerable and related to the relevant terminal illness. This Bill was debated for 2 days and was defeated in late September last year.

There is clearly a consistent undercurrent in Australia in support of euthanasia, with most opinions polls showing strong public support for legislative change, but there is an equally consistent body of resistance, especially in the State and Territory parliaments. With avowals in both Western and Southern Australia that the debate is not over, it will be interesting to see what the next iteration of proposed euthanasia law will bring.

Bernadette Richards

Liability of Hospitals and Health Care Facilities for Sexual Assaults

Liability on the part of hospitals and other health care facilities (facilities) to compensate persons, including patients and employees, who have been injured as a consequence of a sexual assault may arise in several ways.

Facilities may be held personally liable where a duty of care owed to patients, employees, or others is breached by reason of failure to take reasonable care to prevent injury. This may include failure to take reasonable care in the recruitment, training, and supervision of employees for the protection of patients, and failure to take reasonable care to provide a safe system or place of work for employees.

Such facilities may also be held civilly liable on account of the wrongful acts of employees and others that cause harm to patients, employees, or others. Where an employee is negligent or engages in an unlawful act, including an assault, in the course of his or her employment and a patient is thereby injured, vicarious liability may arise. In this context, by imposing liability on an employer for an employee's conduct, the law aims to achieve "a compromise between conflicting policies: on the one end, the social interest in furnishing an innocent tort victim with recourse against a financially responsible defendant; on the other, a hesitation to foist any undue burden on business enterprise"(Fleming 1998, 409–410). In addition, in cases where vicarious liability is not established—because hospitals (and probably other health care providers) owe non-delegable duties of care to both patients (*Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542) and employees (*Kondis v State Transport Authority* [1984] 154 CLR 672), as there is an "element in the special relationship between the parties which generates a special responsibility to ensure that care is taken" (Mason J; Dawson

and Deane JJ agreeing)[1]—breach of such non-delegable duties may also give rise to liability for the unlawful acts of others.

Two recent Australian cases serve to highlight the various and perhaps sometimes overlapping duties of a hospital or similar health care facility, as a provider of medical services to patients, an occupier of premises, and an employer of staff.

Both cases considered the extent to which a facility should be held liable for alleged criminal behaviour (sexual assaults) committed by third parties. The first case, *NB v Sydney South West Area Health Service* [2010] NSWDC 172 arose in the context of an alleged sexual assault of a hospital patient by an employee, and the second, *Sapwell v Lusk & Lusk* [2010] QSC 344 arose following the sexual assault of an employee optical technician by a customer. In *NB* the claim failed by reason of the factual findings that the alleged assault did not occur, however the potential liability of the institutional health care provider appears to have been recognised by the court. In *Sapwell*, the claim succeeded.

(a) NB v Sydney South West Area Health Service

In *NB v Sydney South West Area Health Service (SSWAHS)* [2010] NSWDC 172, a recent decision of the District Court of New South Wales, the Court was required to consider the extent of a hospital's liability for an alleged sexual assault upon a medicated patient by a public hospital staff member. The liability of the Area Health Service was argued to arise in three ways: firstly, vicariously from its employee's conduct (at [118]); secondly from its non-delegable duty (at [125]); and thirdly, directly through its lack of care in recruitment of suitable staff, their training and supervision, and the existence of suitable handling mechanisms for complaints (at [132]).

Facts

NB[2] suffered a cerebellar haemorrhage and required treatment in the intensive care unit (ICU) of the Liverpool Hospital, a major hospital in western Sydney operated by the defendant Area Health Service. NB was 18 at the time of her admission in February 2006 and was within the ICU for 38 days. During this period she was unable to speak because of a tracheotomy and the consequences of her stroke. She was restrained at times to prevent her from dislodging various lines and tubes (at [5]).

It was alleged that the sexual assault occurred within the last 7 days of ND's ICU admission, when a male orderly drew the curtains around the plaintiff's bed, placed his fingers inside her vagina, and touched her breast (at [6]–[7]). ND said that she felt vulnerable and frightened, so she remained quiet and did not move (at [8]).

About 10 days after transfer from the ICU to a neurosurgical ward, ND used a letter board (because she was still unable to speak) to spell out the words "sexual assault" and the first name of the orderly in question. The nursing unit manager was informed and complaints were made to police and to the Health Care Complaints Commission (at [19]). The orderly in question denied the assault (at [30]).

Much of the judgment was devoted to an evaluation of the evidence with a view to determining whether it could be established that the alleged assault occurred. Relevant factual matters included the medical condition and sedation of the plaintiff, the layout of the ward, and the staff present. The court ultimately found that it was probable that the plaintiff was mistaken when she claimed that she was sexually assaulted (at [109]). Collecting the issues, Sidis DCJ said:

> [117] In summary, I took into account the evidence concerning the extent to which the plaintiff was medicated, the absence of any prior record of crime or misconduct by the ward orderly, the absence of opportunity for the ward orderly to commit the assault and the presence of an alternative rational explanation suggested by the treatment required to the plaintiff's perineal area, in concluding that I was not satisfied on the balance of probabilities that the plaintiff was sexually assaulted in the manner alleged.

Vicarious Liability

Sidis DCJ described as "well founded" (at [119]) the submission by the Area Health Service, relying on the

[1] Key features of the relationship that gives rise to a non-delegable duty are control on the part of the defendant said to owe a non-delegable duty and vulnerability on the part of the plaintiff.

[2] An order was made prohibiting the publication or disclosure of the name and any information tending to identify the plaintiff: Section 72, *Civil Procedure Act* 2005 (NSW).

authority of *New South Wales v Lepore* [2003] 212 CLR 511, to the effect that, if the assault occurred, it involved criminal conduct that was outside the scope of the terms of the ward orderly's employment, so that the Area Health Service was not vicariously liable to the plaintiff (at [118]). Sexual assault of the nature alleged by the plaintiff could not on any basis be regarded as a mode, proper or improper, of undertaking the authorised acts involved in fulfilling the role of a ward orderly (at [122])—such conduct being regarded as an "independent criminal act" (at [124]).

Perhaps that conclusion would have been different if the alleged perpetrator had been one of the nursing staff responsible for the perineal care of the plaintiff. In such factual circumstances, the test described above[3] might have been satisfied on the basis that the unauthorised act was a mode—although an improper mode—of doing authorised acts.

Non-delegable Duty

The trial judge stated that the duty owed by a hospital to its patients falls within the limited class of those recognised as non-delegable, which "acknowledges the extra responsibility imposed on hospital authorities to take reasonable care to protect patients from the risk of harm" (at [125]). Reference was made to the remarks of Mason J in *Kondis v State Transport Authority* [1984] 154 CLR 672 (at [687]), who described this level of responsibility as a special duty that:

> … arises because the person on whom it is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised.

As to whether such a non-delegable duty may extend to the criminal conduct of the kind alleged on the part of the ward orderly, Sidis DCJ was able to draw upon (at [128]) the following remark of Gleeson CJ in *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2000] 205 CLR 254 (at [26]):

> Leaving aside contractual obligations, there are circumstances where the relationship between two parties may mean that one has a duty to take reasonable care to protect the other from the criminal behaviour of third parties, random and unpredictable as such behaviour may be. Such relationships may include those between employer and employee, school and pupil, or bailor and bailee.

Sidis DCJ said that such duty arises because of "special vulnerability on the one hand and special knowledge combined with an assumption of responsibility on the other" (citing *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2000] 205 CLR 254 per Gaudron J at [42]).

In the employment context, by reference to the decision of the High Court in *New South Wales v Lepore* [2003] 205 CLR 254 (per Gaudron J at [42]), Sidis DCJ noted that an employer might be held directly liable for the criminal conduct of an employee if there was an element of fault on the employer's part that materially increased the risk of criminal conduct on the part of an employee (at [129]). Accordingly, the trial judge appears to have accepted that the employer– employee relationship, and/or the failings alleged on the part of the defendant as described below, could have led to liability on the part of the defendant by reason of its non-delegable duty (at [130]–[131]).

Recruitment, Supervision, and Complaints Processes

The defendant relied on its established recruitment processes to claim that it had taken reasonable care in the employment of the ward orderly (at [132]), who had commenced in the employ of the defendant only about 2 weeks before the admission of the plaintiff (at [134]). There were limited critical findings in relation to the recruitment process. Two of the three referees provided by the orderly were personal friends, hence unreliable referees (at [140]); the reference check form did not make clear which referees had made the

[3] As formulated in the first edition of Salmond's *The Law of Torts* (at [83]) and accepted in *New South Wales v Lepore* by Gleeson CJ (at [42]) and Kirby J (at [307]), who described the Salmond test—assessing whether the acts could be described as a mode, proper or improper, of performing the employee's role—as the "classic formulation."

comments recorded on the form (at [140]); and the Prohibited Employment Declaration Form, although probably signed, was missing from the relevant file (at [146]).

Evidence was led for the defendant as to systems for reporting of concerns and complaints; however, the trial judge noted that aspects of the report of the alleged incident suggested that complaints were not always handled with the ease and speed suggested by the defendant (at [155]). There was a delay in conveying the present complaint (at [168]).

The Court was left without the benefit of evidence showing who was directly responsible for the ward orderly and the method by which he was supervised. There was no evidence of any assessment of his conduct or the quality of his work notwithstanding his recent recruitment (at [164]). Reference was made in the judgment to the absence of earlier reports in relation to the inappropriate familiarity between the orderly and the patient's family and his remark about the regrowth of her pubic hair (at [167], [14]).

Ultimately, however, the defendant was found not to be in breach of its duty of care to the plaintiff (at [173]), given the finding that on the balance of probabilities the plaintiff was not sexually assaulted (at [117]).

(b) Sapwell v Lusk & Lusk

In *Sapwell v Lusk* [2010] QSC 344, a recent decision of the Supreme Court of Queensland, the Court was required to consider the extent of an optometrist practice's liability for a sexual assault by a client on one of its employees. The liability of the defendant was argued to arise out of breach of the non-delegable duty of care to provide a safe working environment, which was argued to extend to the protection from criminal acts by third parties.

Facts

The plaintiff, Ms Sapwell, was an experienced optical technician who in 2005 was employed at an optometry practice owned and operated by the defendants, situated in a shopping area in an inner Brisbane suburb. The plaintiff was often present at the premises on her own during her working hours, which at the relevant time were between 10 am and 6 pm Tuesday to Friday. While there were security measures in place to protect the shop overnight, no particular security measures were in place to protect the safety of employees of the shop during the day time (at [1]).

On January 18, 2005, Ms Sapwell, while working alone in the shop, assisted a male client, Mr Bartaged, about 70 years old, with a fitting of his glasses (Mr "Bart" proved to be a contraction of the full name of the assailant; at [10]). She then went into the back section of the shop to effect the necessary repairs. The area where repairs were conducted was accessed by a corridor that led to a room with a window in it, which was made of predominantly frosted glass with five slits of clear glass. The entry to the back section could not be shut or locked, as there was no door to that area. There was no view into the back section from the reception area or footpath or street, but some limited vision from the back section into the reception area of the shop (at [6]).

When the plaintiff went to the back section with Mr Bart's glasses, she was unaware that Mr Bart followed her. He placed his hands on her hips and she felt some gyrating behind her. He then cupped his hands on her breasts. She pushed past him and fled to the reception area of the shop (at [7]). After Mr Bart had left and all other customers were taken care of, she locked the door of the shop and called the police, reporting the indecent assault—which she said had distressed her greatly as she was a victim of indecent assault requiring hospitalisation as a 5-year-old (at [8], [9], [23], [24]).

Mr Bart later admitted the assault, which was apparently prompted in part by lack of impulse control arising from a medical condition (at [10]). He was charged but died before hearing (at [13]).

The trial judged found that, despite his medical condition, Mr Bart knew that assaulting Ms Sapwell was wrong and took advantage of the opportunity to assault her when she was out of sight of the public and more vulnerable (at [12]). Her Honour concluded that "(s)he did not face the same risk of assault from him, or indeed anyone else, while she was in public view" (at [12]).

Duty of Care and Breach of Duty

The trial judge identified the duty of care owed by an employer to employees as one requiring the exercise of reasonable care to avoid the foreseeable risk of injury. The common law formulation for the determi-

nation of breach of the standard of care[4] was referred to (at [68]–[69]). Her Honour found that the risk of injury was foreseeable, given that Ms Sapwell was a woman working alone in close customer contact, the performance of her duties took her to a part of the premises that was not visible to passing traffic and unable to be secured, and the task of repairing the glasses required concentration and impeded her capacity to be watchful for her own safety (at [69], [70]).

Justice Atkinson considered that given that an employer's duty of care was non-delegable, an employer could be held liable for the criminal acts of a third party where there was a failure to implement a safe system of work which exposed an employee to an increased risk of injury. She said:

> The duty of an employer to take reasonable care to protect employees from the criminal behaviour of third parties, random and unpredictable as such behaviour may be, was recognised by Gleeson CJ in *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2000] HCA 61 at [26]; [2000] HCA 61; 205 CLR 254. His Honour referred with approval to *Chomentowski v Red Garter Restaurant Ltd* (1970) 82 WN (NSW) 1070, *Public Transport Corporation v Sartori* [1997] 1 VR 168 and *Fraser v State Transport Authority* [1985] 39 SASR 57. The employers were, in each of those cases, found liable for the injury to their employees from the criminal act of a third party because of their failure to implement a safe system of work in circumstances where it was foreseeable that their failure to do so exposed the employee to an increased risk of injury. It is the very nature of the non-delegable duty of care of an employer to his or her employees that give rise to that duty which does not exist in the ordinary neighbour situation where there is no general duty to prevent third parties doing harm to another.
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> The source and content of the employer's duty to the employee was set out in some detail by McColl JA *in Gittani Stone Pty. Limited v Pavkovic* [2007] NSWCA 355, whose analysis I gratefully adopt as apposite to this case. Her Honour referred to the statement of the duty by Gleeson CJ in Modbury Triangle and then continued with regard to the employment situation at [135]–[143]:
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> > [135] In *New South Wales v Lepore* [2003] HCA 4 at [2]; [2003] HCA 4; 212 CLR 511, Gleeson CJ referred to paragraph [26] in *Modbury* to describe the relationship between a school authority and pupil as "one of the exceptional relationships which give rise to a duty in one party to take reasonable care to protect the other from the wrongful behaviour of third parties even if such behaviour is criminal." His Honour's remarks clearly also encompassed the relationship of employment.
> >
> > [136] The reason the employer is subject to that exceptional obligation is because of the heavy burden imposed on employers to take reasonable care for the safety of their employees [71]–[72].

Atkinson J concluded that the reasonable response to such a risk is to be determined by weighing the magnitude of the risk, the degree of probability of its occurrence, and the expense, difficulty, and inconvenience of taking alleviating action (at [73]). Her Honour held that, although not very likely, the risk of a female employee being sexually assaulted whilst working alone was a serious one (at [73]). An obvious way to reduce such risk was to have mechanisms in place which enable an employee who is alone and in a situation where she or he does not have the protection of being able to be seen by members of the general public to exclude others from the work space (at [74]). The evidence showed that the cost of purchasing and installing an infra-red security beam, to warn

[4] Mason J in *Wyong Shire Council v Shirt* [1980] HCA 12 (at [14]); (146) CLR 40 (at [48]): "In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk. The perception of the reasonable man's response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have. It is only when these matters are balanced out that the tribunal of fact can confidently assert what is the standard of response to be ascribed to the reasonable man placed in the defendant's position."

employees of the approach of others, would have been $300-plus GST. The cost of a self-locking door with swipe or pin would have been $1,200-plus GST (not including the door) (at [75]). Given that the consequences of assault were serious, and to guard against such assault was relatively easy and inexpensive, to fail to install such protective mechanisms was a breach of duty (at [76]).

On the issue of causation, the defendant argued that even if such security measures had been installed the plaintiff may not have used them. Given that an employer's duty is not satisfied merely by installing safety devices but also requiring employees how to use them, Atkinson J was satisfied that if there had been a security system in place and instructions to use it, the plaintiff would have done so (at [77]).

Having found that the defendant optometrist practice was in breach of its duty and that this caused the plaintiff's psychiatric injury, Her Honour awarded damages in the sum of $390,558.82.

Concluding Comments

The nature of the duties owed to employees of hospitals and similar health care facilities and the duties owed to patients by such facilities are non-delegable. This is due to the control, special knowledge, and an assumption of responsibility on the part of the facility and the vulnerability on the part of the patient/employee, which creates a reasonable expectation that the facility will ensure reasonable care is taken to prevent injury to both patients and employees. As noted by Gaudron J in *Modbury Triangle Shopping Centre Pty Ltd v Anzil* [2000] 205 CLR 254, this duty may extend to taking reasonable care to protect against harm arising out of the criminal conduct of others:

> [42] There are situations in which there is a duty of care to warn or take other positive steps to protect another against harm from third parties. Usually, a duty of care of that kind arises because of special vulnerability, on the one hand, and on the other, special knowledge, the assumption of a responsibility or a combination of both. Those situations aside, however, the law is, and in my view should be, slow to impose a duty of care on a person with respect to the actions of third parties over whom he or she has no control.[5]

When a sexual assault has been committed, liability may arise on the part of the facility where there is a breach of a non-delegable duty to ensure a safe system of work and safe working environment and an employee suffers a sexual assault that causes injury, as was the case in *Sapwell v Lusk*, or there is a breach of a personal non-delegable duty to take reasonable care in the recruitment, training, and supervision of employees, as was suggested by the decision in *NB v SSWAHS.* Where the sexual assault is committed by an employee in the course of employment, vicarious liability may arise.

Although there are few reported cases in Australia, similar duties have been pleaded before, such as in *Hatch v Central Sydney Area Health Service* [1999] NSWCA 168, where a patient claimed in respect of an injury caused to him by another patient in a drug and alcohol ward (Madden and McIlwraith 2008, at [4.10]) and where a patient claimed that a hospital had an inadequate recruitment process and selected incompetent staff, as discussed in *Wilsher v Essex Area Health Authority.*[6]

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[5] See also *Adeels Palace Pty Ltd v Moubarak; Adeels Palace Pty Ltd v Bou Najem* [2009] HCA 48 (at [23]–[26]).

[6] [1987] QB 730 at 778. See the discussion entitled "Organisational errors" by Jones (2008, at [9–017]).