Health Legal Report – March 2017

Welcome to the March 2017 edition of the Health Legal Report.

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We also set out some of the Bills we are tracking throughout Australia, as well as some useful information links.

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New data breach notification laws

By Giovanni Marino, Senior Solicitor

Introduction

The Privacy Act 1988 (Cth) (**Act**) has been amended by the *Privacy Amendment (Notifiable Data Breaches) Act 2017* (Cth) (the **amending Act**).

The amending Act introduces a mandatory data breach notification regime where an 'eligible data breach' occurs.

The amendments will commence on 23 February 2018, unless they are proclaimed to commence earlier.

Who is required to comply with the new laws?

The new reporting regime will apply to 'APP entities' that hold personal information (those entities that must comply with the Australian Privacy Principles under the Act). In general, private health care organisations, including community health centres, and other private health providers will be considered APP entities. Public hospitals and health services in Victoria will not be considered APP entities.

The regime will also apply to certain credit reporting bodies and credit providers that hold credit reporting or credit eligibility information, and recipients of tax file number information.

What is an 'eligible data breach'?

An 'eligible data breach' occurs where:

- there is:
  - unauthorised access to, or unauthorised disclosure of, the information; or
  - there is loss of the information where unauthorised access or disclosure is likely; and
- a reasonable person would conclude that the access or disclosure would likely result in serious harm to any of the individuals to who the information relates.

These individuals to whom the serious harm would likely result are defined as being '**at risk**'.

'Serious harm' is not defined in the Act, but the Explanatory Memorandum to the amendments states that serious harm could include:

> … serious physical, psychological, emotional, economic and financial harm, as well as serious harm to reputation and other forms of serious harm that a reasonable person in the entity's position would identify as a possible outcome of the data breach.

What are the notification requirements?

If an organisation has reasonable grounds to believe that there has been an eligible data breach, then it must provide a statement to the Australian Information Commissioner (the **Commissioner**) which sets out matters including:

- the identity and contact details of the organisation;
- a description of the eligible data breach;
- the kind or kinds of information concerned; and
- recommendations about the steps that individuals should take in response to the eligible data breach.

As soon as practicable after preparing the statement for the Commissioner, the organisation must also take reasonable steps to notify the statement information to either:

- each individual to whom the information relates; **or**
- if not all these individuals are deemed to be 'at risk', only those affected individuals who are deemed to be 'at risk'.

The Explanatory Memorandum explains that:

> This discretion is intended to provide flexibility to respond to different kinds of eligible data breaches. For example, in some cases it may be impracticable for an entity to consider the circumstances of each affected individual to determine which individuals are at risk from an eligible data breach and which are not. In these circumstances notifying the entire cohort of affected individuals may be appropriate. In other cases it may be practicable for an entity to determine with a high degree of confidence that only some individuals from a broader group of affected individuals are at risk, meaning that notification to the broader group may not be necessary from a harm mitigation perspective.

The Commissioner may also direct an organisation to prepare a statement where the Commissioner has reasonable grounds to believe that there has been an eligible data breach. Prior to the Commissioner giving such a direction, the organisation will be invited by the Commissioner to make submissions to the Commissioner within a specified period.

What is required where an eligible data breach is suspected?

If an organisation has reasonable grounds to *suspect* that there *may* have been an eligible data breach, then it must carry out a reasonable and expeditious assessment of whether there are reasonable grounds to believe that the circumstances amount to an eligible data breach. If this is the case, then the notification requirements described above will apply.

The organisation must take reasonable steps to complete the assessment of the suspected data breach within 30 days.

Are there any exceptions to the data breach notification requirements?

There are certain exceptions to the notification regime, including where an organisation takes remedial action to address any unauthorised access to or disclosure of information, or loss of information, and:

- in relation to unauthorised access or disclosure – the remedial action occurs before there is any serious harm to any affected individuals to whom the information relates, and a reasonable person would conclude the access or disclosure would not likely result in serious harm to any of those individuals; or
- in relation to loss of information – the remedial action occurs:
  - before there is any unauthorised access to or disclosure of the information, and as a result of the action there is no unauthorised access or disclosure; or
  - after there is any unauthorised access to or disclosure of the information, but before the access or disclosure results in serious harm to any individuals to whom the information relates, and a reasonable person would conclude the access or disclosure would not likely result in serious harm to any of those individuals.

If multiple entities are holding the same information, and a single eligible data breach incident affects more than one entity, only one of the entities needs to comply with the notification regime in respect of the data breach.

Determining when access or disclosure will result in serious harm

The amending Act sets out a list of factors to consider in order to determine whether a 'reasonable person' would conclude access or disclosure of information will likely result in serious harm to affected individuals. These include:

- the kind or kinds of information;
- the sensitivity of the information;
- whether the information is protected by one or more security measures, and the likelihood that any of those security measures could be overcome;
- the persons, or the kinds of persons, who have obtained, or who could obtain, the information;
- the likelihood that the persons who have obtained, or who could obtain, the information have the intention of causing harm to any of the individuals to whom the information relates;
- the nature of the harm; and
- any other relevant matters.

What happens if an organisation does not comply with the requirements?

Breach of the data breach notification requirements or the requirement to assess suspected data breaches are taken to be acts that are 'an interference with the privacy of an individual'.

Section 13G of the Act provides that a civil penalty applies to serious or repeated interferences with the privacy of an individual. An individual penalty of $360,000 and a maximum corporate penalty of $1,800,000 currently applies for breach of this provision.

Conclusion

Organisations should review their policies and procedures regarding data breaches, and prepare data breach response plans in line with the requirements of the amending Act (if these are not in place already).

The data breach response plans should contemplate potential remedial action to prevent any serious harm occurring to any affected individuals.

Organisations that hold or share data in collaboration with other entities or service providers may wish to establish processes to enable a coordinated response to any data breach.

*If you have any questions arising out of this article, please contact **Giovanni Marino** on **(03) 9865 1339** or email **giovanni.marino@healthlegal.com.au**.*

Useful information links

At Health Legal we regularly access a broad range of information to ensure we keep up to date on what is happening in our areas of interest, both here in Australia and overseas.

In each publication we will share some of our regularly accessed sources of information, which we believe our clients will find useful. The links we would like to share this time are:

- **Opinions On High**:
  The Melbourne Law School High Court Blog provides commentary on and analysis of recent High Court decisions
- **https://blog.csiro.au/tech/**
  Informative CSIRO blog on technology developments including the Internet of Things, Apps and Big Data.
- **https://www.genome.gov/issues/**
  American National Human Genome Research Institute Issues in Genetics Blog covering policy, ethical and legal issues in genetic research.
- **http://www.ibac.vic.gov.au/IBAC-Insights**
  IBAC Insights subscription providing current news, corruption prevention tips and summary of new reports from the Victorian Independent Broad Based Anti-Corruption Commission.
- **https://www.conveneit.com/secure/oaic/privacy_jul_17/**
  Website for data privacy 2017 conference in Sydney July 2017.

Do your accreditation policies create a contract?

By Alon Januszewicz, Associate Legal Counsel

Introduction

Typically medical specialists must submit their credentials in order to provide services at a hospital. This way, health service organisations are able to ensure that practitioners are sufficiently qualified and experienced to practice with that particular organisation within a defined scope of practice (commonly referred to as an 'accredited practitioner'). In applying to be accredited, practitioners will often be required to agree to abide by a range of by-laws, codes of conduct and policies. The question is; does this agreement create a contract? And if a contract is created, what are the implications for the health service?

Recent cases in Australia

Two State Supreme Courts have recently considered the first question. In the Western Australia case of *Pisano v Health Solutions*, the Court found that the respondent hospital had entered into a contract with the applicant upon re-accreditation, however this only extended so far as to grant clinical privileges and did not confer any rights on the practitioner with respect to the allocation of theatre sessions.

However, a recent New South Wales case of *Page v Healthscope* found that the medical practitioner's reaccreditation amounted to a conditional licence which merely permitted the practitioner to attend the premises of the hospital to render medical services. In this case, the practitioner claimed that the Hospital ought to have handled his bullying complaint in accordance with its policies and that its failure to do so caused him to suffer loss. Had the practitioner been successful in making that argument, the Hospital could have been liable to him for the loss.

The Court was not satisfied that the accreditation of the doctor created any contractual obligations for either party. The Court found in *Page* that the policies and Code of Conduct were merely aspirational, and took effect as statements of good practice. They were not contractually enforceable.

Do accreditation policies create a contract?

A contract will come into existence if the necessary elements are present: offer and acceptance, an intention to enter into contractual relations and consideration.

Mutual consideration needs to be evident when entering into a contract. In its most basic form, consideration may be seen in the price paid for a good or service. However, consideration may also be seen in an exchange of promises. That is, where each party promises to do, or not do, something which is of value to the other party.

According to *Page*, an agreement between a health service and practitioner which simply allows the practitioner to enter the hospital's premises (subject to the continued permission of its general manager) does not constitute 'good consideration'. Hence, the doctor did not enjoy any contractual rights under the hospital's policies.

What are the implications of entering into a contract?

A contract creates binding obligations. Accordingly, where a party does not act in accordance with its binding obligations, the other party may seek damages (for losses caused by the breach) and may also seek an order that would require the party to perform its contractual obligations. Conversely, if the credentialing documents (and related policies) are not binding, neither party can seek to enforce their terms.

In many cases the health service would already be a party to a contract with its medical practitioners. Hospitals may employ the doctors and enter into private practice agreements. However, in *Pisano* and *Page* the practitioners attempted to enforce

rights which they claimed arose under the credentialing policies (in the absence of any other contractual agreements).

In *Pisano,* the Court found that the effect of the credentialing agreement was akin to a 'ticket that provides entry to the showground'. The Court continued: 'It does not carry the right to ride any particular attraction. That right must be the subject of a separate agreement'.

In other words; merely being granted permission to enter the hospital did not grant the practitioners (in both *Page* and *Pisano*) the right to render any services. That would only be the case where additional rights were conferred in a contract.

What can we learn?

Essentially, if the health service intends to rely on its credentialing policies having contractual force, it would be best for the documents to clearly express that intention. That also means that the health service will be subject to the obligations expressed in the document. Otherwise, if the credentialing documents are only intended to express best practice (as the Court found in *Page*), that should be made clear.

Further, as a matter of clinical risk management, hospitals will wish to be able to refuse access to doctors to use the hospital's facilities. Whether that takes place by way of revoking the practitioner's licence, or terminating a contract, the credentialing policies should permit such action. If the credentialing policies are contractually binding, the hospital must also comply with the terms of the policy with respect to the grounds on which, and procedure to be followed, in revoking access to the hospital's facilities.

It is also important that the language of the policies reflect the rights which the health service wishes to confer on its medical practitioners, and equally, the obligations which it agrees to assume.

*If you have any questions arising out of this article, please contact Alon Januszewicz on **(03) 9865 1312** or email **alon.januszewicz@healthlegal.com.au**.*

Compliance Alert Service

In response to client demand we have developed a compliance alert service which complements our existing legislative compliance products and services.

Updates to the Compliance Register and Self-Assessment Questions are delivered on a quarterly in arrears basis so that you are updated on legislative changes which have occurred in previous 3 month period.

We have now launched an alert service which provides you with pro-active advanced warning of the commencement of new significant Acts and Regulations. "Significant" Acts and Regulations means those which will have a significant operational impact on your organisation. As part of this alert, we will provide you with a summary of the legislation and provide you with a link to the relevant Act/Regulation.

This alert service will allow you to prepare for new legislation before the Acts and Regulations have commenced.

LAW COMPLIANCE

If you would like to add this service to your current subscription (or if you have any questions), please contact ***Teresa Pollock*** *on* ***(03) 9865 1337*** *or* ***teresa.pollock@lawcompliance.com.au***.

Medical Decision Making and Advance Care Planning

By Anne Howard, Solicitor and Claudia Hirst, Legal Counsel

Introduction


The *Medical Treatment Planning and Decisions Bill 2016* (Vic) passed the Legislative Assembly on 24 November 2016 and received Royal Assent on 29 November 2016.

The *Medical Treatment Planning and Decisions Act 2016* (Vic) (the **Act**) is set to commence on the earliest of a day to be proclaimed or 12 March 2018.

Background

The main objective of the Act is to ensure that people's preferences and values direct decisions about their treatment and care even if they lose capacity to make decisions. The Act will achieve this by establishing a comprehensive new legislative framework for medical treatment decision making for people who do not have capacity and by giving statutory recognition to advance care directives in Victoria.

Some of the key aspects of the new Act are outlined below.

Refusal of medical treatment

The Act will repeal the *Medical Treatment Act 1988* (Vic) and consequently the ability to complete a refusal of treatment certificate under that Act. Instead the right of a competent patient to refuse medical treatment will be exercised by making an advance care directive (discussed in detail below) and the decision to refuse treatment on behalf of an incompetent patient will be exercised by the person's medical treatment decision maker under the Act.

However, a refusal of treatment certificate in force under the *Medical Treatment Act 1988* (Vic) immediately before the repeal of that Act (that date being 12 March 2018) will remain in force until such time as it is revoked or otherwise ceases to have effect in accordance with that Act.

Advance Care Directives

Under the Act, a person with decision making capacity (including a child) will be allowed to make an advance care directive.

An advanced care directive is a document that sets out a person's binding instructions or preferences and values in relation to the medical treatment of that person in the event that the person loses decision making capacity.

An advance care directive may contain either or both of the following:

- an instructional directive (which allows a person to provide binding instructions about their future medical treatment, including whether they consent or refuse to consent to treatment (including 'special procedures' as defined in the *Guardianship and Administration Act 1986* (Vic)); or
- a values directive (which allows a person to describe their preferences and values in relation to future medical treatment that must then be taken into account by their medical decision maker).

Unlike a refusal of treatment certificate under the *Medical Treatment Act 1988* (Vic), an advance care directive will not be restricted to treatment for a current condition.

For an advance care directive to be valid it must be written in English, include the full name, date of birth and address of the person giving it, be signed by the person giving it and witnessed and certified by two adults, both of whom must certify that at the time of signing the document, the person giving the advance care directive appeared to have decision making capacity in relation to each statement in the

directive. In addition, at least one of the witnesses must be either a registered health practitioner or a person who is authorised by law to take affidavits, including a legal practitioner (sections 16 and 17 of the Act).

Section 50 of the Act requires health practitioners to make reasonable efforts to ascertain whether a person has an advance care directive and to give effect to it, or if it is a values directive, take it into account when making a decision regarding treatment. Failure to comply with this requirement will amount to unprofessional conduct.

Where there is uncertainty as to the validity, meaning or effect of an advance care directive or any other matter in relation to an advance care directive, an eligible applicant may apply to VCAT for an order, revoking, varying or suspending the directive or declaring the directive to be valid. An 'eligible applicant' is defined to include a health practitioner or the medical treatment decision maker of the person (see section 22 of the Act).

Medical treatment decision makers

The Act will repeal Part 4A (except provisions relating to 'special procedures') of the *Guardianship and Administration Act 1986* (Vic), which includes section 37 (Person Responsible). Section 37 will be replaced by the medical treatment decision maker hierarchy set out in section 55 of the Act.

Under section 55 of the Act, if a patient is clinically assessed as not competent to make a 'medical treatment decision', then legally the person's 'medical treatment decision maker' will be the first person listed in section 55 of the Act who is responsible for the patient and who, in the circumstances, is reasonably available and willing and able to make the medical treatment decision. 'Medical treatment decision' is defined to mean a decision to consent to or refuse the commencement or continuation of medical treatment.

The first person listed in section 55 of the Act is a person appointed by the patient under section 26 of the Act to be the patient's medical treatment decision maker. The hierarchy also includes other decision makers such as existing enduring powers of attorney (medical treatment), VCAT appointed guardians and the patient's relatives.

Where a medical treatment decision maker refuses 'significant treatment' (as defined in the Act) on behalf of a person whose preferences and values are unknown, the treating health practitioner must notify the Public Advocate (section 62 of the Act).

The Act will also remove references to 'health' in the *Powers of Attorney Act 2014* (Vic). The effect of this amendment will be that the *Powers of Attorney Act 2014* (Vic) will only govern substitute decision making for financial and lifestyle decisions and the Act will govern substitute decision makers for medical treatment decisions.

However, an enduring power of attorney (medical treatment) or an enduring power of attorney with power to make medical treatment decisions in force under the *Powers of Attorney Act 2014* (Vic) immediately before the commencement of the Act (that date being 12 March 2018) will still remain in force until such time as they are revoked or otherwise cease to have effect in accordance with the *Powers of Attorney Act 2014* (Vic).

Emergency Treatment

The Act contains a similar provision to section 42A of the *Guardianship and Administration Act 1986* (Vic) in relation to emergency medical treatment. Section 53 of the Act provides that medical treatment can be performed without consent where the health practitioner believes on reasonable grounds that the medical treatment is necessary, as a matter of urgency to save the person's life, prevent serious damage to the person's health or prevent the person from suffering or continuing to suffer significant pain or distress.

However, medical treatment cannot be performed where the health practitioner is aware that the person has refused the particular medical treatment, whether by way of an instructional directive or a legally valid and informed refusal of treatment by or under another form of informed consent. This obligation does not, however, require the health practitioner to search for an advance care directive that is not readily available if the circumstances set out in section 53 of the Act apply.

Treatment where there is no medical treatment decision maker

Under section 63 of the Act, where there is no medical treatment decision maker for a person and a health practitioner has been unable to locate an advance care directive for that person, then routine medical treatment may be performed without

consent. However, if the medical treatment is significant treatment, the medical treatment may only be performed if the Public Advocate consents.

'Routine treatment' is defined to mean any medical treatment other than 'significant treatment'.

Issues for implementation

The implementation of the Act will take place over the next twelve months.

We note the Department of Health and Human Services is currently developing educational material and workshops to support health services and aged care providers to understand their obligations under the Act.

Health services and aged care providers will need to review consent and refusal of treatment policies and train staff on the recognition and use of the instructional and values advance care directives and the status of medical treatment decision makers.

*If you have any questions arising out of this article, please contact **Anne Howard** on **(03) 9865 1311** or email **anne.howard@healthlegal.com.au**.*

Policy Service

As a result of client demand we have extended our compliance services to cover policy wordings.

From our perspective:

- understanding where a legislative obligation fits within a policy framework can be difficult, and
- organisations often don't have sufficient resources to keep their policies legally up to date.

Our new service aims to assist organisations to overcome these issues.

Health Legal now offers a new quarterly update service where subscribers are given:

- guidance about the types of policies that may be affected by a legislative change,
- suggested wording for relevant policies to allow subscribers to modify their own policies, and
- completely new policies if Acts in new areas of law are introduced (or existing Acts are substantially re-written).

*If you have any questions about the Policy Service please contact **Teresa Pollock** on **(03) 9865 1337** or **teresa.pollock@lawcompliance.com.au**.*

Staff News

Jeremy Smith will be joining Health Legal as a Compliance Solicitor on his admission in April. Jeremy has become an integral member of our growing compliance team and part of his role will be monitoring legislation as it progresses through Parliament. Congratulations, Jeremy.

Children Legislation Amendment (Reportable Conduct) Bill 2016 (Vic)

By Ksandra Maruna, Compliance Solicitor

Introduction

The *Children Legislation Amendment (Reportable Conduct) Bill* (Vic) (the **Bill**) which will amend the *Child Wellbeing and Safety Act 2005* (Vic) (the **Act**) passed the Upper House of the Parliament of Victoria on 23 February 2017 and is awaiting Royal Assent.

The Bill is due to commence on 1 September 2017 (unless it comes into force earlier).

New reportable conduct scheme – who does it apply to?

The purpose of the Bill is to establish a new reportable conduct scheme (**scheme**) in Victoria that requires an allegation of *reportable conduct* involving a child, committed by an employee within or connected to certain entities, to be reported by the entity to the Commission for Children and Young People (**Commission**).

Reportable conduct includes a sexual offence or misconduct involving a child, physical violence against a child, significant neglect of a child and any behaviour that is likely to cause significant emotional or psychological harm to a child.

The scheme applies to entities listed in Schedules 3, 4 and 5 of the Bill (**entities**). Schedule 3 entities will be required to comply with the scheme from the day the Bill commences and those **Schedule 3 entities** include:

- out of home care service;
- registered schools;
- disability service providers that provide residential services for children with a disability;
- mental health service providers that provide in-patient beds;
- government departments;
- applicable entities that receive State funding to provide child protection services, in-patient beds for drug or alcohol treatment or overnight beds for children as part of housing services or assistance to homeless persons.

Those entities listed in Schedule 4 of the Bill (**Schedule 4 entities**) will be required to comply with the scheme from the day 6 months after the Bill commences. Schedule 4 entities include:

- religious bodies;
- hospitals;
- disability service providers;
- other entities providing disability services.

The entities listed in Schedule 5 of the Bill (**Schedule 5 entities**) will be required to comply with the Scheme from the day which is 18 months after the Bill commences. Schedule 5 entities include children's services; approved providers under the *Education and Care Services National Law* (Victoria), and any prescribed entity that is constituted by or under any Act and that has functions of a public nature.

Obligations imposed on entities

Organisations that are Schedule 3, 4 or 5 entities in accordance with the Bill should be aware that the Bill will introduce section 16K to the Act which requires the head of an entity to ensure that systems are in place to prevent reportable conduct within the course of an employee's employment, and to investigate and respond to any *reportable allegation* (being a reasonable belief that an employee has committed reportable conduct), and to enable any person to notify the head of the entity of a reportable allegation.

In addition, the newly introduced section 16M requires the head of an entity to notify the Commission of certain matters, and within a required timeframe when it becomes aware of a reportable allegation against an employee of the entity. Failure to comply with section 16M is a criminal offence incurring a sanction of 10 penalty units.

The new section 16N will impose an obligation on the head of an entity to respond to reportable allegations, by investigating the reportable allegation or permitting a regulator or independent investigator engaged by the entity or regulator to do so.

Finally, organisations that are Schedule 3, 4 or 5 entities in accordance with the Bill should be aware the newly introduced section 16ZA requires an entity or the head of an entity to provide any assistance to the Commission that is required in connection with the performance of the Commission's functions under the Bill.

*If you have any questions arising out of this article, please contact **Ksandra Maruna** on **(03) 9865 1320** or email **ksandra.maruna@healthlegal.com.au**.*

Precedents/Standard Form Agreements and Policies

Due to client demand, we have developed a range of standard form Agreements and Policies which are commonly used by health, aged care and community service providers. The documents have been prepared in a template form so they can be completed by your staff and include service contracts for the provision of pathology and radiology services, requests for tenders, leases and supply of goods contracts.

Precedents recently added to our range include a consultancy suite hire contract, supply of equipment with associated services agreement, sponsorship agreement and a short form Request for Proposal.

*For further information about these precedents please contact **Natalie Franks** on **(03) 9865 1324** or **natalie.franks@healthlegal.com.au**.*

Compliance Subscribers

Our compliance team are in the midst of obtaining feedback from all legislative compliance subscribers and are gathering expressions of interest in attending a workshop/forum on the products and services currently offered. We will be conducting one for users of our Word based product and others specifically for those who access our content via RiskMan or Advent Manager. If you are interested in attending any of the forums (likely to be a half day), please contact ***Jeremy Smith*** at ***jeremy.smith@healthlegal.com.au***.

Case Report – State Government liability for failure to prevent child abuse

Special Leave to Appeal Granted to State of NSW

By Jeremy Smith, Compliance Officer

Introduction

In this case, the High Court granted special leave to appeal from the decision in *DC v State of New South Wales* [2016] NSWCA 198 (**summarised in the November 2016 edition of the Case Law Update**), in which the State of New South Wales (the **State**) was held liable for the failure of the Department of Youth and Community Services (the **Department**) to prevent the continuing sexual abuse of two children who were the subject of child protection proceedings in the 1970s and 1980s.

Facts

The respondents (**DC and TB**) were sexually and physically abused by their step-father, LX, during the 1970s and early 1980s. In April 1983, TB brought the abuse to the attention of the Department, which investigated the allegations and commenced child protection proceedings under the *Child Welfare Act 1939* (NSW) (**Child Welfare Act**). The abuse allegations were substantiated by admissions from LX and the sisters' mother obtained during the investigation. Following this, the Children's Court made orders placing DC and TB into their mother's care with conditions that were intended to restrict the step-father's access, though there were questions regarding the effectiveness of these orders. In 2001, the sisters filed a complaint with New South Wales Police, which culminated in LX pleading guilty to 9 criminal charges in relation to abuse that had occurred pre-April 1983.

Soon afterwards, the sisters commenced negligence proceedings against the State on the basis that in failing to report LX to the police, the Department failed to discharge its duty of care, which it owed them by virtue of its powers under the Child Welfare Act, to act reasonably in the exercise of their statutory powers. Specifically, they alleged that this duty of care required the Department to report LX to the police pursuant to section 148B(5) of the Child Welfare Act, which then read:

> Where the Director has been notified under… [the Child Welfare Act], he shall –
>
> (a) promptly cause an investigation to be made into the matters notified to him; and
>
> (b) if he is satisfied that the child in respect of whom he was notified may have been assaulted, ill-treated or exposed, take such action as he believes appropriate, which may include reporting those matters to a constable of police.

The sisters alleged that LX had continued to abuse them post-April 1983, and that as a result the State was liable for the injuries (specifically post-traumatic stress disorder).

In the Court of Appeal, the sisters successfully appealed the trial judge's decision in the New South Wales Supreme Court. The majority judgement accepted documentary evidence including interview records and Departmental file notes as supporting a finding that the abuse had continued to occur post-April 1983. Ward JA (with whom Sackville JA agreed) held that the duty owed by the State was a duty, in exercising the powers under the Child Welfare Act, to take 'all reasonable steps in the circumstances of the appellants' case to protect them from the risk of further physical and sexual abuse (and consequent physical and mental harm) at the hands of the step-father'. The Court found that the Department had breached its duty of care on the basis that case officers in the Department were aware of LX's conduct, of his pre-existing criminal record for sexual offences against minors and formally reporting abuse was consistent with internal guidelines in place at the time and was also

consistent with usual practice. The Department's failure to notify police therefore constituted a breach of its duty of care. Basten JA, however, dissented on the basis that the discretionary power should not be construed as requiring the Department to do more than 'consider the available options', and to do so was to 'convert' it to a 'common law obligation' rather than a statutory power.

The State proceeded to a special leave application to the High Court.

Special leave application

Applicant's submissions

Counsel for the Applicant (the State of NSW) submitted that there were two important questions that warranted an appeal:

- Where a duty of care is established by a legislative power that gives the responsible person a number of different choices to be exercised at their discretion depending on the circumstances, if the responsible person, in considering the available options, chooses one such option but not another, does the 'failure to choose the other option give rise to a breach' of that duty of care?
- In cases where legislation empowers a head of a government department to take steps to protect certain people, in this case children, can the State be held vicariously liable where there is no finding of a breach of duty by any officer'?

In relation to the first question, the Applicant submitted that the majority of the Court of Appeal erred in formulating the scope of the duty of care owed to the Respondents by the Department. They argued that the wide breadth of the discretionary power in question required the director to make 'complex multifactorial judgements' before deciding which actions were 'appropriate'. Citing Basten J's dissenting opinion, they submitted that as a matter of principle, construing the duty of care as a duty to take all reasonable steps was inconsistent with the 'discretionary power to take such steps as the Director considers appropriate'. In support, they argued that to do so was to ignore the complexity of such situations. Further, they continued, there was no guarantee that reporting LX to the police would have been any more effective than pursuing the matter through child protection proceedings unless it led to LX's immediate arrest and incarceration.

With regards to the second question, the Applicant also submitted that no breach of duty by officers involved had been established for which the Department could be held vicariously liable.

Respondent's submissions

The Respondent submitted that 'in this particular case duty of care was admitted' and the only relevant question was 'whether it extends to reporting to police in the particular case'.

The Respondent argued that the proper construction of the duty was that it imposed a 'continuing' obligation on YACS to continue monitoring the situation and to take further action when it became apparent that the orders made by the Children's Court were 'ineffective' in protecting the girls. In support of this proposition, they pointed to the assessment of a YACS district officer that LX was 'unlikely to change', and emphasised that the evidence demonstrated that once the girls were back with the mother, LX 'was getting regular access to the girls'. Furthermore, they pointed to evidence that 'the mother openly admitted to the YACS officer that the abuse was continuing'.

In these circumstances, they argued that 'nothing else was going to protect the girls' other than reporting the matter to police. Furthermore, they continued, there was no evidence that reporting the matter to the police was ever actually considered. They submitted that the fact-dependant nature of the case meant that the issue of principle raised by the Applicant should not factor into the proper construction of the scope of the duty in this case.

Further, on the question of vicarious liability, they submitted that they were not required to 'identify the particular individual' but 'merely… to identify the failure', which they submitted they had done.

The Court's decision

The Court granted the application for special leave in relation to the issues of the scope of the duty of care owed by the Department and vicarious liability of the State where no specific failure by an officer of the Department was identified.

Conclusion

This case is noteworthy because it is a reminder that statutory bodies or holders of statutory powers may owe a duty of care that will entitle others to sue in negligence.

The High Court's consideration of the scope of a duty of care established by a statutory power will provide guidance on the way that such powers are to be exercised.

If you have any questions arising out of this article, please contact ***Jeremy Smith*** *on* ***(03) 9865 1342*** *or email* ***jeremy.smith@healthlegal.com.au***

Elder Law Update – Responding to Elder Abuse

By Anne Howard, Solicitor

Introduction

This is an update to the article in the August 2016 Edition of the Health Legal report.

Background

The Australian Law Commission (the ALRC) is currently conducting an inquiry into elder abuse (the Inquiry). The Inquiry is tasked with identifying a "best practice legal framework" for the prevention, mitigation and response to elder abuse.

In June 2016, the ALRC released an Issues Paper inviting submissions by 18 August 2016. For a detailed discussion of the Issues Paper, please see the August 2016 Edition of the Health Legal Report.

The ALRC has released a Discussion Paper in response to the submissions, which includes 43 proposals for law reform and invited further submissions. This will then be followed by a final report in May 2017.

Key proposals

ALRC President Professor Rosaline Croucher AM, Commissioner-in-charge of the Inquiry said the following in relation to the development of the proposals in the Discussion Paper:

> "we have worked to balance the autonomy of older people with providing appropriate protections, respecting the choices that older people make, but also safeguarding them from abuse."

Relevantly, the proposals in the Discussion Paper are in line with the *Medical Treatment Planning and Decisions Act 2016* (Vic). The Act is set to commence on 12 March 2018 (as discussed earlier in this Health Legal Report). One of the main objectives of the Act is to harmonise and simplify the medical treatment decision making process in Victoria and to ensure that people without decision making capacity receive treatment that is consistent with their preferences and values.

Below we highlight some of the specific proposals for law reform advanced by the ALRC Discussion Paper that are particularly relevant to health services and aged care providers.

Enduring powers of attorney and enduring guardianship (proposals 5-1 and 5-10)

The Discussion Paper proposes the establishment of a national online register of enduring documents and court and tribunal orders for the appointment of guardians and financial administrators.

The Discussion Paper identifies that enduring documents may facilitate abuse by the very person appointed by the older person to protect them. For example, the Discussion Paper states that evidence suggests that financial abuse is the most common form of elder abuse. Accordingly, the proposal is intended to ensure that enduring documents are only operative in circumstances genuinely authorised by an older person. The establishment of a national online register of enduring documents will prevent an attorney attempting to rely on an enduring document that has been revoked.

Further, the Discussion Paper recommends the introduction by State and Territory governments of nationally consistent enduring powers of attorney (including financial, medical and persons), enduring guardianship and other substitute decision makers.

Relevantly, the Discussion Paper notes that significant numbers of submissions included instances of elder abuse which were at least, in part, contributed to because of a misunderstanding of the enduring document. Accordingly, the proposal is intended to bring clarity to the nature of the relationship created by an enduring document, the powers and responsibilities it contains and the safeguards in place to protect the principal.

Aged care (proposals 11-1 to 11-6)

Compulsory reporting scheme

The Discussion Paper proposes to amend the aged care legislation to establish a reportable incidents scheme, which would require approved providers to notify reportable incidents to the Aged Care Complaints Commissioner, who would then oversee the approved provider's investigation of and response to, those incidents.

To implement this proposal, the term 'reportable assault' in the Aged Care Act would be replaced with 'reportable incident', defined to mean:

a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or toward a care recipient;

(a) a sexual offence, an incident causing serious injury, an incident involving the use of a weapon, or an incident that is part of a pattern of abuse when committed by a care recipient toward another care recipient; or

(b) an incident resulting in an unexplained serious injury to a care recipient.

The effect of this amendment would be to broaden the range of abusive conduct that approved providers are required to report to the Complaints Commissioner.

The Discussion Paper also proposes removing the exemption to reporting provided by section 53 of the *Accountability Principles 2014* (Cth) regarding alleged or suspected assaults committed by a care recipient with a pre-diagnosed cognitive impairment on another care recipient.

These proposals are intended to enhance safeguards against abuse for older people in receipt of aged care (whether in the home or in residential aged care), where the abuse may be committed by paid staff, other residents in residential care settings, or family members or friends.

National employment screening process

The Discussion Paper proposes the establishment of a national employment screening process for Australian Government funded aged care to determine whether a clearance should be granted to work in aged care, based on an assessment of:

(a) a person's national criminal history;

(b) relevant reportable incidents under the proposed reportable incidents scheme; and

(c) relevant disciplinary proceedings or complaints.

A national database would also be established to record the outcome and status of the employment clearances.

These proposals are intended to ensure that, as far as possible, only those potential aged care workers who are appropriately qualified and do not pose an unreasonable risk are placed in those roles.

The Discussion Paper also proposes to subject unregistered aged care workers, who provide direct care, to the planned National Code of Conduct for Health Care Workers. Relevantly, State and Territory Ministers have agreed, in principle, to implement the Code by State and Territory legislation. The Code operates by not restricting entry into health care work but by setting national standards against which disciplinary action can be taken and if necessary, a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety.

Role of public advocates and public guardians (proposal 3-1)

The Discussion Paper proposes to expand the role of public advocates and public guardians so that they have the power to investigate elder abuse where they have a reasonable cause to suspect that an older person:

(a) has care and support needs;

(b) is, or is at risk of, being abused or neglected; and

(c) is unable to protect themselves from the abuse or neglect, or the risk of it because of care and support needs.

It is proposed that this power could be exercised on receipt of a complaint or referral or on their own motion.

Relevantly, the Discussion Paper notes that while older people may contact elder abuse helplines to seek support and assistance from advocacy services, these services do not have the power to investigate. In addition, to the extent that public

advocates and guardians currently have the power to investigate, they are generally limited and vary between States and Territories. Accordingly, this proposal is intended to harmonise the powers of investigation of State and Territory public advocates/guardians.

Best practice going forward

Health and aged care services should continue to review policies for identifying people at risk of elder abuse, including staff training, recognition of substitute care givers and management of families in conflict. These policies should include clear recognition of advance care plans and powers of attorney.

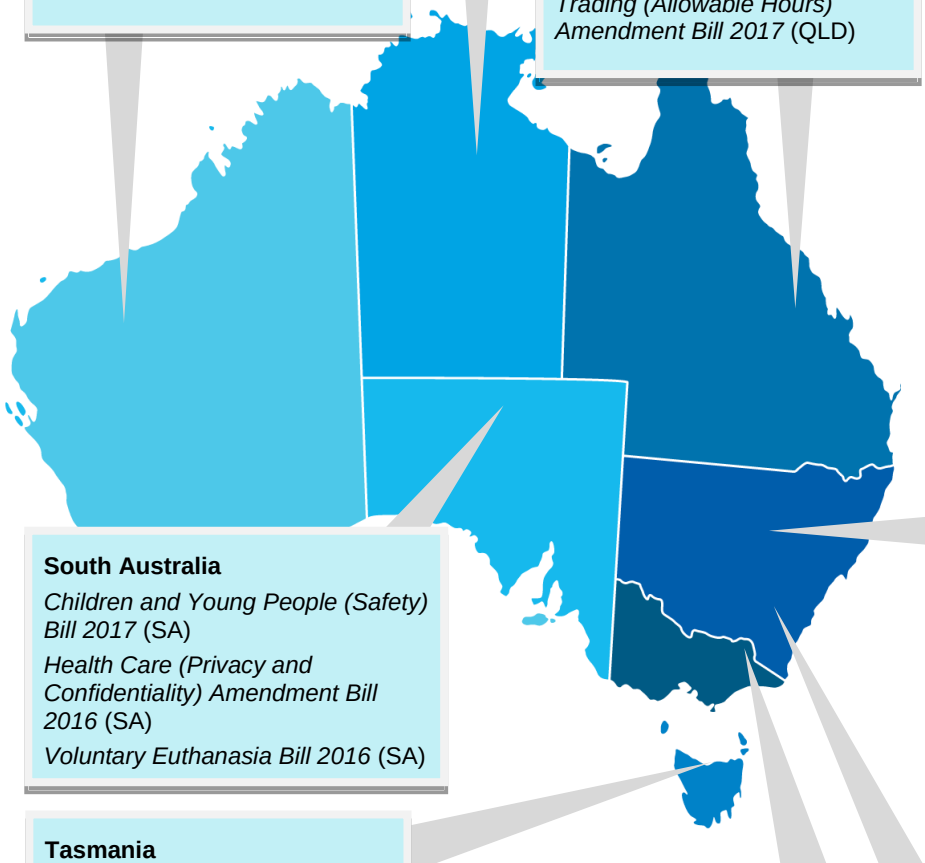
*If you have any questions arising out of this article, please contact **Anne Howard** on **(03) 9865 1311** or email **anne.howard@healthlegal.com.au**.*

Recent Awards

Health Legal was selected as Acquisition International's 'Most Outstanding Healthcare Law Firm' for 2016 in the AI Global Excellence Awards.

Health Legal and Law Compliance are now on LinkedIn. Follow us for current news and updates.

Some of the Legislative Changes being tracked



Western Australia

Container Deposit and Recovery Scheme Bill 2016 (WA)

Gene Technology (Western Australia) Bill 2014 (WA)

Heritage Bill 2016 (WA)

Northern Territory

Termination of Pregnancy Law Reform Bill 2017 (NT)

Queensland

Trading (Allowable Hours) Amendment Bill 2017 (QLD)

Commonwealth

Competition and Consumer Amendment (Misuse of Market Power) Bill 2016 (Cth)

Fair Work Amendment (Pay Protection) Bill 2016 (Cth)

Fair Work Amendment (Protecting Australian Workers) Bill 2016 (Cth)

Fair Work Amendment (Protecting Christmas) Bill 2016 (Cth)

Fair Work Amendment (Protecting Vulnerable Workers) Bill 2017 (Cth)

Fairer Paid Parental Leave Bill 2016 (Cth)

Marriage Legislation Amendment Bill 2016 (Cth)

Migration Amendment (Putting Local Workers First) Bill 2016 (Cth)

Privacy Amendment (Re-identification Offence) Bill 2016 (Cth)

Social Services Legislation Amendment (Omnibus Savings and Child Care Reform) Bill 2017 (Cth)

Therapeutic Goods Amendment (2016 Measures No.1) Bill 2016 (Cth)

South Australia

Children and Young People (Safety) Bill 2017 (SA)

Health Care (Privacy and Confidentiality) Amendment Bill 2016 (SA)

Voluntary Euthanasia Bill 2016 (SA)

New South Wales

Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW)

Fire and Emergency Services Levy Bill 2017 (NSW)

Human Tissue Amendment (Trafficking in Human Organs) Bill 2016 (NSW)

Public Health (Medicinal Cannabis) Bill 2017 (NSW)

Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2016 (NSW)

Tasmania

Care and Consent to Medical Treatment Bill 2016 (TAS)

Voluntary Assisted Dying Bill 2016 (TAS)

Workers Rehabilitation and Compensation Amendment Bill 2016 (TAS)

Victoria

Freedom of Information Amendment (Office of the Victorian Information Commissioner) Bill 2016 (Vic)

Public Administration Amendment (Public Sector Communication Standards) Bill 2016 (Vic)

Wrongs Amendment (Organisational Child Abuse) Bill 2016 (Vic)

Australian Capital Territory

Justice and Community Safety Legislation Amendment Act 2017 No. 5 (ACT)

Residential Tenancies Legislation Amendment Act 2016 No. 50 (ACT)

Waste Management and Resource Recovery Act 2016 No. 51 (ACT)

Workers Compensation Amendment Act 2016 (No 2) (ACT)

Workplace Privacy Amendment Act 2016 No. 22 (ACT)

If you would like details of these new Bills please contact ***Teresa Pollock*** *on* ***(03) 9865 1337*** *or* ***teresa.pollock@lawcompliance.com.au****.*

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