APQ v Commonwealth Serum Laboratories & Commonwealth of Australia

Creutzfeldt-Jakob Disease – Is a Duty of Care Owed?

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APQ was treated with a fertility hormone known as HPG produced from human pituitary glands. HPG was manufactured, packaged and distributed by the Commonwealth Serum Laboratories under the authority of the Commonwealth Department of Health (the Defendants).

APQ, along with 2,500 other hormone recipients, is at risk of contracting Creutzfeldt-Jakob Disease (CJD) for which there is no cure or test for infection and which has an incubation period of up to possibly 30 years. APQ has suffered severe injuries including recognisable psychiatric injuries as a result of learning of the risk.

The *Update* has previously reported on the unsuccessful interlocutory application by the Defendants who sought judgement or a stay of proceedings on the ground that the Statement of Claim did not disclose a cause of action. What follows is an elaboration on the arguments put to the Court and which may again be argued

The Defendants alleged in the absence of any physical manifestation of CJD that there was no cause of action because:

1. There was no sufficient proximity between the parties. The Defendants placed much reliance on traditional nervous shock authorities where a secondary victim suffered nervous shock as a result of the negligence of another.

   Their submissions reflected a narrow interpretation of Deane J. in *Jaensch v Coffey* [1] and Lord Ackner in *Alcock v Chief Constable of South Yorkshire*[2] as supporting requirements-

   (i) that a disturbance or illness must have a basis in shock/sudden sensory perception;

   (ii) that shock must be precipitated by a particular phenomenon;

   (iii) that the shock must be caused by physical proximity to the phenomenom or its immediate aftermath;

   (iv) that psychiatric injury, although it may be foreseeable does not give rise to a duty of care unless it has its derivation in the happening of a traumatic injury or traumatic death.

2. Public policy considerations operate to preclude the implication of a duty of care.

3. Injuries were not of a kind which the law recognises as sounding in damages.

The Defendants submitted that such authorities demonstrated that simply being advised of a distressing fact, such as the risk of contraction of a potentially fatal disease, does not fall within the parameters for recovery for nervous shock. For a nervous shock claim to succeed, it must be one single phenomenon such as an accident with an accompanying physical proximity and not simply a mere apprehension by APQ that she may suffer disease at some indeterminate time in the future.

APQ's Statement of Claim alleged that she had been directly injured as a consequence of the alleged negligence of the Defendants in manufacturing defective hormones.

There is a clear distinction between APQ as a primary victim of the Defendants' negligence and secondary victims in cases like *Jaensch* and *Alcock*. Subsequent to Harper J's decision of 2/2/95 the Statement of Claim was amended to plead shock in the alternative. Support for the distinction between primary and secondary victims was found in a number of recent English and Australian cases[3].

Likewise, the UK Law Commission has noted the distinction between primary and secondary nervous shock victims[4]. The same distinction was made by Lord Oliver in *Alcock* where he stated there was nothing unusual in the recognition by the law that compensatable injury may be caused just as much by direct assault upon the mind or nervous system as by direct physical contact with the body[5]. Lord Oliver went on to say that while it was customary to classify cases in which the damages were claimed for injury occasioned in this way under a single generic label as a case of liability for nervous shock, the only similarity is that there has been an assault upon the nervous system either through witnessing or taking part in the event.

The cases are divided at least into two categories, those of primary and secondary victims. The cases of the former type are not particularly helpful with the latter and vice versa. The primary victim case illustrates the directness of relationship and thus a

duty which is almost self evident from a statement of the facts.

The nexus between APQ and the Defendants is that the direct consequence of her injury is nothing more or less than the negligence of the Defendants in allowing her to be treated with the hormone that they knew or ought to have known could have killed her. APQ's illness is the direct result of that negligence.

CJD is not like HIV affected blood which can be tested to see if it is HIV positive or not. With CJD, victims will never know until the disease strikes and death inevitably occurs in approximately nine months after the onset of the symptoms. The issue of proximity is satisfied by APQ in much the same way as someone who suffers physical injury as a result of another's negligence.

Mullany & Handford argue for an extension of liability for the nervous shock as psychiatric knowledge is more advanced today in that it is hard to feign psychiatric illness[6]. Psychiatrists will be able to testify as to the effect that this knowledge has on people.

Deane J. in *Jaensch* acknowledged that the decided cases have been largely confined to circumstances where psychiatric injury resulted from direct sensory observation at the scene of the apprehended or actual injury. His Honour did not exclude the possibility of a plaintiff being successful in cases where psychiatric injury did not arise from a direct sensory observation.[7]

Both in *Walker* and *Gillespie* the Plaintiffs recovered for psychiatric illness suffered at work without any requirement that the illness be shock induced and without relying on the typical secondary victim nervous shock cases. The UK Law Commission has stated:

As the floodgates objection, in its most important sense, is not in play (in *Walker* or in *Gillespie*) we would expect the law to continue to develop by allowing claims by primary victims for psychiatric illness in a variety of situations (irrespective of whether the illness was shock induced or not). We see no valid reason to object to such development.[8]

Decisions such as *Alcock* and *Jaensch* have included the policy consideration of a fear of opening the floodgates which may be relevant to secondary victims but is not relevant to primary victims. Where a woman is given a substance through the direct authorisation of the Defendants who knew or ought to have known at the time of the potential to be lethal involves very different policy considerations to *Alcock* and *Jaensch*.

Proximity v Reasonable Forseeability

It is worth considering the debate over different approaches to the role of proximity and reasonable foreseeability in establishing the existence of a duty of care as the difference between notions of proximity and reasonable foreseeability has become obscured.

The Australian approach has been to use a general principle of proximity. The UK approach has been to develop new categories of duty incrementally and by analogy with categories already the subject of common law decisions.

McHugh J once predicted that the reason why the principle of proximity should not prevail was because it was of indeterminate reference, its context narrowest in nervous shock and economic loss cases and widest in rescue cases. 9 The use of a general principle avoids any open articulation of the social and moral considerations relevant to elements of determination of a duty.

Deane J. has denied that the requirement of proximity was a rigid formula which could be "automatically applied as part of the syllogism of formal logic to determine whether a duty of care arises ... in a particular category"[10]. The movement away from a notion of reasonable foresight and proximity being synonymous has been largely the result of cases dealing with the development of law concerning negligent advice, pure economic loss and nervous shock.

Deane J. in *Sutherland Shire Council v Heyman*[11] saw proximity as more important in such less developed areas of negligence where the identity and relative importance of factors for determining proximity varies. McHugh J. concluded that as a notion of nearness or closeness was at the centre of proximity, it gave no real assistance to a Court in determining whether a duty exists, a Court making its determination by reference to induction or deduction, fairness and public policy.

The doctrine of proximity gives no guidance as to which one or more of these factual considerations is determinative of the existence of a duty in a particular case or why the presence of one or more of them does not lead to a duty in a particular case.

The modern law of negligence suggests that it is unwise to attempt precise definition of essential criteria which must always be present in order to attract a duty in particular situations. New

categories of duty demand recognition while criteria for existing categories may also require re-definition. The Defendants in APQ sought to define such criteria as mandatory requirements. The difference between primary and secondary victims highlighted by the circumstances of APQ demonstrates that existing criteria evolving from nervous shock car accident cases for instance should not be determinative of whether a duty of care exists.

There has been a much greater emphasis on using proximity as a general principle in Australia in contrast to the UK. Vines has commented that use of such a general principle allows Australian Courts to draw on the power of the general social understandings of responsibility of fault in a way which the English categorical approach with its emphasis on reasonable foreseeability cannot.[12]

Dean J's use of the inclusive word "involves" in his authoritive statement on proximity in *Jaensch* suggests that he was not making a definitive statement on physical, circumstantial and causal proximity.

The relevant aspects of proximity are not closed and it may be possible from a process of reasoning from previous cases to identify an aspect of proximity not yet recognised or at least to reinterpret a previously recognised aspect of proximity in a different respect for a particular category of case.[13]

The Defendants in APQ sought to rely on criteria from road accident and rescue nervous shock cases. In so doing, they really applied the incremental approach of the UK Courts in cases like *Alcock* so giving narrow import to Dean J's formulation of proximity.

APQ seeks not to create a new category of negligence but primarily that she is in the same position as someone who suffers physical injury as a primary victim of another's negligence. The English view of proximity is a narrow one in that what is really required to establish a duty of care for nervous shock is reasonable foreseeability of nervous shock.

The barriers to recovery for psychiatric injury should be lowered and psychiatric damage treated like any other personal injury. Mullany & Handford have proposed that a nervous shock Plaintiff should recover on showing:

(a) medical causation between a Defendant's careless conduct and a recognisable psychiatric injury to a Plaintiff; and

(b) foreseeability that such conduct will inflict injury by shock They regard recognisable psychiatric injury as the most significant control device in their formula.

The Courts have already allowed Plaintiffs to recover for shock induced psychiatric injury caused by witnessing damage to property.[14] The gist of both actions was that a wrong had been done and damages were available for mental distress subsequent upon damage to property, provided rules for remoteness of damages were satisfied. It would seem a little odd if a Plaintiff can recover more easily for psychiatric illness consequent on damage to a property rather than in APQ's position.

According to a recent decision of the House of Lords in *Page v Smith*, liability to primary victims of negligence for the infliction of psychiatric injury is no longer dependent on proof that such injury is reasonably forseeable. As long as there is reasonable forseeability that physical injury is a likely result, such would be sufficient for a defendant to be held liable for the infliction of psychiatric injury, even if no physical injury occurs.

While the decision has its critics, there is recognition of chronic fatigue syndrome as a clinically valid psychiatric illness of the difference between primary and secondary victims and emphasis on reasonable foreseeability rather than proximity in circumstances where psychiatric injury was held as equivalent to physical injury.

Where to Next?

APQ has issued an interlocutory application seeking discovery from the Defendants of submissions made by doctors, scientists and officers of the Defendants to the Allars' Inquiry recorded in its Report tabled in Parliament in June 1994.

The Defendants have indicated they will strenuously oppose the application and will assert that Section 135A of the National Health Act prohibits the devulging of such information. The Commonwealth will also rely upon the doctrine of public interest immunity in respect of discovery of such documents.

The matter will come before the Listing Master on 14th February 1996 when the matter will be listed for hearing by Harper J. within the next month or two. Subject to any applications for leave to appeal any adverse decision by the Defendants, we anticipate that the Court will be in a position to appoint a trial date in the second half of this year. While the Defendants have appeared content to

proceed to trial of APQ's action, alone, there are recent indications to suggest that the Defendants are categorising the other 129 litigants for whom we act according to an assessment on liability.

Many of the people for whom we act were treated with HPG after 1980. At this stage, we believe the Defendants knew or should have known of the risks of CJD by 1971 but at latest by 1975.

We have been working in conjunction with English Lawyers. Their actions on behalf of those who have died from CJD in the UK are to come to trial in mid April 1996.

In December 1994 we settled four claims by those dependent on women who have died from CJD and whose claims were brought under the Administration & Probate Act and the Wrongs Act.

Footnotes:

1. (1984) 155 CLR 549.
2. [1992] 1 AC 310.
3. *M v Newham London Borough Council* [1994] 2WLR554, Sir Bingham at 575: Sion v Hampstead Health Authority (1994) 5 Medical Law Reports 170, Lord Staughton at 173: Lord Gibson at 176; Gillespie v The Commonwealth of Australia (1993) ATR 81-217; *Walker v Northumberland* [1995] 1 AllER 737.
4. Common and Public Law Liability for Psychiatric Illness. A consultation paper No. 137 (1995).
5. Alcock [1992] lAC310, at 407.
6. N. Mullany & P. Handford 'Tort Liability for Psychiatric Damage' 1993.
7. (1984) 155 CLR 549, 605, 608.
8. UK Law Reform Commission above n4, 85.
9. McHugh J. "Neighbourhood Proximity & Reliance", in PD Finn (ED) Essays on Torts (1989) 5.
10. *Stevens v Brodribb Sawmilling Co. Pty. Ltd.* (1986) 160 CLR 16.
11. (1985) 157 CLR 424.
12. P. Vines "Proximity as a Principle or Category: Nervous Shock in Australia and England (1993) UNSW Law Journal Volume 16 (2) 459; D. Mendelsen "The Defendants' Liability for Negligently Caused Nervous Shock In Australia - Quo Vadis?" (1992) 18 MON U L REV 16.
13. Butler D. "Mass Media Liability for Nervous Shock: A Novel Test of Proximity" (1995) 1 Torts Law Journal 75.
14. See *Attia v British Gas PLC* [1988] QB304 & *Campbelltown City Council v McKay* (1989) 15 NSW LR 501.

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