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Contents

Introduction 2

HEALTH & AGED CARE

Legal Issues for the Next Generation of Healthcare - E-health, Cybersecurity, Privacy, Duty of Care and the Obligation to Follow-up in an Electronic Healthcare Environment 3

CCTV, videos and photos in health, aged care and retirement living and disability facilities– your rights and obligations 7

Australian Law Reform Commission's Elder Abuse discussion paper 11

Guardianship Update 14

When Can a Disclosure in Relation to a Healthcare Practitioner's Registration be a Breach of Privacy? What is a "lawful collection"? The hazards of incorrectly redacting a document. What does providing access to personal information "without excess delay or expense mean? - *AIN v Medical Council of New South Wales [2017] NSWCATAP 21, AIN v Medical Council of New South Wales [2017] NSWCATAP 22, and AIN v Medical Council of New South Wales [2017] NSWCATAP 23* 15

MEDICO-LEGAL

The Importance of Understanding your Medical Malpractice and Civil Liability Policy – *Mace v Justice and Forensic Health Network; The GEO Group Australia Pty Ltd v AAI Limited t/as Vero Insurance* [2016] NSWSC 803 19

LIFE SCIENCES

Mandatory Data Breach Notification to Commence – *Privacy Amendment (Notifiable Data Breaches) Act 2017* (Cth) 21

What are the Rules in Advertising Health Services and Therapeutic Goods, including Testimonials? *Australian Health Practitioner Regulation Agency* v *Limboro* (15 February 2017) 23

GENERAL

What You Need to know About the Significant Change to Strata Laws in NSW 26

How to Deal with Bullying and Harassment When Dealing with Complaints 27

What Pharmacies Need to Know about the Reduction in Penalty Rates 30

PROFILED LAWYERS 32

Introduction

Welcome to the May 2017 edition of the Holman Webb Health Law Bulletin.

"The only thing that is constant is change" - Heraclitus

This Health Law Bulletin discusses issues such as:

- legal issues for the next generation of healthcare, including e-health, cybersecurity, privacy, duty of care;
- recent cases such as *AIN v Medical Council of New South Wales* [2017] NSWCATAP 23 and *Mace v Justice and Forensic Health Network; The Geo Group Australia Pty Limited v AAI Limited trading as Vero Insurance* [2016] NSW SC 803;
- law reform in relation to elder abuse, guardianship, privacy and strata title; and
- other recent legal developments of relevance to the industry.

We trust that this edition of the Health Law Bulletin brings to you articles of relevance to the sector.

The health, aged care/retirement living and life science sectors form an important part of the Australian economy. They are economic growth areas, as more Australians retire with a significantly longer life expectancy and complex health care needs.

Against this background, Holman Webb's health, aged care and life sciences team provides advice that keeps pace with the latest developments. Our team has acted for health and aged care clients over a number of years, in the government, "for profit" and the "not for profit" sectors.

Some of our team members have held senior positions within the health industry.

Please do not hesitate to contact me or any member of our legal team should you have any questions about the Health Law Bulletin content and articles or if one of your colleagues would like to be added to our distribution list. ■

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Legal Issues for the Next Generation of Healthcare - E-health, Cybersecurity, Privacy, Duty of Care and the Obligation to Follow-up in an Electronic Healthcare Environment

By Alison Choy Flannigan, Partner

Recent media attention concerning the privacy breach by the Australian Red Cross Blood Service highlights privacy and cybersecurity risks with health information.

The penalty for a serious or repeated interference of privacy under the *Privacy Act 1988* (Cth) can be up to $1.8 million for a body corporate or $360,000 for an individual.

The increased use of technology is revolutionising modern medical practice. Health care providers are required to uphold high standards for protecting patient privacy, whether in hard copy or electronically. They need to ensure that they have appropriate privacy and security risk management strategies in place concerning how they collect, use and disclose personal information.

What is personal information?

Personal information is information or an opinion about an identified individual, or an individual who is reasonably identifiable:

(a) whether the information or opinion is true or not; and

(b) whether the information or opinion is recorded in a material form or not.

What is sensitive information?

Sensitive information includes details about an individual's:

- health information;
- racial or ethnic origin;
- sexual orientation or practices;
- political opinions and membership of political associations, professional or trade associations or trade unions;
- religious beliefs or affiliations and other philosophical beliefs; and
- criminal record.

Health information is included in 'sensitive information'. As such, it requires a higher level of privacy protection than other personal information.

The legal framework underpinning changing norms

The key legislation articulating the levels of protection required for all health information in the Australian private sector is the *Privacy Act 1988* (Cth) (**Privacy Act**). There is also State and Territory legislation including *the Health Records and Information Privacy Act 2002* (NSW), the *Health Records Act 2001* (Vic) and the *Health Records (Privacy and Access) Act 1997* (ACT)[1].

The Privacy Act regulates the collection, use and disclosure of 'personal information'.

The Australian Privacy Principles set out in the Privacy Act apply to all private sector health service providers.

Under the Privacy Act, every private sector health care practitioner is required to have and make available a Privacy Policy setting out:

- the kinds of personal information that the entity collects and holds;
- how the entity collects and holds personal information;
- the purposes for which the entity collects, holds, uses and discloses personal information;
- how an individual may access personal information about the individual that is held by the entity and seek the correction of such information;
- how an individual may complain about a breach of the Australian Privacy Principles or a registered APP code (if any) that binds the entity, and how the entity will deal with such a complaint;

[1] *Privacy Act 1988 (Cth); My Health Records Act 2012 (Cth); Health Records (Privacy and Access) Act 1997 (ACT); Health Records and Information Privacy Act 2002 (NSW); and Health Records Act 2001 (Vic)*

- whether the entity is likely to disclose personal information to overseas recipients; and
- if the entity is likely to disclose personal information to overseas recipients – the countries in which such recipients are likely to be located if it is practicable to specify those countries in the policy.

Overseas disclosure may be relevant, for example, if the practitioner stores information using a cloud-based provider that stores information outside of Australia and the cloud-based provider is able to access the data. Potential issues were clearly brought to light in 2014, when it was reported that Luxottica Retail Australia who provided optometry services to Australia's Defence Force lost its $33.5 million contract with the Australian Defence Force because of data storage in China, in breach of their contract.[2]

Each practitioner must take such steps as are reasonable in the circumstances to protect personal information from misuse, interference and loss and from unauthorised access, modification or disclosure.

In addition to privacy obligations, practitioners owe obligations of confidentiality to their patients.

The Office of the Australian Information Commissioner's *Pound Road Medical Centre Own Motion Investigation Report* (July 2014) examined some of the security requirements required in relation to health information – refer to our previous article contained in Holman Webb's Health Law Bulletin (August 2014) available at: http://www.holmanwebb.com.au/blog/health-law-bulletin-august-2014.

Sometimes, it is permitted under the Privacy Act to use health information and personal information for medical research, even in the absence of patient consent to the researchers involved provided that stated guidelines are complied with. The rationale for this rests on the public benefit that comes from research.

What are the required steps to protect patient privacy?

The first step is an analysis of what personal information is collected and held, how it is used and what are the potential security risks. This should include a review of what legal requirements and industry standards apply and how the practice's existing information systems and policies compare. Relevant polices should cover the practices, procedures, monitoring and reporting of data security, and management of complaints.

Coupled with these policies is the regular training of staff and designating accountability for the implementation, oversight and management of data breaches to a person or position within the practice.

It is also recommended to review options for technologies to enhance data security. These may include robust encryption and password protection, the protection of electronic and hard copy communications, access controls and intrusion detection.

Importantly, all of these steps should be regularly reviewed in light of new risks, the current and emerging standards of practice, and changes to compliance requirements.

What are the industry codes and guidelines?

Many medical professional organisations have guidelines relating to patient confidentiality and privacy, including in the emerging needs for electronic communications.

The Medical Board of Australia – G*ood Medical Practice, A Code of Conduct for Doctors in Australia* requires medical practitioners to ensure that their medical records are held securely and are not subject to unauthorised access.[3]

It is a breach of the Code to breach the confidentiality of the doctor patient relationship by making records available to others not involved in the care of the patient or without the patient's permission (other than as may be required by law).

What is the duty of care in relation to medical records and referrals?

Modern models of care require a multi-disciplinary team working in a collaborative manner to treat patients. In this multi-faceted environment, communication and follow up is essential. In relation to communications between specialists and other clinicians, there are a number of legal duties. These centre around clearly informing patients of the importance of proposed management plans, following up on them and ensuring that the information communicated between health care providers is accurate.

In more detail, medical practitioners' duty of care can be summarised by the following:

(a) The law recognises that a doctor has a duty to warn a patient of a material risk in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner was or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[4] Therefore, if the patient has a serious medical condition then the medical practitioner should advise them of the seriousness of the situation and the importance of attending further referred tests, and appointments etc.

[2] http://www.news.com.au/national/luxottica-loses-contract-with-adf-after-sending-diggers-data-offshore/news-story/12ce2059969a116dcff308ce28293bf4

[3] Paragraph 8.4(2) of *Good Medical Practice: A Code of Conduct for Doctors in Australia*

[4] *Rogers v Whitaker* (1992) 175 CLR 479. Available at http://www.healthlawcentral.com/rogers-v-whitaker/

(b) There is a duty to ensure that the medical records are accurate. This includes ensuring that medical records communicated to other clinicians are accurate.[5]

(c) A medical practitioner has a duty of care to find out the outcome of a test he or she has requested. He or she must be sure to know of the test results and to offer appropriate treatment to the patient in light of the report.[6]

(d) There is also a duty of care to follow up patient who does not return for further testing or consultation despite being asked to do so. There can be two types of negligence. Under the first scenario, an allegation can be made that the medical practitioner was negligent by failing to tell the patient to return in the appropriate timeframe regardless of their ongoing symptoms. Under the second, the medical practitioner fails if he or she has not created a robust follow up system. However, the courts recognise that if a patient knows of the risks but makes his own decision not to undergo testing, then provided that the medical practitioner has established that they appropriately advised the patient of the risks, the medical practitioner will not be negligent.[7]

The standard required of a person practising a profession in Australia is that they must act in a manner that is widely accepted in Australia by peer professional opinion as competent professional practice at the time the service was provided. A person practising a profession ('a **professional**') does not incur a liability in negligence arising from the provision of a professional service if it is established that his or her behaviour conformed to that standard.[8]

What to do in case of a data breach?

The Office of the Australian Information Commissioner offers a guide for managing data breaches of patient information.[9]

1. Prevention: Take a proactive approach to data security and privacy protection
2. Containment: Assess the events that lead to a breach and if you can retrieve or secure the data
3. Evaluation: Assess the risks that could or have arisen from the breach, including the potential harm that could result to minimise them?
4. Notification: Determine if you will contact affected parties, and, if so, how? Determine if you should contact the relevant privacy authority (Office of the Australian Information Commissioner).
5. Future prevention: What changes should be made in light of learning from this breach to prevent future issues and to better respond in case of a future breach?

Mandatory Data Breach Notification Laws

In Australia it is currently not mandatory to notify affected individuals, however, the *Privacy Amendment (Notifiable Data Breaches) Act* 2017 *(Commonwealth)* will come into effect within the next twelve months. Refer to the article in this Health Law Bulletin on that development.

The current guidance is that it is considered good practice and highly recommended to communicate any breach that could harm affected individuals.

What does the future hold?

In 2014 70% of Australian GPs reported using electronic medical records exclusively (i.e. were paperless).[10] The movement away from letters, fax and handing papers to patient to electronic transmission has been slower across the health care systems.

The Royal Australian College of General Practitioners has noted that the majority of medical communication is not conducted through secure electronic channels.

[5] *Kite v Malycha* (1998) 71 SASR 321
[6] *Kite v Malycha* (1998) 71 SASR 321
[7] *Kite v Malycha* (1998) 71 SASR 321; *Grinham v Tabro Meats Pty Ltd & Anor; Victorian WorkCover Authority v Murray* [2012] VSC 491
[8] For example, section 50 of *Civil Liability Act 2002* (NSW)
[9] Office of the Australian Information Commissioner: https://www.oaic.gov.au/agencies-and-organisations/guides/data-breach-notification-a-guide-to-handling-personal-information-security-breaches

[10] Britt H, Miller GC, et al. General practice activity in Australia 2013–14. General practice series no. 36. Sydney: Sydney University Press, 2014. Available at https://ses.library.usyd.edu.au/bitstream/2123/11882/4/9781743324226_ONLINE.pdf

Does the means of communication change the privacy requirements?

Privacy obligations apply regardless of the mode of communication. Practitioner's privacy obligations equally apply to the use of new technologies.

The Office of the Australian Information Commissioner has stated that "email is not a secure form of communication and you should develop procedures to manage the transmission of personal information via email".[11]

What does this mean in the context of collaborative care?

Quality communication is critical for collaborative care.

Best practice in collaborative care will require modern, secure and accurate communication between all those involved in patient care – including the primary care, hospitals, and, in some cases, the patient themselves.

Clinical innovation and information technology offers significant advances in modern health care and improved communication with patient outcomes.

The use of secure messaging and secure cloud-based technologies, which enable practitioners to store and to send information securely, can assist practitioners with their duties of care. Such technologies can create additional opportunities to better identify patients, manage their health information and assist with patient follow up, to clearly track patient attendances across health care providers, which can improve patient care and outcomes and decrease practitioners' medico-legal risks.

Patients are demanding the best and latest technologies with appropriate privacy and cybersecurity protection.

This article is an adaptation of a previous article published in MIVision written by the author and Dr Kate Taylor, Chief Executive Officer, Oculo

[11] Office of the Australian Information Commissioner: https://www.oaic.gov.au/agencies-and-organisations/guides/guide-to-securing-personal-information

CCTV, videos and photos in health, aged care and retirement living and disability facilities– your rights and obligations

By Alison Choy Flannigan, Partner and Nicholas Heinecke, Special Counsel

CCTV, videos and photos in health, aged care and retirement living and disability is becoming more of an issue following the increase in the use of social media and disturbing media reports of a "secret camera" capturing the alleged abuse of an elderly man in an Adelaide nursing home in July 2016.

There are laws in each of the Australian States and Territories which restrict the use of listening, optical, data and tracking surveillance devices, some with criminal offences, including, for example, in New South Wales:

- privacy legislation, including the *Privacy Act 1988* (Cth) and the *Health Records and Information Privacy Act 2002* (NSW);
- legislation which deals with workplace surveillance, *Workplace Surveillance Act 2005* (NSW);
- legislation which deals with CCTV, the *Surveillance Devices Act 2007* (NSW);
- laws protecting confidential information under common law or contract;
- laws regulating telecommunications and cybersecurity, including *Criminal Code 1995* (Cth); and
- criminal laws prohibiting the taking or publishing of indecent images, for example, the *Crimes Act 1900* (NSW), section 578C and indecent filming without consent, *Crimes Act 1900* (NSW), sections 91K to 91M.

Further, in relation to age care, the *User Rights Principles 2014* (Cth) provides care recipients the right to personal privacy and the full and effective use of his or her personal, civil, legal and consumer rights.

There may also be contractual rights, including under the agreement between the provider and the resident/patient.

Privacy

The *Privacy Act 1988* (Cth) applies to "organisations"/businesses (which can include an individual or a company) that is not a small business operator, a State/Territory agency or other excluded persons. The Privacy Act applies to all Australian private sector health service providers that hold health information (other than in an employee record), irrespective of their annual turnover.[12]

However, generally, the Privacy Act does not apply to an individual acting in a personal capacity. Currently, the Privacy Act does not apply to employee records, which are dealt with separately under the laws of confidentiality and workplace surveillance laws.

The Privacy Act would apply to private sector Australian hospitals and aged care and disability service providers (and their employees), but not, for example, residents and patients.

The Privacy Act does regulate the disclosure of personal information about an individual for a benefit, service or advantage.[13] So there may be scope to regulate the actions of photographers or 'bloggers'.

The Privacy Act regulates the collection, use and disclosure of "personal information" which is information or an opinion about an individual who is reasonably identifiable whether the information or opinion is true or not and whether the information or opinion is recorded in a material form or not. A photo of a person's face or identifying feature (such as a tattoo) would identify the individual.

Firstly, you must only collect personal information if it is reasonably necessary for, or directly related to, one or more of your functions or activities. In addition, an organisation must only collect personal information by lawful and fair means.[14] It must also notify people of the collection of their personal information.[15] Further, it must only use and disclose personal information for:

- the primary purpose of collection;
- a secondary purpose if the individual would reasonably expect the organisation to use the information for the secondary purpose and the secondary purpose is directly related to the primary purpose for sensitive information such as health information;
- with the individual's consent; or
- as otherwise permitted under the Privacy Act or law.

[12] Section 6D(4)(b) of the *Privacy Act 1988* (Cth)
[13] Section 6D(4)(c), (d) of *Privacy Act 1988* (Cth)
[14] Australian Privacy Principle 3.5
[15] Australian Privacy Principle 5

It is recommended that if an operator wishes to photograph, video or take any other images or recordings of personal information of a patient or resident and wishes to use that image for business purposes that the consent (preferably written) of the individual is obtained.

Further, if an organisation holds images of a person, including CCTV footage, that information is "personal information" and the individual has the right to access that information unless an exception applies under APP 12. If access is provided, then the images of other people will need to be pixilated to protect their privacy.

The *Health Records and Information Privacy Act 2002* (NSW) applies to both the public sector and private sector in New South Wales and has similar provisions.

Confidential information

It is a well-settled principle of law that where one party ('the **confidant**') acquires confidential information from or during his service with, or by virtue of his relationship with another ("the **confider**"), in circumstances importing a duty of confidence, the confidant is not ordinarily at liberty to divulge that information to a third party without the consent or against the wishes of the confider.[16]

In some cases, information, including conversations, documents and images may be taken and provided in confidence and cannot be disclosed without consent.

Obligations of confidence can apply in employment situations and between the operator of a health and aged care facility and residents and patients and also between residents and patients and their families.

[16] *Attorney-General v Guardian Newspapers* [No. 2] [1998] 2 WLR 805

Workplace Surveillance Legislation

Under the *Workplace Surveillance Act 2005* (NSW) an employer commits an offence if it engages in the surveillance of an employee without providing written notice at least 14 days before the surveillance commences.[17]

The notice must indicate:

- the kind of surveillance to be carried out (camera, computer or tracking);
- how the surveillance will be carried out;
- when the surveillance will start;
- whether the surveillance will be continuous or intermittent; and
- whether the surveillance will be for a specified period or ongoing.

For camera surveillance of an employee, it is only permissible to use cameras for surveillance where:

- the cameras are clearly visible in the place where the surveillance is taking place; and
- there are signs notifying people that they may be under surveillance in that place which are clearly visible at the entrance to that place.[18]

Written notice by the provision within a workplace policy is sufficient.

It is important to note the definition of employer under section 3 of the *Workplace Surveillance Act* which extends to "another person for whom an employee performs work pursuant to a contract or other arrangement between that other person and the employee's employer (such as a labour hire contract).

The definition of employer includes a person for whom an employee performs voluntary work.

Covert surveillance is permissible in very limited circumstances, for example, for the purpose of establishing whether or not an employee is involved in any unlawful activity while at work for the employer. Law enforcement agencies are permitted to conduct such surveillance and usually only with authority of a warrant issued by a Judge or Magistrate. If an employer has reasonable grounds to suspect that an employee is engaging in unlawful activity while at work, it can either make a report to police or other relevant authority or it may apply for a covert surveillance authority under the Workplace Surveillance Act. Such authority is only granted on an application to a Magistrate, is limited to time and any conditions as set by the Magistrate. A covert surveillance authority is only to be used in relation to unlawful conduct and may not be used for performance or other matters concerning the employee / employer relationship and covert surveillance must not be taken in any change room, toilet facility or shower or other bathing facility.[19]

Under NSW legislation it would be open for an operator/Approved Provider (with or without the consent of the relevant Resident) to apply for a covert surveillance authority if there were grounds to suspect that an employee was (for example) assaulting patients/residents. However, the grounds for such suspicions would need to be plainly established for a Magistrate to authorise (without the consent of the resident) the installation of a camera into the room of a resident.

Any employer (including a person contracting for services) conducting surveillance in breach of the Workplace Surveillance Act is liable to prosecution under that Act.

Surveillance may be undertaken by agreement: section 14.

Surveillance Devices Legislation

The *Surveillance Devices Act 2007* (NSW) contains an offence of knowingly installing, using or maintaining an optical surveillance device on or within premises or a vehicle or on any other object, to record visually or observe the carrying on of an activity, if the installation, use or maintenance involves:

- entry onto or into the premises or vehicle without the express or implied consent of the owner or occupier of the premises or vehicle; or
- interference with the vehicle or other object without the express of implied consent of the person having lawful possession or lawful control of the vehicle of object: section 8.

This does not apply to the installation, use or maintenance of an optical surveillance device in accordance with a warrant, emergency authorisation, corresponding warrant or corresponding emergency authorisation.

This also does not apply if each principal party to the private activity consents expressly or impliedly to the installation, use or maintenance.

An owner of a private residence is lawfully able to install and record from a CCTV device all activities within their home or vehicle.

There are also restrictions on the overhearing, recording, monitoring and listening of private conversations to which the person is not a party and the use of tracking devices without consent.

Arguably, in relation to residential aged care facilities, both the resident and the Approved Provider "own" and/or "occupy" those premises and therefore, the consent of both is required. Certainly the Approved Provider occupies common and public areas. The consent of the resident should be obtained for their private room.

[17] Section 10 of *Workplace Surveillance Act 2005* (NSW)
[18] Section 11 of *Workplace Surveillance Act 2005* (NSW)
[19] Section 20 of *Workplace Surveillance Act 2005* (NSW)

The installation of a secret CCTV recording device in a room of a facility is an offence under the Surveillance Devices Act unless permitted under the Act and can incur penalties for a contravention of up to 5 years imprisonment and fines of $11,000 for individuals and $55,000 for corporations.[20] The person who installs a camera device is also liable to prosecution under the Surveillance Devices Act.

If you wish to install, use or maintain a listening or optical surveillance device (separate to workplace surveillance), then you should either obtain consent or contact the Police for a warrant. This would include concerned families of residents who are unable to resolve their complaint with the approved provider.

Telecommunications and cybersecurity

The *Telecommunications (Interception and Access) Act 1979* (Cth) regulates access to telecommunications content and data in Australia.

The *Telecommunications (Interception and Access) Act* makes it an offence for a person to intercept or access private telecommunications without the knowledge of those involved in that communication.

The *Criminal Code 1995* (Cth) (as was amended by the *Cybercrime Act 2001* (Cth)), division 477 regulate cybercrimes involving computers.

Alternative solutions

The *User Rights Principles 2014* (Cth), which applies to residential aged care facilities requires Approved Providers to provide residents the right to personal privacy and to full and effective use of his or her personal, civil, legal and consumer rights.

If an Approved Provider/operator wishes to restrict people (including Residents, staff and visitors) from infringing the rights of other residents and staff by videoing or recording without their consent, an option which may be explored is the introduction of a reasonable policy or code of conduct, setting out rules as a condition of entry into their premises, similar to conditions of entry into shopping centres. In order to achieve this, reasonable notice must be provided of the conditions of entry.

The common areas of an aged care facility or hospital may be "private property", to which the *Inclosed Lands Protection Act 1901* (NSW) and the laws of trespass to property might apply to restrict access to non-residents if the policy/code is infringed.[21]

There may be an action in nuisance where the activity unduly interferes with the use or enjoyment of land.

The common law in Australia does not recognise an action such as trespass to person unless the act caused the victim physical harm or psychiatric illness.

Commentary

The use of technology and surveillance in health, aged care and retirement living and disability has its advantages, including:

- the security provided by CCTV; and
- lifesaving GPS location devices may provide people with mental health issues, disabilities such as autism, Alzheimer's or dementia more freedom of movement (for example, being able to spend time in the fresh air outdoors), rather than being confined indoors.[22]

In relation to concerns of elder abuse, one would think that secretly filming a carer would have been a last resort, and a better solution would be a discussion and resolution of the concerns.

Certainly, concerned family and friends may be willing to, for ease of mind, pay for the privilege of being able to have more contact with their loved one by way of information technology such as photos, videos and skype.

However, balanced against those rights are legal obligations of privacy and compliance with surveillance and other laws, which are summarised above.

In residential aged care or community homes for people with disabilities, there is a blurring of the workplace and people's homes.

If there is concern sufficient to warrant covert surveillance, the recommended approach is to contact the Police to seek a court warrant. ■

[20] Section 8 of the *Surveillance Devices Act 2007 (NSW)*

21 *Halliday v Neville* (1984) 155 CLR 1, 8; *TCN Channel Nine Pty Ltd v Anning* (2002) 54 NSWLR 333

[22] http://www.alzheimers.net/8-8-14-location-devices-dementia/

Australian Law Reform Commission's Elder Abuse discussion paper

By Alison Choy Flannigan, Partner

1. **Introduction**

   The Australian Law Reform Commission (**ALRC**) published a discussion paper on Elder Abuse in December 2016. The ALRC has been asked to consider existing Commonwealth laws and frameworks which seek to safeguard and protect older persons from misuse or abuse by formal and informal carers, supporters, representatives and others, and to examine the interaction and relationship of these laws with state and territory laws. Submissions closed on 27 February 2017.

   A number of proposals were made which will affect health and aged care providers. Please find below a summary of our submission.

2. **What is Elder Abuse?**

   While there is no universally accepted definition of elder abuse, a widely used definition is the one put forward by the World Health Organization, describing elder abuse as a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.

   Commonly recognised categories of elder abuse include psychological or emotional abuse, financial abuse, physical abuse, neglect, and sexual abuse. Using drugs to sedate older people when unnecessary is another type of abuse, sometimes called chemical abuse.

3. **Proposal 3–5 Any person who reports elder abuse to the public advocate or public guardian in good faith and based on a reasonable suspicion should not, as a consequence of their report, be:**

   (a) liable, civilly, criminally or under an administrative process;

   (b) found to have departed from standards of professional conduct;

   (c) dismissed or threatened in the course of their employment; or

   (d) discriminated against with respect to employment or membership in a profession or trade union.

   We support the proposition that reporting elder abuse should not be subject to a breach of laws, including privacy laws.

4. **Proposal 5–1 A national online register of enduring documents, and court and tribunal orders for the appointment of guardians and financial administrators, should be established.**

   Who should be permitted to search the national online register without restriction?

   We support an online register, however, access to such a register should be appropriately restricted for privacy issues, particularly if registration becomes compulsory and the relevant individual does not wish to disclose certain matters to certain people, including family members who have 'fallen out' with that individual.

5. **Proposal 5–2 The making or revocation of an enduring document should not be valid until registered. The making and registering of a subsequent enduring document should automatically revoke the previous document of the same type.**

   We are concerned that mandatory registration of enduring documents may not be practical for many elderly people with mobility and complex health issues and of limited financial means. Therefore, we suggest voluntary registration.

6. **Proposal 5–4 Enduring documents should be witnessed by two independent witnesses, one of whom must be either a:**

   (a) legal practitioner;

   (b) medical practitioner;

   (c) justice of the peace;

   (d) registrar of the Local/Magistrates Court; or

   (e) police officer holding the rank of sergeant or above.

   Each witness should certify that:

   (a) the principal appeared to freely and voluntarily sign in their presence;

   (b) the principal appeared to understand the nature of the document; and

   (c) the enduring attorney or enduring guardian appeared to freely and voluntarily sign in their presence.

We are concerned that the proposed witnessing requirements may not be practical for many elderly people with mobility and complex health issues and suggest that the list of authorised witnesses be expanded, for example, to include registered nurses and pharmacists. Further discussion is required regarding potential liability in relation to the certification process as to capacity to understand the nature of the document.

7. **Proposal 5–5 State and territory tribunals should be vested with the power to order that enduring attorneys and enduring guardians or court and tribunal appointed guardians and financial administrators pay compensation where the loss was caused by that person's failure to comply with their obligations under the relevant Act.**

   It is our experience that most enduring guardians act in good faith without any reward over a number of years by volunteering their time, however, family disputes often arise.

   Any penalty or payment of compensation should only be made in exceptional circumstances where there is a lack of good faith, gross negligence or criminal activity. It would be adverse to the elderly if there is a significant disincentive for a person to take on the role and responsibilities of their enduring guardian.

8. **Proposal 5–8 Legislation governing enduring documents should explicitly list transactions that cannot be completed by an enduring attorney or enduring guardian including:**

   (a) making or revoking the principal's will;

   (b) making or revoking an enduring document on behalf of the principal;

   (c) voting in elections on behalf of the principal;

   (d) consenting to adoption of a child by the principal;

   (e) consenting to marriage or divorce of the principal; or

   (f) consenting to the principal entering into a sexual relationship.

If the care recipient clearly indicates a desire to enter into a relationship, including a sexual relationship, why should the enduring guardian not be able to consent? Requiring a court order to consent to a sexual relationship is against the rights of residential care recipients under the *User Rights Principles 2014* (Cth) to select and maintain social and personal relationships with anyone else without fear, criticism or restriction.

9. **Proposal 5–10 State and territory governments should introduce nationally consistent laws governing enduring powers of attorney (including financial, medical and personal), enduring guardianship and other substitute decision makers.**

   We agree with this approach. Inconsistency with the laws in relation to enduring powers of attorney, enduring guardianship and other substitute decision makers has created great confusion within the health and aged care industry.

10. **Question 6–1 Should information for newly-appointed guardians and financial administrators be provided in the form of:**

    (a) compulsory training;

    (b) training ordered at the discretion of the tribunal;

    (c) information given by the tribunal to satisfy itself that the person has the competency required for the appointment; or

    (d) other ways?

    Once again, many enduring guardians act in good faith and without any reward and many have limited means. Compulsory training should only be implemented if government were to provide the training at no cost to the enduring guardian and flexible training options are available, such as on-line training in multiple languages.

11. **Proposal 11–2 The term 'reportable assault' in the *Aged Care Act 1997* (Cth) should be replaced with 'reportable incident'.**

    With respect to residential care, 'reportable incident' should mean:

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

    (b) 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

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

    With respect to home care or flexible care, 'reportable incident' should 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.

    Further discussion on the definition of "neglect" is required. Does neglect include being late for an appointment for an hour or neglect over a period of time?

12. **Proposal 11–3 The exemption to reporting provided by s 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, should be removed.**

    We propose that the aged care industry be consulted further regarding the removal of this exemption.

13. **Proposal 11–4 There should be a national employment screening process for Australian Government funded aged care. The screening process should 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

    Whilst we support a national employment screening process at manageable cost to the Approved Providers, however, many reports or "reportable incidents" may be unsubstantiated. Health and aged care staff should only be precluded if those reports are proved rather than just alleged.

14. **Proposal 11–6 Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.**

    We welcome this proposal, subject to industry consultation on the National Code of Conduct for Health Care Workers.

15. **Proposal 11–7 *The Aged Care Act 1997* (Cth) should regulate the use of restrictive practices in residential aged care. The Act should provide that restrictive practices only be used:**

    (a) when necessary to prevent physical harm;

    (b) to the extent necessary to prevent the harm;

    (c) with the approval of an independent decision maker, such as a senior clinician, with statutory authority to make this decision; and

    (d) as prescribed in a person's behaviour management plan.

    Who is a 'senior clinician'? Many aged care providers do not have access to independent medical practitioners on site. Restraint may be required in emergency situations.

16. **Proposal 11–8 Aged care legislation should provide that agreements entered into between an approved provider and a care recipient cannot require that the care recipient has appointed a decision maker for lifestyle, personal or financial matters.**

    Where the care recipient does not have the legal capacity to enter into an agreement, the approved provider can only deal with the care recipient's legal representative. ■

Guardianship Update

By Alison Choy Flannigan, *Partner*

The New South Wales Attorney-General has asked the NSW Law Reform Commission to review and report on the desirability of making changes to the *Guardianship Act 1987* (NSW) (**Act**). On 28 February 2017 Question Papers 4, 5 and 6 were released for comment. Submissions close on 12 May 2017.

The Questions Papers relate to:

- Question Paper 4 – Safeguards and procedures
- Question Paper 5 – Medical and dental treatment and restrictive practices
- Question Paper 6 – Remaining Issues.

Some of the questions discussed in Question Paper 5 include the capacity to consent to medical and dental treatment, consent to medical and dental treatment, clinical trials, advance care directives and restrictive practices.

Health and aged care

Under Part 5 of the Act, a person responsible can consent to major and minor treatment for a person who lacks decision-making capacity.

If the patient is under the age of 18, the person responsible is someone who has parental responsibility for them. In most other cases, the person responsible is whoever sits at the top of the hierarchy set out in the legislation. That hierarchy is, in descending order:

(a) the patient's guardian (if any), who has been appointed with the power to give consent for medical and dental treatments;

(b) the patient's spouse (if their relationship is close and continuing and the spouse is not under guardianship);

(c) a person who has care of the patient, and

(d) a close friend or relative of the patient.[23]

Relevant questions set out in Question Paper 5 for the health and aged care sector include:

Question: 4.6:

- Is the person responsible hierarchy appropriate and clear? If not, what changes should be made?
- Does the hierarchy operate effectively? If not, how could its operation be improved?

Pharmaceutical, medical device and life sciences

The paper also considers the question of who can authorise a patient's participation in a clinical trial and in what circumstances?

Relevant questions for the pharmaceutical, medical device and life science sectors include:

Question 5.3: Who can consent to clinical trial participation?

(1) Who should be able to approve a clinical trial?

(2) Who should be able to consent to a patient's participation in a clinical trial if the patient lacks decision-making capacity?

(3) How can the law promote the patient's autonomy in the decision-making process?

[23] *Guardianship Act 1987* (NSW), section 33A(4)

When Can a Disclosure in Relation to a Healthcare Practitioner's Registration be a Breach of Privacy? What is a "lawful collection"? The hazards of incorrectly redacting a document. What does providing access to personal information "without excess delay or expense" mean? - *AIN v Medical Council of New South Wales [2017] NSWCATAP 21, AIN v Medical Council of New South Wales [2017] NSWCATAP 22, and AIN v Medical Council of New South Wales [2017] NSWCATAP 23*

By Alison Choy Flannigan, *Partner* and Bill Lo, Solicitor

In *AIN v Medical Council of New South Wales* [2017] NSWCATAP *21, AIN v Medical Council of New South Wales* [2017] NSWCATAP *22, and AIN v Medical Council of New South Wales* [2017] NSWCATAP 23, the registered medical practitioner appealed several decisions made by the New South Wales Civil and Administrative Tribunal (**Tribunal**) relating to the collection, use and disclosure of her personal information by the predecessor of the Medical Council of NSW, Medical Board of NSW (**Medical Council**).[24] This article examines the interpretation of the *Protection of Personal Information Act 1988* (NSW) (**Act**) by the Appeal Panel of the Tribunal (**Appeal Panel**). There are similarities between the Act and the *Privacy Act 1988* (Cth).

Background

The facts may be briefly summarised as follows:

- AIN (a pseudonym) was a registered medical practitioner with general registration. AIN applied for full general registration but her application was refused. There had never been a complaint about AIN's conduct to any medical authority.
- AIN provided the Medical Council with her personal information to determine whether she was suitable for general registration as a medical practitioner.
- The Medical Council granted AIN general registration subject to conditions.
- AIN appealed the Medical Council's decision to the Medical Tribunal. The parties settled the matter by agreeing to orders imposing revised conditions on AIN's general registration. The Medical Tribunal granted a non-publication order which prohibited, amongst other things, the publication of AIN's name.
- The Medical Council notified the conditions on AIN's general registration to the Australian Health Practitioner Regulation Agency (**AHPRA**).
- The Medical Council published the decision on its website (**Contravening Publication**), however, used the Adobe software to redact references to the name. With some versions of the Adobe Acrobat Reader, AIN's name was displayed whenever the mouse hovered over the redacted lines. Any person with a PDF editing tool was able to remove the blanking in each of the lines so that AIN's name was displayed. The Contravening Publication contained "Re A Practitioner" and the parties were stated to be "A Practitioner" and "Office of the Healthcare Complaints Commission" (the **HCCC**). The latter party was incorrect. The catchwords referred to the duty of the Medical Council to protect public health and safety. There was no reference in the catchwords section to returning to practice after an extended absence.
- On googling AIN's name, the Medical Council's decision came up.
- AIN was concerned that the Contravening Publication gave an incorrect disclosure that conditions were imposed upon her registration due to a HCCC Complaint.

Grounds of Appeal

AIN appealed the Tribunal's decisions regarding various matters including:

1. the collection of AIN's personal information by the Medical Council;
2. the use of AIN's personal information by the Medical Council;
3. the disclosure of the conditions on AIN's general registration by the Medical Council to AHPRA against a non-publication order;

[24] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 21; *AIN v Medical Council of New South Wales* [2017] NSWCATAP 22; *AIN v Medical Council of New South Wales* [2017] NSW CATAP 23; and *AIN v Medical Council of New South Wales* [2017] NSWCATAP 36.

4. AIN's access to personal information held by the Medical Council, including access "without excessive delay or expense";
5. the Medical Council's failure to check the accuracy of AIN's personal information before use; and
6. the Contravening Publication.

Collection of Personal Information

AIN provided the Medical Council with her personal information to determine whether she was suitable for general registration as a medical practitioner. The Medical Council subsequently (after the matter was settled at the Medical Tribunal) acknowledged that AIN had always had the status of general registration and therefore she was not required to make an application for general registration. On this basis, AIN alleged that the Medical Council had contravened section 8(1) of the Act because the Medical Council collected her personal information for an unlawful purpose.

Section 8(1) of the Act states:

A public sector agency must not collect personal information unless:

(a) the information is collected for a lawful purpose that is directly related to a function or activity of the agency, and

(b) the collection of the information is reasonably necessary for that purpose.

The Tribunal adopted the description of "lawful purpose" set out by the *Administrative Decisions Tribunal in PN v Department of Education and Training* [2009] NSWADT 287 at paragraph 153 and endorsed on appeal in *PN v Department of Education and Training* [2010] NSWADTAP 59 at paragraph 23:

"Lawful purpose" has been stated to generally mean, a purpose that is not forbidden, rather than positively authorised, by law: NX v Officer of the Director of Public Prosecutions [2015] NSWADT 74 at paragraph 22.

The Tribunal found in favour of the Medical Council and said, whilst the collection of AIN's personal information by the Medical Council was due to a mistaken belief by the Medical Council, it did not detract from its lawfulness.[25]

The Appeal Panel held that the Tribunal failed to respond to substantial evidence and submissions by AIN that the Medical Board knew that she did not need to re-apply for general registration and that error was a breach of procedural fairness to exercise jurisdiction.[26]

In addition, the Appeal Panel did not agree with the Tribunal because it failed to consider whether "the collection of the information is reasonably necessary for that purpose". The Appeal Panel said whether the collection of information was reasonably necessary would depend on the evidence of any witnesses on the state of mind of the Medical Council.[27] If it was established that the Medical Council knew that AIN did not need to re-apply for general registration but nonetheless collected her information, then the collection by the Medical Council would not be reasonably necessary.

Disclosure of Personal Information

AIN alleged that the Medical Council's disclosure to AHPRA contravened section 18 of the Act because there was a non-publication order in place. The Tribunal held that the Medical Council did not contravene section 18 of the Act because an exception in section 18 of the Act applied. Section 18 of the Act relevantly provides a public sector agency that holds personal information must not disclose the information to a person unless:

1. the disclosure is directly related to the purpose for which the information was collected, and the agency disclosing the information has no reason to believe that the individual concerned would object to the disclosure; or
2. the individual concerned is reasonably likely to have been aware that information of that kind is usually disclosed to that other person.

The Appeal Panel agreed with the Tribunal's decision. The Appeal Panel examined the *Medical Practice Act 1992* (now repealed) which allowed the Medical Tribunal to make the non-publication order. It relevantly allowed the Medical Tribunal to direct that:

1. the name of any witness is not to be *disclosed* in the proceedings;
2. the name and address of a registered medical practitioner not to be *published*.

The Medical Tribunal only had a power to direct that the name of a registered medical practitioner not to be *published*. It did not have a power to direct that the name of a registered medical not to be *disclosed*.

The Appeal Panel noted the definition of "publish" in the Macquarie Dictionary referred to "issue to the public" and "to make publicly or generally known.[28]

Accordingly, the non-publication order did not prohibit the Medical Council's disclosure to AHPRA. The Appeal Panel noting AIN's reason for applying a non-publication order was to prevent the "world at large" being informed of the conditions on her general registration said AIN was aware that the conditions on her general registration would be disclosed to AHPRA.[29]

[25] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 22, paragraph 33
[26] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 22, paragraph 38
[27] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 22, paragraphs 39 and 40
[28] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 22, paragraph 79
[29] The Appeal Panel also found the exceptions in sections 18(1)(a) and 25(b) applied. The former applied because APHRA had the functions of maintaining the national register of health practitioners and the Medical Council had no reason to believe that AIN would object to the disclosure. The latter applied because section 221 of the *Health Practitioner Regulation National Law* lawfully authorised the Medical Council not to comply with section 18 of the Act.

Access by AIN

AIN sought access to her personal information held by the Medical Council. The Medical Council initially provided some documents to AIN and informed AIN that it had provided her with all the requested information. AIN challenged the Medical Council's response and later received documents that the Medical Council initially said it did not hold. AIN applied for internal review by the Tribunal complaining the Medical Council's conduct in dealing with her right to access to personal information under section 14 of the Act.

Section 14 of the Act states:

A public sector agency that holds personal information must, at the request of the individual to whom the information relates and without excessive delay or expense, provide the individual with access to the information.

The Tribunal accepted the Medical Council's submission that the complaint should be dismissed because AIN had been provided with the requested information and that any issue relating to delay or expenses in providing AIN with access would go to remedy.

The Appeal Panel did not agree with the Tribunal. The Appeal Panel held that a public sector agency who complies with a request for personal information but failed to do so without excessive delay or expense contravenes section 14 of the Act.[30]

Accordingly, section 14 of the Act has two limbs:

1. Whether the request for access to personal information has been complied with; and
2. Whether the request for access to personal information was provided without excessive delay or expense.

The failure of the Tribunal to determine whether or not access was provided without excessive delay or expense resulted in a failure by the Tribunal to consider a significant part of AIN's case.[31]

The Contravening Publication - Disclosure

The Medical Council published the decision regarding AIN's application for full registration on its website (**Contravening Publication**), however, used the Adobe software. With some versions of the Adobe Acrobat Reader, AIN's name was displayed whenever the mouse hovered over the redacted lines. Any person with a PDF editing tool was able to remove the blanking in each of the lines so that AIN's name was displayed. Apparently what you are supposed to do is print out the document as amended by Adobe and scan the redacted version, thereby removing the meta data/data trace.

There was no dispute that the Medical Council had contravened section 18 of the Act.

Section 18 of the Act states:

18 Limits on disclosure of personal information

(1) A public sector agency that holds personal information must not disclose the information to a person (other than the individual to whom the information relates) or other body, whether or not such other person or body is a public sector agency, unless:

(a) the disclosure is directly related to the purpose for which the information was collected, and the agency disclosing the information has no reason to believe that the individual concerned would object to the disclosure, or

(b) the individual concerned is reasonably likely to have been aware, or has been made aware in accordance with section 10, that information of that kind is usually disclosed to that other person or body, or

(c) the agency believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person.

(2) If personal information is disclosed in accordance with subsection (1) to a person or body that is a public sector agency, that agency must not use or disclose the information for a purpose other than the purpose for which the information was given to it.

Section 16 of the Act states:

A public sector agency that holds personal information must not use the information without taking such steps as are reasonable in the circumstances to ensure that, having regard to the purpose for which the information is proposed to be used, the information is relevant, accurate, up to date, complete and not misleading.

AIN contended that the Contravening Publication did not accurately set out what was agreed.

The grounds of appeal included the duration of the breach of section 18 of the Act, the nature and scope of publication and hence the nature of the breach of section 18, and section 16 and remedies.

The Appeal Panel found, amongst other matters that the Tribunal at first instance had erred in finding that AIN's personal information was "masked from the human eye" based on an error of fact which was unreasonably arrived at and clearly mistaken.

In addition, the Appeal Panel found that the Contravening Publication falsely conveyed that AIN had been the subject of a complaint about her conduct and this was a breach that impacted very adversely on her reputation and caused her significant distress and anxiety.[32]

[30] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 21, paragraph 24
[31] *AIN v Medical Council of New South Wales* [2017] NSWSCATAP 21, paragraph 44

[32] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 23, paragraph 65.

The Contravening Publication - Use

AIN alleged that the Medical Council had contravened section 16 of the Act by using her personal information in the Medical Council's creation of the Contravening Publication.

The Appeal Panel acknowledge that there can be an overlap between use and disclosure, however, the Act reveals a legislative intention to identify district stages of the information handling process, ranging from collection, to holding, to access, to use, and to disclosure, with varying agency obligations at each stage.[33]

The Tribunal found that the Medical Council did not contravene section 16 of the Act on this point because that particular section does not apply to "external disclosure" and there was no "identifiable internal use" of AIN's personal information.[34]

The Appeal Panel agreed with the Tribunal and referred to *AFC v The Sydney Children's Hospital Speciality Network (Randwick and Westmead)* [2012] NSWADT 189. In that case, it was held that "writing and dispatching [a] letter should be viewed as one course of conduct that falls to be considered as a disclosure."[35] Accordingly, the Medical Council in compiling and disclosing the Medical Tribunal's decision did not contravene section 16 of the Act.

The question of the duration of the breach of section 18, relief and costs were remitted for redetermination.

[33] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 23, paragraph 75

[34] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 23 *paragraph 69,* In *PK v Department of Education and Training* [2010] NSWADTAP 59, it was found that section 16 of the Act did not apply to a disclosure of personal information outside the public sector agency ("external disclosure"). In *Department of Education and Communities v VK* [2011] NSWADTAP 61, it was found that there might be both a use for the purpose of section 16 of the Act (see above) and a disclosure for section 18 in the one sequence of events, but only where there were separate "identifiable internal use" and "identifiable external disclosure" transactions or actions.

[35] *AIN v Medical Council of New South Wales* [2017] NSWCATAP 23, paragraph 81

The Importance of Understanding your Medical Malpractice and Civil Liability Policy – *Mace v Justice and Forensic Health Network; The GEO Group Australia Pty Ltd v AAI Limited t/as Vero Insurance* [2016] NSWSC 803

By Zara Officer, Special Counsel

A recent case highlights the need for health care providers to understand their medical malpractice and civil liability policy terms and conditions.

The facts

Mr Shayne Mace was taken on remand to Parklea Correctional Centre (**Parklea**) and was an inmate there from 3 March 2010 to 7 March 2010. The statement of claim alleged that while at Parklea Mr Mace was displaying and/or expressing signs of acute mental illness, and on 7 March 2010 he threw himself from a landing in 5C Block of Parklea. He landed on his upper back and neck, was transported to Westmead Hospital by ambulance where he underwent a craniotomy to evacuate an extradural haematoma on 9 March 2010. Mr Mace, by his tutor Mrs Kathy Mace (his mother), brought claims in negligence against Justice & Forensic Health Network (**Justice Health**), the State of NSW and the Geo Group Australia Pty Limited (**Geo**) for these injuries. Geo was the entity which operated Parklea under an agreement it entered with the Commissioner of Corrective Services. Mr Mace's claims were settled in December 2015.

Geo pursued a crossclaim against its insurer AAI Limited t/as Vero Insurance (**Vero**). Geo was insured under a "Medical Malpractice Civil Liability Insurance Policy" (**Policy**), and Geo made a claim under that Policy in May 2012 in respect of Mr Mace's claim.

The insurance issues

The Court considered whether or not Geo's claim fell within the terms of the Policy. Geo had contracted to provide the services of psychologists, counsellors and custodial staff at Parklea. Justice Health provided medical services for inmates and Mr Mace had received nursing services from Justice Health nursing staff while he was at Parklea. The question arose whether Mr Mace ought to have received the services of the counsellors or the psychologists that Geo employed at Parklea, so as to trigger the Policy.

The insuring clause of the Vero policy provided:

> *"The Insurer will indemnify the Insured against civil liability for compensation and the claimant's costs and expenses in respect of any Claim or Claims first made against the Insured and notified to the Insurer during the Period of Insurance* ***resulting from the conduct of the Health Care Services****." (our emphasis)*

Health Care Services were defined as the "provision of medical services and treatment including services and treatment provided by psychologists and counsellors". Those services involved inmate assessment. The Policy extended to claims concerning acts and also omissions in the conduct of those services and treatments.

There was no evidence during the time Mr Mace was on remand at Parklea from Wednesday, 3 March to Sunday, 7 March 2010 that he received any services from either the psychologists or the counsellors employed by Geo. Mr Mace's complaint was that he should have received such services both on admission and subsequently, as this would have identified him as an inmate at risk of self harm, and Geo would take steps to manage that risk.

Vero argued that it was a result of the failures on the part of the corrective services staff that Geo employed at Parklea to refer Mr Mace to the psychologists or the counsellors. Vero contended that those failures were not failures which fell within the Policy, because they were failures in Geo's operation of the centre, not in the provision of counselling and psychological services to Mr Mace.

Vero's position was that the Policy only covered the acts and omissions of those who had actually supplied the services falling within the definition of health care services. This definition included services by psychologists and counsellors.

Contractual obligations

Geo was required by its contractual obligations to assess, identify and manage inmates at risk of self harm in custody when they entered Parklea. Geo employed psychologists and counsellors to meet those obligations. There was no evidence that Mr Mace had been assessed for risk of self harm when he entered Parklea, as Geo was obliged to do. Geo was not only contractually obliged to devise procedures for such assessments to be undertaken by its psychologists, but it was obliged to manage any risks identified and implement the management plan.

Vero's position

The Court characterised Vero's case, in essence, to be that Geo's failure to have a psychologist or counsellor assess the risks of self harm to Mr Mace was not something which occurred in the conduct of health care services. Vero submitted that failing to recognise the plaintiff was displaying symptoms of acute mental illness and failing to refer Mr Mace for treatment was not something for which it had insured Geo, because this was not something which occurred in the conduct of medical services. This was a failure of operational services, not medical services.

The decision

The Court did not accept Vero's position. Geo owed a duty of care to Mr Mace and also was contractually obliged to provide staff psychologists and counsellors to assess inmates, to determine whether they presented risks of self harm or mental illness. Geo was further contractually obliged to address the risks identified in those assessments of inmates, including Mr Mace.

The Court took the view that what was insured involved more than what occurred during the provision of the services of a particular psychologist or counsellor to a particular inmate. It included claims which resulted from how Geo conducted the provision of such services. In Mr Mace's case, this was by *failing* to provide him with the services of its psychologists. Mr Mace's claims against Geo were concerned with its failure to undertake a risk assessment and to manage his risk of self harm. In the language of the insuring clause, that was a claim "resulting from" its "conduct" of the insured "Health Care Services".

In this way, the Court found that the Vero Policy covered the failure of Geo to assess and manage Mr Mace's risk of self harm. The Court found that the requirement to assess and manage the risk of self harm was not a medical service which was the responsibility of Justice Health to provide. Geo's omission was characterised as misadventure in the conduct of the health care services rather than a misadventure in the actual provision of health care services, so that the Policy cover applied.

The case is the subject of an appeal to the NSW Court of Appeal. ■

Mandatory Data Breach Notification to Commence – *Privacy Amendment (Notifiable Data Breaches) Act 2017* (Cth)

By Alison Choy Flannigan, Partner

The *Privacy Amendment (Notifiable Data Breaches) Act 2017* (Cth), which amends the *Privacy Act 1988* (Cth) (**Privacy Act**) was passed on 22 February 2017 and will commence on a date to be proclaimed within 12 months.

The amendments will apply to all organisations which are subject to the Privacy Act, including private sector health care providers who collect, use and disclose health information.

Health care providers must update their privacy policies and procedures now in preparation for the new changes, including internal monitoring and reporting of data breaches and procedures to deal with data breaches. Maintaining the status quo is no longer an acceptable option.

Examples of unauthorised access to, unauthorised disclosure of, or loss of, personal information include:

- Malicious breach of security – e.g. cyber security incident
- Accidental loss of IT equipment or hard copy documents
- Negligent of improper disclosure of information

Penalties for serious or repeated interference with Privacy under the Privacy Act are up to $1.8 million for a corporation or $360,000 for an individual.

The amendments set up a scheme for notification of "eligible data breaches".

What are your obligations concerning the security of personal information?

Under Australian Privacy Principle 11, an entity must take reasonable steps to protect personal information it holds from misuse, interference and loss, as well as unauthorized access, modification or disclosure.

Where an entity no longer needs personal information for any purpose for which the information may be used or disclosed in accordance with the Australian Privacy Principles, the entity must take reasonable steps to destroy the information or ensure that it is de-identified.

What is an "eligible data breach"?

An "eligible data breach" happens if:

(a) both of the following conditions are satisfied:

  (i) there is unauthorised access to, or unauthorised disclosure of, the information;

  (ii) a reasonable person would conclude that the access or disclosure would be likely to result in serious harm to any of the individuals to whom the information relates; or

(b) the information is lost in circumstances where:

  (i) unauthorised access to, or unauthorised disclosure of, the information is likely to occur; and

  (ii) assuming that unauthorised access to, or unauthorised disclosure of, the information were to occur, a reasonable person would conclude that the access or disclosure would be likely to result in serious harm to any of the individuals to whom the information relates.[36]

There is an exception for remedial action if the entity takes remedial action before access or disclosure results in serious harm to any of the individuals to whom the information relates and as a result a reasonable person would conclude that the access or disclosure would not be likely to result in serious harm to any of those individuals.[37]

Matters to consider when determining whether or not the disclosure would result in serious harm

In determining whether a reasonable person would conclude that access to, or a disclosure of information would or would not be likely to result in serious harm to the individual to which the information relates, regard should be had to the following:

- the kind or kinds of information;
- the sensitivity of the information;
- whether the information is protected by one or more security measures;
- if the information is protected by one or more security measures — 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;
- if a security technology or methodology:
  - was used in relation to the information; and
  - was designed to make the information unintelligible or meaningless to persons who are not authorised to obtain the information;

[36] *Section 26WE(2) Privacy Act 1988* (Cth)
[37] *Section 26WF Privacy Act 1988* (Cth)

the likelihood that the persons, or the kinds of persons, who:

- have obtained, or who could obtain, the information; and
- have, or are likely to have, the intention of causing harm to any of the individuals to whom the information relates;

have obtained, or could obtain, information or knowledge required to circumvent the security technology or methodology;

- the nature of the harm;
- any other relevant matters.[38]

Whilst serious harm is not defined in the Privacy Act, the Guidelines mentioned below includes examples of harm as including reputational damage, loss of assets, financial disclosure, extortion and legal liability.

Examples of serious harm could include:

- Unauthorised disclosure of credit card details which could be used fraudulently
- Unauthorised loss or disclosure of health records which can adversely impact upon the mental health and reputation of an individual or family court proceedings

Assessment of suspected eligible data breaches

An entity must carry out a reasonable and expeditious assessment of whether there are reasonable grounds to believe that the relevant circumstances amount to an eligible data breach and take all reasonable steps to ensure that the assessment is completed within 30 days after the entity becomes aware.[39]

Notification requirements

If there are reasonable grounds to believe that there has been an eligible data breach, then the entity must, as soon as practicable it becomes aware:

- prepare a statement that complies with the Privacy Act; and
- give a copy of the statement to the Office of the Australian Information Commissioner.[40]

The statement must set out:

- the identity and contact details of the entity;
- a description of the eligible data breach that the entity has reasonable grounds to believe has happened;
- the kind or kinds of information concerned;
- recommendations about the steps that individuals should take in response to the eligible data breach that the entity has reasonable grounds to believe has happened; and
- if the breach if of one or more entities, the identify of those other entities.[41]

If practical, the entity must notify the content of the statement to each of the individuals to whom the relevant information relates and/or individuals who are at risk from the eligible data breach . Otherwise, the entity must publish a copy of the statement on its website (if any) and take reasonable steps to publicise the contents of the statement.[42]

Guidelines

The Office of the Australian Information Commissioner has previously published a Data Breach Notification Guide: A Guide to Handling Personal Information Security Breaches which will be updated ahead of the amendments:

Further information is available at:

https://www.oaic.gov.au/media-and-speeches/statements/mandatory-data-breach-notification

[38] *Section 26WG Privacy Act 1988* (Cth)
[39] *Section 26WH Privacy Act 1988* (Cth)
[40] *Section 26WK(2) Privacy Act 1988* (Cth)
[41] *Section 26WK(3) Privacy Act 1988* (Cth)
[42] *Section 26WL Privacy Act 1988* (Cth)

What are the Rules in Advertising Health Services and Therapeutic Goods, including Testimonials? *Australian Health Practitioner Regulation Agency* v *Limboro* (15 February 2017)

By Alison Choy Flannigan, *Partner and Bill Lo, Solicitor*

Advertising health services and therapeutic goods is regulated by a number of laws and codes including:

- The *Competition and Consumer Act 2010 (Cth), including the Australian Consumer Law*;
- The *Therapeutic Goods Act 1989* (Cth) and the *Therapeutic Goods Advertising Code 2015* (Cth) in relation to advertising to consumers;
- If the company is a member of Medicines Australia, the *Medicines Australia Code of Conduct*;
- If the company is a member of the Medical Technology Association of Australia, the *Medical Technology Code of Practice*;
- The *Health Practitioner Regulation National Law (NSW) (or equivalent)* (**National Law**);
- *Medical Board Good Medical Practice – A Code of Conduct for Doctors in Australia; and*
- *Guidelines for Advertising Regulated Health Services.*

Australian Consumer Law

Section 18 of the *Australian Consumer Law* prohibits a person from, in trade or commerce, in engaging in conduct that is misleading or deceptive or is likely to mislead or deceive.

The maximum penalty for false or misleading and unconscionable conduct, pyramid selling and breaches of relevant product safety provisions is:

- $1.1 million for corporations
- $220 000 for individuals.

The National Law

Section 133 of the National Law provides a person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that:

- is false, misleading or deceptive or is likely to be misleading or deceptive;
- offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer;
- uses testimonials or purported testimonials about the service or business;
- creates an unreasonable expectation of beneficial treatment; or
- directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Maximum penalty—

(a) in the case of an individual—$5,000; or

(b) in the case of a body corporate—$10,000.

A person does not commit an offence against subsection (1) merely because the person, as part of the person's business, prints or publishes an advertisement for another person.

In proceedings for an offence against this section, a court may have regard to a guideline approved by a National Board about the advertising of regulated health services.

(4) In this section— regulated health service means a service provided by, or usually provided by, a health practitioner.

This obligation does not only cover health practitioners but anyone (including corporations) who "advertises" a "regulated health service".

Who is a health practitioner?

A "health practitioner" means an individual who practises a health profession.

What is a health profession?

A "health profession" means the following professions, and includes a recognised specialty in any of the following professions—

(a) Aboriginal and Torres Strait Islander health practice;

(b) Chinese medicine;

(c) chiropractic;

(d) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);

(e) medical;

(f) medical radiation practice;

(g) nursing and midwifery;

(h) occupational therapy;

(i) optometry;

(j) osteopathy;

(k) pharmacy;

(l) physiotherapy;

(m) podiatry;

(n) psychology.

Note. See Division 15 of Part 12 which provides for a staged commencement of the application of this Law to the Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy professions.

Whilst the Guidelines for Advertising Regulated Health Services are not a legislative instrument, a court may have regard to the Guidelines in proceedings for an offence against section 133 of the National Law.[43]

For current and previously registered health practitioners,[44] a breach of section 133 of the National Law may also lead to disciplinary action under the National Law.

The *Medical Board Good Medical Practice – A Code of Conduct for Doctors in Australia* states:

"Good medical practice involves:

8.6.1 Making sure that any information you publish about your medical services is factual and verifiable.

8.6.2 Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients.

8.6.3 Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations.

8.6.4 Not offering inducements or using testimonials.

8.6.5 Not making unfair or inaccurate comparisons between your services and those of colleagues."

The *Guidelines for Advertising Regulated Health Services* states:

6.2.3 Testimonials

The National Law does not define 'testimonial', so the word has its ordinary meaning of a positive statement about a person or thing. In the context of the National Law, a testimonial includes recommendations, or statements about the clinical aspects of a regulated health service.

The National Law ban on using testimonials means it is not acceptable to use testimonials in your own advertising, such as on your Facebook page, in a print, radio or television advertisement, or on your website.

This means that:

1. you cannot use or quote testimonials on a site or in social media that is advertising a regulated health service, including patients posting comments about a practitioner on the practitioner's business website, and

2. you cannot use testimonials in advertising a regulated health service to promote a practitioner or service.

Health practitioners should therefore not encourage patients to leave testimonials on websites health practitioners control, such as Facebook or Linkedin in that advertise their own regulated health services, and should remove any testimonials that are posted there.

Testimonials in relation to Therapeutic Goods

In addition, *Good Medical Practice: A Code of Conduct for Doctors in Australia* states:

"Doctors must be honest and transparent in financial arrangements with patients. Good medical practice involves:

8.12.5 Being transparent in financial and commercial matters relating to your work, including in your dealings with employers, insurers and other organisations or individuals. In particular:

- *declaring any relevant and material financial or commercial interest that you or your family might have in any aspect of the patient's care*
- *declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and*
- *not making an unjustifiable profit from the sale or endorsement".*

[43] Section 133(3) of National Law.
[44] Section 139G of the National Law provides disciplinary actions may be taken in relation to a person's behavior while registered as a health practitioner as if the person were still registered under the National Law.

The Therapeutic Goods Administration (**TGA**) is responsible for regulating therapeutic goods including medicines, medical devices, biologicals, blood and blood products.

If the advertising only comprises pricing for prescription-only (Schedule 4 and 8) and certain pharmacist-only (Schedule 3 of the Poisons Standard) medicines, then the advertisement must comply with the *Therapeutic Goods Act 1989*, *Therapeutic Goods Regulations 1990*, the *Therapeutic Goods Advertising Code 2015* and the *Price Information Code of Practice*.

A list of practitioners permitted to advertise price information for certain Schedule 3, Schedule 4 and Schedule 8 medicines is included in the Price information code of practice, available via the TGA website: www.tga.gov.au.

If the advertising promotes one or more therapeutic goods (under the *Therapeutic Goods Act 1989*, then the advertising must comply with the *Therapeutic Goods Act 1989*, *Therapeutic Goods Regulations 1990*, the *Therapeutic Goods Advertising Code 2015* and, where relevant, the *Price Information Code of Practice*.

Advertisers should note the definition of 'advertisement' in the *Therapeutic Goods Act 1989*.

See Appendix 4 of the *Guidelines for Advertising Regulated Health Services* for more information about advertising therapeutic goods.

The Therapeutic Goods Advertising Code, section 4(7) states that testimonials must be documented, genuine, not misleading and illustrate typical cases only.

We also recommend to require any person providing a testimonial to sign an appropriately worded privacy consent form, including a warranty and representation as to the truth of their testimonial.

Prosecution under the Health Practitioner National Law – Hance Limboro

On 15 February 2017, in a landmark ruling, a Sydney chiropractor, Dr Hance Limboro, was convicted of falsely advertising a regulated health service and using testimonials in his advertising in contravention of the Health Practitioner Regulation National Law after he pleaded guilty to 13 charges filed by the Australian Health Practitioner Regulation Agency (**AHPRA**) in August 2016. Dr Limboro was convicted for making false advertising and using testimonials on the website for his clinic. The advertisements included claims that chiropractic adjustments could prevent, treat and cure cancer and that chiropractic adjustments are safe and risk free. Mr Limboro was fined $29,500 by the Court and was ordered to pay AHPRA's legal costs.

What You Need to know About the Significant Change to Strata Laws in NSW

By Robyn Chamberlain, Special Counsel

Many health care providers own or lease business premises which are the subject of Strata title and currently more than a quarter of NSW's population lives in, owns or manages Strata property.

Significant changes to Strata laws in NSW commenced on 30 November 2016 under the *Strata Schemes Management Act 2015*, the *Strata Schemes Management Regulations 2016*, the *Strata Schemes Development Act 2015* and the *Strata Schemes and Development Regulations 2016*. The changes are designed to better suit the way we live and communicate today.

Some of the changes are set out below

What's new for owners?

1. Get renovations approved

Getting renovations approved is now simpler. 'Cosmetic Work' that affects common property (like painting, laying carpet etc.) no longer require approval.[45]

There is also a streamlined approval process that makes it clear what approval is required for 'minor renovations', for example kitchen renovations, changing recessed light fittings, installing or replacing wood or other hard floors, configuring walls etc.[46]

2. Dealing with parking issues

Unauthorised parking has been a common headache. A new option has been introduced to manage parking through a commercial arrangement between a local council and a strata scheme.[47]

3. Get involved with new voting options

Procedures to adopt modern technology have been introduced. Participation in a meeting from a remote location is now possible. Voting on a matter to be determined by the corporation or committee is permitted by means of teleconferencing, video-conferencing, email or other electronic means.[48]

4. Collectively sell or renew your Strata

A new measure has been introduced to facilitate the collective sale or redevelopment of freehold strata schemes. The *Strata Schemes Development Act* 2015 (NSW) now sets out a procedure if at least 75% of the owners agree and other conditions are met.[49]

What's new for tenants?

There are also changes that affect tenants. This includes the opportunity for tenants to be represented on Strata Committees if there are tenants for at least half the number of lots in the Scheme, and being able to attend meetings of the Owners Corporation where major decisions are made.[50]

What must I do now?

Owners should be aware that the changes now impose an obligation that the bylaws of Strata Schemes must be reviewed by 30 November 2017. Owners can use the new model bylaws as a guide or they can contact the writer to assist with reviewing their existing bylaws. ■

[45] Section 109 of *Strata Schemes Management Act* 2015
[46] Section 110 of *Strata Schemes Management Act* 2015
[47] Section 650A of *Local Government Act* 1993
[48] Regulation 14 of Strata Schemes Management Regulations 2016.
[49] SSDA Part 10

[50] *Strata Schemes Management Act* 2015 s 33 and *Strata Schemes Management* Regulations 2016 Reg 7

How to Deal with Bullying and Harassment When Dealing with Complaints

By Robin Young, Partner and Ethan Brawn, Senior Associate

Introduction

It is common for health, aged care and life science companies to experience bullying and harassment when dealing with complaints. This can cause stress and anxiety for staff in the work environment.

Key WHS Legislation

The key work, health and safety legislation relating to this situation is the *Work, Health and Safety Act 2011* (NSW) (**WHS Act**) and *Work Health and Safety Regulation 2011* (NSW) (**WHS Regulations**). There is similar legislation in other States and Territories.

Purpose of *Work, Health and Safety Act 2011*

The WHS Act provides the framework to protect the health, safety and welfare of all workers at work, and of other people who might be affected by the work. The WHS Act aims to protect the health and safety of workers and other people by eliminating or minimising risks arising from work or workplaces.

In furthering these aims, regard must be had to the principle that workers and other persons should be given the highest level of protection against harm to their health, safety and welfare from hazards and risks arising from work as is reasonably practicable.

Under the WHS Act, a 'workplace' is any place where a worker goes or is likely to be while work is carried out for a business or undertaking. This may include offices, shops, construction sites, vehicles, ships, aircraft.

To this effect, a client's home in relation to home care would be considered a 'workplace' to which the WHS Act and WHS Regulations would apply, whilst workers are performing their duties.

Importantly, the WHS Act imposes duties on other persons at the workplace. Section 29 of the WHS Act relevantly states:

Any person at a workplace, including customers and visitors, must:

(a) take reasonable care for his or her own health and safety;

(b) take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons; and

*(c) comply, so far as the person is reasonably able, with any reasonable instruction that is given by the person conducting a business or undertaking (**PCBU**) to allow the PCBU to comply with the WHS laws.*

This WHS duty would apply to family members of the care recipient visiting the workplace of a health service provider, where their actions affect the health and safety of health care workers.

Primary duty of care – Health care providers

Health care providers must ensure, so far as is reasonably practicable, the health and safety of:

- workers engaged, or caused to be engaged by the person; and
- workers whose activities in carrying out work are influenced or directed by the person, while the workers are at work in the business or undertaking.

Healthcare providers must ensure, so far as is *reasonably practicable*, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.

Without limiting the above, health care providers must ensure, so far as is reasonably practicable, the provision and maintenance of a work environment without risks to health and safety.

The person with management or control of a workplace must ensure, so far as is reasonably practicable, that the workplace, the means of entering and exiting the workplace and anything arising from the workplace are without risks to the health and safety of any person.

What is "reasonably practicable" is expanded in the WHS Act. The courts have on numerous occasions noted that what is "reasonably practicable" is to be determined objectively. This means that a duty holder must meet the standard of behaviour expected of a reasonable person in the duty holder's position and who is required to comply with the same duty. This objective test is demonstrated by the requirement in section 18 of the WHS Act to take into account what the person ought reasonably to know.

As part of the objective test, the courts will look at what was reasonably foreseeable by someone in the position of the duty holder at the particular time. Given this, any significant incident such as verbal abuse or bullying and harassment by the assailant towards a healthcare worker, would most likely be viewed as "reasonably foreseeable", which could result in the healthcare provider being in breach of its primary duty of care obligations. To minimise this risk, it is critical that the healthcare provider's documents, actions and reviews are all recorded. These records must focus on identifying the means to either eliminate or minimise the current risks identified in servicing the client, to an acceptable level of risk.

Potential Bullying and Harassment of workers

Whilst an assailant is not an employee of the healthcare provider, there are times when they may be reasonably expected to be present at the facility. Hence the assailant is a visitor to the workplace, and it is possible that their actions could be classified as verbal abuse, bullying and harassment of workers.

Guidance material from Safe Work Australia states bullying is a hazard because it may affect the emotional, mental and physical health of workers.[51] The risk of bullying is minimised in workplaces where everyone treats each other with dignity and respect.

The WHS Act defines 'health' as both physical and psychological health. This means the duty to ensure health and safety extends to ensuring the emotional and mental health of workers. This duty would apply to both the health care provider and the client/patient and his/her family, as both are directly involved with the 'workplace'.

What is workplace bullying?

Workplace bullying is repeated, unreasonable behaviour directed towards a worker or a group of workers, that creates a risk to health and safety.[52]

- "Repeated behaviour" refers to the persistent nature of the behaviour and can refer to a range of behaviours over time.
- "Unreasonable behaviour" means behaviour that a reasonable person, having regard to the circumstances, would see as victimising, humiliating, undermining or threatening.

Bullying can also be unintentional, where actions which, although not intended to humiliate, offend, intimidate or distress, cause and could reasonably have been expected to cause that effect. Sometimes people do not realise that their behaviour can be harmful to others. In some situations, behaviours may unintentionally cause distress and be perceived as bullying.

[51] https://www.safeworkaustralia.gov.au/bullying

[52] Dealing with Workplace Bullying -A Worker's Guide. Available: https://www.safeworkaustralia.gov.au/bullying

Impact of workplace bullying:

Bullying can be harmful for the workers who experience it and those who witness it. Each individual will react differently to bullying and in response to different situations. Reactions may include any combination of the following:

- distress, anxiety, panic attacks or sleep disturbance;
- physical illness, such as muscular tension, headaches and digestive problems;
- reduced work performance;
- loss of self-esteem and feelings of isolation;
- deteriorating relationships with colleagues, family and friends; and
- depression and risk of self-harm.

Those who witness bullying may experience guilt and fear because they cannot help or support the affected person in case they too get bullied.

Agreements and managing expectations

In some cases, such as aged care and disability services, it is possible to have an agreement setting out expectations and responsibilities.

For example, the *User Rights Principles 2014* (Cth) under the *Aged Care Act 1997* (Cth) sets out the following responsibility for residential aged care:

"Each care recipient has the following responsibilities:

(a) to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;

(b) to respect the rights of staff to work in an environment free from harassment;

…."

Further, it can be appropriate to impose conditions of entry to your premises, setting out acceptable standards of behaviour and requiring compliance with work, health and safety laws or requiring treatment to be provided under certain places with certain conditions such as additional security personnel. Adequate notice of the conditions of entry is required.

In addition, in order to manage the situation, certain complaints can be re-directed to particular senior persons within the organisation or to its external lawyers or the relevant external complaint bodies, such as the, Australian Health Practitioner Regulation Agency, the Health Care Complaints Commission or the Aged Care Complaints Commissioner.

Holman Webb has developed a draft Code of Conduct for Residential Aged Care in consultation with Aged and Community Services Australia (**ACSA**), which is free for clients and ACSA members.

Please contact Alison Choy Flannigan at Alison.choyflannigan@holmanwebb.com.au for a copy.

Inclosed Lands Protection Act 1901 (NSW)

The common areas of a public or private hospital or an aged care facility may be "private property", to which the *Inclosed Lands Protection Act 1901* (NSW) and the laws of trespass to property might apply to restrict access to non-residents if they infringe any policy or code.[52]

Apprehended Violence Orders

If justified, providers can apply for an Apprehended Violence Order restricting access to certain staff of the facility.

Policies and Guidelines

The relevant NSW policy for public hospitals, which is also a useful guide for other health care providers, is "Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach".[54]

[53] *Halliday v Neville (1984)* 155 CLR 1, 8; *TCN Channel Nine Pty Ltd v Anning (2002)* 54 NSWLR 333.
[54] www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2015_001.pdf

What Pharmacies Need to Know about the Reduction in Penalty Rates

By Rachael Sutton, Partner

On 23 February 2017 the Full Bench of the Fair Work Commission announced the reduction of a number of penalties in respect to work on Sundays and/or public holidays in modern awards, effective from 1 July, which will be phased in over at least two annual instalments.

The decision impacts the following modern awards:

(a) *Fast Food Industry Award 2010* (**Fast Food Award**)

(b) *General Retail Industry Award 2010* (**Retail Award**)

(c) *Hospitality Industry (General) Award 2010* (**Hospitality Award**)

(d) *Pharmacy Industry Award 2010* (**Pharmacy Award**)

(e) *Registered and Licensed Clubs Award 2010* (**Clubs Award**); and

(f) *Restaurant Industry Award 2010* (**Restaurant Award**).

The Full Bench reviewed the Saturday penalty rates in the Fast Food, Hospitality, Restaurant and Retail Awards and was satisfied that the existing Saturday penalty rates achieve the modern awards objective – they provide a fair and relevant minimum safety net. The review of Saturday penalty rates in the Clubs and Pharmacy Awards is to be the subject of further proceedings.

The Full Bench decided that the existing Sunday penalty rates in the Hospitality, Fast Food, Retail and Pharmacy Awards do *not* achieve the modern awards objective, as they do not provide a fair and relevant minimum safety net.

Except in the Fast Food Award, the Full Bench did not reduce the Sunday penalty rates to the same level as the Saturday penalty rates, noting that for many workers Sunday work has a higher level of disutility than Saturday work, though the extent of the disutility is much less than in times past. The Full Bench also noted that it is implicit in the claims advanced by most of the employer interests that they accepted the proposition that the disutility associated with Sunday work is *higher* than the disutility associated with Saturday work. If this was not the case then they would have proposed that the penalty rates for Sunday and Saturday work be the same, but they did not.

The Full Bench was not persuaded to make the changes proposed to the loadings for work before 7.00 am and between 9.00 pm and midnight, on weekends and Monday to Friday.

The Commission sought comment from interested parties about appropriate transitional arrangements, to minimise the immediate impact of the changes to Sunday penalty rates. Once transitional provisions are agreed, the Commission has said it will insert "loaded rates" into these Awards—allowing an employer to pay a higher hourly rate for each hour worked—in lieu of other penalties, loadings and allowances.

The Commission called interested parties to make submissions on other changes sought, such as changes to the terminology used in some awards, and the review of other awards.

The Full Bench said the changes "provide no warrant for the variation of penalty rates in other modern awards".

The Pharmacy Award covers assistant pharmacists, experienced pharmacists, pharmacist in charge, pharmacist managers, pharmacy students and pharmacy interns.

The proposed changes under the Pharmacy Award are summarised below:

Award	**Sunday penalty rates**	**Public holiday rates From 1 July 2017**
Pharmacy Award (7am–9am only)		
Full-time and part-time employees	200% to 150%	250% to 225%
Casual employees	200% to 175%	275% to 250%

Holman Webb Health Team Listed in Best Lawyers International

ALISON CHOY FLANNIGAN
Finalist as Partner of the Year

We are delighted to announce that 7 of our firm's senior team members have been selected in the Tenth edition of **Best Lawyers – Australia** and that Alison Choy Flannigan has been named a Finalist in the **Lawyers Weekly Partner of the Year Award for Health** 2017

Congratulations to the following lawyers on their selection (by their peers) to be included in the 2018 list, announced by Best Lawyers International and published in the **Australian Financial Review** on Friday 7 April 2017.

- **John Chouris (Insurance Law)**
- **Alison Choy Flannigan (Health & Aged Care Law)**
- **Caroline Knight (Occupational Health & Safety)**
- **Mark Sheller (Insurance Law)**
- **Dr Timothy Smyth (Health & Aged Care Law)**
- **John Van de Poll (Insurance Law)**
- **John Wakefield (Alternative Dispute Resolution)**

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