

# H&C

HEALTH & COMMUNITY LAW ALERT



# OVERCOMING CHALLENGES OF PROVIDING CARE TO VULNERABLE PEOPLE

By Alison Choy Flannigan, Partner

Caring for the vulnerable, including children, the aged, the disabled, refugees and patients who are unable to consent (whether on a temporary or permanent basis, including the mentally ill) provide a number of challenges for health, aged care and community service providers.

The demand for care is growing, funding is getting tighter and community expectations are higher. It is also becoming more difficult to attract and retain qualified staff.

There have been number of Royal Commissions into the health, aged care and community sectors, including the following:

- the current Royal Commission into Aged Care Quality and Safety (2018/2019);
- the current Victorian Royal Commission into Mental Health (2019);
- the current Queensland Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying (2019);
- the Royal Commission into Abuse in Disability recently announced by the Australian Government (2019); and
- the previous Royal Commission into Institutional Responses to Child Sexual Abuse (2017).

Some common issues include:

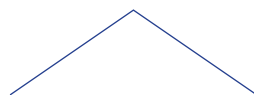
- consent, notably the lack of capacity to consent and substitute decision making;
- dealing with alleged abuse;
- mandatory reporting;
- qualifications and checking of people who care for the vulnerable, including police checks and child protection checks;
- corporate and clinical governance and risk management;
- guardianship; and

- restraint, both chemical and physical – what is reasonable?

The inquiries into the Oaken Older Persons Mental Health Service in South Australia (which involved systematic abuse of aged care persons) resulted in two reports:

- *The Oakden Report – The Report of the Oakden Review* – Dr Aaron Groves, Chief Psychiatrist (April 2017)
- *Oakden, A Shameful Chapter in South Australia's History* – A Report by the Hon Bruce Lander QC ICAC (February 2018).

**THERE IS CERTAINLY A ROLE FOR TECHNOLOGY, FOR EXAMPLE, CLINICAL SOFTWARE HAS BEEN PROVEN TO REDUCE MEDICATION ERRORS.**



The reviews have also resulted in the independent Review of the National Aged Care Quality Regulatory Processes<sup>1</sup> and the announcement of significant reforms.

Oakden dealt with both aged care and mental health.

The Hon. Bruce Lander QC stated in his report on Oakden:

<sup>1</sup> <https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes>

*This report offers some salient lessons about identifying and properly dealing with complaints, the consequences of attempting to 'contain' issues of concern and withhold information from senior persons and the extraordinary dangers associated with poor oversight, poor systems, unacceptable work practices and poor workplace culture.*

*Above all it highlights what can occur when staff do not step up and take action in the face of serious issues. I appreciate that it is not always easy to step up in such circumstances. But that is what is expected of every person engaged in public administration and particularly so in respect of public officers in positions of authority who have information that might expose serious or systemic issues of corruption, misconduct or maladministration.*

This is one of the most salient lessons for directors and managers of health, aged care and community providers caring for the vulnerable – essentially, do you expect, enable and encourage your staff to 'step up and take action in the face of serious issues'?

Additional lessons can be learnt from the other recommendations from the ICAC inquiry into Oakden, including:

1. a review the clinical governance and management of services;
2. a review of management structures to match those of overall clinical governance structures;



3. the assignment of responsibilities, and the expectations and responsibilities imposed upon each member of staff;
4. training and reporting obligations for staff;
5. more frequent inspections and unannounced visits to facilities than in the past;
6. community visitors more frequently exercising the power to conduct unannounced inspections and visits than in the past;
7. a review of the community visitor scheme;
8. a review as to whether resources should be increased;
9. public reporting on the physical condition of all facilities for the purpose of determining whether the physical condition of those facilities are fit for the purpose for which they are being used and, if not, in what respect the physical condition of any facility is not fit for purpose;
10. further training in relation to complaints and the reporting of complaints;
11. new standards in relation to the use of restrictive practices and making the observance of those standards mandatory; and
12. the review of the level and nature of staff support at facilities at which services are provided to determine

whether there are adequate staff to provide the necessary support at such facilities.

The Government has responded by requiring new consumer-based standards including the following:

- Aged Care Approved Providers will be assessed by the new Aged Care Quality Standards (based on consumer outcomes) from 1 July 2019: *Quality of Care Amendment (Single Quality Framework) Principles 2018*.
- From 1 July 2018, NDIS providers were required to comply with the NDIS Quality and Safeguarding Framework. The Framework provides a nationally consistent approach to help empower and support NDIS participants in exercising choice and control, ensures appropriate safeguards are in place, and establishes expectations for providers and their staff to deliver high-quality supports: *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018*.
- Following the *Report into the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals* (2008), by Peter Garling SC, the Inquiry recommended a Statewide System for Improving Recognition and Response to deteriorating patients be implemented across NSW. One of the best initiatives following this report was the 'Between the Flags' Program, which is a 'safety

net' for patients. This program assists clinicians to intervene in the process of patient deterioration with two key interventions, namely clinical review and rapid response. Why can't agencies such as the Clinical Excellence Commission be charged with developing similar programs for the aged, disabled and mental health sectors in terms of identifying and rapidly responding to high-risk clinical issues?


- Root cause analysis, sophisticated risk management systems and open disclosure have been in place in the hospital sector for some time, however, are just being developed in some aged care and disability settings.
- NDIS has introduced new standards concerning restraint and the government has announced that chemical and physical restraint in aged care homes will be better regulated.

There is certainly a role for technology, for example, clinical software has been proven to reduce medication errors.

It is a challenging time for health, aged care and community service providers. However, hopefully it is not a lost opportunity and we can learn more and do better for the vulnerable in our community with clearer guidelines to assist providers.

**Stop press:** the government has just released the *User Rights Amendment (Charter of Aged Care Rights) Principles 2019* (Cth).





IT IS ABSOLUTELY MISSION  
CRITICAL FOR HOSPITALS  
TO HAVE PROPERLY STERILIZED  
EQUIPMENT AND THAT THE  
EQUIPMENT IS AVAILABLE  
AT ALL TIMES.

# WHAT HOSPITAL OPERATORS NEED TO KNOW ABOUT THE NEW STERILIZATION STANDARDS

By Alison Choy Flannigan, Partner

## THE CHALLENGE

According to the press, Australian hospitals face an estimated \$1 billion overhaul of their sterilization departments to improve the processing of medical equipment under new Australian Standards – AS/NZ Sterilization Standards 4187:2014 (see ‘Hospitals to improve sterilization processes in push to beat postoperative infections’, *The Courier Mail*, 22 October 2016).

New sterilization standards for Australia and New Zealand became operational in December 2016 and set out tougher regulations into the reprocessing of reusable medical devices in health service organisations. The changes aim to make the standards be more consistent with European standards. Hospitals are required to comply by December 2021 and the time to implement capital works to comply is drawing near.

The new sterilization standards were prepared by the Joint Standards Australia/Standards New Zealand Committee HE-023, Processing of Medical and Surgical Instruments. They supersede AS/NZS 4187:2003 *Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities*.

Australian hospitals are required to be licensed in the relevant State and Territory, and must comply with safety and quality requirements. For example, in Victoria, private health facilities are required to comply with the *Health Services Act 1988* (Vic) and the *Health Services (Health Service Establishment) Regulations 2013*

(Vic). In NSW, hospitals are required to be registered under the *Private Health Facilities Act 2007* (NSW) and the *Private Health Facilities Regulation 2017* (NSW).

In order to attract private health insurance, hospitals are required to be accredited against the National Safety and Quality Healthcare (NSQHS) Standards<sup>1</sup>: Private Health Insurance (Accreditation) Rules 2011 (Cth).

Health departments (regulators) determine which services must undertake accreditation to the NSQHS Standards. All States and Territories have agreed that hospitals and day procedure services will be accredited to the NSQHS Standards from January 2013.

NSQHS does not specifically refer to AS/NZS 4187:2014; however, that is implied by the term ‘relevant national standards’.

The Australian Standard AS/NZS 4187 is the national standard most commonly used to meet the requirements in Action 3.14.1 (of the 2<sup>nd</sup> Edition, which are applicable from 1 January 2019).

To comply with the requirements of Action 3.14.1, where health service organisations apply AS/NZS 4187:2014, health service organisations will need to:

- complete a gap analysis to determine the current level of compliance with AS/NZS 4187:2014 and document the findings;
- document a detailed implementation plan specifying timeframes to enable full implementation of AS/NZS 4187:2014 over a five-year period, from December 2016; and

- implement the plan and demonstrate progress toward implementation

Hospitals are required to comply by December 2021.<sup>2</sup> Accreditation is awarded on a three or four-year cycle, depending on the accrediting agency, so some facilities are coming up for re-accreditation.

We understand that a number of hospitals currently do not meet the new standards and that it will be very expensive to upgrade current facilities to be compliant. We also understand that a number of hospitals are experiencing difficulties complying with the new water quality standard.

It is absolutely mission critical for hospitals to have properly sterilized equipment and that the equipment is available at all times.

Hospitals would want to avoid issues with the sterilization and non-availability of hospital equipment like those faced at Fiona Stanley Hospital in 2015 when delays were experienced in returning sterilized medical equipment to the hospital (see ‘Serco stripped of control for sterilising Fiona Stanley Hospital’s medical equipment’, *ABC News*, 24 February 2015).

Hospital operators should be assessing their compliance with the new standards and implement planning for compliance if they are not already compliant.

<sup>1</sup> <https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf>

<sup>2</sup> [https://www.safetyandquality.gov.au/wp-content/uploads/2017/10/Advisory-A16\\_03-Reprocessing-of-reusable-medical-devices-in-health-service-organisations.pdf](https://www.safetyandquality.gov.au/wp-content/uploads/2017/10/Advisory-A16_03-Reprocessing-of-reusable-medical-devices-in-health-service-organisations.pdf)

# RETIREMENT VILLAGE UPDATE

By Emma Kulinitich, Senior Associate

There have been some noteworthy changes to the retirement villages legislation that will not only require compliance but a serious amount of attention to detail.



## WHAT IS HAPPENING IN NEW SOUTH WALES?

Laws: The *Retirement Villages Act 1999* (NSW), the *Retirement Villages Regulation 2017* (NSW) and the *Retirement Villages Amendment Act 2018* (NSW) (to commence 1 July 2019).

Commencing 1 July 2019, operators must provide the following services to residents in compliance with the *Retirement Villages Act*:

Changes required - 1 July 2019	Additional proposed changes
<p>An annual <b>contract 'check-up' meeting</b> with residents to discuss their contract. The operator must provide the resident with a written summary of the explanation at the meeting.</p> <p>The resident is entitled to bring a support person with them or have that support person represent them during the contract 'check-up' meeting.</p>	<p><b>Mandatory conduct rules</b> will prescribe rules of conduct to those staff that are managing or operating the retirement villages. The rules cover professionalism, training, competencies, performance and behaviour when performing their role.</p>
<p>Operators must now develop and maintain customised village-by-village <b>emergency plans</b>, and ensure that both residents and staff are familiar with the plan. Furthermore, the operator is required to undertake a safety inspection at least once a year and report on such findings to residents.</p>	<p>Operators will have to maintain an <b>asset management plan</b> for the village's capital items and make the plan available to current and prospective residents.</p>
<p>Operators must conduct an <b>annual evacuation exercise</b> for residents to ensure familiarity with emergency protocols.</p> <p><b>Key safety information</b> must also be displayed in both communal areas and villages, as well as provided to residents.</p>	<p>Operators must obtain the residents' consent each year before appointing a person as the <b>auditor of the accounts</b> for the retirement village.</p>



## WHAT IS HAPPENING IN QUEENSLAND?

Laws: *Retirement Village Act 1999* (Qld), *Retirement Villages Regulation 2018* (Qld), *Housing Legislation (Building Better Futures) Amendment Act 2017* (Qld) and *Health and Other Legislation Amendment Bill 2018* (Qld).

Required changes – 1 February 2019	Proposed phases
<p><b>PRIOR TO</b> Retirement Village Living – operators must comply with certain pre-contractual disclosure obligations when engaging, communicating and providing information to prospective residents.</p> <p>Specifically, operators must provide a Form 3 Village Comparison Document, a Form 4 Prospective Costs Document, the residence contract (eg a lease) and any by-laws for the village at least 21 days before entering into the residence contract.</p> <p>An entry condition report must also be prepared by the operator prior to the resident occupying the unit.</p>	<p>Additional phases will continue to roll out throughout the year, which will deal with:</p> <ul style="list-style-type: none"><li>• redevelopment;</li><li>• change of ownership;</li><li>• new standards for residence contracts; and</li><li>• financial reports and budgets.</li></ul>
<p><b>DURING</b> Retirement Village Living – operators must make available a variety of ‘operational documents’ to residents who request access to them.</p>	
<p><b>POST</b> Retirement Village Living – operators must provide certain documents to the resident upon exit. These include information about reinstatement, renovation works and statutory buy-back provisions.</p> <p>An exit condition report must also be provided by the operator to the resident within 14 days of the resident vacating the unit.</p>	

## WHAT IS HAPPENING IN VICTORIA?

Laws: *Retirement Villages Act 1986* (Vic) and *Retirement Villages (Contractual Arrangements) Regulations 2017* (Vic).

Overview	Recommendations
<p><i>The Retirement Villages (Contractual Arrangements) Regulations 2017</i> (Vic) commenced on 30 July 2017 and focuses on:</p> <ul style="list-style-type: none"><li>• payments that are made to residents on exit;</li><li>• when financial assistance will be provided; and</li><li>• how a residential accommodation deposit or daily accommodation payments are calculated.</li></ul>	<p>The Regulations are extremely prescriptive in terms of what content is to be included and prohibited from resident contracts, management contracts, disclosure statements and fact sheets.</p> <p>Given this, it is advisable for operators to have these documents legally reviewed.</p>

## RETIREMENT VILLAGE ACCREDITATION SCHEME STANDARDS

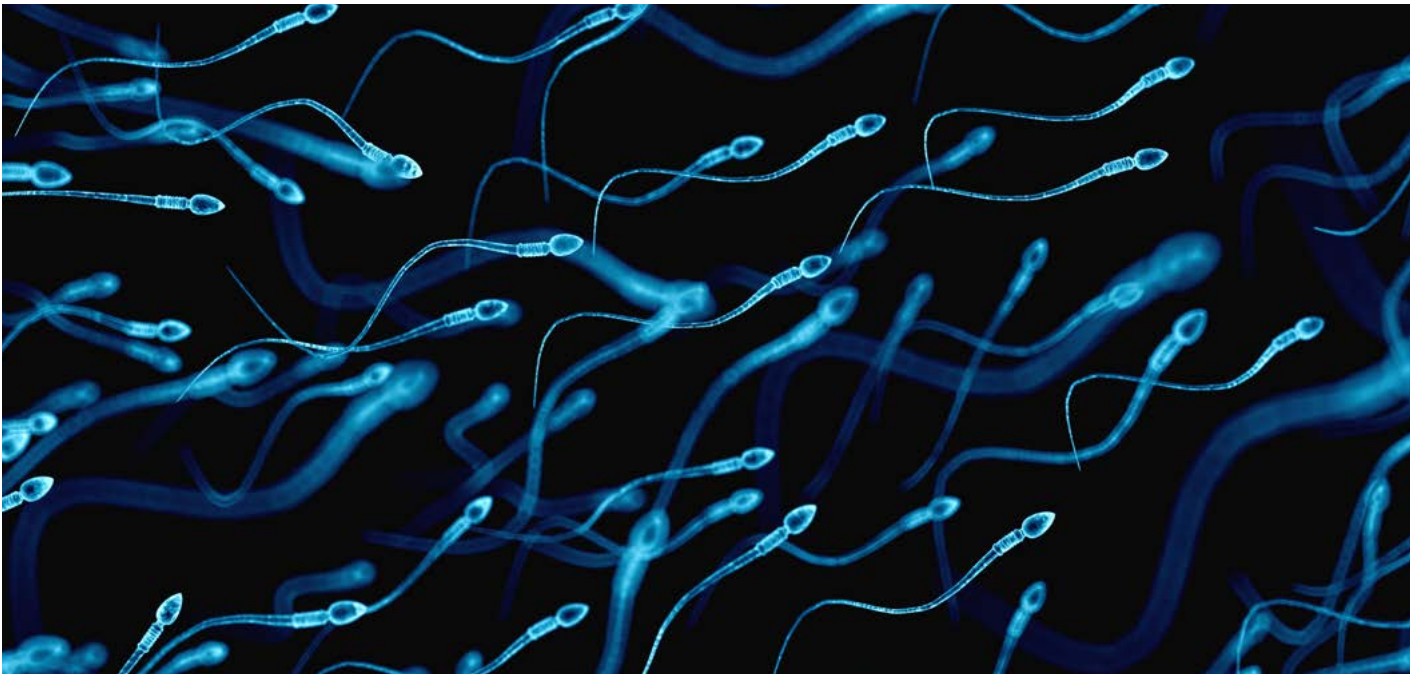
The Australian Retirement Village Accreditation Scheme (**ARVAS**) has been created jointly by the Property Council of Australia and Leading Age Services Australia (**LASA**), two organisations that represent retirement village owners and operators around the country. The draft

has been released for comment.<sup>1</sup>

These new standards create a unified accreditation scheme for all Australian retirement villages, which ensure that each village meets minimum quality standards and processes when delivering and operating services.

<sup>1</sup> [https://www.propertycouncil.com.au/Web/Content/News/RLC/2019/Accreditation\\_development\\_background.aspx](https://www.propertycouncil.com.au/Web/Content/News/RLC/2019/Accreditation_development_background.aspx)

As part of ensuring that operators, residents and other interested stakeholders have an opportunity to be heard on the accreditation standards, Leading Age Services Australia and the Property Council of Australia have opened a feedback window from now until Friday, 12 April 2019. Feedback can be emailed directly to [retirementliving@lasa.asn.au](mailto:retirementliving@lasa.asn.au).



# ARE THERE PROPRIETARY RIGHTS IN SPERM?

*GLS V RUSSELL-WEISZ & ORS [2018] WASC 79.*

*By Anne Wilson, Lawyer*

## BACKGROUND

There have been a number of cases involving women attempting to access the sperm of their deceased former or ex-partner.

Western Australian law prohibits the use of donated gametes after the owner's death to impregnate a woman.<sup>1</sup>

In this case<sup>2</sup>, the 42-year-old plaintiff,<sup>3</sup> GLS, was the de facto partner of 'Gary' at the time he died. He suffered a cardiac arrest, which rendered him unconscious on 27 January 2016. He was pronounced brain dead on 2 February 2016. After discussions with his family, including

GLS, the decision was made to take Gary off life support and allow him to die. Permission was granted to GLS to arrange for sperm to be removed from Gary's body soon after death, with the intention for her to use the sperm to conceive a child. At the time of the hearing, two years after Gary's death,<sup>4</sup> the sperm had been stored (**cryopreserved**) by a fertility clinic (**licence holder**)<sup>5</sup> since extraction.

GLS informed the Supreme Court of Western Australia that a clinic in the Australian Capital Territory was prepared to use Gary's sperm in IVF procedures in the ACT to assist GLS to fall pregnant. However, Clause 6.5 of the Directions also prohibits a licence holder from exporting

(or facilitating export of) 'donated' gametes from the State for use in an artificial sterilization procedure without prior approval of the Reproductive Technology Council of WA (**RTC**). An application by GLS to the RTC to export Gary's sperm to the ACT was refused.

## APPLICATION TO THE WA SUPREME COURT

GLS sought declaratory relief through an application to the Supreme Court of Western Australia in order to direct the clinic to transfer Gary's sperm to the ACT. As she (and her legal advisers) was of the view that she did not actually need the approval of the RTC to do so, she also sought a declaration to that effect, or in the alternative, that the Directions were invalid

1. Clause 8.9 of Directions issued under section 5(5) the <i>Human Reproductive Technology Act 1991</i> (WA) (Directions). Section 5(5) provides that Directions given by the CEO shall have effect, except to the extent of any inconsistency with the regulations	2. <i>GLS v Russell-Weisz &amp; Ors</i> [2018] WASC 79.	3. At n 1, at para 10.	4. At n 1, at para 10.	5. Under Part 4 of the <i>Human Reproductive Technology Act 1991</i> (WA). A license holder is a person who holds a licence under Part 4 of HRT and is authorised or permitted, in accordance with section 51, to carry on, supervise	6. A low deposit home loan available to first and non-first homebuyers in WA.
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(to the extent approval is required) and should be read down such that approval is not required.

In support of her application, a number of affidavits were prepared in evidence to support the contention by GLS that she was Gary's de facto partner, and that he had a strong desire to father a child with her. The plaintiff was 42 at the time of the hearing, and was anxious to resolve the issues around the export of the sperm to the ACT, so that she could conceive as soon as possible. The defendant (the CEO of the Department of Health, WA) did not raise an issue about the fact that she had waited two years to commence proceedings, and other than a cursory observation by Chief Justice Martin, this issue was not taken any further.

The affidavit evidence was that GLS had met Gary in November 2009, when they were both single. Gary had children from a previous relationship. They were both of limited means, with Gary working occasionally and GLS employed part time. They started living together in April 2010, and in March 2011, Gary bought GLS a puppy to test how they would cope with parenthood, once they could afford to have children.

Although GLS accepted Gary's marriage proposal in mid-2012, she deferred the marriage until they had their own home. In October 2014, Gary suggested GLS have his sperm frozen so she could have his children if he died prematurely. The evidence of GLS was that Gary had a fear of dying young like his father and uncle. However, she did not share the fear and, partly due to the cost, she did not act on Gary's suggestion. Gary also gave GLS a number of baby gifts and raised the topic of having children again in September 2015. In September 2015, GLS applied for a 'Keystart' home loan,<sup>6</sup> which was approved in December 2015. Settlement of a unit as a result of that process took effect in February 2016, about a month after Gary died.

Gary's son (and executor of Gary's estate), JDT, consented to the use of Gary's sperm by GLS on the condition that she did not contact him or his immediate family (with the exception of his mother) or ask for financial assistance. GLS's mother, her sister and a friend of Gary's also swore statements, which were attached to the affidavit of GLS, to corroborate

her evidence that Gary had suggested freezing his sperm in case something happened to him, and that the topic of having children was discussed regularly between the couple.

### PROCESS OF APPLYING TO RTC

Solicitors for GLS applied to the RTC for approval to export Gary's sperm to the ACT, even though they did not believe the approval was necessary on the basis that clauses 6.5 and 6.6 of the Directions did not apply, as the sperm was not donated. However, after consideration of further information provided by GLS and her solicitors, the RTC took a different view and refused to grant the approval. Although the RTC's ruling was not discussed in any detail in this decision, it appears that the thrust of the reasons for the refusal was that using gametes, which were extracted posthumously, could contravene clause 8.9 of the Directions.

The picture painted by GLS about the relationship she had with Gary appeared to be inconsistent with an entry made by a social worker in his medical records at the time of his admission to hospital, after his cardiac arrest. It seems that although they had been in a relationship for six years, Gary drank excessively, was homeless and unemployed and they had not lived together for over two years. However, GLS was noted variously as Gary's next of kin, girlfriend and partner elsewhere in the records. On that basis, the posthumous removal of Gary's sperm was approved under section 22 of the *Human Tissue and Transplant Act 1982* (WA) (**HTTA**).

GLS swore to a second affidavit setting out in detail her relationship with Gary from the time they met until his death.

They commenced living together in April 2010 at various rented premises until June 2013. After this time, they were forced to live apart for a period due to the difficulty they had finding further accommodation because of the property boom in Perth. However, they continued to socialise and they maintained a sexual relationship. Gary's financial situation deteriorated to the point that he lived in his car. He moved to a rented room, followed by various temporary places of accommodation, with the financial assistance of GLS over the course of the next 12 months. GLS funded Gary's accommodation in a hotel when his daughter visited him from the country.

Over the following year, Gary and GLS made an application in the Keystart program, hoping to buy a house in which they could live together. Gary travelled to Karratha (funded by GLS) in an attempt to find work in early 2016, and then returned to Perth just before his death. GLS paid for Gary's funeral.

### QUESTIONS THE COURT WAS ASKED TO DETERMINE

Based on the evidence GLS had put before the court, she sought the court's determination of the following questions:

1. whether Gary's sperm could be transferred from WA to the ACT;
2. if the court determined the sperm could be moved, whether GLS required the approval of the RTC before the move, and in that regard, whether the gametes were 'donated gametes' within the meaning of clause 6.5 and 6.6 of the Directions (**Directions**) issued under the *Human Reproductive Technology Act 1991* (WA) (**HRTA**); and



3. if approval was required, were clauses 6.5 and 6.6 of the Directions invalid on the basis they are:
  - a. inconsistent with section 22 of the HTTA;
  - b. inconsistent with section 22 of the *Sex Discrimination Act 1984* (Cth);
  - c. inconsistent with section 69 of the *Australian Capital Territory (Self Government) Act 1988* (or alternatively, contrary to section 92 of the Commonwealth Constitution); or
  - d. contrary to section 118 of the Commonwealth Constitution.

The parties to the application agreed that the answer to Question 1 should be answered affirmatively. Chief Justice Martin was of the view that if Question 2 was answered in the negative, GLS must succeed in her claim, and addressing Question 3 became unnecessary. If it was necessary to answer Question 3 (that is, if Question 2 was answered in the affirmative) and Question 3 was answered negatively, the claim must fail.

Chief Justice Martin concluded that clauses 6.5 and 6.6 of the Directions did not apply to the circumstances of the case as they do not involve the 'donation' of gametes.

### QUESTION 3

On the basis of the affirmative answer to Question 1 (Gary's sperm could be transferred from WA to the ACT), and the negative answer to Question 2 (the gametes were not 'donated gametes' within the meaning of clause 6.5 and 6.6 of the Directions), GLS was entitled to the relief she sought, and it was considered inappropriate to resolve Question 3.

### CONCLUSION

This judgment raises interesting questions of ownership and legal recognition of property rights in human tissue. This particular decision is limited to the unique situation of the plaintiff, GLS. What is clear is that decisions of this nature will be heavily influenced by the factual context in which such applications are made, as well as the specific legislative framework in place in the relevant jurisdiction.

*A version of this article was first published in the Australian Health Law Bulletin.*

# ARE STAFFING RATIOS RELEVANT TO NEGLIGENCE?

## INQUEST INTO THE DEATH OF JARROD WRIGHT – 17 DECEMBER 2018 AND 18 JANUARY 2019

*By Rachael Arnold, Partner, and Catherine Blair, Senior Associate*



Mr Jarrod Wright (42) had been admitted and was being treated for cellulitis in his right thigh at Liverpool Hospital on 30 June 2016 when complications arose and ultimately ended in his death on 9 July 2016. The inquest into Mr Wright's death considered whether Mr Wright's treatment in the intensive care unit (ICU) and, in particular the nursing-to-patient ratio in the ICU, had been appropriate.

## FACTS

On 3 July 2016, Mr Wright was transferred from the orthopaedic ward to ICU after nursing staff had encountered difficulty maintaining intravenous access to administer his antibiotics (which caused Mr Wright to miss some doses on 1 and 2 July) and Mr Wright had become hypoxaemic, with the levels of oxygen in his blood sinking to 60%.

In ICU, it was suspected that Mr Wright was suffering acute respiratory distress syndrome (**ARDS**), which is respiratory failure characterised by rapid onset of inflammation in the lungs. In order to improve Mr Wright's respiratory function, he was placed on oxygen support ventilation administered through a mask (**CPAP**).

However, Mr Wright became increasingly frustrated with his non-rebreather mask and then refused to use it at all. The registered nurse (**RN**) informed the ICU registrars that he was concerned that Mr Wright's agitation was adversely impacting his ability to comply with treatment. He secured a dose of Diazepam to help settle Mr Wright.

At around 3pm, Mr Wright became angry and frustrated when he was told he should use a bedpan instead of accessing the toilets. Mr Wright removed his blood pressure cuff and refused to replace it or to take any further Diazepam.

Later, after the RN had returned from his meal break, he found that Mr Wright had disconnected from his monitor again to go to the bathroom and that his oxygen levels had dropped. The RN remained in Mr Wright's room until he was satisfied that Mr Wright's oxygen saturation levels had returned to an acceptable level. He called for assistance from the ICU registrars, at which point a sedative of Dexmedetomidine in the form of an infusion was prescribed.

From 7pm, a new RN had taken over the shift and stayed with Mr Wright until 10pm. In that time, Mr Wright remained agitated and continually attempted to remove his oxygen mask, with the result each time that his saturation levels dropped to between 60 and 80%. Also during that time, the senior ICU registrar requested that the RN increase Mr Wright's ventilation pressure.

When Mr Wright fell asleep at approximately 10pm, the RN left the room to attend to his other patient. Fifteen

minutes later, the RN returned and found Mr Wright lying across his bed with the monitoring leads detached. There was a trail of blood and faeces from the bathroom. The RN replaced Mr Wright's oxygen mask and raised the alarm, noting that Mr Wright's skin was bluish in colour, he was unresponsive and his breathing was shallow. Mr Wright's care was escalated to life support.

Although the resuscitation team achieved a return to spontaneous circulation, Mr Wright had received significant brain damage due to his lack of oxygen. On 9 July, Mr Wright's family made the difficult decision to remove him from life support.

## THIS CASE IS PARTICULARLY INTERESTING BECAUSE THE CORONER HAD SPECIFICALLY MENTIONED THE ISSUE OF STAFFING RATIOS AS A POTENTIAL CONTRIBUTOR TO THE ADVERSE OUTCOME.

### CAUSE OF DEATH

At the inquest, the medical experts generally agreed that the cause of Mr Wright's death was his failure to receive sufficient oxygen to maintain his cardiac function with the immediate triggering event being the removal of Mr Wright's oxygen support (likely by himself). It was considered that the reason Mr Wright required oxygen support was most likely related to the effect of the *Escherichia coli* (**E. coli**). It was not possible to diagnose a distinct cause for the *E. coli* septicaemia, although the experts considered it unlikely to have been the thigh cellulitis, which was resolving at the time Mr Wright's respiratory distress developed.

### APPROPRIATENESS OF NURSING RATIO

At the time of Mr Wright's death, the local hospital guideline regarding nurse/patient ratios stated that patients who were critically ill or ventilated, required a 1:1 nursing ratio. This included intubated and ventilated patients, patients who were on non-invasive ventilation and patients who were restless, agitated and clinically unstable. It appeared to the deputy coroner

that the guideline had been interpreted in such a way that CPAP ventilation did not always require 1:1 nursing.

In the opinion of Associate Professor Richard Lee (intensive care specialist and anaesthetist), Mr Wright was too agitated to cooperate with his essential oxygen support and, in the circumstances where Mr Wright was suffering a severe hypoxemic lung condition, intubation was justified or, at the very least, continuous nursing observation required.

It was the evidence of the junior registrar and the nursing unit manager that they were not aware of the severity of Mr Wright's agitation or the extent to which it was placing him at risk. The deputy coroner took this as an inference that, had they been aware, they would have acknowledged that Mr Wright met at least one of the existing criteria for 1:1 nursing, namely that Mr Wright was 'restless, agitated and clinically unstable.'

Accordingly, the deputy coroner concluded that Mr Wright did not receive appropriate nursing care allocation and that the reason for this was related to a '*lack of effective communication*' regarding Mr Wright's nursing needs together with '*a lack of clarity as to the criteria for 1:1 nursing.*' She adopted as a recommendation a submission from the NSW Nurses & Midwives Association that there would be benefit in upgrading the revised guideline to the status of a policy directive. In doing so, the deputy coroner noted that, where the guideline for the 1:1 ratio that had been in place at the time of Mr Wright's death and had either not been properly understood or properly regarded by ICU staff, revising the guideline to a policy directive would enhance its importance.

The deputy coroner noted:

*It is acknowledged that nursing and medical staff receive training to assist them with such communication issues. Despite this the personal and cultural impediments to effective communication within hospital hierarchies remain a recurring feature in the circumstances of hospital deaths like [Mr Wright's].*

### COMMENTARY

This case is particularly interesting because the Coroner had specifically mentioned the issue of staffing ratios as a potential contributor to the adverse outcome.



# SOCIAL AND AFFORDABLE HOUSING – INVESTING IN HUMAN CAPITAL

*By Mark Richards, Special Counsel*



Investment in social infrastructure delivers both tangible and intangible benefits such as improvements to health, education and shelter.

There are bi-directional benefits to housing and health, with:

- the provision of effective shelter improving quality of life;
- improving housing quality standards reducing reliance on health services through reduced doctor and hospital referrals, resulting in a health dividend; and
- increased household formation – when young people can leave the family home, this results in savings to the health system.

On the flip side, loss of shelter is the primary cause of mental health issues among the homeless, resulting in increased government expenditure across health, justice and other welfare systems.

Is this why the Scottish Government are building 50,000 affordable homes before 2021?

## **DO WE NEED TO BUILD MORE SOCIAL AND AFFORDABLE HOUSING?**

An Australian Housing and Urban Research Institute (**AHURI**) report in 2017 estimated 1.3 million households were in a state of

housing need, whether unable to access market housing or in rental stress, with this figure estimated to rise to 1.7 million by 2025.

More recent research estimates that 730,000 new social housing dwellings will be required over the next 20 years to address the current deficit and future need.

While Labour have pledged to build 250,000 affordable homes over 10 years, one can only imagine the productivity benefits and health dividend to be derived from having over a million households lifted out of rental stress and afforded the opportunity to focus on more entrepreneurial endeavours.

## **HOW DO WE RECTIFY THE CURRENT IMBALANCE?**

Sustainable and inclusive social infrastructure asset growth requires assistance from both government and the private sector.

To deliver the high volumes needed to close the current housing gap, Australia need only look overseas to leverage new ways to deliver social infrastructure assets. The Scottish Futures Trust HubCo model, for example, enables the development of co-located social infrastructure facilities, made up of area partnerships between councils,

health authorities and the private sector. These partnerships agree on a long-term strategic development plan, enabling the construction of targeted developments to cater for localised need. The Scottish Government is leveraging the HubCo model to deliver its 50,000 affordable homes target.

At a recent forum, we were fortunate to have Martine Letts, Committee for Melbourne CEO, who advised that the Committee for Melbourne has identified “Housing Mix” as a Strategic Need which will guide the Committee’s future agenda with a series of tangible policy initiatives. This has been identified as a priority due to the high cost of living – of which housing costs are a major determinant – which has a detrimental effect on a city’s creativity and innovative capacity. Expensive cities make self-employment and entrepreneurship more difficult. In addition, without affordable housing, emergency and public service workers will be unable to live near their place of work.

The Committee for Melbourne’s Housing Mix Taskforce project scope has been agreed and the Taskforce will now map out how to achieve affordable housing outcomes for Greater Melbourne.



# CLEARING THE WAY FOR JUSTICE: NSW REMOVES BARRIERS TO REDRESS FOR VICTIMS OF ORGANISATIONAL CHILD ABUSE

By Ahranee Vijayaseelan, Partner, and Erin Doyle, Lawyer

Following the profound and often shocking revelations that came to light during the Royal Commission into Institutional Responses to Child Sexual Abuse, the NSW Government has acted swiftly to adopt a range of measures designed to assist future victims of institutional child abuse to gain access to legal redress.

Previously, survivors of organisational child abuse faced numerous legal hurdles when attempting to seek redress for the immeasurable harm they suffered.

On 26 October 2018, the *Civil Liability Amendment (Organisational Child Abuse Liability) Act 2018 (NSW) (Act)* was enacted. The new legislation introduces a statutory duty on both public sector agencies, private organisations and unincorporated organisations to prevent the abuse of children. Relevantly, the Act applies only to child abuse perpetrated after the enactment date.

In brief, the key changes implemented by the Act are as follows:

- a statutory duty of care is imposed on organisations that exercise care, supervision or authority over children to prevent child abuse perpetrated by individuals associated with the organisation;
- the duty of care owed by an organisation to protect a child from abuse is non-delegable such that the organisation will be responsible even where it has delegated care, supervision and authority of the child to another organisation;
- the usual onus of proof that applies in negligence cases is reversed so that the organisation must establish that it took reasonable precautions to prevent the abuse; and
- vicarious liability is extended to include child abuse perpetrated by non-employees whose relationship with the organisation is 'akin to employment' – closing the 'loophole' where organisations would escape liability simply because the perpetrator was

not technically an 'employee' of the organisation.

It is yet to be seen how effective these measures will be at achieving their purported outcomes, given the Act's relative infancy. Nevertheless, organisations that routinely work with or around children should ensure their child safety policies and risk management procedures are regularly reviewed, updated and implemented. Organisations will need to review their staff recruitment and management policies and procedures. In particular, position descriptions should be developed for positions and volunteer roles of people who work with children unsupervised that identify the requirements and training needs for the role.

If in doubt as to how the provisions in the Act may affect your organisation, legal advice should be sought as soon as possible.

# GENOMICS AND GENETICS: LEGAL AND ETHICAL ISSUES

By Alison Choy Flannigan, Partner

**Genetics is the study of heredity, whereas genomics is defined as the study of genes and their functions, and related techniques.**

The main difference between genomics and genetics is that genetics scrutinises the functioning and composition of the single gene, whereas genomics addresses all genes and their inter-relationships in order to identify their combined influence on the growth and development of the organism.

Genomics can assist in personal health profiling, disease diagnostics, research and precision medicine.

Legal and ethical issues arise in relation to genomics, including equity of access, consent, confidentiality, availability for the greater good versus privacy, patient choice and ownership.

Currently, gene technology is regulated in Australia through a number of laws including the following:

- *Gene Technology Act 2000* (Cth), specifically section 32 which prohibits a person from dealing with genetically modified organisms without a licence or other authority under that legislation;
- human tissue legislation, such as the *Human Tissue Act 1983* (NSW); and
- *Prohibition of Human Cloning for Reproduction Act 2002* (Cth).

While genomics brings the prospect of benefits for patients and the potential to revolutionise diagnosis, screening, prevention and treatment, it also raises a number of ethical challenges, including:

**Equity of access:** should access only be available to those who can afford to pay for it?

**Consent:** can a person consent without knowing the full implications of what they are consenting to? With genomics, the boundaries of the possibilities are constantly expanding.

**Confidentiality:** the sharing of patient information is vital in order to assess the significance of individual genetic variants by comparing them to the norm. Genomics may test the boundaries of consent, particularly when information is known about one person, but could be of significant value to their family members and their health care providers.

**THE TIME IS FAST APPROACHING WHERE THE DEVELOPMENT OF TECHNOLOGY IS TESTING THE BOUNDARIES. THE QUESTION IS WHETHER OR NOT THE LAW (AND LEGAL PROTECTION) WILL KEEP PACE?**

**Availability for the greater good and adequate protection of genetic data:** what if something is discovered of clinical significance to humanity? The uniqueness of our genetic data means that it can never be truly anonymous. Protections need to be put in place to reduce the risk of discrimination based on genetic characterisations.

**Patient choice:** many patients have suffered several years of delayed diagnosis. Genomics may result in significant improvement of patient outcomes.

In the future, should genomic testing be mandatory for the population to assist with health planning? However, people should have a right to privacy and many people may make the conscious choice not to be provided with information concerning their mortality. Ultimately, the challenge is to enable patients to have the choice. If they have the choice, then are they stealing from their family members their choice as well?

**Ownership:** what if a particular individual's genome is so unique as to unlock a key in medical discovery? Should pharmaceutical companies own intellectual property rights and therefore monopoly rights involving the fabric of a person's genome?

**Ethics and religion with selection and genomic manipulation:** at what point does genomic manipulation become acceptable? To save a life? To save many lives? To save a population? What religious and cultural considerations should be taken into account? How far should patient choice go? For example, medical science is used already in some cases in relation to the non-selection of embryos with defective genes, or testing for the risk of birth defects. What about using it for choosing the sex of a baby and/or physical or mental attributes?

The time is fast approaching where the development of technology is testing the boundaries. The question is whether or not the law (and legal protection) will keep pace?





# CHANGES TO MODERN HEALTH AND COMMUNITY AWARDS: WHAT YOU NEED TO KNOW

By Kylie Groves, Partner, and Louise Chen, Lawyer

Both employees and employers need to be aware of changes made to modern awards in the health and community services sector over the past six months. Not only do the changes impact on employee entitlements and employer obligations, they can also have an impact on current workplace practices and policies. Failure to comply can give rise to employees making underpayment claims and/or penalties for breaching the award.

Modern awards in this sector include the:

- *Health Professionals and Support Services Award 2010 (HPSS Award)*;
- *Ageed Care Award 2010*;
- *Medical Practitioners Award 2010*;
- *Nurses Award 2010*; and
- *Social, Community, Home Care and Disability Services Award. (Awards)*.

Recent changes that have been made to all modern awards include the following:

## **Family and domestic violence leave:**

In the middle of last year, awards were amended to provide employees with five days' unpaid leave to deal with family and domestic violence. The full five days of unpaid leave is available at the start of each 12-month period but does not accumulate from year to year. This change is now also reflected in the NES following amendments to the *Fair Work Act 2009* (Cth), which took effect on 12 December 2018.

## **Right to request casual conversion:**

A new clause was inserted into awards in September 2018 so that regular casual employees can now request in writing for their employment to be converted to full-time or part-time. The employer may only refuse this request on 'reasonable grounds' after consultation with the employee.

It is also now a requirement that an employer must provide a casual employee with a copy of the relevant award clause

within the first 12 months of the employee starting work. Casual employees already employed as at 1 October 2018 had to be provided with a copy of the clause by **1 January 2019**. If you have not yet done this as an employer, it is important you do this as soon as possible.

In addition, the following amendments were made to the awards late last year:

## **Individual flexibility arrangements**

**(IFA):** If the employer proposes to vary the terms of the award with the employee's agreement (by making an IFA) and they are aware, or reasonably should be aware, that the employee has limited understanding of English, then they must take reasonable steps to ensure that the employee understands the proposal. Employers are now required to take 'measures' to ensure the employee understands the proposal if they are made aware the employee has limited understanding of English.

## **Notice of termination by an employee:**

A change to the Termination of Employment clause now makes it clear that an employer cannot deduct more than one week's wages from an employee who fails to provide the requisite amount of notice. Furthermore, employers must not make **any** deductions from the employee's wage if the employee is under 18.

## • **Payment on termination of**

**employment:** The awards have also been amended so that it is now a requirement that an employer must pay an employee their termination pay/entitlements within seven days after the termination of employment.

## • **Request for flexible working**

**arrangements:** Before responding to a request for flexible working arrangements, employers are now required to discuss with the employee their request, with regard to certain factors such as the needs of the employee arising from their circumstances. Any reasonable


business grounds for refusing the request must also be discussed. If the employer refuses the request, their written response must address possible alternative options.

In addition to the above changes that were made to all awards, further award-specific amendments have been made. For instance, the following changes have been made to the HPSS Award:

- **Rostering:** The amendments enable a roster to now be altered at any time without consultation to enable the functions of the hospital, facility or organisation to be carried on, due to the absence of another employee because of personal/carers' leave, compassionate leave, ceremonial leave and leave to deal with family and domestic violence. This was previously restricted to 'on account of illness or in an emergency'.
- **Meal breaks:** An amendment of the meal breaks clause means an employee who works less than six hours may choose to skip their meal break with the consent of their employer.
- **Shift work:** Casual employees working shift work will now be paid a loading of 40% of their ordinary rate of pay instead of the casual loading of 25%. The shift loading of 15% (which applies to shifts that start and/or finish late) does not apply to shift work performed by any employee on Saturday, Sunday or public holidays where the extra loading for those days already apply.

It is important to keep up to date with variations that apply to your organisation because a failure to comply with an applicable award can give rise to employees making underpayment claims and/or the imposition of a penalty for breaching the award. It is also important because sometimes amendments are made to an award to provide greater flexibility for the benefit of the employer.





**IT IS IMPORTANT TO KEEP UP  
TO DATE WITH VARIATIONS THAT  
APPLY TO YOUR ORGANISATION  
BECAUSE A FAILURE TO COMPLY  
WITH AN APPLICABLE AWARD CAN  
GIVE RISE TO EMPLOYEES MAKING  
UNDERPAYMENT CLAIMS AND/OR  
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FOR BREACHING THE AWARD.**



# WHAT ARE THE TAX ADVANTAGES FOR CHARITIES, PUBLIC BENEVOLENT INSTITUTIONS AND HEALTH PROMOTION CHARITIES?

By Peter Murray, Partner

Non-profit organisations in the health and aged care sectors may be entitled to taxation benefits such as an income tax exemption, fringe benefits tax (**FBT**) concessions and stamp duty exemption. Registration as a charity with the Australian Charities and Not-for-profits Commission (**ACNC**) is generally a requirement to obtain these benefits. Charities registered with the ACNC as a Public Benevolent Institution (**PBI**) or Health Promotion Charity (**HPC**) may access additional benefits such as deductible gift recipient (**DGR**) status.

Specific requirements apply for registration as a HPC or PBI. Broadly, a PBI must be a charitable institution whose principal purpose is to relieve poverty, sickness, suffering or disability. A HPC must be a charitable institution whose principal purpose is to promote the prevention or control of diseases in human beings.

Charities should keep in mind their approvals and charitable objects in making decisions to expand their operations to ensure that they do not put their charitable tax approvals at risk. For example, an expansion into childcare services for the general community is not a PBI activity unless incidental to the charity's approved purpose.

## INCOME TAX EXEMPTION

Registered charities, including PBIs and HPCs, can obtain an income tax exemption. An endorsement from the Australian Taxation Office (**ATO**) is required to access this exemption.

## FBT CONCESSIONS

An FBT exemption is available for registered PBIs and HPCs, public and non-profit hospitals and public ambulance services. For each employee, the exemption is capped at \$30,000 for registered HPCs and PBIs and \$17,000 for public and non-profit hospitals and public ambulance services.

Charities ineligible for the FBT exemption may be able to access a FBT rebate. The FBT rebate is available for institutions that are registered as charities with the ACNC. Certain other non-government or non-profit organisations may also qualify for the FBT rebate. The FBT rebate is currently 47% of the grossed up value of benefits provided.

For both the FBT exemption and FBT rebate, a \$5000 capping threshold applies for salary packaged meal entertainment and entertainment leasing expense benefits.

## PAYROLL TAX EXEMPTION

Wages paid by non-profit organisations, PBIs and health care service providers may be exempt from payroll tax. Payroll tax is a State-based tax and it is necessary to consider the requirements for each relevant State or Territory.

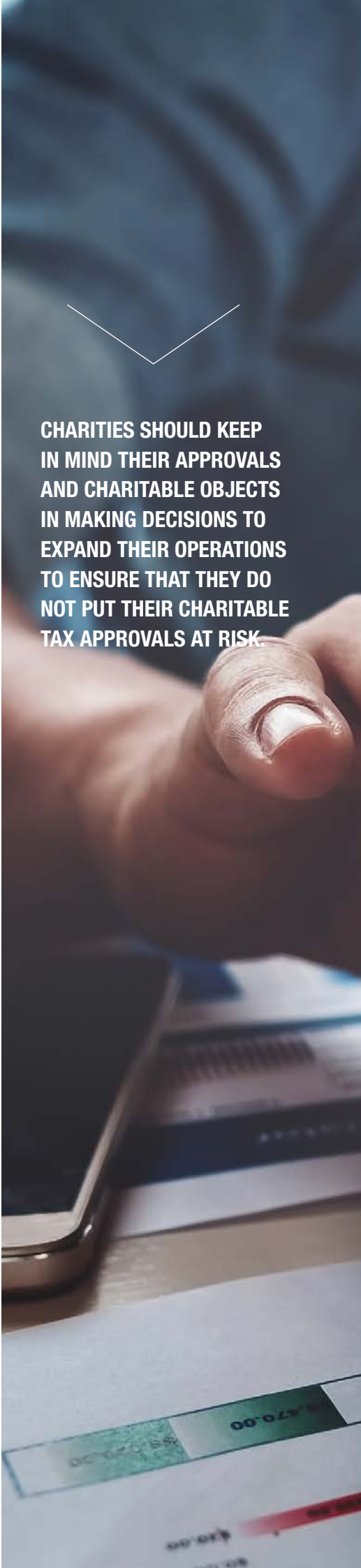
## STAMP DUTY EXEMPTION

Charities may also be entitled to an exemption from stamp duty. Again, stamp duty is a State-based tax and it is necessary to consider the requirements for each relevant State or Territory.

## DGR STATUS

Registration as a charity does not of itself provide an organisation with deductible gift recipient (**DGR**) status, allowing certain donations to be tax deductible for the donor. Only certain categories of entities are entitled to DGR status, which requires a specific application and endorsement with the ATO. Registered PBIs and HPCs may obtain an endorsement for DGR status.

Hall & Wilcox has a very experienced charity and not-for-profits service offering, which can assist organisations in the health and aged care sectors to determine their eligibility for the above tax concessions.



CHARITIES SHOULD KEEP IN MIND THEIR APPROVALS AND CHARITABLE OBJECTS IN MAKING DECISIONS TO EXPAND THEIR OPERATIONS TO ENSURE THAT THEY DO NOT PUT THEIR CHARITABLE TAX APPROVALS AT RISK.



**EMMA KULINITSCH**  
**SENIOR ASSOCIATE, SYDNEY**

We are delighted to announce Emma Kulinitsh has joined our Health and Community team as a Senior Associate based in our Sydney office.

Emma has experience across a range of industries, including aged care, technology and commercial. She has also worked with research and development corporations, and in the not-for-profit environment.

Emma's previous experience includes in-house roles with a major NSW-based residential aged care and home care services provider and retirement living operator and a provider of innovative e-health solutions for pharmacists.



**CHRIS WEST**  
**SPECIAL COUNSEL, BRISBANE**

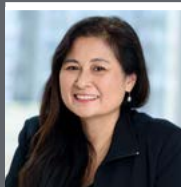
Chris West specialises in medical defence litigation defending hospital operators and medical practitioners.

After studying science at Canberra University and nursing studies at Sydney University, Chris has had a career in government (predominantly with the Federal Department of Health); unforgettable times at St Vincent's Hospital; midwifery at the Royal Women's Hospital (RWH) Brisbane; community nursing; work in NICU; out-of-hours nurse manager at the RWH; and post-grad study and work at Kings College London neonatal intensive care, which at the time was at the forefront of fetal medicine and pioneering ECMO for babies.

He has practised in health law since 1999.

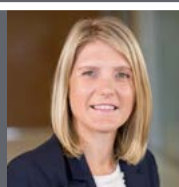
Chris's clinical background assists his relationships with clinicians and administrators, and his ability to quickly understand clinical scenarios and distil the pertinent issues. He can contextualise care, and empathise and relate to clinicians, as well as patients/claimants.

## Key contacts



**Alison Choy Flannigan**

Partner - Corporate and commercial  
T +61 2 8267 3241  
alison.choyflannigan@hallandwilcox.com.au



**Rachael Arnold**

Partner - General Insurance  
T +61 2 8267 3808  
rachael.arnold@hallandwilcox.com.au



**Jacqui Barrett**

Partner - Corporate and commercial  
T +61 2 8267 3201  
jacqui.barrett@hallandwilcox.com.au



**Kylie Groves**

Partner - Employment  
T +61 8 9482 7961  
kylie.groves@hallandwilcox.com.au



**Mark Inston**

Partner - Banking and financial services  
T +61 3 9603 3597  
mark.inston@hallandwilcox.com.au



**John O'Kane**

Partner - Property and projects  
T +61 3 9603 3120  
john.okane@hallandwilcox.com.au



**Karl Rozenbergs**

Partner - Employment  
T +61 3 9603 3583  
karl.rozenbergs@hallandwilcox.com.au



**Chris West**

Special Counsel - General Insurance  
T +61 7 3231 7776  
chris.west@hallandwilcox.com.au