IN THE HIGH COURT OF AUSTRALIA

BRISBANE REGISTRY No. B63 of 2019

BETWEEN: STATE OF QUEENSLAND

Appellant

and

THE ESTATE OF THE LATE JENNIFER LEANNE MASSON

Respondent

RESPONDENT'S SUBMISSIONS

Part I:

1. These submissions are in a form suitable for publication on the internet.

Part II:

2. It is settled that the 2002 QAS Clinical Practice Manual (CPM) did not mandate the use of adrenaline for every asthmatic who was categorised as being in "imminent arrest". Further, it is also not in dispute that the CPM represented the opinion of the QAS that salbutamol is not as effective as adrenaline when treating a patient suffering a life-threatening asthma attack. As such, the second issue raised in the Appeal is not a live one.

3. In treating Ms Masson, there is no suggestion that Mr Peters purported to follow any opinion other than the one he believed was that of the QAS. By attempting to use his State authority's opinion as the basis for his decision-making, Mr Peters shared the same mindset that every reasonable ambulance officer in his position would have had.

4. Liability in the present case turns entirely on the issue of whether Mr Peters' initially reasonable mindset miscued because of his mistaken belief that the CPM prohibited the use of adrenaline for asthmatics in Ms Masson's condition. If the QAS sent an ambulance officer into the field with this misconception of its opinion about adrenaline, the Appellant is liable for the catastrophic injuries that Ms Masson sustained as a result.

5. Accordingly, the sole determinative question of liability before this Court is encompassed in the first issue of the Appeal:

> *Did Mr Peters consider the use of adrenaline in his initial treatment of Ms Masson?*

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6. Apart from the issue of liability, the third and fourth issues raised in the Appeal present this Court with an opportunity to answer two ancillary questions.

7. The first ancillary question is one of fact, asking whether a responsible body of specialist physician opinion existed in 2002 to validate Mr Peters' decision to administer salbutamol to Ms Masson.

8. Assuming such a body did exist, the second ancillary question raises an issue of law which, while inconsequential to the outcome of the present case, is potentially one of social import:

> *In responding to an emergency that was contemplated by their clinical practice manual, should ambulance officers be allowed to rely upon an external body of specialist physician opinion which deviates from the opinion of their State authority?*

9. Whichever conclusions the Court reaches on these two ancillary questions, The Estate of the Late Jennifer Masson is entitled to retain the damages awarded to it by the Court of Appeal of Queensland.

Part III:

10. The Respondent considers that no notice is required to be given pursuant to s 78B of the *Judiciary Act 1903* (Cth).

Part IV:

11. The facts and procedural history are accurately summarised in the judgment below at paragraphs [2] to [39].

12. On 21 July 2002, Ms Masson suffered a severe asthma attack. When ambulance officers arrived, they noted she was centrally cyanosed (meaning she was blue in the face); her respiratory rate was almost non-existent at only 2 retracted breaths per minute; and her score on the Glasgow Coma Scale (GCS) was recorded as only 6, meaning she was effectively unconscious.

13. As the trial judge put it, Ms Masson was *"near the point of dying"* at the time of initial treatment.[1] Her GCS score of 6 placed her firmly in the category of "imminent arrest". This was the most severe category of asthma attacks, and included any patient with a GCS score of under 12,[2] bradycardia (a heart rate of under 60 beats per minute) or absent pulses.[3]

14. For pharmacological treatment of asthmatics like Ms Masson who were in imminent arrest, the CPM prompted ambulance officers to *"[c]onsider adrenaline"*. Contrary to

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[1] Core Appeal Book (CAB), p 22 [64].
[2] CAB, p 35 [115]; p 70 [22].
[3] CAB p 35 [114]-[115]; p 70 [22].

the Appellant's case pleaded at trial,[4] Ms Masson's tachycardia (a heart rate of above 100 beats per minute) did not mean the use of adrenaline was prohibited.

15. Adrenaline was – as a matter of medical fact – the only correct drug to administer to Ms Masson in her dire condition. Salbutamol was the wrong drug, the administration of which led to catastrophic results. Adrenaline would have avoided Ms Masson's severe brain injury in circumstances where salbutamol did not.[5] These facts are not in dispute.

16. Despite finding it was the only correct drug, Henry J held that Mr Peters' failure to administer adrenaline was not a breach of duty. This conclusion was reached on the basis of three findings made by his Honour:

a. Firstly, that Mr Peters made a clinical assessment in which he considered adrenaline but rejected it because of the risk of serious adverse reaction to it raised by the presence of tachycardia and hypertension (high blood pressure);[6]

b. Secondly, that there would have existed a responsible body of opinion in the medical profession in 2002 which preferred the use of salbutamol in view of Ms Masson's high heart rate and high blood pressure; [7] and

c. Thirdly, that the existence of that responsible body of medical opinion in 2002 meant Mr Peters' decision as an ambulance officer to administer salbutamol instead of adrenaline was a reasonable response to the known risks.[8]

17. It was only necessary for the Court of Appeal to overturn the first of these findings to conclude that there was a breach in this case. It unanimously overturned all three. The Court held:

a. Firstly, that Mr Peters immediately rejected adrenaline, not because of a clinical judgment, but because he misunderstood the CPM by thinking that in no case was adrenaline to be given to a patient who was not bradycardic;[9]

b. Secondly, that there was no responsible body of medical opinion in 2002 which deviated from the opinion of the QAS that adrenaline was superior to salbutamol in life-threatening asthma attacks, even where the patient's heart rate and blood pressure were high;[10] and

c. Thirdly, that even if such a body of medical opinion did exist in 2002, it would still have been a breach by Mr Peters to follow it instead of the opinion of the

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[4] Respondent's Book of Further Materials (**RBFM**) p 40 [4(a)(x)].
[5] CAB p 47 [167]; p 51 [182]; p 100 [168].
[6] CAB p 44[148].
[7] CAB p 29 [93].
[8] CAB p 44 [151].
[9] CAB p 97 [151].
[10] CAB pp 98-99 [160]-[161].

QAS, because he had more limited education, training and experience compared with medical specialists.[11]

Part V:

The settled issue: *The CPM did not mandate the use of adrenaline, but it did represent the opinion of the QAS that salbutamol is not as effective as adrenaline when treating an asthmatic patient in imminent arrest.*

18. The Appellant at paragraphs 31 to 36 of its submissions incorrectly suggests that the Court of Appeal's interpretation of the words *"[c]onsider adrenaline"* in the CPM differed from that of the trial judge. Both courts recognised that the CPM did not
10 mandate the use of adrenaline, but instead required ambulance officers to consider adrenaline when treating asthmatics in imminent arrest.[12]

19. Also contrary to the Appellant's submissions, there is no implication in the Court of Appeal's judgment that the CPM was mandatory in nature. The Court of Appeal accepted that the CPM was designed to be a flexible guideline which preserved Mr Peters' freedom to make a clinical decision. In isolation, his decision to administer salbutamol to an asthmatic in imminent arrest was not inconsistent with the terms of the CPM, and did not necessarily amount to a departure from the standard of a reasonable ambulance officer.

20. While recognising the words *"[c]onsider adrenaline"* did not mandate adrenaline, the
20 two lower courts also agreed that the opinion of the QAS as represented in the CPM was that salbutamol is not as effective as adrenaline when an asthmatic patient is in imminent arrest.

21. At [106] of the trial judgment, Henry J noted that the preference for the use of adrenaline was *'obviously reflected'* in the flowchart in the CPM. According to his Honour, the QAS did not regard salbutamol to be as effective as adrenaline in responding to the most severe asthma attacks. [13] An example his Honour noted of this opinion in the CPM's asthma flowchart (A2-8) was that the only drug for consideration for asthmatics in imminent arrest was adrenaline, with no reference to the option of salbutamol.[14]

30 22. The Court of Appeal also acknowledged this lack of reference to salbutamol as an example of the State authority's view that adrenaline was superior.[15] It went on to note other examples in the CPM of this opinion held by the QAS:

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[11] CAB p 97 [149].
[12] CAB p 39 [129]-[130]; p 42 [144]; CAB p 70 [22]-[23]; p 73 [37]-[39].
[13] CAB p 33 [106].
[14] CAB p 33 [106]; see also CAB pp 31-32 [100].
[15] CAB p 73 [35].

a. The flowchart indicated that adrenaline may be considered if a patient did not respond to salbutamol, but it did not recommend the use of salbutamol after a lack of response to adrenaline.[16]

b. In the CPM's Adrenaline Drug Data Sheet (B6), directions are given for the quantities of adrenaline to be administered in cases of *"[a]sthma or severe bronchospasm with imminent arrest"*. There is no reference to a case of that severity in the Salbutamol Drug Data Sheet (B-49 and B-50).[17]

c. A comparison of the two drug data sheets also informs the reader that adrenaline has a quicker onset and peak time than salbutamol.[18]

23. The opinion of the QAS, as represented in the CPM, was that adrenaline was not compulsory in every case of imminent arrest, but that it was the preferred drug for a fast and effective dilation of the bronchial passages, so as to avoid death or the permanent effects of the deprivation of oxygen to the brain.[19] Reading the CPM, any reasonable ambulance officer would have concluded that adrenaline was superior to salbutamol in effecting bronchodilation. This is not in dispute.

24. Paragraphs 31 to 36 of the Appellant's submissions are underpinned by an apparent misunderstanding of the Court of Appeal's decision. The effect of the appellate court's judgment is not that "consideration" according to the CPM meant the preferred drug had to be applied. It was expressly recognised by the Court of Appeal that there will be cases where, in accordance with the CPM, a reasonable response to treating an asthmatic patient in imminent arrest is to consider the preferred drug, adrenaline, but to then administer the non-preferred drug, salbutamol.[20]

25. By finding the present case was not one in which the use of the non-preferred drug was reasonable, the Court of Appeal was not implying that such a response was prohibited by the CPM, or that it would always be unreasonable. Rather, as will be discussed below, it decided that a reasonable ambulance officer in the position of Mr Peters would have administered the preferred adrenaline to Ms Masson, and not the non-preferred salbutamol. Contrary to what the Appellant has suggested, this finding is consistent with the correct interpretation of the CPM as a flexible guideline.

26. The Appellant is untenably conflating the settled issue of the CPM's interpretation as a non-proscriptive document with the breach inquiry of whether Mr Peters acted reasonably. In its opposition to the Court of Appeal's reasoning, the Appellant's argument appears to be that a reasonable ambulance officer would have administered salbutamol to Ms Masson in her condition, simply because the CPM did not prohibit the use of the non-preferred drug for asthmatics in imminent arrest. Paradoxically, this

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[16] CAB p 73 [35].
[17] CAB pp 72-73 [34]; Appellant's Book of Further Materials (ABFM) pp 7-8.
[18] See CAB p 71 [26]; p 72 [30]; ABFM pp 7-8; 11-12.
[19] CAB p 99 [162].
[20] CAB p 97 [151].

is the only argument being run by either side that falls foul of the Appellant's correct assertion that the CPM as a guideline is not determinative of the breach issue.[21]

27. Paragraph 37 of the Appellant's submissions again mischaracterises the Court of Appeal's decision and, misapplying the principle from *Strong v Woolworths Ltd*[22], fails in its attempt to raise a question of any relevance to causation.

28. Whether Mr Peters would have administered adrenaline had he considered it is a subjective question which is irrelevant to both breach and causation. The Court of Appeal found that a reasonable ambulance officer would have considered adrenaline and, using the opinion of the QAS in the CPM as the basis for his or her decision-making, would have decided to administer adrenaline to Ms Masson. Nothing has been alleged by the Appellant which could have broken the causal link between that decision and the act of administering the drug. Adrenaline was available and in the control of the ambulance officers who treated Ms Masson at the scene; there is no reason why a decision to administer it could not have been carried out.

The determinative issue: *Did Mr Peters consider adrenaline in his initial treatment of Ms Masson?*

29. On 21 July 2002, the QAS was called to respond to a severe asthma attack; a medical emergency caused by a disease which can lead to life-threatening oxygen deprivation. The ideal response to a risk of such a high magnitude would have been to send specialists in emergency medicine to treat Ms Masson. The QAS did not send such specialists, or even medical practitioners. Instead, it sent ambulance officers who are trained to stabilise the condition of patients and ensure their speedy transfer to hospital.

30. Had QAS sent a specialist in emergency medicine, he or she would have been able to apply their theoretical knowledge and practical experience to make a fine judgment about the alternative treatments for Ms Masson. No breach is alleged for this failure by QAS to send a specialist in emergency medicine. It is recognised that there are finite resources in society; the expense, difficulty and inconvenience of sending emergency physicians to treat severe asthma attacks outweigh the benefit of giving every asthmatic an expert in emergency medicine to treat them at the scene of their asthma attack.

31. Both courts agreed the relevant standard expected of Mr Peters is lower than that of a medical practitioner or an emergency physician.[23] The standard expected of Mr Peters was that of a person with the special skill or competence of an ambulance officer; a standard which is informed by the CPM and by *'the common approach of skilled ambulance officers in respect of the administration of adrenaline for asthma.'*[24]

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[21] See Appellant's Submissions, paragraph 69.
[22] (2012) 246 CLR 182.
[23] CAB p 13 [30].
[24] CAB p 13 [29]; CAB p 96 [146].

32. When Mr Peters arrived at the scene of Ms Masson's asthma attack, he understood the dire nature of her condition. To him, *'the risk of oxygen deprivation and consequent brain damage, and potentially death, was readily apparent.'*[25] Whether his response to that serious risk was reasonable is the determinative issue in this case.

33. Assessing whether Mr Peters' response met the reasonable standard of an ambulance officer requires the Court to undertake a *Shirt* calculus,[26] *'a contextual and balanced assessment of the reasonable response to a foreseeable risk.'*[27]

34. The CPM provided by the QAS to its ambulance officers is an acknowledgement that their education, training and experience, while not insignificant, is limited compared to that of emergency medical specialists.[28] To narrow these gaps in knowledge and experience in how to respond to the risks faced by asthmatic patients, the CPM contains an asthma guideline to assist ambulance officers. If a patient is assessed to have a GCS score of under 12, bradycardia, or absent pulses, they fall into the most severe asthma category of "imminent arrest", and officers are required to *"[c]onsider adrenaline"*.

35. The trial judge and the Court of Appeal each identified parts of the CPM which shed light on what a reasonable ambulance officer's consideration of adrenaline would entail:

    a. The trial judge at [98] quotes the introductory section to the CPM, which states the manual is designed to *"assist clinical judgment, using the problem-solving approach, to achieve best practice."* Deviations from the guidelines must be documented, and *"officers must be able to justify that their treatment was in the patient's best interests."*

    b. At [126] of the trial judgment, Henry J highlights the "Clinical Pharmacology" section of the CPM which requires ambulance officers to *"[w]eigh up the potential benefits of the drug and the potential adverse effect"*, noting that *"[s]ound clinical judgment is as much about when not to administer drugs as when to give them."*

    c. The Court of Appeal at [24] points to the "Glossary of Specific Terms" in appendix 2 of the CPM, which defines the term *"consider"* as involving a *"judgement regarding application of the following treatment modalities based on potential benefits and adverse effects."*

36. It is clear from what is written in the CPM that the words *"[c]onsider adrenaline"* in the asthma flowchart required ambulance officers to engage in a decision-making process which weighed the potential benefits and risks of adrenaline. The CPM was, in effect, a manualised description of the common law standard of reasonableness; a

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[25] CAB p 14 [33].
[26] See *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47-48 (Mason J).
[27] *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330, 354 [69] (Gummow J).
[28] CAB pp 96-97 [147]-[148].

guideline requiring its readers to assess the risk to the patient, and to respond as a reasonable ambulance officer would.

37. Rather than mandating the use of adrenaline in all "imminent arrest" cases, the CPM and the common law expected Mr Peters to conduct a balancing act of adrenaline's potential benefits and adverse risks before deciding whether to administer it to Ms Masson. A failure to consider adrenaline was necessarily a departure from both the CPM and from the standard of a reasonable ambulance officer.

38. Unfortunately, due to his misunderstanding of the CPM, Mr Peters believed Ms Masson's tachycardia and hypertension precluded him from considering adrenaline. This is evident in his written and oral evidence, and by his excessive administration of salbutamol. He did not weigh up adrenaline's benefits and risks because he thought the CPM prohibited such a balancing act where the asthmatic patient had a high heart rate and high blood pressure.

39. Mr Peters' belief was wrong in two important ways. Firstly, it is settled that the CPM is not categorically binding in nature and could not have prohibited the administration of either adrenaline or salbutamol. Secondly, whilst the CPM indicates that adrenaline has a particular use in cases where the patient is bradycardic, it does not follow that adrenaline lacks a proper use for a patient who is tachycardic.[29] Nowhere in the CPM does it suggest that tachycardia can be a reason for not using adrenaline, particularly in asthma attacks where a patient is as close to cardiac arrest and death as Ms Masson was at the time of initial treatment.

40. Mr Peters fundamentally misunderstood the opinion of the QAS about adrenaline and when to use it for asthmatic patients. This is evident in his 2009 written statement:

> "29. In view of the fact that Ms Masson was tachycardic, that is she had a heart rate that was greater than 100 beats per minute and peripheral pulse were palpable, intravenous Adrenaline was <u>not permitted</u> under the Asthma protocol. I therefore elected to administer intravenous Salbutmol [sic]."

41. Describing his decision to eventually administer adrenaline about 20 minutes after initial treatment, Mr Peters wrote in the same statement that:

> "36. At approximately 23:19... her heart rate slowed from 136 beats per minute (which was the reading displayed on the cardiac monitor immediately prior to 23:19) to a bradycardia with a palpable carotid pulse...
>
> 37. As Ms Masson was bradycardic and hypotensive, she <u>met the criteria</u> for the administration of intravenous Adrenaline..."

42. His 2009 written statement unambiguously demonstrates Mr Peters' mistaken belief that the use of adrenaline was not permitted by the CPM until the patient's heart rate fell under 60 beats per minute (bpm). He made no reference to adrenaline as an

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[29] CAB pp 79-80 [60].

alternative to salbutamol, nor did he refer to Ms Masson as being in the category of imminent arrest.[30] The Court of Appeal concluded at [43] that:

> '... On the face of the statement, Mr Peters misunderstood the CPM, by thinking that Ms Masson's tachycardia precluded the possible use of adrenaline. The same reasoning is evident from paragraph 37 of his 2009 statement, where Mr Peters said that it was only when Ms Masson became bradycardic that she met the criteria for the administration of adrenaline.'

43. Mr Peters' oral evidence at trial is consistent with his 2009 written statement. In examination-in-chief, he repeated that the fall in Ms Masson's heart rate was the reason why adrenaline only became the most appropriate drug about 20 minutes after initial treatment.[31] In cross-examination, Mr Peters again said that he was prohibited from administering adrenaline and that salbutamol was *"clearly the defined pathway I was required to go down."*[32]

44. At no point did Mr Peters suggest his 2009 written statement was inaccurate in any respect.[33] This blunts the suggestion that Mr Peters' evidence was somehow corrupted by "legal forum and review", rather than representing his genuine interpretation of the effect of the CPM.[34]

45. In responding to Ms Masson's life-threatening asthma attack, Mr Peters operated under the misapprehension that while Ms Masson's heart rate remained over 60 bpm, he was precluded by the CPM from weighing the risks and benefits of adrenaline. This misapprehension was plainly evident in Mr Peters' actions at the scene, where he continued to administer salbutamol – doubling the maximum dosage prescribed by the CPM's Salbutamol Drug Data Sheet – until Ms Masson became bradycardic.[35]

46. The evident explanation for Mr Peters' decision to administer twice the maximum dosage of salbutamol to Ms Masson was that she was not satisfactorily responding to the initial treatment.[36] Mr Peters understood the urgency of the situation and that death would soon follow if Ms Masson's breathing was not restored quickly, but he did not understand the CPM allowed him to consider and administer adrenaline regardless of the patient's heart rate.

47. His belief the CPM prohibited adrenaline for tachycardic patients was carried into the Appellant's pleaded defence, in which it argued for precisely the same misinterpretation of the CPM which it now denies Mr Peters had at the time of initial treatment.

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[30] CAB p 74 [43].
[31] CAB p 75 [45].
[32] CAB pp 75-76 [48]-[49].
[33] CAB p 75 [46].
[34] See Appellant's Submissions, paragraph 20(f)(i).
[35] CAB p 75 [47].
[36] CAB pp 97-98 [152].

48. The Appellant had earlier contended that twice the maximum dosage of salbutamol was *"in accordance with"* the CPM and adrenaline was *"not permitted"* because Ms Masson's tachycardia meant she did not fulfil the definition of "imminent arrest".[37] It also maintained, as Mr Peters did in his written and oral evidence, that Ms Masson first met the QAS criteria for adrenaline only once she became bradycardic.[38] The implication in the Appellant's current case is that, despite the evidence to the contrary, its pleaded case contradicted Mr Peters' true belief about the effect of the CPM.

49. The Court of Appeal concluded:

> '... To the extent that Mr Peters did avert [sic] to the use of adrenaline, he immediately rejected it, not because of a clinical judgment, but because he misunderstood the guideline by thinking that in no case was adrenaline to be given to a patient who was not bradycardic.'[39]

50. On the totality of the evidence, there is no weight to the Appellant's assertion that Mr Peters demonstrated an awareness of the availability of adrenaline as a pharmacological option for treating asthmatics with tachycardia.[40] The Court of Appeal correctly concluded that the requisite adrenaline risk-benefit balancing was absent from Mr Peters' decision-making process:

> 'At no point in his testimony did Mr Peters say that he was concerned by the risk of a serious adverse reaction to adrenaline, which he then weighed against the apparent benefits, according to the CPM, of adrenaline as the preferred drug for a patient in the category of "imminent arrest".'

51. The Appellant's response to this determinative finding is to argue that, although Mr Peters does not precisely use the words of the Court of Appeal, his evidence shows that he chose salbutamol over adrenaline because of Ms Masson's presentation and the risks of adrenaline.[41]

52. Of course, Mr Peters did not have to recite the Court of Appeal's paragraph [65] verbatim to demonstrate he had considered the benefits and risks of adrenaline before administering salbutamol. However, it is clear that Mr Peters did not believe there were any benefits to administering adrenaline to Ms Masson in her condition. Nor did he ever mention the potential side effects of adrenaline. Mr Peters simply applied what he mistakenly thought was the opinion of the QAS – namely, that adrenaline is not to be used if the patient's heart rate is above 60 bpm.

53. In overturning the trial judge's decision, the Court of Appeal did not disturb any findings of fact or credit made by his Honour. The guidance in *Fox v Percy*[42] was not

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[37] RBFM p 40 [4(x)].
[38] RBFM p 40 [4(xv)-(xvi)].
[39] CAB p 97 [151].
[40] See Appellant's Submissions, paragraph 20(d).
[41] See Appellant's Submissions, paragraphs 24 and 25.
[42] (2003) 214 CLR 118.

contravened. On any view of the evidence, the necessary balancing was not conducted by Mr Peters. Indeed, nothing in the trial judgment suggests otherwise.

54. The trial judge did not find that Mr Peters had conducted any weighing-up of adrenaline's potential benefits and risks. Rather, his Honour simply found that the fact Mr Peters believed he was prohibited by the CPM from administering adrenaline did not mean he had failed to consider it and reject it on the basis of Ms Masson's tachycardia and hypertension. According to the trial judge, *"[s]uch views are not mutually exclusive."*[43]

55. This is where the trial judge fell into error. By deciding the evidence could be reconciled in this way, the trial judge abandoned his Honour's own formulation of what it means to consider a drug. Earlier in his Honour's judgment, Henry J referred to the "Clinical Pharmacology" section of the CPM which requires ambulance officers to weigh up potential benefits and the potential adverse effect of a drug before administering it. His Honour had correctly noted that:

> 'That passage makes plain the importance of clinical judgment and caution in not only determining what drug to administer, but also in determining "when not" to administer a particular drug, bearing in mind its "potential adverse effect".'[44]

56. What the trial judge overlooked was that the clinical judgment of deciding "when not" to administer a drug in this case applied equally to salbutamol. Henry J adopted the wrong approach at law when his Honour found that *'...it is the negative risk associated with adrenaline, rather than salbutamol which is of relevance here.'*[45]

57. The Court of Appeal correctly found this reasoning to be *'problematic, because a negative risk associated with salbutamol... was clearly relevant to the question of whether the exercise of reasonable care required the administration of adrenaline, rather than salbutamol.'*[46]

58. In the context of a choice between two drugs, any risk uniquely associated with salbutamol amounts to a benefit of adrenaline. The inverse is also true. Even if the trial judge was correct to find Mr Peters considered the risks of adrenaline's side effects before deciding to administer salbutamol (which remains in dispute), it is not in dispute that he failed to consider any of the risks of salbutamol, which include the benefits of adrenaline.

59. These benefits were unambiguously indicated in the CPM and the respective drug data sheets. As discussed above, the opinion of the QAS was clearly that adrenaline is

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[43] CAB p 41 [140].
[44] CAB pp 38-39 [127].
[45] CAB p 23 [69].
[46] CAB p 86 [98].

superior to salbutamol in life-threatening asthma attacks. The only contra-indication for adrenaline was where the patient had a *"[k]nown severe adverse reaction"*.[47]

60. Nowhere in the CPM does it suggest that adrenaline should not be administered to an asthmatic in imminent arrest if they are tachycardic or hypertensive. In fact, the Salbutamol Drug Data Sheet states that tachycardia and tachyarrhythmias are also side effects of salbutamol. Despite this, Mr Peters administered twice the maximum dosage of salbutamol to Ms Masson while waiting for her to become bradycardic.[48]

61. In circumstances where Ms Masson was so close to death, her high heart rate and blood pressure were not sufficiently important factors to displace the priority in that life-threatening situation; a fast and effective dilation of the bronchial passages and oxygenation of the brain. For any reasonable ambulance officer in the position of Mr Peters, *'the "consideration" of adrenaline should have proceeded on that premise.'*[49]

62. Like Mr Peters, a reasonable ambulance officer would have the proper mindset of using the opinion of the QAS as the basis of his or her decision-making in how to treat Ms Masson. By contrast to Mr Peters, a reasonable officer would not have misunderstood that opinion to be that a heart rate above 60 bpm prevented the administration of adrenaline and, having no reasonable basis to use the non-preferred drug salbutamol, would have administered the preferred drug adrenaline. This would have avoided Ms Masson's catastrophic injuries. By sending into the field an ambulance officer who acted on a misunderstanding of the State authority's opinion about adrenaline, the QAS is vicariously liable for the consequences.[50]

63. For these reasons, the Court of Appeal was correct to overturn the trial judge's conclusion on breach. The Appellant was negligent and The Estate of the Late Jennifer Masson is entitled to retain its damages.

First ancillary question: *Did a responsible body of opinion in the medical profession exist in 2002 which deviated from the guidance provided by the CPM?*

64. Paragraph [93] of the trial judgment contains his Honour's second erroneous finding:

> 'I conclude that there would have existed a responsible body of opinion in the medical profession in support of the view that Ms Masson's high heart rate and high blood pressure, in the context of her overall condition, provided a medically sound basis to prefer the administration of salbutamol to the administration of adrenaline at the time of initial treatment.'

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[47] See CAB p 98 [155]; AFBM pp 11-12.
[48] CAB p 71 [29]; pp 97-98 [152].
[49] CAB p 99 [162].
[50] As the employer of Mr Peters (see *Ambulance Service Act 1991* (Qld) s 13(1) (as in force on 15 March 2002), the State of Queensland is vicariously liable for Mr Peters' negligent act which occurred in the course of his employment: see *Hollis v Vabu Pty Limited* (2001) 207 CLR 21, 36 [32]; 40 [42]; see also *Roane-Spray v State of Queensland* [2016] QDC 348, affirmed on appeal in *Queensland v Roane-Spray* [2018] 2 Qd R 511.

65. In reversing this finding, the Court of Appeal did not reject any of the medical evidence relied upon by the trial judge. Nor did it suggest the Appellant's medical experts lacked credibility or expressed their views with a less serious case than Ms Masson's in mind. Rather, the Court of Appeal identified two faults in the trial judge's reasoning which undermined his Honour's conclusion.

66. The first fault was that each of the three medical practitioners who gave evidence in the Appellant's case believed salbutamol was an equally effective drug for bronchodilation. None of them began with the premise which was the opinion of the QAS – namely, that adrenaline was the superior drug for the treatment of an asthmatic at immediate risk of cardiac failure and death. Without accepting the preference of the QAS for adrenaline as the starting point, the Appellant's experts could not show *'that the risk from using an inferior drug was outweighed by the risk of side effects from the adrenaline.'*[51]

67. In response, the Appellant at paragraph [52] of its submissions states that its experts did recognise the superiority of adrenaline in cases of true cardiac standstill and anaphylaxis. However, the opinion of the QAS was that adrenaline was superior in treating asthmatics in imminent arrest, save for where the patient had a *"[k]nown severe adverse reaction"* to the preferred drug. This is not overcome by the evidence of the Appellant's medical experts, which deal with two only examples of imminent arrest.

68. It is remarkable that the Appellant's ultimate case attempts to disprove its own opinion as expressed in the CPM, by contending that salbutamol and adrenaline are equally effective drugs for bronchodilation. The Court of Appeal also made a note of this peculiarity.[52]

69. The Appellant's persistent attempt to argue that adrenaline and salbutamol are equally effective in treating asthmatics in imminent arrest is even more peculiar in view of the settled finding by Henry J that adrenaline would have saved Ms Masson in circumstances where salbutamol did not. Without a challenge to this causation finding by the Appellant, and without evidence that it was anything other than adrenaline's superiority over salbutamol that would have saved Ms Masson (her response to adrenaline is not alleged as having been unique), the Appellant's contentions in paragraphs 38 to 58 of its submissions fall short of congruently arguing for an affirmative answer to the first ancillary question.

70. Of the experts who did recognise the medical fact that adrenaline is superior to salbutamol in bronchodilation (such as Professor Fulde), none opined that tachycardia or hypertension could give rise to potential side effects of adrenaline that could justify the use of salbutamol in the treatment of asthmatics in imminent arrest.[53] As such, it

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[51] CAB p 99 [162].
[52] CAB p 36 [36].
[53] CAB p 99 [166].

was not open on the evidence for Henry J to find a responsible body of opinion validated Mr Peters' decision to administer salbutamol.

71. The second fault in the trial judge's reasoning – resolved by the Court of Appeal and not addressed in the Appellant's submissions to this Court – relates to the time when the responsible body of medical opinion is alleged to have existed, in the year 2002.

    a. In the trial judgment, his Honour observes that *'the practising medical profession's traditional view in favour of ordinarily administering adrenaline to asthmatics in extremis was likely a predominant view in the profession [in 2002].'*[54]

    b. From this recognition of a preference for adrenaline in 2002, his Honour finds there has since been *'a shift in the extent of that preference'* for adrenaline, and while there is still a credible body that prefers adrenaline, *'there is also a credible body of medical practitioners who regard salbutamol as an at least equally preferable drug to administer to asthmatics in extremis.'*[55]

    c. Up to that point in the trial judge's reasoning, all that has been observed is that the extent to which adrenaline is preferred by medical practitioners (note: not ambulance officers) is lower in the present day than it was in 2002. His Honour, despite acknowledging the expert medical practitioners did not focus in any detail on the timing and degree of the shift in preferences in clinical practices, concludes there were *'credible views in 2002 favouring the equivalent utility of salbutamol for asthmatics in extremis.'*[56]

72. It is unclear upon which basis the trial judge eventually promotes the finding of those *'credible views in 2002'* to the ultimate conclusion that a *'responsible body of opinion in the medical profession'* existed at the time of the incident. His Honour mentions that the traditional view would not have precluded the use of salbutamol if the patient's condition called for it,[57] but this falls well short of demonstrating that a *'responsible body'* in 2002 preferred to use salbutamol for treating asthmatics in imminent arrest if they had a high heart rate and blood pressure.

73. The lack of a responsible body of medical opinion favouring salbutamol in 2002 is further evidenced by the terms of the CPM which favour the use of adrenaline in severe asthma attacks, even when the patient is tachycardic and hypertensive.[58]

74. The Court of Appeal recognised the trial judge's unjustified leap in logic and found that no relevant body existed in 2002.[59] The Appellant in its submissions does not address this logical incongruity in the trial judgment.

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[54] CAB p 20 [56].
[55] CAB p 20 [55].
[56] CAB p 20 [56].
[57] CAB p 20 [57].
[58] CAB 98-99 [160].
[59] CAB pp 98-99 [160].

75. Breach being a prospective inquiry (ie examining reasonable foresight as at the occasion for the exercise of the duty) which must not benefit from the wisdom of hindsight,[60] the standard practices that some specialist physicians have allegedly adopted after the event are not to be applied retrospectively. It was correct for the Court of Appeal to overturn the trial judge's second erroneous finding and, whilst it is inconsequential to the issue of liability, the first ancillary question – the Appellant's third issue – should be answered in the negative.

Second ancillary question: *In responding to an emergency that was contemplated by their clinical practice manual, should ambulance officers be allowed to rely upon a body of specialist physician opinion which deviates from the opinion of their State authority?*

76. Even if the first ancillary question is answered in the Appellant's favour, and a responsible body of medical opinion validating the use of salbutamol is found to have existed in 2002, the second ancillary question, raised in the fourth issue of the Appeal, should be answered in the negative, even if it is irrelevant to liability in the present case.

77. In his treatment of Ms Masson, there is no evidence that Mr Peters was aware of any opinion about adrenaline other than what he believed to be that of the QAS. His misunderstanding of the CPM led him to believe that the QAS prohibited the administration of adrenaline to patients who were not bradycardic.

78. Mr Peters has never claimed to have referred to any external body of opinion, let alone an opinion of medical practitioners specialising in emergency medicine, as a basis for his decision-making. The Appellant's arguments at paragraphs 63 to 65 are completely unsupported by the evidence. As discussed above, Mr Peters initially had the only mindset a reasonable ambulance officer would have had; to treat Ms Masson according to how his State authority, the QAS, believed she should be treated. His initial reasonable mindset was unfortunately corrupted by a misunderstanding of the true opinion of the QAS about adrenaline.

79. As this is not a case of an ambulance officer intentionally disregarding his or her State authority's opinion in favour of an outside body's opinion, the fourth issue raised in the Appeal is moot.

80. The Court of Appeal held in obiter that, even if he had been aware of a responsible body of medical opinion external to the CPM, and followed it instead of the true opinion of the QAS, Mr Peters would still have been negligent.[61]

81. In paragraphs 66 to 70 of its submissions, the Appellant calls into question the correctness of the Court of Appeal's finding on this hypothetical case. It argues that the CPM is not determinative of the breach issue, and whether it is followed or not is

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[60] *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330, 354 [65] (Gummow J).
[61] CAB p 99 [163].

immaterial if the ambulance officer's action is supported by a responsible body of medical opinion.[62]

82. The Respondent agrees that the CPM cannot be determinative of the breach issue. Indeed, there is no suggestion that Mr Peters was in breach merely because he failed to treat an asthmatic in imminent arrest with the drug preferred by the QAS. However, in the present case, where the terms of the CPM mirrored the reasonable standard at common law, and the actions of a reasonable ambulance officer would have been to administer the preferred drug adrenaline, the failure to follow the CPM coincided with the failure to take reasonable care.

10 83. It was correct for the Court of Appeal to find that Mr Peters would still have been in breach if he had followed the opinion of an external body instead of the opinion of the QAS.

84. This is the only sound position to take on this hypothetical issue, in view of the difference in care and skill to be expected of an ambulance officer compared to that expected of a specialist in emergency medicine. Both lower courts referred to the New South Wales Court of Appeal judgment in *Ambulance Service of New South Wales v Worley* [2006] NSWCA 102, in which Basten JA (with whom Tobias and McColl JJA agreed) said:

> '[29] Ambulance officers are not medical practitioners, let alone specialists in
20 emergency medicine. Their training is by no means insignificant, but it does not equip them with the theoretical knowledge which would permit a fine evaluation of alternative treatments...
>
> [30] Perhaps surprisingly, and not including the treating medical practitioners, each party at trial called five medical specialists, whose evidence was directed mainly to the question of what was accepted medical and pharmacological practice in relation to the administration of adrenaline in 1998. Without objection, experts in emergency medicine discussed their own practices in well-equipped teaching hospitals, with far less attention being given to the position of ambulance officers and the nature and
30 purpose of the protocols which governed their conduct.'

85. By virtue of the finite resources in society, emergency services cannot send specialists in emergency medicine out into the field to respond to every emergency. Instead, ambulance officers equipped with instructions and guidance from manuals such as the CPM are entrusted to respond to emergencies and stabilise patients enough for transport to a hospital. They do not have the education, training and experience to make fine professional judgments that depart from the guidance of their manuals.[63] Ambulance officers cannot be expected to study – and should be discouraged from

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[62] Appellant's Submissions, paragraphs 69 and 70.
[63] CAB p 97 [148].

studying – competing bodies of medical opinion, as they are not competent to make an assessment of their respective merits.[64]

86. It would have been a different matter entirely if the QAS had instead decided to send an emergency medicine physician into the field to treat Ms Masson. In those circumstances, the reasonableness of the physician's assessment of the alternative treatments for Ms Masson would have been relevant to liability.

87. It is remarkable that the Appellant is challenging the Court of Appeal's conclusion on this second ancillary question, given the potential consequences it could have on the State authority's functioning. By allowing ambulance officers to consult external bodies of medical opinion which compete with their manuals, they would be afforded a discretion not commensurate to their education and experience. The ability of emergency services such as QAS to regulate ambulance officers' conduct through the manuals would be severely diminished, and the state of the law would encourage ambulance officers to research matters of medicine in which they have insufficient relevant expertise.

88. Answering the second ancillary question in the Appellant's favour would not change the outcome for liability in the present case, but it may nevertheless have far-reaching consequences. For example, in the recent Queensland flood class action, Beech-Jones J in the New South Wales Supreme Court found breach on the basis of the failure by engineers to comply with their flood mitigation manual.[65] It was held that the appropriate response of the reasonably competent flood engineer was to *'conduct flood operations in accordance with the Manual irrespective of their own preferences and views about how flood operations should be conducted.'*[66]

89. Should the Court in the present case find that ambulance officers may reasonably deviate from their manuals and instead follow their preferred competing body of medical opinion, it would raise questions about why flood engineers – who were much more qualified than ambulance officers to hold views that departed from their manual (and in fact were involved in the manual's drafting)[67] – could not reasonably deviate from the flood mitigation manual without breaching their duty.

90. The Appellant should not be allowed to escape liability in the future if an ambulance officer chooses to follow an opinion external to the one expressed in their clinical practice manual. It would disincentivise State emergency services from preparing manuals that comprehensively cover widely-accepted medical opinion.

91. If an ambulance officer without the same expertise as the medical experts who draft the manual could intentionally choose an external body's opinion over his State

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[64] CAB p 99 [161].
[65] See *Rodriguez & Sons Pty Ltd v Queensland Bulk Water Supply Authority trading as Seqwater (No 22)* [2019] NSWSC 1657, Chapter 12 at [2] – [11] (Beech-Jones J).
[66] *Rodriguez & Sons Pty Ltd v Queensland Bulk Water Supply Authority trading as Seqwater (No 22)* [2019] NSWSC 1657, Chapter 12 at [6].
[67] *Rodriguez & Sons Pty Ltd v Queensland Bulk Water Supply Authority trading as Seqwater (No 22)* [2019] NSWSC 1657, Chapter 12 at [11].

authority's, the expense and inconvenience incurred in preparing and updating the manuals would no longer have the same legal justification. This would potentially leave the patients in the hands of under-informed ambulance officers, free to follow outside medical opinions of their probably unsophisticated choosing without any consequences for actions that cause tortious damage.

92. For these reasons, this Court should answer the second ancillary question in the negative. However, even if it does not, the Appellant remains liable in the present case.

Part VI:

10 93. Not relevant.

Part VII:

94. It is estimated that the oral argument for the respondent will take no more than one and a half hours.

Dated: 3 February 2020

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ANNEXURE A

The following statute is referred to in the Written Submissions of the Respondent:

Ambulance Service Act 1991 (Qld) – Reprinted as in force on 15 March 2002 (includes amendments up to Act No. 76 of 2001)