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

APPELLANT'S SUBMISSIONS

Part I:

1. I certify that this submission is in a form suitable for publication on the internet.

Part II:

2. This Appeal raises the following issues:

   (a) Whether the Queensland Court of Appeal erred in overturning the trial judge's conclusions that the attending ambulance service officer, Mr Peters, had considered the administration of adrenaline in accordance with the Clinical Practice Manual and then in finding that Mr Peters had not done so[1]?

   (b) Did the Clinical Practice Manual by calling for "consideration" of adrenaline require the use of adrenaline in Ms Masson's presenting circumstances so that Mr Peter's failure to do so was (necessarily) a causative breach of duty?

   (c) Whether the Queensland Court of Appeal erred in overturning the trial judge's conclusions to the effect that there was a responsible body of opinion in the medical profession in 2002 to support the administration of salbutamol to a

1 Core Appeal Book ("CAB") pp 97-98 [151], [153], [154]

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patient with Ms Masson's high heart-rate and high blood pressure and in so doing finding that such a conclusion was not supported by the evidence[2].

(d) If there was a responsible body of opinion in the medical profession in 2002 to support the administration of salbutamol to a patient with Ms Masson's high heart-rate and high blood pressure, whether it was correct for the Queensland Court of Appeal nonetheless to conclude that Mr Peter's was negligent to act in accordance with it because, to do so, was not in accordance with the Clinical Practice Manual?

Part III:

3. The appellant certifies that it has considered whether any notice should be given to the Attorneys-General in compliance with s.78B of the *Judiciary Act* 1903 (Cth) and has concluded no such notice need be given.

Part IV:

4. The primary judgment medium-neutral citation is *Masson v State of Queensland* [2018] QSC 162.

5. The Supreme Court, Court of Appeal judgment medium-neutral citation is [2019] QCA 80.

Part V:

7. On 21 July 2002, Jennifer Masson ("Ms Masson") was 25 years old and living in Cairns. She had a history of severe asthma, requiring hospitalisation on a number of occasions. Whilst at a private residence, Ms Masson complained of shortness of breath and shortly after, collapsed.

8. The Queensland Ambulance Service ("the ambulance service") was called at 22.52, and ambulance officers were at the scene at 22.58, six minutes later[3]. On arrival Mr Peters noticed Ms Masson lying supine on the grass while a male performed external

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2 CAB pg 99 [164], [165]
3 CAB pg 8 [7]

compressions on her[4]. She was in respiratory arrest[5]. Her respiratory rate was recorded as only 2 retracted (laboured) breaths per minute[6]. Her blood pressure was high and she had a very high heart beat (150 beats per minute)[7]. Mr Peters concluded Ms Masson was "hypoxic and deprived of oxygen and required oxygen immediately"[8]. She was ventilated and an intravenous cannula applied to her elbow pit for the administration of intravenous drugs. One minute after arrival (at 22.59) Mr Peters commenced administering intravenous salbutamol[9].

9. The administration of salbutamol appeared effective, and the Trial Judge found it was reasonable to think salbutamol was having a positive effect.[10] Ms Masson's respiration improved and the apparent improvement in symptoms continued through to and beyond the point when she was loaded into the ambulance and transportation commenced[11]. Shortly after departure, at 23.14, the ARF records she had a regular pulse rate of 94, improved but still high blood pressure, a respiratory rate of 14 which was still retractive and her colour was normal rather than cyanosed[12].

10. It was not until 23.17 that her condition deteriorated[13].

11. Attempts were made to revive Ms Masson and she was ultimately delivered to the Cairns Base Hospital ("the Hospital"). There was no evidence that the ambulance service knew, or ought to have known, Ms Masson's medical history.

12. At the Hospital, Ms Masson was profoundly unconscious. Ms Masson at no time regained consciousness but survived at home in New South Wales for 13 years. She passed away in February 2016.

13. During her life-time, Ms Masson instituted proceedings against the ambulance service (represented by State of Queensland) for negligence. Commencing 12 February 2018, her surviving damages claim was tried in the Queensland Supreme Court at Cairns, before Henry J. It was a 9 day trial where the only issue was liability.

14. Ms Masson's case was that the ambulance officers ought to have administered adrenaline immediately upon, or shortly following, attendance on her because this was what the ambulance service Clinical Practice Manual ("CPM") and accepted medical practice required.

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4 CAB pg 8 [9]
5 CAB pg 8 [10]
6 CAB pg 9 [10]
7 CAB pg 9 [10], [11]
8 CAB pg 9 [12]
9 CAB pg 9 [12]
10 CAB pg 26 [79]
11 CAB pg 10 [15], [17]
12 CAB pg 10 [17]
13 CAB pg 10 [19]

15. The defence position was that the CPM required a clinical assessment of Ms Masson's condition, followed by "consideration" of clinical signs and pharmacology, in particular, but not mandating, the administration of adrenaline, and that both the CPM, and another body of respectable medical opinion in 2002, supported the use of salbutamol for Ms Masson.

16. Henry J determined[14]:

    (a) the required "consideration" of adrenaline under the CPM had occurred with Mr Peters deciding to administer salbutamol in light of Ms Masson's clinical state, and his knowledge of the risks of adrenaline[15];

    (b) breach was not made out, because the CPM requirements were met (see CAB pg 44 at [151]) and because of the support for Mr Peters' actions by a responsible body of medical opinion[16] (notwithstanding the existence of another body of opinion opposed to Mr Peters' actions);

    (c) that there existed in 2002 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[17].

17. On 10 May, 2019, the QCA (Fraser and McMurdo JJA, and Boddice J) overturned the trial judge's decision.

18. The QCA ruled that:

    (a) the trial judge's finding that Mr Peters did give the required "consideration" to adrenaline was not supported in the evidence: CAB pg 80 at [65];

    (b) since the CPM content was significant as evidence of the required standard of care, it would not be consistent with the exercise of reasonable care for an ambulance officer to depart from the guidance of the CPM (even if that coincided with a responsible body of medical opinion);

    (c) there was no responsible body of medical opinion to support Mr Peters' actions;

    (d) accordingly, breach of duty of care was made out.

Part VI:

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14 The central finding is at CAB pg 45 [155]
15 CAB pg 44 [148]
16 CAB pg 29 [93] and CAB pp 44-5 [151-152]
17 CAB pg 29 [93]

First Issue: *Whether the Queensland Court of Appeal erred in overturning the trial judge's conclusions to the effect that the attending ambulance service officer, Mr Peters, had considered the administration of adrenaline in accordance with the CPM and then in finding that Mr Peters had not done so?*

The Trial Judge

19. The ultimate finding of the trial judge is at CAB pg 44 [148]:

> "On a careful consideration of the whole of Mr Peters' testimony I am satisfied he did make such a clinical assessment (that the use of adrenaline in a tachycardic, hypertensive patient might make matters worse: see CAB pg 44 [147]), considering the possibility of administering adrenaline, deciding not to administer it because of the risk of serious adverse reaction to it raised by the presence of tachycardia and hypertension and instead deciding to administer Salbutamol ..."

20. The trial judge's reasons for concluding as he did were:

(a) Mr Peters' experience and expertise as an ambulance officer which, in 2002, relevantly included six years volunteer service, full-time ambulance officer service since 1996, qualification as an Intensive Care Paramedic in 2001, a successful history of ongoing training and assessment (QCAR pg 104: Trial Exhibit 1), his authorisation to administer salbutamol (from 1996) and adrenaline (from 2000), and Mr Peters' testimony that his training included use of the CPM: see CAB pg 39 [132];

(b) Mr Peters' testimony of having assessed Ms Masson's clinical presentation, including that she was hypertensive (high blood pressure), tachycardic (rapid heart rate), and had an altered level of consciousness, which presentation led Mr Peters "fairly convincingly" to the fact that Ms Masson required immediate pharmacological intervention utilising salbutamol: see CAB pp 39-40 [133];

(c) Mr Peter's evidence that had Ms Masson initially presented as bradycardic/hypotensive he "would have been straight into adrenaline"[18]. His evidence was that Ms Masson's presenting vital signs precluded the administration of adrenaline[19];

(d) At a later time, responsive to different clinical signs (principally, bradycardia[20]), Mr Peters administered adrenaline, demonstrating an awareness of the

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18 CAB pg 43 [145], pg 44 [147]
19 CAB pg 42 [145]
20 A Slow heart rate, less than 60 bpm

availability of adrenaline and salbutamol for treatment of severe asthma, depending on patient presentation: see CAB pp 40-41 [136 – 7], also CAB pp 43-4 [146][21];

(e) Commencing at CAB pg 41 [140], Henry J considered aspects of Mr Peters' evidence which supported the Respondent's submission that, in the initial treatment phase, administration of adrenaline was not considered at all[22]. This included a witness statement by Mr Peters of 5 July 2009;

(f) However, the trial judge also referred to and carefully considered contrary factors, including:

(i) Mr Peters' witness statement was given seven years after the events, was the product of "legal forum and review", used language at odds with the CPM[23], and suggested a proscriptive approach which was not the approach of the CPM: see CAB pg 42 [144] – this caused "reason to doubt" whether the statement accurately reflected the clinical decision-making, in fact, taken by Mr Peters in 2002: see CAB pg 42 [144];

(ii) Some of Mr Peters' initial treatment of Ms Masson was the very treatment contemplated by that part of the CPM to the right of the first diamond: see CAB pg 42 [144];

(iii) Other parts of Mr Peters' testimony supported that the required consideration had occurred (see CAB pp 42-3 [145]).

21. The trial judge's conclusion was plainly open to him on the evidence as a whole.

The Court of Appeal

22. The Court of Appeal's consideration of this topic commenced at CAB pg 73 [40], continuing to [66], where the Appeal Court expressed its ultimate finding that:

> " … The trial judge erred in finding that Mr Peters made the clinical assessment which his Honour described at [148] of the Reasons. The finding was not only

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21 "… It is clear however that Mr Peters well appreciated that Salbutamol and Adrenaline were potential pharmacological options in treating an asthma attack …"

22 Henry J's assessment of the factors in favour of, and tending against, the proposition continued until CAB pg 44 [149].

23 For example, "protocol", a term not used in the Clinical Practice Manual: see CAB pg 42 [143].

inconsistent with the 2009 statement by Mr Peters, it was also inconsistent with his oral evidence."

23. In support of this at [65] the Appeal Court stated[24]:

> "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".

24. It is literally correct that one does not see that precise formulation of words used in Mr Peters' evidence. But the evidence as a whole shows Mr Peters chose to use salbutamol and not adrenaline because of the risks of the latter and the presentation of Ms Masson. This is the very 'consideration' that the trial judge identified and made a finding about.

25. Mr Peters administered salbutamol because (amongst other things) Ms Masson was hypertensive and tachycardic[25]. Further, Mr Peters said, had Ms Masson initially presented as bradycardic/hypotensive he "would have been straight into adrenaline"[26]. The administration of adrenaline in the ambulance on the way to the hospital occurred because of her change of condition to one of bradycardia where Ms Masson was or was about to be hypotensive[27]. The decision first to apply salbutamol, then to apply adrenaline, involved judgments based upon Ms Masson's presenting circumstances and Mr Peters' knowledge of the side effects of adrenaline (to which we shall return). Mr Peters did not give evidence describing his processes employing the language formulated by the Court of Appeal in paragraph [65] of its reasons, but the plain inference from the evidence given is that Mr Peters' judgment was based on the "potential benefits and adverse effects" of the respective possibilities. As Henry J found, "It is unsurprising in light of the expert evidence discussed above that the presence of a high heart rate and high blood pressure was influential in the determination of the initial pharmacology"[28].

26. The Court of Appeal set out passages of Mr Peter's statement of 2009[29] and reasoned that the statement was carefully considered, unambiguous that the administration of adrenaline was not permitted by the CPM, and a misstatement of the effect of the CPM: see CAB pg 74 [43]; pg 80 at [61]; and pg 80 [61], also CAB pg 74 [43].

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24 CAB pg 80
25 CAB pp 74, 75 [44]
26 CAB pg 43 [145], pg 44 [147]
27 CAB pg 75 [45]
28 CAB pg 41 [138]
29 CAB pg 73 [41] and pg 74 [42]

27. However, the Court of Appeal did not have the trial judge's advantage of hearing all the evidence and, in particular, Mr Peters. The trial judge recognised the tension between the suggestion in the statement of something being prohibited (not permitted at all) and Mr Peters having undertaken a consideration of the administration of adrenaline or salbutamol. But his Honour resolved that after a careful consideration of the evidence.

28. The trial judge had regard (as he was entitled to do) to the evidence of Mr Peters to the effect that he considered adrenaline but concluded it should not be administered because Ms Masson was tachycardic and hypertensive[30].

10 29. The trial judge's approach (which was plainly open on the material before him) was that:

(a) the CPM required "consideration" of the pharmacology[31];

(b) the effect of the guideline for Imminent Arrest was not to require the administration of adrenaline but to permit administration of salbutamol in circumstances where Mr Peters reasonably assessed that Ms Masson was being responsive to salbutamol, and was not showing clinical signs of imminent cardiac arrest or anaphylaxis[32];

(c) a respectable body of medical opinion supported that the CPM could have this effect[33];

20 (d) this interpretation of the CPM was consistent with Mr Peters' actions "on scene" in 2002, and was able to be reconciled with his written, and oral, evidence[34].

30. This was a principled approach which was evidence-based, and which ought not to have been overturned by the Court of Appeal. Having done so is contrary to the guidance given by this court in *Fox -v- Percy*[35] and other authorities.

Second Issue: *Did the CPM by calling for "consideration" of adrenaline require the use of adrenaline in Ms Masson's presenting circumstances so that Mr Peters' failure to do so was (necessarily) a causative breach of duty?*

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30 CAB pg 39 [140]
31 CAB pg 44 [151]
32 CAB pg 44 [151], CAB pg 41 [138], CAB pg 40 [133], and CAB pg 28 [90]
33 CAB pp 28-9 [90 – 93]
34 CAB pg 44 [148-149]
35 (2003) 214 CLR 118

31. The Respondent's case was that Mr Peters should have "considered" adrenaline; that what fell for consideration was not whether adrenaline ought to be administered but rather how adrenaline should be administered[36]. This interpretation was rejected by the trial judge[37], who found that the word "consider", when used against drug names in the flowchart, means "consider" the administration of the named drug, not "administer" the drug[38]. Henry J accepted the evidence of Mr Hucker that the fact that adrenaline was referred to did not mean that it had to be used: there remained an element of judgment to be used by the ambulance officer[39]. The word "consider" indicated that it remained for the ambulance officer to exercise professional judgment[40].

32. However, McMurdo JA found that the CPM was not relevantly ambiguous (CAB pg 98 [159]; that the exercise of reasonable care required the ambulance officer to be guided by the CPM (CAB pg 99 [161]); that the CPM made sufficiently clear that adrenaline was the preferred drug in order to achieve a fast and effective dilation of the bronchial passage, so as to avoid death or the permanent effects of deprivation of oxygen to the brain (CAB pg 99 [162]); and that, in approaching the manual in that way, "consideration" meant, in effect, that the "preferred drug" (adrenaline) had to be applied (CAB pg 99 [162])[41].

33. This approach was, with respect, incorrect. It overlooked the role of the CPM as something, in its own terms, less than proscriptive: a "guide"; "to assist in patient management"; and "to guide all officers in considering appropriate patient care options"[42]. It also is difficult to reconcile with the definition of the term "Consider" in the CPM, referred to by the Court of Appeal earlier in its Reasons[43]. In the Glossary of Terms in the CPM, "Consider" was defined as follows:

> "When this term is used it implies that the ambulance officer has to make a judgment regarding application of the following treatment modalities based on potential benefits and adverse effects. It does not imply that the following

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36 CAB pg 37 [122]

37 CAB pg 38 [125], pg 39 [128]

38 CAB pg 39 [128]

39 The observations of Henry J as to the meaning of the words "consider adrenaline" are at CAB pg 37-39. His acceptance, relevantly, of the evidence of Mr Hucker is at CAB pg 36-37, [119], [120]

40 CAB pg 37 [122]

41 These findings of the Court of Appeal are difficult to reconcile with the views expressed by the Court at CAB pg 70 [22]-[23], where the Court agreed with the trial judge's interpretation as to the meaning of "[c]onsider adrenaline", holding that this required the officers to consider whether to administer adrenaline (and if so how), rather than compelling its administration in some form in every case of imminent arrest.

42 Henry J, Reasons CAB pp 29-30 [95], [96], [98], CAB pp 38-39 [126] – [130]

43 CAB pp 70-71 [24]

treatments are automatically appropriate or sanctioned. Consultation should be used if doubt exists": see QCA Reasons [24]: CAB pg 71.

34. The approach of the Court of Appeal is to give a proscriptive effect to the CPM which the CPM did not, in terms, purport to have.

35. Paramedics are required to exercise clinical judgment in the treatment of patients. So much is recognized by the fact that the Manual is a "guide". The better view is the view consistent with the evidence of Mr Hucker; "The QAS guidelines are designed to be flexible and used by well-educated paramedics practicing sound clinical judgment for the many various ways a patient can present with a disease or injury"[44]. Hence, Henry J correctly found (at CAB pg 37 [120]):

> "The following of the right arrow invites consideration of the option of administering adrenaline, it does not mandate that it must be administered. The fact that it was not administered does not per se indicate the asthma guideline was not followed or that there was an underestimation of Ms Masson's condition"

36. There are other supporting indications that this is the correct construction or approach to be given to the CPM:

a. The adrenaline drug data sheet (B-5,6) lists various indications and includes "Bronchospasm unresponsive to salbutamol." On the face of the drug data sheet, this introduced, at least, the availability of salbutamol as a treatment option for Ms. Masson (if not a trial of, and consideration of the patient response to, salbutamol).

b. The drug data sheet for adrenaline list side effects. The serious risk posed by one potential side-effect, tacahyarrythmias, is emphasized at B6 of the adrenaline data sheet by a notation: "Caution: The use of adrenaline may lead to hypertension, stroke, MI or a life-threatening arrhythmias"

37. The approach of the Court of Appeal to the interpretation of the Manual, and to its application to the issue of the discharge by Mr Peters of his duty of care, had the effect of obscuring an underlying issue of causation critical to the Respondent's case, namely, "would Mr Peters have administered adrenaline had he "considered" it?[45]" There was no direct evidence that, had Mr Peters "considered" adrenaline, he would have applied it: indeed, his process of reasoning in respect of the application of

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44 Hucker Exhibit 18 para 7(h): Appellant's Book of Further Materials ("AFM") p272, set out in the Reasons of Henry J at CAB pp 36-7 [119]; see also Mr Kenneally AFM pp 299-300, T4-80 ll 35-40, T4-81

45 : "Proof of the causal link between an omission and an occurrence requires consideration of the probable course of events had the omission not occurred": *Strong v Woolworths Ltd* (2012) 246 CLR 182 at [32]. The issue is "approached by applying common sense to the facts of the particular case": *Hunt and Hunt Lawyers (a firm) v Mitchell Morgan Nominees Pty Ltd* (2013) 247 CLR 613 at [43]

salbutamol shows he would not have applied adrenaline[46]. Unless the CPM is construed and applied in the proscriptive way adopted by the Court of Appeal, the Respondent has not proved that, had Mr Peters considered adrenaline, he would have applied it, thus avoiding Ms Masson's injuries.

Third Issue: *Whether the Queensland Court of Appeal erred in overturning the trial judge's conclusions to the effect that there was a responsible body of opinion in the medical profession in 2002 to support the administration of salbutamol to a patient with Ms Masson's high heart-rate and high blood pressure and in so doing finding that such a conclusion was not supported by the evidence ?*

10 38. While the ultimate issue is whether the appellant exercised reasonable care and skill in the provision of the paramedic services, it is plainly highly relevant that the clinical judgment made was one which was supported by a responsible body of the medical profession. [47]

39. The Court of Appeal (it is submitted wrongly) rejected and reversed the trial judge's conclusions that there was a responsible body of opinion in the medical profession to support the administration of salbutamol to a patient with Ms Masson's high heartrate and blood pressure. Indeed the Court of Appeal stated that such a conclusion was not supported by the evidence (QCA Reasons CAB pg 99 [164] & [165]).

The Trial Judge

20 40. There were six medical experts[48] called to give oral evidence, who between them had provided 20 reports[49] tendered before the trial judge. They were examined and cross examined over a total of five days[50].

41. Henry J's treatment of the expert medical evidence was extensive. It commenced at [44] until [93]:

> "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

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46 Henry J, Reasons CAB pg 40 [133]. There was no relevant finding on this issue by the Court of Appeal (except to find that Mr Peters did not "consider" adrenaline prior to Ms Masson's cardiac arrest).

47 *Rogers -v- Whitaker* (1992) 175 CLR 475; *Naxakis v Western General Hospital* (1999) 197 CLR 269; see also *Piwonski v Knight* (2002) 83 SASR 400, on appeal [2003] SASC 169 (appeal dismissed).

48 For the plaintiff: Dr John Vinen, Professor Gordian Fulde, and Professor John Raftos; for the defendant: Professor Anthony Brown, Associate Professor Rob Boots, and Associate Professor Geoffrey Ramin.

49 Dr Vinen – three reports (Exhibit 4: AFM pp 13-56); Professor Fulde – five reports (Exhibit 8: AFM pp 84-123); Professor Raftos – four reports (Exhibit 9: AFM pp124-161); Professor Brown – three reports (Exhibit 10: AFM pp 162-213); Professor Boots – three reports (Exhibit 12: AFM pp 214-240); and A/P Ramin – two reports (Exhibit 17: AFM 241-264).

50 Days three, five, six, seven, and eight.

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."

42. His Honour returned to the topic at CAB pg 44 [150] to CAB pg 45 [155].

43. His Honour's finding was, it is submitted, well-founded. The evidence included –

c. Professor Brown (Exhibit 10 at page 402)- "I find no fault with this care. I say this with absolute confidence as there is no medical evidence published anywhere in the world that shows adrenaline IV has any absolute, or relative beneficial outcome effects over and above nebulised or intravenous salbutamol in severe or critical asthma". [51]

d. Professor Boots (ex 12 Page 474 to 475) - "For a pure respiratory arrest which is what Ms Masson suffered, certainly adrenaline is a reasonable but not the only possible therapy. I have reviewed this literature recently (Holley AD, Boots RJ. Management of Acute and Near Fatal Asthma. Emergency Medicine Australia. 2009: 21:259-268) and on balance IV salbutamol and IV adrenaline are at least equivalent and indeed there is literature to support greater adverse reactions with adrenaline." [52]

e. Associate Professor Ramin (Exhibit 17 page 538): "Regarding whether adrenaline should have been used at this time it should be noted that just like with salbutamol there is no conclusive evidence for its use in such circumstances. There is no evidence that it alters outcome or improves survival in the setting of severe life-threatening asthma. Some clinicians would use adrenaline preferentially under such circumstances whilst others would use salbutamol. There is no evidence that one agent is superior to the other and theoretical arguments could be mounted for the use of either"[53].

44. At paragraphs [80] and [83][54] the trial judge referred to the evidence of Professor Brown:

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51 See also Professor Brown's evidence at Exhibit 10, AFM pp 186-7, 200, 202 and 203. See also transcript for Professor Brown at T6.30 LL15-30, T8-30 LL1-10, and T6-31 L36, AFM pp 277, 278, 280

52 See also Professor Boots Exhibit 12, AFM pg 218-219, pg 220. See also Professor Boots transcript T7-20 L40 to T7 – 21 L6, T7 – 21 L37, T7 – 22 L45, T7 – 25 L15, and T7 – 25 LL30-45, AFM pp 287-289, 292

53 See also Professor Ramin Exhibit 17, AFM pg 254, pg 259, and see generally pp 248-250. See also Professor Ramin transcript T7 – 44 LL15-20, and T7 – 40 LL5-10, AFM pp 305-306

54 CAB pg 26; see also [73] at CAB pg 24 and pg 26 [80]

> "Adrenaline is probably the most potent drugs doctors use day to day and at a therapeutic dose, in some people, it can have the feared side effects. Particularly if they are hypoxic or tachyarrhythmias, myocardial infarction, a stroke"....
>
> "You don't give adrenaline to somebody who has got a rapid pulse and a high blood pressure, because it is a dangerous drug that will cause, in the face of hypoxia, a dangerous arrhythmia such as ventricular tachycardia or ventricular fibrillation. And that's why the safety of adrenaline is difficult, and you wouldn't use when somebody still has perfusing rhythm ... that's why salbutamol is given".

10 45. His Honour referred to the evidence of Professor Boots at [85] and [86][55] and found (at [86]) (the finding is not contested):

> "The effect of Associate Professor Boots' evidence was that once a patient has gone into cardiac arrest there is not much to be lost by the use of adrenaline, whereas prior to that point, where the patient is hypoxic as was likely the case here, he explained the administration of adrenaline "can make it worse by stunning the heart into all manner of funny rhythms"."

46. We refer also to the consideration by Henry J of the evidence of Professor Raftos[56] (who accepted in cross-examination that it was reasonable to have used salbutamol); and Mr Kenneally[57]. pg 28 [88] and [89], noting [63].

20 47. The evidence available to and considered by the trial judge established that-

a. The clinical trials and medical literature did not support any absolute or relative beneficial effects for adrenaline IV over salbutamol IV in critical asthma, but did show increased side effects for adrenaline, relative to salbutamol.

b. These risks/benefits supported use of high-dose salbutamol in preference to adrenaline for acute, or severe, asthma.

The Court of Appeal

48. The Court of Appeal's review of the medical evidence commenced at CAB pg 81 [67] until CAB pg 91 [130]. The Court of Appeal addressed the trial judge's findings about the expert evidence commencing at CAB pg 91 [131].

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55 CAB pg 27

56 CAB pg 25 [79], noting also [78]

57 CAB pg 28 [88] and [89], noting [63]. See also Mr Kenneally Exhibit 7 paragraph 15, AFM pg 65 and T4-72 ll 10-15, AFM pg 298

49. The Court of Appeal's consideration of whether there was a responsible body of medical opinion to support the administration of salbutamol was, however, very brief: see CAB pg 99-100, [164]-[167]. The central finding is at [164]:

> "But further, in my respectful opinion, His Honour's finding that there was a responsible body of opinion in the medical profession to support the administration of salbutamol to a patient with Ms Masson's high heart rate and blood pressure was not supported by the evidence".

50. The Court of Appeal stated that: "His Honour did not specifically find that the risks from the use of adrenaline were such as to make the use of salbutamol a reasonable course" (at [133]).

51. This last finding, however, overlooks paragraph [151] (CAB pg 44), where His Honour concluded: "Opting to administer salbutamol in those circumstances was a reasonable response to the known risks"; and also, at [92][58]: "That concern (*that is, we interpolate, the risk that the administration of adrenaline might worsen her condition, see [91]*) provided a logical basis to prefer the administration of salbutamol and, if Ms Masson's condition did not improve, or if it worsened, revert to considering the administration of adrenaline."

52. The Court of Appeal, when addressing the evidence of the medical practitioners called by the Appellant, stated that that "none of them said that upon the premise that adrenaline was the superior drug for the treatment of an asthmatic at immediate risk of cardiac failure and death, that the risk from using an inferior drug was outweighed by the risk of side effects from the adrenaline" (at [165]). However, what was said by the appellant's experts, but seemingly overlooked by the Court of Appeal, was that adrenaline was only superior to salbutamol for treatment of true cardiac standstill (circulatory arrest), or anaphylaxis. Apart from these cases IV salbutamol and IV adrenaline were each reasonable choices for treating acute asthmatics in respiratory arrest and that, with treatment (including salbutamol), progression to cardiac arrest was preventable and certainly, not inevitable.[59]

53. This treatment by the Court of Appeal is plainly against the weight of the evidence. The medical evidence led was given about and in relation to the treatment of Ms Masson as her conditions presented to the paramedics. Ms Masson was not at the time of the initial treatment known to be in cardiac arrest[60]. On the other hand, the evidence demonstrated that myocardial infarction was one potential risk of adrenaline (see, for example, the evidence of Professor Brown and Professor Boots, particularly in

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58 CAB pg 29 [92]
59 See Professor Ramin T7 – 40 LL5-10, AFM pg 305
60 CAB pg 28 [90]

circumstances where the patient was suffering tachycardia and was hypertensive. Hence, the carefully considered finding of the trial judge at [91][61]:

> "On the other hand, her high heart rate and blood pressure were conditions founding a legitimate concern that the administration of adrenaline might worsen her state by plunging her into a dangerous arrhythmia or causing her heart to stop – that is, would heighten the risk of death".

54. It cannot sensibly be said that the medical specialists, in so far as they gave evidence supporting the use of salbutamol, did so without having regard to the context in which the question of salbutamol, or adrenaline, was being debated.

55. The premise relied on by the Court of Appeal at [165], that adrenaline was the superior drug for the treatment of an asthmatic at immediate risk of cardiac failure and death, appears to have been influenced[62] by the respondent's submission, advanced for the first time before the Court of Appeal, that part of the CPM referenced by the Court of Appeal at [30] "does provide support for the [then] appellant's case that Adrenaline was likely to have been the more effective drug for bronchodilation" (at [33]); (and see the reference at CAB pg 99 at [162] to adrenaline being the preferred drug to achieve a *fast* and effective dilation of the bronchial passages).

56. However, that was not part of the plaintiff's evidence at trial, and was not canvassed by the experts' reports, or made the subject of submissions before the trial judge. The trial evidence was that both adrenaline and salbutamol could be effective.

57. The trial judge's approach (which was plainly open on the material before him) was that[63]:

f. The CPM did not require adrenaline to be administered but prompted consideration of the administration of adrenaline;

g. The administration of adrenaline was considered but rejected by reason of the concerning presence of tachycardia and hypertension;

h. The presence of those conditions would have been regarded by a responsible body of opinion in the medical profession as supporting the view that Ms Masson's high heart rate and high blood pressure, in the context of her overall

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61 CAB pg 92
62 CAB pg 72 [30], [32], [33]
63 CAB pg

condition, provided a medically sound basis to prefer the administration of salbutamol to the administration of adrenaline at the time of initial treatment;

i. Opting to administer salbutamol in preference to adrenaline in those circumstances was a reasonable response to the known risks.

58. This was a principled approach which was evidence-based, and which ought not to have been overturned by the Court of Appeal.

Fourth Issue: *If there was a responsible body of opinion in the medical profession in 2002 to support the administration of salbutamol to a patient with Ms Masson's high heart-rate and high blood pressure, whether it was correct for the Queensland Court of Appeal to conclude that Mr Peter's was negligent to act in accordance with it because, to do so, was not in accordance with the CPM?*

59. In the event that this Honorable Court determines that there was a responsible body of opinion in the medical profession to support the administration of salbutamol to a patient with Ms Masson's high heartrate, but that Mr Peters did not "consider" the use of adrenaline or otherwise act in accordance with the CPM, the question arises as to whether Mr Peters was negligent?

60. The Court of Appeal held[64]:

> Had there been a body of medical opinion that adrenaline should not be used in a case such as this, and had Mr Peters been aware of it, and followed that opinion, where adrenaline was the indicated drug according to the CPM, that would have involved a failure to take reasonable care"

61. The Court of Appeal observed[65]:

> "Further, again because of the more limited education, training and experience of ambulance officers compared with medical specialists, it would not be consistent with the exercise of reasonable care and skill for an ambulance officer to depart from the guidance of the CPM ... Unlike the medical specialist, the ambulance officer does not have the requisite competence to make their own professional judgment about the merits of competing views within a field of specialized medical practice."

62. This reasoning is flawed on a number of levels.

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64 CAB pg 99 [163]

65 CAB pg 97 [149]

63. *First*, the observation that, because of the more limited education, training and experience of ambulance officers compared with medical specialists, it would not be consistent with the exercise of reasonable care and skill for an ambulance officer to depart from the guidance of the CPM was not based on evidence. Mr Kenneally, an ambulance officer called by the respondent, gave no such evidence. The trial judge did, however, agree with the reasoning of Mr Hucker, an ambulance officer called by the appellant, who gave evidence that "The QAS guidelines are designed to be flexible and used by well-educated paramedics practicing sound clinical judgment for the many various ways a patient can present with a disease or injury"[66].

64. The CPM calls for the paramedic to make clinical judgements. That is what is encompassed by the expression 'consider'. Mr Peters was a highly qualified paramedic. His clinical judgment was one which coincided with a responsible body of professional medical opinion. While it may be accepted that paramedics are not as highly trained as specialist medical practitioners in various respects, there is no factual foundation for concluding that they are not, or more particularly Mr Peters was not, able to make the reasoned clinical judgment in this case (and in the circumstances the same clinical judgment as would have been made by a responsible body of the medical specialists).

65. *Second*, this is especially so as the reasoning requires that Mr Peters is to be taken to be aware of the relevant body of medical opinion. The CPM calls for the exercise of clinical judgment, and that is in a situation where the paramedic is aware of a body of medical opinion that adrenaline *should not be used* in a case such as this. There is no evidence supporting a conclusion that the only reasonable course is to suspend clinical judgment, put aside that knowledge, and proceed strictly in accordance with a guideline (the CPM).

66. *Third*, the approach of the Court of Appeal leads to the surprising outcome that a paramedic who cannot be required to perform to the (assumed higher) level of clinical judgement of a medical specialist will be held negligent even if he or she does so.

67. The Appellant submits that, contrary to the reasoning of the Court of Appeal, if Mr Peters treated Ms Masson in accordance with a responsible body of opinion in the medical profession, then he did not breach his duty of care to Ms Masson.

68. Mr Peters owed to Ms Masson a duty to exercise reasonable care relevantly in circumstances where what he was seeking to do was to avoid the risk of oxygen deprivation and consequent brain damage, and potentially death. The duty, it is submitted, is a "single comprehensive duty covering all the ways in which [*an ambulance officer*] is called upon to exercise his skill and judgment"[67].

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66 Henry J, Reasons, CAB 34-35, [119] – [121]

67 *Rogers v Whitaker* (1992])175 CLR 479 at 483, quoting *Sidaway v Governors of Bethlam Royal Hospital* [1985] AC 871 at p 893 per Lord Diplock

69. The test of reasonable care is an objective one. The orthodox approach is that a guideline – here the CPM – is not determinative of the breach issue, although it may be relevant in establishing a standard of care[68].

70. Although the CPM may inform the standard of care, an ambulance officer does not owe to a patient a duty to follow the CPM.[69] This, it is submitted, follows logically from the proposition that a failure to follow a guideline is not determinative of the issue of breach[70]. The duty of an ambulance officer is to exercise reasonable care and skill in the treatment of a patient. Assuming the Court finds there was a responsible body of medical evidence which supported the administration of salbutamol, then it is submitted that the court should find that the standard was met. Whether the manual was followed, or not, is material in a secondary, but not in an ultimate sense. Where the manual says one thing, but is not followed, an ambulance officer will not be negligent where his care of the patient meets the standard of an ordinary person exercising and professing to have the skill of an ambulance officer.

Part VII:

Orders Sought

71. That the orders of the Court of Appeal, made on 10 May and 13 September, 2019, be set aside.

72. That in lieu of such orders, it be ordered:

(e) that the Respondent's claim is dismissed, and Judgment be entered for the Appellant.

(f) that the Respondent pay the Appellant's trial costs, and its costs on appeal to the Court of Appeal and to the High Court of Australia, including costs of the Application for Special Leave to Appeal, on the standard basis.

Part VIII:

73. It is estimated that the oral argument will take one day.

Dated: 10 January 2020

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68 CGU Insurance Ltd v Porthouse (2008) 235 CLR 103, 122

69 See Beech-Jones J in *Rodriguez & Sons Pty Ltd v Queensland Bulk Water Supply Authority trading as Seqwater (No 15)* [2018] NSWSC 1019 at [126]: "The Manual is not a vehicle for imposing strict liability."

70 *Rodriguez & Sons Pty Ltd v Queensland Bulk Water Supply Authority trading as Seqwater (No 15)* [2018] NSWSC 1019, Chapter 3: [2], [124], and [126], also *Lowry v Hendry Mayo Newhall Memorial Hospital* 229 Cal 620 (1986).

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