

Part I: Civil Liability for the Administration of Medication in Non-Emergency Situations

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Introduction

In modern times, the role of the school has gone well beyond that of simply providing education and supervision to students. In response to increasing parental demands and the changing needs of students, schools have now taken on a variety of non-educational duties such as administering medication to students. As a result of concern expressed by school staff as to their potential liability¹ if they administer medication erroneously, the Education Department of Western Australia has developed guidelines.² As guidelines are only an *interpretation* of the law, they are not legally binding. However, they may be used by the court as, for example, persuasive evidence of the minimum standard of care that is expected of staff in a negligence action.³ The adequacy of these guidelines is the subject of this article. The article is divided into two parts, the first dealing with the administration of medication in non-emergency situations, and the second with the administration of medication in emergencies. It is argued that many of the suggested procedures outlined in the guidelines unnecessarily expose staff to potential liability under the civil law and expose students to potential injury. In furtherance of these arguments, part two concludes, with some suggestions for reform to the guidelines and considers, whether legal mechanisms should be put in place to alleviate staff liability in certain circumstances.

Interviews were conducted with principals, teachers, parents and school nurses from six schools in the metropolitan area of Western Australia⁴ to determine the type and extent of medication being administered in schools and the concerns of staff with this duty. The scope of the research was limited to government primary schools since the majority of these schools do not have a school nurse and, therefore, medication is administered by staff.⁵ This article is concerned with the administration of prescription medication such as that required to treat disabilities including ADHD, asthma, epilepsy, diabetes, and anaphylaxis.

Civil Liability for the Administration of Non-Emergency Medication

Increasingly, parents are asking (and expecting) schools to administer medication to students in non-emergency situations. These requests place schools in a difficult position because of the potential liability they could face in negligence if medication is administered incorrectly or not at

all. The concern with liability in this situation has been heightened by the large number of students who now require Ritalin or Dexamphetamine on a regular basis to treat ADHD.⁶

Duty of Care

School authorities and their delegates owe a duty of care to students given the law's recognition of the 'special' relationship that exists between them. This duty of care is an onerous one and extends beyond negligent acts or omissions to a positive duty to prevent harm. It is generally assumed that those who teach or care for the young will be more aware of potential dangers than the students they supervise, who are usually more curious and accident prone.⁷ Essentially, the special dependence or vulnerability of a child gives rise to an assumption of responsibility on the part of a school authority and its delegates to care for and protect children while they are at school and away from the care and protection of their parents.⁸ While the existence of these special relationships is undisputed, the outer limits of the duty of care owed have not been exhaustively defined.

Education Department

(a) Common Law

The common law duty of care owed by a school authority to students⁹ arises as soon as the school authority receives a child into one of its schools and is sustained by the continued acceptance of the child as a student.¹⁰ A school authority will generally be vicariously liable for a breach by its employees of their special duty of care.¹¹ However, as the High Court made clear in *Commonwealth of Australia v Introvigne*,¹² a school authority will also owe an independent, non-delegable duty of care to its students regardless of the arrangements it makes for the staffing of a school.¹³ Consequently, a school authority may be held liable even in circumstances where staff are found not to be negligent.¹⁴

Although no case has yet arisen to determine whether the administration of medication comes within a school authority's duty of care, it is unlikely to be in dispute. It is self-evident that fundamental to the care and responsibility of students is ensuring that they are in good health. Providing students with basic first aid and health care has been the practice of schools for many years and it has never been disputed that this is part of their duty of care (e.g. checking for head lice, applying band-aids to scraped knees). In modern times however, the *type* of health care schools are providing to students has become more complicated; not only are schools providing basic first aid, they are also now administering more serious medication, such as Ritalin and Dexamphetamine.¹⁵ These changes have largely come about as a result of three factors. First, the effect of Australian anti-discrimination legislation¹⁶ has been to encourage the integration of students with disabilities into mainstream schools. Because these students have greater health needs, schools are now required by statute to provide greater health services to accommodate them. Second, major advances have been made in medical science with regard to the discovery of previously unrecognised illnesses such as ADHD and the treatment for those illnesses. Third, there have been significant *social* changes to the dynamics of the traditional 'family'. The increasing trend in modern times is for both parents to work, which has meant that it is simply now more *convenient* for a school to administer medication to students during school hours. Many parents

work away from the home during school hours and therefore no longer have the ability to undertake these responsibilities themselves.¹⁷ Whilst these changes have made the provision of health care more difficult for schools, they have not altered the fact that a duty of care exists to care for and attend to the needs of students during school hours. Essentially, if the needs of students change as a result of social, legal or medical factors then the *scope* of the duty of care must expand to keep pace with those changes. In any event, the High Court has clearly stated in *Commonwealth of Australia v Introvigne* that ‘the responsibility of a school goes beyond that of a parent in many respects’.¹⁸ This suggests that if a parent would administer medication to the child if they were at home, so too must the school authority while the child is at school.

(b) *Statute*

The *School Education Act 1999 (WA)* makes it compulsory for children to attend school until age 15 by requiring parents to enrol their children.¹⁹ Due to this mandatory requirement, parents cannot care for children during school hours and, for this time period, the school authority therefore comes to assume the majority of the parents’ obligations.²⁰ Mirroring the common law principles, these obligations include compliance with parents’ reasonable requests for the administration of medication to children.²¹

Section 16(1)(g) of the Act goes some way to defining the scope of the duty of care owed by a school authority to students. The section provides that ‘a person who wishes to apply for enrolment at a school must provide details of *any condition* of the enrollee that may call for special steps to be taken for the benefit or protection of the enrollee or other persons in the school’. Although the Act fails to define the section’s key terms, the terms are sufficiently broad to cover a variety of situations, which may include the administration of medication (‘special steps’) to a child requiring medication (‘condition’). The ‘benefit’ to or ‘protection’ of the health of a disabled child by giving medication is self evident, particularly when the medication is life saving. Furthermore, as the Act is not specific with regard to the kind of ‘condition’ the enrollee is to disclose, ‘condition’ could certainly include a *medical* condition.

Rule 28 of the *School Education Regulations (WA) 2000* also suggests that administering medication comes within a school authority’s duty of care. It provides that if ‘a student has a medical condition that needs attention when the enrollee is attending school the principal may seek advice from the Executive Director of Public Health or a registered medical practitioner as will assist the principal in determining whether any member of the staff is to give attention to the student’s medical condition; or to assist a staff member when giving attention to the student’s medical condition’. Although rule 28 is entitled ‘specialised health care needs’, which suggests that it is concerned with students whose ‘medical condition’ requires more complicated treatment than simply ingesting medication (e.g. catheterisation or toileting), students who *only* require medication could still be brought within the words of this rule as they too have a ‘medical condition that needs attention’. Interestingly the rule appears to be more concerned with *who* will be providing the attention to a student with a ‘medical condition’ rather than *whether* that attention will be provided at all. With the emphasis on *who* will be providing the care, the rule assumes that if a student has a ‘medical condition that needs attention’, the school will accept this responsibility if staff have the skills to provide it.

(c) The Guidelines

In accordance with the common and statute law discussed above, the guidelines provide that the Education Department of Western Australia is obliged to comply with reasonable requests for assistance in the administration of medication to students.²²

Teachers

Although a school authority owes a non-delegable duty of care to students, delegation is essential for the *performance* of part of that duty of care. Consequently, the High Court has recognised that the duty of care owed by a school authority is similar in ‘material respects’²³ to the duty owed by its delegates.²⁴ Therefore, if a school authority delegates a responsibility to staff, the staff *and* the school authority may be liable for any breach. However, there are two essential differences between the duty owed by a school authority and that owed by staff. First, as has been discussed, the direct liability imposed upon a school authority means that it will almost always be liable for injuries that occur to students even where staff have not been negligent.²⁵ Second, there is a difference in the *extent* of the duty of care owed by school authorities, principals and teachers, particularly with regard to the degree of supervision they are expected to exercise.

(a) Common law

Aside from their primary teaching role, teachers have a duty to supervise²⁶ and discipline students, protect students against the vagaries of their own behaviour and safeguard students from damage caused to them by other students.²⁷ As the ‘special’ duty of care primarily addresses children’s vulnerability and need for protection against injury, it is likely that it also includes a duty to administer medication, particularly given that the consequences of a failure to do so may result in harm, injury or even death to a student. Depending on the age and capacity of a student,²⁸ the student may not be responsible enough to remember to take the medication or to safely store it away, out of the reach of other students who may be harmed if they wrongfully ingest it. Furthermore, if the duty of care owed by staff and school authorities is similar in ‘material respects’, it is likely that the school authority’s duty to administer medication is also owed by teachers.

(b) The Guidelines

The 1997 guidelines provide that because the school authority has a duty to administer medication, staff are accordingly required to comply with reasonable requests for assistance to administer medication.²⁹ By contrast, the 2001 draft guidelines provide that although schools have a responsibility to manage requests for health care assistance, individual members of staff³⁰ may decline to administer prescribed medication.³¹ The 1997 guidelines therefore imply that staff cannot refuse to administer medication, whereas the 2001 draft guidelines suggest that staff have a choice as to whether or not they will administer medication. The element of ‘choice’ in the 2001 draft guidelines is problematic, considering that teachers likely have a common law duty of care to administer medication. It would be absurd for teachers to have a duty and a choice to exercise that duty because if the duty is not ‘mandatory’ it is rendered useless. If teachers could elect not to discharge this duty and a student did not receive medication, the consequences could be grave.

Perhaps then, the implication of having both a duty and choice is that teachers cannot refuse to administer medication unless they delegate it to another responsible staff member.

Principals

(a) Common Law

The law imposes a similar duty of care upon a principal as that imposed upon a teacher. However, the extent of supervision required by a principal is greater, and is more akin to that expected of a school authority. Not only are school authorities and principals responsible for effectively discharging their own duty of care, they are also required to supervise the actions of other staff and manage the school.³² For school authorities, this duty extends to overseeing all government schools and staff, whereas for principals, the duty extends to their particular school and staff. Therefore, although school authorities, teachers and principals share some aspects of their duty of care, the duty of school authorities and principals is more extensive.

(b) Statute

Section 63 of the School Education Act seemingly mirrors the common law. It provides that the functions of the principal include ‘the responsibility for the day to day management and control of the school, including all persons on the school premises; and to ensure the safety and welfare of students on the school premises and away from the school premises but on school activities’. The principal is also responsible for ‘establishing a plan for the school in consultation with the school council and the school’s teaching staff setting out its objectives and how they will be achieved’.

Both common and statute law place very onerous responsibilities on principals since they will only adequately discharge their duty of care by ensuring that staff adequately discharge *their* duty of care. Case law has demonstrated that, if a student is injured because of a teacher’s lack of supervision, the principal may be liable for failing to ensure there were staff in sufficient numbers and sufficient proximity to supervise the students’ activities.³³ Similarly, a principal may be held responsible for a student’s injury if a staff member has administered medication erroneously or failed to administer it at all.

(c) The Guidelines

The guidelines indicate on which matters a principal must develop and implement school policy. The guidelines require principals to promote communication about medication administration, between parents, staff and appropriate health professionals.³⁴ The guidelines also require principals to ‘approve’ teachers’ medical administration.³⁵ Although the word ‘approval’ may suggest that staff need the principal’s permission to administer medication, ‘approval’ more likely requires the principal to ensure that teachers are properly administering medication in accordance with school policy.

Breach of the Duty of Care

In order to prove negligence the plaintiff must not only show that a duty of care exists but also that it has been breached. In determining whether the duty has been breached the plaintiff must prove that the defendant was at fault. To determine fault the court will assess the competing demands on a

school authority and its delegates with regard to the foreseeability of risk of injury on the one hand and what reasonable precautions could have been taken on the other, bearing in mind factors such as the magnitude of risk, degree of the probability of its occurrence, practicability and cost of eliminating risk, utility of the conduct and, particularly relevant in this context, whether there has been compliance with guidelines.³⁶ Failure to comply with guidelines may be considered persuasive evidence of a breach of duty of care. However, if the guidelines themselves are fraught with risks, the court may find that they *unwittingly* encourage negligent practices. Therefore in considering breach of duty, key aspects of the guidelines will be critically analysed to demonstrate that some of the guidelines expose students to potential injury and the school authority and its delegates to unnecessary legal risks.

Standard of Care

In determining whether the defendant is at fault, the court will measure the defendant's conduct against a standard of care.³⁷ If conduct falls short of the standard, the defendant may be found to be in breach of their duty and, therefore, negligent. In the school context, although the school authority is ultimately *liable*, the court generally considers the conduct of the school authority's delegates in determining the standard of care.

The courts traditionally described the standard of care expected of school personnel as that of the careful or reasonable parent.³⁸ However, this test has fallen from favour in more recent times. The courts have recognised that the careful parent test is unreal in a school setting given the large numbers of students within the school's care at one time³⁹ and the fact that the responsibilities of a school in many respects go *beyond* that of a parent.⁴⁰ Moreover, the courts have experienced difficulty in applying the test to the wide variety of situations encountered in schools. For example, it is uncertain what standard of care teachers or principals will be held to if they administer medication erroneously, particularly given that this task is outside their traditional teaching or supervisory roles. Furthermore, the appropriate standard of care depends on the circumstances of *each* case. Given this uncertainty, 'standard of care' will be considered in four different scenarios, which take into account a number of variables that may affect the court's decision.

(a) Following medical instructions

If students suffer injury when a teacher administers them medication in strict accordance with a medical practitioner's instructions and with the parents' consent, fault will lie with the instructing medical practitioner rather than the teacher. No breach of duty issues arise.

(b) Training but erroneous administration

In this scenario a teacher has been given special medication administration training (e.g. first aid) but nevertheless administers the medication erroneously. The standard of care is ordinarily measured by what the reasonable person of ordinary prudence would do in the circumstances. However, the standard is raised where the person has acquired special skill, since that skill is not part of the ordinary equipment of the reasonable person.⁴¹ If a person develops skill through training and experience, and then undertakes a task which calls for the use of that skill, they must

not only exercise reasonable care but must also measure up to the standard of proficiency that can be expected from a person with that skill.⁴²

The risk of being held to a higher standard of care concerns many teachers and discourages them from obtaining medication administration training; teachers are not currently required to obtain training before administering medication.⁴³ Although the majority of teachers are quick to recognise the benefits of this training for students (e.g. knowledge about different illnesses, the required medication and the associated risks and side effects of the medication), those teachers who voluntarily obtain training fear that they are worse off legally than those without training. Trained teachers are likely to be held to at least the standard of care expected from a teacher in similar circumstances with similar training, which is higher than the standard of the ordinary reasonable person.⁴⁴

(c) Following parental instructions

In this scenario the teacher has no instructions from a medical practitioner and simply follows the parents' instructions, which turn out to be injurious to the student. Teachers have reported in the interviews that some parents of children with ADHD are quite 'experimental' with their child's medication, in that they regularly change the dose and expect teachers to comply with their varied requests, regardless of school protocol.

The guidelines provide that 'school staff should only administer prescribed medication in accordance with the instructions of a medical authority'.⁴⁵ The rationale behind this guideline is clearly to reduce the risk of injury to students (and also the liability of teachers) by ensuring that only those with expert medical knowledge make decisions about a student's medication. As such, courts will likely use this guideline to set the minimum standard of care and the particular practice the teacher ought to have followed.⁴⁶ Consequently, if teachers do not follow the guidelines and simply follow parents' instructions they may be held responsible for students' injuries.

Nevertheless, the extent of liability is questionable. Given that the action was taken on the advice of the student's parent, who is ultimately responsible for the child, courts may accordingly apportion liability between the teacher and the parent. Notwithstanding, teachers should only ever administer medication in strict accordance with the guidelines if they wish to avoid liability.

(d) Discretion of the teacher

In this scenario, a parent gives a teacher an entire bottle of Ritalin. Unlike the previous scenario the parent instructs the teacher to administer more Ritalin whenever the teacher believes the student is misbehaving. Alternatively, the teacher is given medical instructions to administer medication but, believing that the student does not need it, decides not to.

Lay persons may be judged against the expert standard if they take on a task which demands expert skill, even if they do not have expert skill or expert advice, or if they disregard expert advice.⁴⁷ In the above examples, the task of *giving* medication may not require expert skill but the *manner* in which that medication is given undoubtedly calls for expert skill; the teacher is independently determining the frequency, type or amount of medication to administer. If a teacher exercises discretion in administering medication, the court may consider the danger inherent in that process sufficient to warrant imposing a medical standard of care. The guidelines clearly separate

the roles of teacher and doctor with regard to medication issues - the teacher's role is merely to follow instructions and give medication at specified times; the prescribing doctor's role is to determine the manner of medication administration. The rationale behind this practice is clear - students may suffer serious injury if they are given too much, too little or the wrong type of medication. For example, a consequence of too much Ritalin is motor tics syndrome.⁴⁸ Therefore, in the above examples, aside from being in breach of the guidelines, a teacher may be held to the standard of care of a medical expert.⁴⁹

Foreseeability of Risk

A foreseeable risk is one that is real in the sense that a reasonable person would not dismiss it as being 'far-fetched or fanciful'.⁵⁰ As this test is so 'undemanding',⁵¹ almost any risk of injury will be regarded as foreseeable. This is particularly so in the school context, because of the well known 'mischievous tendencies'⁵² of children and their inability to 'fully comprehend the consequences of what they do'.⁵³ The reasonable teacher or principal is therefore expected to foresee 'fairly exotic possibilities',⁵⁴ especially if they are aware that a student's disability heightens their susceptibility to injury. Furthermore, the risk of only 'some injury'⁵⁵ need be foreseen, rather than 'the very injury actually sustained by the plaintiff in the way they sustained it'⁵⁶ - making the foreseeability test even easier to fulfil.

Allowing untrained staff members to administer dangerous medication in a busy classroom setting, or to store medication in an unlocked drawer creates obvious risks of injury to students that are unlikely to be dismissed as 'far fetched and fanciful'.

Probability and Gravity of Risk

Given that the foreseeability test has such a low threshold, greater importance has been placed on other limiting factors such as the 'gravity, frequency and imminence'⁵⁷ of a recognisable risk. Conduct will only be negligent if there is more than a theoretical chance that it will miscarry⁵⁸ and thereby subject others to harm. There must be a recognisable risk of *injury* sufficient to cause a reasonable person to pause.⁵⁹ A high degree of care is called for when harm is inherently likely to occur,⁶⁰ as the following risks will demonstrate.

(a) Untrained administrators

It is inherently risky to allow untrained persons to administer potentially dangerous medication such as Ritalin or Dexamphetamine. Despite the risks, the guidelines state that medication administration training is not required.⁶¹ Presumably, the rationale behind this is that the task of giving a tablet is simple, requiring no special skill, therefore making training unnecessary. In practice, however, the lack of training concerns teachers because they are administering potentially dangerous medication without knowing anything about how it affects the student's mind or body, the consequences of failing to give the medication and its possible side effects, the symptoms associated with misuse or what to do if a student wrongfully ingests another student's medication.

(b) Classroom Administration

Another potential risk stems from teachers administering medication in the classroom, which is a practice clearly contemplated by the guidelines.⁶² In the majority of schools interviewed, teachers not only single handedly teach, supervise and care for an average of 28 students at a time, but also administer medication.⁶³ The predominant concern among these teachers is that, given their already onerous duties, there is a wide margin for error. Many teachers admitted that they frequently forget to give medication. Others expressed concern that they might confuse students' medication, or give the wrong medication or dose to a student, because their attention is needed elsewhere in the classroom.

(c) Storage

The guidelines provide⁶⁴ that any medication that is to be stored by the school is to be handed to the assigned staff member for safe storage. They also provide that most prescribed medication will be stored in a lockable compartment or cupboard which can only be accessed by authorised persons. Furthermore, medication which requires refrigeration should be under the care of the staff member responsible for the student and isolated in a secure, labelled container.

However, the practice in many of the schools interviewed was for all the medication to be kept in the top drawer of the teacher's desk amongst stationery and other miscellaneous items. In many cases, the drawer is left unlocked either because the desks are very old and the keys are lost or the teachers are afraid of losing the key and therefore not being able to access the medication. 'Lockable compartments or cupboards' simply do not exist in classrooms because most school budgets cannot afford to provide them. Teachers expressed concern that students could easily take medication out of the drawer (either accidentally or on purpose) and wrongfully ingest it while the teacher is busy attending to other students.

The risks associated with each of the above practices are so self-evident that there is more than a 'theoretical chance of miscarriage' and there is 'a recognisable risk of injury to students sufficient to cause a reasonable person to pause'. Students who are not given medication, given too much medication or who wrongfully ingest medication may sustain physical or psychological injury or may even die. Therefore, the consequences of these risks are both grave and highly probable.

Reasonable Precautions

The court will next consider whether precautions against these risks are available and, if so, whether they are reasonable, with regard to their 'expense, difficulty and inconvenience'.⁶⁵

(a) School nurse

If all schools employed a full-time nurse, medical administration could be delegated to the nurse and the above risks could be largely avoided. However, the high cost⁶⁶ of taking this precaution makes it an ineffective use of already limited resources available to the Health and Education Departments, especially in schools with only a small number of students.⁶⁷ Furthermore, an employee of the Health Department stated that, 'except at special needs schools, the role of a school nurse is not to administer medication but rather to attend to general health needs, such as personal

hygiene and sex education'.⁶⁸ Consequently, even where school nurses are employed, teachers are still administering medication.

(b) Training/dissemination of information

As a nurse cannot be employed at every school, a reasonable precaution might be for a school authority to provide training, or at least written information, on symptoms of illnesses and relevant medication. In *Watson v Haines*,⁶⁹ it was held that the New South Wales (NSW) Education Minister's failure to distribute information to schools and staff, warning them of the dangers of young males with long thin necks playing rugby in the scrum, constituted a breach of duty of care when that danger eventuated. In *Watson v Haines* the information was brought to the attention of the Education Minister because it was not well known and it was thought that its dissemination would assist in avoiding such injuries.

By contrast, it is well known that there are grave dangers associated with uninformed and untrained staff administering dangerous medication to students. However, as Allen J acknowledged, 'risks and dangers that are apparent to most people may still require some degree of expertise or expert tuition to fully appreciate those dangers and risks'.⁷⁰ Therefore, that the school authority knows or ought to know of these dangers and yet has not provided the schools with training or information is analogous to *Watson v Haines* as a clear breach of its duty of care.

Research revealed that information and training on illnesses and particular medication is readily available to staff from hospitals and disability support groups.⁷¹ Moreover, it is free or available at a very small cost. Remarkably, however, very few schools have taken advantage of these services, as they are not aware that they are available.⁷² Although not as cost effective, another option would be for staff to take a first aid course, such as those offered by St John's Ambulance. It is notable that the Education Departments of other Australian states have various mechanisms for disseminating information to staff and providing them with training on illnesses and medication. In Tasmania, the Departmental guidelines on medication administration contain information about particular illnesses, medication used to treat those illnesses and symptoms associated with the use or misuse of that medication.⁷³ In NSW there is a St John's Ambulance course available to staff which deals specifically with the administration of prescribed medications. All of the above precautions could be easily pursued by the Education Department of Western Australia at a relatively small cost. Furthermore, the suggested precautions would be of little inconvenience to staff as they are given five days for professional development each year which would allow them to attend training seminars or study information.

(c) Central administration

As an alternative to administering medication in the classroom, the guidelines could require that all non-emergency medication be stored in and administered from the school's front office, at set times, by at least two delegated staff members who do not have teaching duties (e.g. principal, deputy principal, registrar, secretary). By having two administrators one can give the medication to the student while the other checks that the correct type and dose of the medication is given. Furthermore, by having a set time, medication is less likely to be forgotten. However, there may be problems for those students who require medication at different times and, in those circumstances,

special arrangements may have to be made. Central storage would also be cheaper and safer for schools as they would only have to purchase one secure storage facility. Another advantage of this practice is that it is a responsible delegation of the duty to administer medication by those staff members who are uncomfortable administering medication themselves. Several of the schools interviewed have already adopted a similar practice, and consider it to be working effectively. This practice is not only more convenient than the current classroom administration practice but it is also cheaper and safer.

(d) Requirement to 'administer' medication

Although the guidelines provide that schools have a duty to administer medication, the term 'administration' is not defined. Consequently, schools are uncertain as to whether 'administration' requires them to simply hold students' medication until they collect it or whether they have a responsibility to locate the students and give them their medication. Similarly, they are uncertain as to whether 'administration' requires them to ensure that students swallow their medication and what they are supposed to do if students refuse to take their medication. Given that the rationale behind the school-student duty of care is one of protection, it is difficult to see how the duty can be effectively discharged if the onus of taking the medication is placed upon the student. This is particularly so if the student concerned is very young. Although age is not necessarily determinative of a person's level of competency,⁷⁴ generally the younger the child the greater the potential for danger and therefore the greater the level of the duty of care owed.⁷⁵

As the degree of risk inherent in expecting students to remember to collect their medication is great, particularly when that medication is life saving, the court will likely expect school authorities and delegates to make a *reasonable* effort to locate students who fail to collect their medication.

It would also be prudent for schools to supervise students swallowing medication, to avoid risks such as medication being forgotten, lost, stolen or sold if students walk away with medication in their hand or pocket. If students refuse to take medication a school can reasonably persuade them to ingest it, but cannot forcibly require them to, as this may constitute assault or battery.⁷⁶ A reasonable precaution would be for the school to contact the student's parents to inform them of their child's refusal - beyond that there is very little the school can do. Therefore, the guidelines need to be amended to specify what is meant by 'administration' and what staff are expected to do in the event that students refuse to take medication.

As has been argued, the cost of preventing injury is likely to be less than the gravity of the injury and the probability of its occurrence. The Education Department should therefore consider implementing the suggested precautions if it wishes to avoid potential liability.

Civil Liability for Injury to Other Students

It is highly likely that a school authority and its delegates will be liable if a student suffers injury as a *direct* result of erroneous medication administration. However, an equally important consideration is the potential risk to other students who do not require medication but who may nevertheless be injured as a *secondary* consequence of having medication on the school premises.

Self-Administration - Stolen/Lost Medication

The guidelines provide that, where possible, students should be encouraged to administer their own medication.⁷⁷ The guidelines allow for students to be supervised or assisted by staff in administering their medication⁷⁸ but in practice this is rarely done. From the research carried out with school staff and parents, it was found that self-medicating students generally carry their medication either in loose form in their pocket,⁷⁹ in their lunch box wrapped in glad-wrap, or carry the entire bottle of medication in their school bag, and self-administer when convenient, without supervision. There is a strong chance that medication being carried in this manner will be lost, stolen or sold, and subsequently ingested by a student for whom it is not intended. Although tablets are occasionally lost, the major concern among schools and parents is with students who sell their Dexamphetamine and Ritalin tablets to other students. The Department of Teaching and Learning estimated that in 2000 approximately 4.5% of the student population were prescribed Ritalin or Dexamphetamine and about 5% of those tablets ended up in the wrong hands.⁸⁰ This medication has the same effect as illicit drugs such as speed and ecstasy but is a cheaper and more convenient alternative, making it attractive to curious and vulnerable students. Bottles of up to 400 tablets can be obtained from pharmacies and subsequently sold in playgrounds for between 50 cents and \$10.00 per tablet. Although all medication is dangerous, especially if misused, this medication can have particularly severe side effects if too much is ingested.⁸¹ Encouraging students to self-medicate perpetuates these problems as it means that the medication is unregulated. Although the guidelines require parents to inform the school if their child is carrying and self-administering medication,⁸² there is no requirement that the medication be stored by the school; full responsibility for the storage of medication is undertaken by the student who may not understand the dangers associated with its misuse. Ironically, the guidelines acknowledge that 'the presence of quantities of drugs at schools can be a problem that needs to be monitored',⁸³ yet still favour self-administration.

Despite the risks associated with students self-administering medication, the court will often weigh the gravity of the risk against the utility of the conduct.⁸⁴ Staff advocate self-administration because 'it relieves the school of the responsibility of administering medication'; one principal stated that 'self-administration is a private agreement between parent and child that does not involve the school'. However, in light of the above discussion, which highlights the risks to *other* students that result from self-administration, the court is likely to give little weight to this argument.

From a social perspective, some parents and teachers argue that self-administration encourages students to become more responsible and self-sufficient. Parents also argue that self-administration allows their children to retain some dignity; many students do not want others to know that they are taking medication because they are afraid of being ridiculed. Self-administration allows students to be more discreet. Although there is merit in these arguments, the court will likely favour the safety of all students over the potential loss of dignity of one.

The above risks could be reasonably avoided if the guidelines required storage of *all* medication in a lockable compartment in the school's front office. Parents or guardians should be required to bring their child's medication to school, rather than the student.⁸⁵ The guidelines should

prohibit unsupervised self-administration by insisting that students who wish to self-administer do so under the supervision of a staff member. If students are embarrassed about taking their medication, they could agree to meet with a particular staff member each day in a location at the school that is away from other students. These precautions would simultaneously teach students responsibility and reduce risks to other students.

The school authority and its delegates are unlikely to be held liable for injuries to students who buy medication from other students if parents disobey the above precautions and students bring medication onto the school premises without the school's knowledge. If the school authority does not implement precautions such as these and a student is injured as a result of ingesting other students' medication, the school authority and its delegates may be held liable for that student's injuries.

Failure to Administer Medication

A school authority and its delegates may be liable if another student is injured as a result of the *failure* of staff to give medication to a student. To take an example, liability may ensue if a staff member fails to administer medication to an ADHD student who is known to be aggressive without medication, and that student subsequently assaults another student.⁸⁶ In *Haines v Warren*⁸⁷ the state of NSW was held to be liable to a student who was severely injured, in an unsupervised area of the playground, by a student known to be aggressive. The risk of the student injuring other students was held to be foreseeable if he was not supervised or properly disciplined⁸⁸ prior to the injury occurring. Unlike *Haines v Warren*, supervision and discipline are likely to make very little difference to the behaviour of an unmedicated ADHD student since the behaviour stems from a chemical imbalance in the student's body rather than regular 'mischievous tendencies'.⁸⁹ However, the similarity between the cases is that students' aggressive temperaments are likely to be well known to staff prior to the injury occurring, therefore rendering the risk of 'some injury'⁹⁰ not only foreseeable but also highly probable. This is especially applicable to ADHD students since staff are generally aware that, without their medication, they often become agitated and aggressive; the effect of the medication is to calm their behaviour. As one teacher stated, 'when ADHD children miss their medication, that is likely the day when they will explode or do something really wrong'.⁹¹

Most staff members are well aware of these problems through either their own experiences with ADHD students, experience of other staff who share their grievances or parents' information. Given this awareness, the court is likely to expect a higher standard of care in relation to reasonable precautions that could be taken. The establishment of a central location for medication administration would greatly reduce the risk of staff forgetting to administer medication.

Conclusion

As has been demonstrated above, there are unavoidable risks and problems associated with the administration of medication in schools. Part two of this article considers the above arguments and scenarios in the context of the administration of medication in emergency situations and concludes,

with some suggestions for reform to the guidelines which have been outlined in both parts of the article.

Endnotes

* This article is based on the thesis submitted by Jenny Thrum in partial fulfilment of the LLB (Hons) degree, School of Law, University of Western Australia

1. It is acknowledged that it is highly unlikely for individual staff members to be personally liable to an injured student if they are found negligent. Generally, the Education Department will be vicariously liable for the actions of school staff.
2. Administration Policy and Procedures, Education Department of Western Australia, 1997; Student Health Care Guidelines January 2001, Education Department of Western Australia; Student Health Care Guidelines June 2001, Education Department of Western Australia. The June and January 2001 guidelines are still in *draft* form only.
3. *Wyong Shire Council v Shirt* (1980) 146 CLR 40; *McLean v Tedman* (1984) 155 CLR 306.
4. All interview participants were provided with an information sheet which outlined the nature of this research project. After reading the information sheet the participants were asked to sign a consent form which stated that they were voluntarily participating in the interview and could withdraw at any time. The consent form also provided that the research project would not publish the name of any participant, the school they worked at or the name of any student who attended that school. However, the participants consented to the publishing of quotes and experiences they had had with regard to administering medication to students.
5. Government high schools were not included in this research project because the students were either old enough to administer their own medication or, because of the size of the school, the Health Department had employed a school nurse. Private schools were also not included in this project because it was found that these schools generally employed a full-time nurse. Non-mainstream schools (i.e. schools for students with special needs) were not included in this project because the severity of the disabilities of the students at these schools was so great that a full-time school nurse was necessary (e.g. toileting, catheterisation etc).
6. Ben Harvey, 'Year 3s caught out', *The West Australian* (Perth), 11 August 2001, 10. In this article it was reported that the Department of Teaching and Learning estimated that in 2000 between 17,551 and 18,553 children aged between four and 17, or 4.2% - 4.5% of the student population, had been prescribed Ritalin or Dexamphetamine. Furthermore, nearly 13 million Dexamphetamine tablets were prescribed during 2000, 90% of which went to children. In 1999, a State Government report found that Western Australian (WA) children were prescribed the stimulants at seven times the rate in other states.
7. *State of Victoria v Bryar* [1970] ALR 809; *Geyer v Downs* (1977) 138 CLR 91; *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258; CCH, *Australian Professional Liability – Education*, vol 1 (at 15,051) ¶ 20-000.
8. *Jones v Bartlett* (2000) 176 ALR 137; *Richards v State of Victoria* [1969] VR 136; *Modbury Triangle Shopping Centre Pty Ltd v Anzil* (2000) 176 ALR 411; *Perre v Apand Pty Ltd* (1999) 198 CLR 180.
9. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258; *Ramsay v Larsen* (1964) 111 CLR 16; *State of Victoria v Bryar* [1970] ALR 809; *Australian Capital Territory Schools Authority v El Sheik*

- (2000) Aust Torts Reports ¶81-577; *Rich v Queensland; Samin v Queensland* (unreported) Qld Sup Ct 27 July 2001, McPherson, Thomas and Williams JJA; *Australian Capital Territory Schools Authority v Raczkowski* (unreported) ACT Sup Ct 22 June 2001, Crispin J.
10. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258, 279 (Brennan J); *Ramsay v Larsen* (1964) 11 CLR 1, 28 (Kitto J); Gordon Avenell. 'The demise of *in loco parentis*?' (1990) 12(4) *The Practising Administrator* 16-19, 38.
 11. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258; *Glenn Smith v Her Majesty's Attorney General for the State of Tasmania* (unreported) Tas Sup Ct 7 March 1991, Wright J, 5.
 12. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258, 279 (Brennan J).
 13. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258, 279 (Brennan J); *Rich v Queensland; Samin v Queensland* (unreported) Qld Sup Ct 27 July 2001, McPherson, Thomas and Williams JJA.
 14. For example: *Watson v Haines* (1987) Aust Torts Reports ¶80-094. The Minister for Education had been provided with a warning by a medical expert that young men with long thin necks, such as the plaintiff, were predisposed to the particular injury suffered by the plaintiff if they played rugby in the position of hooker. The medical expert had even provided the Minister with special kits to educate teachers and students about this risk. Although the Minister had directed a senior departmental official to distribute the kits, the official had failed to do so. The teachers that had allowed the plaintiff to play the position of hooker were completely absolved of all liability since they had not been aware of the dangers. Therefore, notwithstanding the absence of negligence on the part of the teachers, the department had failed to discharge its non-delegable duty to the plaintiff to implement an adequate system to ensure that no pupil was exposed to any unnecessary risk of injury.
 15. Dexamphetamine is a medication used for the treatment of ADHD. Its effect is to assist students in concentrating and to inhibit impulsive behaviour. Ritalin has a similar effect to Dexamphetamine but it has a shorter effective life.
 16. *Disability Discrimination Act 1992 (Cth)*, s.22(1).
 17. As one parent stated, 'it is unfair for the Education Department to take no responsibility for administering my child's medication because it's like telling me that I cannot work, I cannot study – I cannot have a life because I have to be on call six hours a day for medication duties'.
 18. (1982) 150 CLR 258, 275 (Murphy J).
 19. Section 9 of the *School Education Act 1999 (WA)* is titled 'When enrolment compulsory'. The section provides that a child is to be enrolled in an 'education programme'. 'Education programme' is defined in s.4 of the Act to mean an organised set of learning activities designed to enable a student to develop knowledge, understanding, skills and attitudes relevant to the student's individual needs.
 20. Legal opinion offered by the Crown Solicitor's Office: Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4.
 21. Legal opinion offered by the Crown Solicitor's Office: Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4.
 22. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4.
 23. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258, 264 (Mason J).

24. For example, the duty to teach, the duty to supervise, the duty to provide safe premises etc.
25. See footnote 38.
26. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258; *Richards v State of Victoria* [1969] VR 136, 141; *Vandescheur (by his next friend Vandescheur) v State of New South Wales* (unreported) NSW Sup Ct 1 July 1999, Giles, Fitzgerald JJA and Cole AJA.
27. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258; *Richards v State of Victoria* [1969] VR 136, 141; *Australian Capital Territory Schools Authority v El Sheik* (2000) Aust Torts Reports ¶81-577; *Glenn Smith v Her Majesty's Attorney General for the State of Tasmania* (unreported) Tas Sup Ct 7 March 1991, Wright J.
28. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)*(1992) 175 CLR 218.
29. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4 (emphasis added).
30. Under paragraph 2.2 of the Student Health Care Draft Guidelines January 2001 (page 5) and June 2001 (page 6), 'school staff' is defined to include principals and other administrators, teachers, education assistants, school community nurses, residential supervisors, and registrars. School officers, who are persons who undertake roles such as that of a secretary, are not included within this definition. A number of principals expressed concern with regard to this omission given that secretaries were often the persons who were responsible for administering medication at a school. Principals considered that, if school officers were not included in the definition, they could not be expected to administer medication since, if they did so, the Education Department would take no responsibility whatsoever should an error occur and consequently school officers would be personally liable.
31. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 16; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 17.
32. *Australian Capital Territory Schools Authority v El Sheik* (2000) Aust Torts Reports ¶81-577 (The plaintiff was injured following a 'play fight' with another student. Although the principal of the school was acquitted of negligence, the case against him was that he failed to ensure that there were staff in sufficient numbers and sufficient proximity to supervise the activities of the students); *Geyer v Downs* (1978) 52 ALJR 142.
33. *Australian Capital Territory Schools Authority v El Sheik* (2000) Aust Torts Reports ¶81-577; *Geyer v Downs* (1978) 52 ALJR 142.
34. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 5, Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 9; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 10.
35. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 5.
36. *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47-48 (Mason J).
37. *Glasgow Corporation v Muir* [1943] AC 448, 454 (Lord Thankerton); *Paris v Stepney Borough Council* [1951] AC 367, 384 (Lord Oaksley).

38. *Williams v Eady* (1893) 10 TLR 41, 42; *Carmarthenshire County Council v Lewis* [1955] AC 549, 561; *Camkin v Bishop* [1941] 2 All ER 713, 715.
39. *Geyer v Downs* (1977) 138 CLR 91.
40. *Commonwealth v Introvigne* (1982) 150 CLR 258, 275 (Murphy J).
41. *The Wagon Mound (No 2)* [1963] SR (NSW) 948, 955; JG Fleming, *The Law of Torts* 9th edn (North Ryde NSW: LBC Information Services, 1998), 120-121.
42. *Rogers v Whitaker* (1992) 175 CLR 479.
43. The January and June draft 2001 guidelines specifically state that medication administration training is not required (pages 12 and 13 respectively).
44. *Cook v Cook* (1986) 162 CLR 376; *Philips v William Whitely Ltd* [1938] 1 All ER 566.
45. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 6; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 26; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 28 (The 2001 guidelines include a sample form for the prescribing doctor to fill out for the student's medication requirements. The form states that no action can be undertaken by the school or school staff unless the information required by the form is filled out).
46. Graeme Lowe, 'The Liability of Teachers and School Authorities for Injuries Suffered by Students', (1983) 13(1) *University of Queensland Law Journal*, 39.
47. *Papatonakis v Australian Telecommunications Commission* (1985) 156 CLR 7.
48. Motor tics syndrome is a neurological disorder characterised by tics – involuntary, rapid, sudden movements or vocalisations that occur repeatedly in the same way. Motor tics is a possible side effect of the ingestion of too much Ritalin.
49. There is also the possibility the teacher may be prosecuted under the *Nurses Act 1992* (WA) or the *Medical Act 1894* (WA) for undertaking a task in a manner which the Act confines to that of a medical practitioner or a nurse.
50. *The Wagon Mound (No 2)* [1967] 1 AC 617, 642.
51. *Shirt v Wyong Shire Council* [1978] 1 NSWLR 631, 641 (Glass JA).
52. *Williams v Eady* (1893) 10 TLR 41, 42 (Lord Esher MR); *Reffell v Surrey County Council* [1964] 1 WLR 358, 363.
53. *Edgecock v Minister for Child Welfare* [1971] 1 NSWLR 751, 758.
54. Heffey, PG 'The Duty of Schools and Teachers to Protect Pupils from Injury', (1985) 11 *Monash University Law Review*, 8.
55. *Bills v South Australia* (1982) 32 SASR 312, 319; *Richards v State of Victoria* [1969] VR 136, 145.
56. *Bills v South Australia* (1982) 32 SASR 312, 319; *Richards v State of Victoria* [1969] VR 136, 145.
57. *Mercer v Commissioner of Road Transport and Tramways (NSW)* (1936) 56 CLR 580, 601 (Dixon J).
58. JG Fleming, *The Law of Torts* 9th edn (North Ryde NSW: LBC Information Services, 1998), 127.
59. *Ibid.*
60. *Hampton Court Ltd v Crooks* (1957) 97 CLR 367, 371 (Dixon CJ); *Glasgow Corporation v Muir* [1943] AC 448, 456 (Lord MacMillan).

61. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 12. Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 13. Training is only required if the medication needs to be administered by way of a complicated health procedure such as by injection or suppository. The 1997 guidelines make no reference to training at all.
62. Although the guidelines do not expressly state that teachers are required to administer medication in the classroom, the fact that the guidelines are predominantly concerned with individual teachers administering medication suggests, by implication, that teachers will be administering medication from their classrooms.
63. One particular teacher had a class of 32 students, seven of whom required Ritalin or Dexamphetamines at different times throughout the school day.
64. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 8; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 16; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 17.
65. *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47 (Mason J).
66. It is acknowledged that negligence cannot be reduced to a purely economic equation; in assessing the cost of taking precautions the inquiry should not be directed at the actual resources of the defendant but should be decided on a purely objective basis: JG Fleming, *The Law of Torts* 9th edn (North Ryde NSW: LBC Information Services, 1998), 132; *PQ v Australian Red Cross Society* [1992] 1 VR 19, 33(McGarvie J).
67. Telephone interview with employee at the Health Department of Western Australia (who did not want to be named) on 12 September 2001 at 3.13pm.
68. Telephone interview with employee at the Health Department of Western Australia (who did not want to be named) on 12 September 2001 at 3.13pm.
69. (1987) Aust Torts Reports ¶ 80-094
70. (1987) Aust Torts Reports ¶ 80-094, 68,560.
71. Princess Margaret Hospital offers free seminars, specifically for teachers, on ADHD, diabetes, asthma and epilepsy which include oral, written and visual information as well as some practical training. The hospitals also offer to send out free information to the schools on these issues. Similar services are provided by disability support groups. For example, the Asthma Foundation ('Asthma WA') has a free service where it comes out to schools and gives talks on asthma, the required medications and what to do in an emergency. Asthma WA also offers to show schools how to become an 'asthma friendly school' and provides them with emergency plans for asthma sufferers. *Note - the June 2001 draft guidelines now make reference to services provided by Asthma WA and include a checklist for schools on how to become 'asthma friendly' (see page 43). Reference is also made to the services provided by Princess Margaret Hospital with regard to Diabetes and Hypoglycaemia (see page 51).
72. See footnote 72 regarding the amendment to the June 2001 guidelines.
73. The June 2001 guidelines have now included information on some illnesses and the medication required to treat those illnesses (pages 41-43, 45-51). However, the information predominantly relates to illnesses such as anaphylaxis, diabetes, hypoglycaemia and asthma. No information has been included on epilepsy or ADHD and the medication required to treat those disabilities.

74. Competency depends on whether a particular person has the capacity to perform a particular decision-making task at a particular time and under specified conditions: *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (HL); *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218.
75. *McHale v Watson* (1966) 115 CLR 199; *Thomas v The State of South Australia* (unreported) SA Sup Ct 24 July 1992, Mullighan J.
76. In this article 'assault' refers to a teacher's potential liability for assault in either civil or criminal law. 'Battery' has the meaning given to it by civil law.
77. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4-5; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 15; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 16.
78. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 10; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 11.
79. One parent described how she put a Ritalin tablet inside a marshmallow which the child carried in his pocket.
80. Ben Harvey, 'Stolen drugs for pupils', *The West Australian* (Perth), 7 June 2001, 5; Ben Harvey, 'Child Drug Deals', *The West Australian* (Perth), 11 August 2001, 1; Ben Harvey, 'Year 3s caught out', *The West Australian* (Perth), 11 August 2001, 10; Ben Harvey, 'Pupils sold attention deficit disorder tablets for 50¢', *The West Australian* (Perth), 11 August 2001, 10; Ben Harvey, 'ADD drugs abused: study', *The West Australian* (Perth), 16 August 2001, 5.
81. Motor Tics syndrome is a common side effect of too much Ritalin but a fatal overdose may also occur, particularly given that the tablets can be purchased so cheaply and therefore in large quantities by students who are unaware of how dangerous they are.
82. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 6; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 10 Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 11.
83. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 4.
84. *Mercer v Commissioner for Road Transport* (1936) 56 CLR 580, 589.
85. It is acknowledged that this requirement may not be practical for all parents. It was found that some parents rarely attend their child's school. For example, some parents leave for work early in the morning and return home late at night. Consequently, the child makes his or her own way to and from school (bus, cycling or walking) and therefore has to carry his or her own medication. In these circumstances, perhaps the guidelines could provide that medication be brought to the school by a 'responsible adult'.
86. It is acknowledged that staff members could also be injured by the student in this scenario in which case the Education Department may be liable to them for any injuries sustained. However, given the numerous issues that this topic would raise (e.g. Workers Compensation legislation), it is beyond the scope of this article.

87. (1987) Aust Torts Reports ¶ 80-115.
88. (1987) Aust Torts Reports ¶ 80-115.
89. *Williams v Eady* (1893) 10 TLR 41, 42 (Lord Esher MR); *Reffell v Surrey County Council* [1964] 1 WLR 358, 363.
90. *Hughes v Lord Advocate* [1963] AC 837; *Mount Isa Mines v Pusey* (1970) 125 CLR 383; *Richards v State of Victoria* [1969] VR 136, 145.
91. G Gleeson, 'Experiences, problems and 'felt needs' of teachers educating students with attentional deficits' (Paper presented at the National Conference on the Behaviour management and behaviour Change of Children and Youth with emotional and/or behaviour problems, Melbourne, 1996), 147.