SUPREME COURT OF QUEENSLAND

CITATION:	*State of Queensland v Ringuet* [2020] QCA 61
PARTIES:	**STATE OF QUEENSLAND** (appellant) **v** **LISA ANNE RINGUET** (respondent)
FILE NO/S:	Appeal No 6872 of 2019 DC No 189 of 2014
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	District Court at Southport – [2019] QDC 91 (Muir DCJ)
DELIVERED ON:	3 April 2020
DELIVERED AT:	Brisbane
HEARING DATE:	1 November 2019
JUDGES:	Morrison and McMurdo JJA and Mullins AJA
ORDER:	**Appeal dismissed with costs.**
CATCHWORDS:	EMPLOYMENT LAW – LIABILITY AT COMMON LAW FOR INJURY AT WORK – PARTICULAR CASES – SAFE SYSTEM OF WORK – GENERALLY – where the respondent was employed as a nurse in a mental health unit at a hospital operated by the appellant – where the respondent sustained a back injury and a consequential psychiatric injury as a result of preventing a patient's escape – where the trial judge found the appellant was negligent, by failing to provide a system of work under which, if there was a prospect that a patient would attempt such an escape from the mental health unit because the patient was then in the vicinity of the door in a certain area within the unit, a nurse in the respondent's position could call for the assistance of a security officer as he or she was about to open the door – where the appellant argued that such a system was impractical and would create an unreasonable burden – whether the system identified by the trial judge was a precaution that a reasonable person in the position of the appellant would have taken, within the meaning of s 305B of the *Workers' Compensation and Rehabilitation Act* 2003 (Qld) APPEAL AND NEW TRIAL – APPEAL - GENERAL PRINCIPLES – POINTS AND OBJECTIONS NOT TAKEN BELOW – WHEN NOT ALLOWED TO BE RAISED ON APPEAL – QUESTIONS NOT RAISED ON PLEADINGS

OR IN ARGUMENT – GENERALLY – where the system identified by the trial judge was acknowledged by the judge to be more confined than what was broadly pleaded and ultimately argued by the respondent at trial – where the appellant argued that the respondent succeeded on a case which she had not advanced at the trial – where the appellant argued that that further evidence could have been adduced, and submissions made, had this particular case been pleaded and pursued – whether the appellant was deprived of a chance of meeting this basis of liability by not adducing further evidence

Workers' Compensation and Rehabilitation Act 2003 (Qld), s 305B, s 305C, s 305D

COUNSEL: G W Diehm QC, with K S Howe, for the appellant
B Walker SC, with M O'Sullivan, for the respondent

SOLICITORS: McInnes Wilson Lawyers for the appellant
Shine Lawyers for the respondent

[1] **MORRISON JA:** I have read the reasons of McMurdo JA and agree with those reasons and the order his Honour proposes.

[2] **McMURDO JA:** On the morning of 9 August 2012, the respondent was working as a nurse at a hospital operated by the appellant. She was working in the Acute Young Adult Mental Health Unit in which there was a secure area called the Psychiatric Intensive Care Unit ("the PICU"). As she opened the door to the PICU, a young male patient attempted to escape from there. The respondent managed to push back against the door to prevent his escape, before she was assisted by other nursing staff. From this incident she sustained a back injury and a consequential psychiatric injury.

[3] She claimed damages for negligence and breach of her contract of employment. After a five day trial in the District Court she was given judgment in the sum of $326,312.75.[1] The trial judge held that the appellant was negligent, by failing to provide a system of work under which, if there was a prospect that a patient would attempt such an escape from the PICU because the patient was then in the vicinity of the door in a certain area within the PICU, a nurse in the respondent's position could call for the assistance of a security officer as he or she was about to open the door.[2] By this appeal, that finding is challenged and an order is sought for the dismissal of the respondent's claim. There is no challenge to the judge's assessment of damages.

The PICU

[4] At the time of the incident, the respondent was aged 46 and was healthy and fit. After working in other occupations, she had studied nursing for three years until the beginning of 2010, when she obtained a graduate position as a registered nurse at

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1 *Ringuet v State of Queensland* [2019] QDC 91 ("Reasons").
2 Reasons [194].

this hospital. In 2011, she obtained a permanent placement to work in the Acute Young Adult Mental Health Unit.

[5] The unit in which the respondent worked comprised two sections. There was the PICU, which was a unit which was secured by the door being locked, and an area adjacent to the PICU which the trial judge described as the "open side". On the open side was the nurses' station, next to which was a large clear glass window which looked into a communal area in the PICU.

[6] Within the PICU were five bedrooms, including one described as a secure seclusion room, as well as the communal area in which there was a television, lounges and a breakfast bar, and from which there was a door to an outdoor (but secure) courtyard. There was also what was described as a medication room.

[7] The door where the incident occurred was about two metres to the right of the nurses' station and was about 90 centimetres wide. It was a wooden door except for a rectangular section of clear glass, about 15 centimetres in width, which provided some view into the PICU. There was a duress button on the open side to the left of the door. The door from the PICU could not be unlocked without a security pass. No key or security pass was needed from the open side. The door swung into the open side.

[8] The view into the PICU was assisted by a convex mirror, which was positioned on the ceiling adjacent to the nurses' station. It provided some vision of the part of the communal area of the PICU which was near the door to the open side, for a nurse who was at the station, but not once a nurse was standing at the door and about to open it. There were no CCTV cameras anywhere in the PICU other than in the seclusion room.

The incident

[9] The respondent commenced her shift at 7 am on that morning. Staff working here were required to work in pairs, and the other nurse on this shift was Nurse White. As the respondent was opening the door, Nurse White was already in the PICU, working with a patient in the medication room. Nurse White was otherwise occupied, and there is no suggestion that she ought to have been assisting in the respondent's safe entry into the PICU, or that the respondent should have sought her assistance to do so. As was the standard practice, each of them was carrying a duress alarm device. The respondent was unable to use her device during the incident because all of her strength and energy was applied in holding back the door as the patient attempted to escape.

[10] The trial judge made findings of fact, as to the occurrence of the incident, which are now unchallenged and which include the following:[3]

(a) from the nurses' station, the respondent observed this patient, as he sat calmly on a bench in the communal area of the PICU at about 10 am;

(b) the distance from where he was sitting to the door was approximately 15 metres;

(c) from the nurses' station the respondent walked to the door, intending to enter the PICU to perform the task of clearing rubbish from there;

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[3] Reasons [85].

(d) she looked through the small rectangular glass panel within the door as she opened it;

(e) in the period of approximately four seconds from when he was seen by the respondent, sitting on a bench in the communal area, the patient ran across the communal area to the door, and attempted to push through as soon as the respondent had turned the handle from the open side;

(f) using all of her strength through her hands and shoulders, the respondent managed to push the door back and immediately called out for help;

(g) she called for help twice, and on the second occasion two nurses rushed to her assistance from the open side, placing their hands against the door and, for a few seconds, trapping the respondent between them and the door as they did so;

(h) after no longer than about 40 seconds, the respondent was able to manoeuvre herself away from the door, allowing those nurses to take over the struggle with the patient who was subsequently subdued.

[11] In the days preceding this incident, the patient had absconded twice from the hospital. He did so on the morning of 4 August, and again at about 12.30 pm on 8 August, when he went to his mother's house. He was returned to the hospital by his family. After his return to the PICU, he attempted to abscond by grabbing keys from a staff member. All of this was noted in a "Progress Note" by one of the nurses who was on duty in the shift immediately preceding the respondent's shift. This nurse noted that he was showing signs of distress and/or anger as well as psychotic symptoms. She noted that in addition to his history of absconding, he had a history of refusing treatment and frustration about his hospitalisation and involuntary treatment, and he was assessed as having a high risk of aggression and absconding.[4] This nurse recommended him for a further risk assessment.

[12] The respondent's evidence was that she was unaware of the content of that note. She could not recall receiving any information about the patient or being told that an incident had occurred on the previous shift, or more generally of any need to take extra precautions with this patient.[5] The respondent said it was not her practice to check progress notes from the previous shifts. Her practice was that there would be another document, called a handover document, which would be given to the staff commencing the new shift, which would express any particular concerns about a patient. The handover document at the commencement of the respondent's shift on this occasion was not in evidence, because in the usual course it had been destroyed.[6] The trial judge said that it was "most surprising … that the plaintiff was not told of the risk screening tool conducted at 3.00am prior to her shift commencing …". But ultimately her Honour accepted that the respondent did not know of it. The trial judge found, however, that the respondent was aware that this patient had behavioural issues from her previous experience with him, and that the respondent understood him to be a schizophrenic, problematic patient who did not want to be in this unit.[7]

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4 AR 643-644.
5 Reasons [61].
6 Reasons [64].
7 Reasons [65].

[13] Notwithstanding the high risk of this patient absconding, it was not part of the appellant's case that a nurse ought to have been instructed not to go into the PICU at all.[8] The respondent was not provided with any particular protocol or guideline about how and when she should enter the PICU. That was left for the judgment of the nurse, and her Honour found that the respondent's judgment in this case, that she could be safely within the PICU, was a reasonable one and in conformity with such guidelines as were given for the management of the PICU, and all relevant practices and policies.[9]

The respondent's case at the trial

[14] By paragraph 26 of the statement of claim, the respondent pleaded some 20 acts and omissions which ought to have been taken by the appellant as a reasonable employer, to avoid the risk of an injury from an occurrence of this kind. However, her Honour noted that by the end of the trial the respondent's case was confined to 10 matters, as set out in the outline of argument on behalf of the respondent, as follows:[10]

> "(a) The plaintiff should have been provided with clear instructions [guidelines or protocols or risk assessments] as to the safe way to enter the PICU;
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> (b) The plaintiff should have been instructed to ensure and/or request patients back away from the nurses station door when staff entered the unit;
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> (c) The plaintiff should have been instructed to ensure that she never entered the unit prior to communication of her intention to do so with the other nurse on duty in the PICU and that the other nurse observe the entry to ensure that the patient could not attempt to escape during the entry;
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> (d) The plaintiff should have been instructed to ensure that she worked in unison or pairs with the other nurse on duty so that they were both present when entry to the unit was undertaken by one or both nurses only when they both agreed that entry was safe and no patient was in a position to attempt escape from the unit;
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> (e) There should have been a system in place that ensured two nurses but more appropriately and reasonably in the circumstances, a nurse and a strong male nurse or security officer or assistant [the plaintiff and a co-worker] were present at the nurses station door when accessing the locked unit of the PICU or, at the very least, to ensure a system where the two nurses [or nurse and co-worker] could and would observe each other, from their respective positions, at the door and in the medicine room, so that there was an agreed assurance between them that the person entering the locked unit, the strong male co-worker or security officer as vanguard, could do so without

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8 Reasons [70].
9 Reasons [88].
10 Reasons [6].

> the risk that a patient would or could attempt an escape from the locked unit and in doing so pose a risk to the safety of staff, including the plaintiff;
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> (f) The plaintiff should have been instructed to use the convex mirror and trained in its use;
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> (g) The above proposed instructions and system should have been implemented, monitored and enforced by the defendant prior to the subject incident;
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> (h) The patient should have been placed in seclusion pending further review by professional psychiatrists because of his observed behaviour and the risk assessment completed at 3.00am on the morning of his attempted escape;
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> (i) A second convex or other mirror should have been placed opposite the nurses door so that staff could look through the glass window in the door and observe what was outside the door and in the corridor; and
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> (j) There should have been CCTV monitors at the nurses' door allowing staff at the door to see whether entry could be made without the risk of an attempted escape by a patient."
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> (Footnotes omitted.)

[15] One of the appellant's arguments is that the finding of negligence upon which the respondent succeeded was not one which was pleaded or ultimately argued. The respondent argues that the finding was within paragraph (e) of those submissions, which was in the terms of paragraph 26(p) of the statement of claim.

The findings about negligence

[16] As to the case particularised within (a), her Honour noted that this was a broad contention for which it was not said what those "clear instructions" ought to have been.[11] She said that:

> "When pressed, counsel for the plaintiff submitted that the guidelines should have required that there be two nurses one of which included a strong male nurse or a security assistant or another co-worker keeping watch. These steps and a few others are maintained by the plaintiff under separate headings and are discussed below."[12]

Her Honour found that there was no breach of duty as alleged by this particular.[13]

[17] As to the case within paragraph (b), it seemed to her Honour that this argument originated from the fact that after the incident, a notice was placed on the door to the PICU, instructing nurses to ensure and/or request that patients backed away from the door when it was opened. Her Honour was not persuaded that the patient would have complied with such a request and added the further reason that there

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11 Reasons [141].
12 Ibid.
13 Reasons [146].

was no evidence that the patient had been standing behind the door, rather than rushing towards it as the door opened.[14]

[18] The matters argued in paragraphs (c), (d) and (e) were considered together because they related to "nurses working in pairs and unison with each other and others (such as security) as they enter through the PICU door."[15]

[19] For these allegations, her Honour discussed the evidence of other nurses who testified as to the normal practice for staff working in the PICU. Her Honour accepted evidence from one of those witnesses, to the extent that it supported a finding that it was possible for a nurse to observe the location of a patient prior to entering the PICU door without someone else doing it for them.[16] But there were limitations upon that possibility, from the fact that the view through the glass panel in the door was only of what was "directly in front on the other side", and that someone sitting on the breakfast bar bench in the communal area could not be viewed from the entrance to the PICU because of a wall which blocked it from sight.[17]

[20] After a further discussion of the evidence, her Honour found that it was not a "reasonable, practical or necessary precaution for the defendant to have implemented a system that the nurses on duty in the PICU were to be the eyes and ears of each other to the extent agitated by the plaintiff such that one would need to be at the nurses station to watch the other as they entered in and out of the PICU through the PICU door".[18] Her Honour did not accept that it would be a reasonable, practical or necessary precaution for two nurses to have entered the PICU at the same time.[19]

[21] Her Honour was not persuaded by the argument that a "strong male nurse" should have been provided as one of the pair of the nurses working on a shift. She noted that there was no evidence about the ratio of male to female nurses employed at the hospital and most relevantly of the availability of male nurses able to work in this unit.[20] Her Honour noted the imprecision in the requirement that the other nurse be a strong person, and made the indisputable observation that not all men are physically stronger than all women.[21]

[22] Her Honour then turned to the allegation, within paragraph (e) of those submissions, that there should have been a system under which there would be a security officer "as vanguard". She referred to the evidence of a witness, Nurse Calvird, who was the acting nurse shift manager for the ward at the time of this incident, who said this about the suggestion of a security officer being provided:

> "Look, it would have been nice to have, but it's not practical. We – we can't usually get security to be on – present on the ward constantly. It's something we have to get permission from – from our hospital executive to do. It's quite an expensive exercise to do that,

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14 Reasons [150].
15 Reasons [153].
16 Reasons [162].
17 Ibid.
18 Reasons [170].
19 Reasons [171].
20 Reasons [176].
21 Reasons [178].

> and security have got limited resources and they have to call in extra staff if they have people permanently based on a ward."[22]

Her Honour accepted evidence from the same witness that it would be impractical to have a security officer present "on [all of] those occasions when staff have to go into the unit", because the nature of the work was that staff went in and out of the PICU all of the time, so that that would require the presence of a security officer on a full time basis.[23]

[23] Her Honour then turned to another, more limited precaution which might have been in place. It was here that she made the critical finding, the reasons for which were as follows:

> "[191] The defendant submits that the Patient "has impulsively just rushed or run at the door. The employer is not liable for this risk. It is one of the inherent risks of the work. An absence of reasonable care is not responsible for the incident and injury". I reject this submission for two reasons. First, in my view, it is not correct to characterise the Patients conduct as an impulsive act. It was opportunistic but in the circumstances known to the defendant it was not "impulsive" or "spontaneous". Second, I accept the risk of escape was an inherent risk of the work. But the defendant was on notice and well aware of the risk that the Patient would try to escape through the PICU door entrance given the chance. As far I can determine on the evidence, the defendant took no relevant precautions to meet this particular risk.
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> [192] Nurse Calvird conceded under cross examination that when taking into account all of the incidences involving the Patient leading up to the Incident and with the benefit of hindsight it would have been appropriate to take some steps to ensure that staff were protected by having security on the floor. Relevantly he said "Extra staff, whether it's security or nursing, would've been great in any instance. It's always great to have extra staff, but…"
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> [193] I accept Nurse Calvird's evidence that it would have been impractical to have a security person in the PICU all of the time or every time a nurse came in and out of the PICU. I also accept his evidence that it would have been appropriate to take some steps to ensure that staff were protected by having security on the floor. Given what the defendant knew about the Patient at the time, in my view this statement cannot be said to be one made through the prism of hindsight.
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> [194] Upon this analysis, I am satisfied that there was a reasonable and practical precaution available to the defendant to reduce the risk in this case. I find that the defendant ought to have implemented a system in which a security officer was to be called to attend the PICU to assist nursing staff to make safe

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22 Reasons [187].

23 Reasons [188].

> access to the unit on the occasions where at the time the nurse needed to enter the PICU, the Patient was observed [whether in a calm or agitated state] to be in the communal area of the PICU. This system does not require a security officer to be called every time a nurse went into the PICU, only when the Patient was observed to be within the vicinity of the PICU door in the communal area – an area obviously close enough to the PICU door for the Patient to be able to make a run for it.
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> [195] The evidence was that security officers were employed and present at the hospital. In my view such a system would not be too difficult or costly to implement. It would not entail more security needing to be employed. I accept that depending on the availability of a security officer at the time [for example the security officers may be attending to issues elsewhere in the hospital] this system may necessitate the nursing staff waiting a few minutes or even longer, before undertaking the required task in the PICU. But in my view this system was a reasonable and practical precaution to the risk in this case.
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> [196] This precaution is more confined than what was broadly pleaded and ultimately argued by the plaintiff at trial. But at trial there was a reasonable amount of evidence about the issue of the presence of a security guard at the time of a nurse's entry into the PICU. It was also addressed in the defendant's written submissions at trial. It follows and I find that the defendant is not taken by surprise or prejudiced by my finding.
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> [197] There was no evidence about what security officers at the hospital wear, or about the nature of the training they were given. But common knowledge and sense dictates and I find accordingly, that the security officer employed at the hospital would be easily identifiable by a uniform and well trained to deal with emergency situations such as a patient attempting to escape. I am satisfied that if such a system had been implemented, it would have most likely avoided the Incident because the presence of a security officer would have foiled the Patients attempt to make an opportunistic run for the PICU door.
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> [198] It follows and I find that the defendant has breached its duty to the plaintiff by failing to implement such a system."
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> (Footnotes omitted.)

[24] The trial judge rejected the case argued under paragraph (f) about the convex mirror. Her Honour accepted that there ought to have been "a consistent policy and practice about its use". But where this patient had been observed by the respondent, any further instruction and training of the respondent in the use of the mirror to view areas within the PICU would not have been consequential.[24]

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24 Reasons [200]-[201].

[25] As her Honour observed, the case within paragraph (g) added nothing to what had been argued within earlier paragraphs.

[26] As to paragraph (h), under which it was argued that this patient should have been placed in seclusion pending a further review by professional psychiatrists, her Honour accepted evidence from a psychiatrist that the proper approach is to use that facility as a last resort,[25] and in her Honour's view, whilst the evidence established that this patient had a high risk of absconding, he was not an "extreme risk to safety". She noted that his behaviour in the hours leading up to the incident did not indicate any aggression. In particular, her Honour said, there was no evidence of how the patient was behaving at 3.00 am on that morning, when the assessment recorded in the Progress Note was conducted; indeed it was unclear that the patient was awake at the time.[26]

[27] As to the case in paragraph (i), her Honour was not persuaded that it was a reasonable precaution for a second mirror to have been placed opposite the nurses' door so that observations could be made through the glass window in that door, and nor was she satisfied that this would have resulted in this patient being seen to be rushing at the door as he did.[27]

[28] Lastly, her Honour rejected the respondent's argument, in paragraph (j), that the installation of CCTV monitors would have avoided the incident.

[29] Her Honour concluded, for the reasons which I have set out, that there was a reasonable and practical precaution available to the appellant to reduce the risk in this case, namely having a security officer called to the PICU, and that if that had been done, it would have most likely avoided the incident.[28]

[30] There was a plea of contributory negligence, which was premised upon the case, originally advanced for the respondent, that the patient had been crouching behind the door waiting for it to be opened, rather than rushing towards it as he anticipated it would be opened. Given her Honour's findings that the incident occurred in that second way, there was no basis for a finding of contributory negligence.[29]

The appellant's arguments

[31] The first ground of appeal is that the respondent succeeded on a case which she had not advanced at the trial. It is contended that this was unfair to the appellant, whose case was conducted upon the assumption that the claim would be confined to the pleading. The argument emphasises the trial judge's acknowledgement, at [196] of the Reasons, that "this precaution is more confined than what was broadly pleaded and ultimately argued by the plaintiff at trial."

[32] It is submitted for the appellant that further evidence could have been adduced, and submissions made, had this particular case been pleaded and pursued. There could have been evidence going to the likely frequency of the required presence of a security officer, under the system which her Honour found was required. There could also have been evidence which was relevant to the practicality of this system,

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25 Reasons [211].
26 Reasons [208].
27 Reasons [216].
28 Reasons [223].
29 Reasons [225].

including suggested difficulties which could arise from a patient no longer being within the proximity of the door by the time of the arrival of the security officer. There was also the prospect of relevant evidence and submissions directed to the question of what impact such a system could have upon a patient's behaviour.

[33] The appellant was clearly on notice, from the terms of paragraph 26(p) of the statement of claim, of a case that in the circumstances of this incident, including the facts and circumstances of this patient, there ought to have been a system under which a nurse did not enter the PICU without the protection of a security officer standing next to him or her as a vanguard. Notably, the appellant did not address that part of the respondent's case in the evidence which the appellant led from witnesses. Nurse Calvird was a witness called by the appellant, but in his brief examination in chief, he was asked nothing which was relevant to this part of the respondent's pleaded case. His evidence in chief was confined to his witnessing the incident itself and more generally the use which could be made of the convex mirror.[30] Nor was any other evidence called by the appellant to address whether the requirement for the presence of a security officer was a reasonable precaution, having regard to its cost, practicability or any other relevant consideration. As I have discussed, her Honour rejected the case that there should have been a security officer present on every occasion that a nurse went into the PICU, but only upon the basis of evidence which Nurse Calvird gave in cross examination.

[34] Yet it is argued that had the respondent pleaded, in the alternative, the more limited requirement upon which her claim succeeded, evidence would have been led by the appellant to answer it. Beyond the general submissions for the appellant which I have set out, there is no indication of what that evidence might have been.

[35] It may be accepted that this precaution could have involved some extra cost in the operation of the hospital, but it is not apparent there was evidence which could and would have been adduced, to the effect that the extra cost would have made the system one which was prohibitively expensive.

[36] As to whether such a system would have been impracticable, it is not apparent that the resolution of that issue could have been assisted by further evidence. The system would have required a judgment to be made by the nurse about whether the patient's presence in a certain place within the communal area was sufficiently proximate to the door for the nurse to require the assistance of the security officer. But the practicality of that judgment was not materially different from that which was centrally relevant to several parts of the respondent's case. And as to the suggested impracticality of a security officer being called unnecessarily to the PICU, the prospect of that occurring was not something which required any further evidence.

[37] Therefore, it cannot be accepted that the appellant was deprived of a chance of meeting this particular basis of liability by not adducing further evidence.

[38] As to the appellant's not having an opportunity to make submissions about this case at the conclusion of the trial, in my respectful view, her Honour ought to have invited further submissions. But those submissions, presumably, would have been

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30 There was also a written statement by Nurse Calvird, also describing the incident, and to which the trial judge referred at Reasons [81].

those which are now made for the appellant in this Court under the other grounds of appeal. If they are ultimately unpersuasive, no injustice has been caused by those submissions not being put to the trial judge.

[39] For these reasons, this first ground of appeal is not established.

[40] The second ground of appeal[31] contends that the trial judge erred in saying that the appellant had taken no relevant precautions to meet the known risk that this particular patient might attempt to escape. The appellant's submission in support of this ground is that there were precautions in place: there was a PICU with a locked door and a number of ways in which staff could look into the PICU immediately before entering through that door.

[41] The statement in the Reasons which is the subject of this ground of appeal is the last sentence of [191] which is set out above. It is clear that her Honour was not saying that there were no precautions which had been put in place. Her Honour was addressing the question of whether there were any relevant precautions to meet the particular risk which was presented *by this patient* at that time, as distinct from the more general risk of escape by any patient who had been placed in the PICU. No error is demonstrated by this ground of appeal.

[42] It is the third ground of appeal[32] which was most strongly argued for the appellant. It was submitted that there were several difficulties with the system which the trial judge found was required, and it is necessary to discuss each of them.

[43] The first is that the system required a judgment by the nurse as to whether the patient was so proximate to the door that they might be able to make a run for the door to escape through it. It is argued that this would involve an "arbitrary" judgment. It is true that the system would require a judgment to be made by the nurse, as to whether it was safe to enter the door without the presence of a security officer. It is also true that some nurses might be more conservative than others in making that judgment, and that there would be a possibility of error by a nurse in making that judgment. But none of those things meant that this system was inappropriate because it required that judgment.

[44] Next, it is argued that the system would involve a difficulty in instructing staff as to what was expected of them in making such a judgment and the means by which they might make it. As to that, staff would have had to be instructed about the system and of the reasons for it, so that they would understand that they should err on the side of caution. However, the judgment which nurses would have to make could have been explained to and understood by them.

[45] It is said that this judgment "would lack temporal quality" in that the patient might be sufficiently close to the door at one point but not at the time of the nurse's entry through the door. This argument cannot be accepted. This is a criticism that sometimes a security officer would be called where ultimately their presence would be unnecessary. That is a common characteristic of many things which are done, and have to be done, to avoid a risk of injury.

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31 Ground 2(b) in the Notice of Appeal.

32 Ground 2(c) of the Notice of Appeal.

[46] A further but similar difficulty is said to be that a patient might be sufficiently proximate to the door at the time of the nurse's judgment, but not so by the time of the arrival of the security officer being required. More generally, the extent of any time in waiting for the arrival of the officer would depend upon the application by the appellant of sufficient resources so that the relevant risk could be avoided or minimised.

[47] A similar submission is that there would be a difficulty in cases where a request for a security officer was cancelled, because the patient had moved from his proximity to the door, which might then be followed by movement of the patient back after that cancellation. Again, this would not have been an impediment to the success of the system as a risk avoidance measure.

[48] It is said that there was no reason to suppose the risk was confined to when the nurse was attempting to enter the PICU, because the risk would exist "in equal measure" when the nurse was intending to leave it. It is said that therefore a security officer might have to be called twice, if the time between entry and exit did not warrant the security officer remaining at the door. That would hardly be a substantial difficulty in the operation of this system. Further, clearly a nurse inside the PICU would not have the same difficulty in judging the safety of an exit from the unit, because the patient would be on the same side of the door, and more visible.

[49] It is submitted that this critical finding should not have been made without evidence, adduced in the respondent's case, to prove that the burden for the appellant would be any less than the full time presence of a security officer. However, there were differences which permitted an inference that this system would be less burdensome. First, this was a system which was not required for every patient within the PICU, but rather when there was a patient with a particular risk of attempting escape which this patient had. Secondly, it was a system to be applied only where the patient was sufficiently close to the door to be able to make the sudden attempt to escape as this patient did. For these reasons, the number of movements through the door requiring the support of the security officer would be expected to be less than if the officer was required to be present on every occasion, effectively on a full time basis at the PICU.

[50] It is submitted that there was no evidence to show that delays in waiting for security to attend would not be "substantial, individually or collectively, and in turn adversely affect the proper operation of the unit …". It is said that under this system, a security officer could not be demanded as a matter of urgency (unlike where the duress alarm was sounded). As to that submission, there would be some occasions when the security officer's presence could be required urgently. On some other occasions, it would not be urgently required because the nurse could see that there were other things which he or she could do before it was safe to enter the PICU without the assistance of the security officer. It is unlikely that this system would lead to a delay in the performance of a nurse's work. It is more likely that without this system, a nurse would be delayed by having to wait until it was safe to enter the secured area, without the protection of the security officer.

[51] It is submitted that given the lack of evidence as to the frequency of the operation of this system, there was no evidence from which it could be concluded that it would not have placed an undue burden on security staff. As to that, it must be accepted that the system would have added to the work to be performed by security staff,

possibly requiring additional resources to be employed by the appellant. However, that is not to say that it would be so burdensome as to be an unreasonable response to expect from the appellant in the discharge of its duty. The trial judge's reasoning, that whatever would be the extra burden, it would be significantly less than the burden of having a security officer working effectively full time at the PICU, was correct.

[52] It is submitted that under this system, a patient would not have known if a security officer was present, so it would not have been a deterrent to their escape. This submission cannot be accepted. Inevitably, patients would become aware of this use being made of security officers. And even without that awareness, the presence of the security officer would be obvious to the patient as the door opened, at which point the patient might not persist with their attempt to escape.

[53] The remaining difficulty in the operation of this system is said to have been that the nurse would have had to have made a judgment similar to that which was required under the system which was in place. However, the systems would operate differently and would call for a different assessment by the nurse. Under the system which was in place, a nurse with an imperfect view of what was on the other side of the door would have to judge the risk of opening the door in the context of having to get on with his or her work. Under the system which should have been in place, the nurse would have to judge whether there was a chance that it would be dangerous to enter without the safety provided by the security officer.

[54] It is said that her Honour misinterpreted Nurse Calvird's evidence as offering any support for the precaution so found. The relevant statement by her Honour was in [192] of the Reasons. The relevant evidence was in this passage of his cross examination:

> "Now, if we put all that together with the entries that I gave you for the 8th of August and the morning of the 9th of August, can I put it to you that it would've been entirely appropriate to take some extra steps to ensure that staff were protected by having security on the floor?---Well, look, you know, in hindsight, yes, I guess it would be appropriate to do that. At that stage, we didn't know Sol was going to try and barge through the door again. We thought PICU - the step of putting him into PICU and - would've been a step in the right direction to containing his behaviour, but, in hindsight, yes, extra staff, you know, would've been great.
>
> Extra - - -?---It's always great to - - -
>
> Extra sec - - -?---It would've been good - - -
>
> Sorry. You finish?---Extra staff, whether it's security or nursing, would've been great in any instance. It's always great to have extra staff, but - - -"[33]

The submission is that this passage was misunderstood as offering any support of the appropriateness of the precautions so found. That cannot be accepted. It was the witness himself who said it would have been "appropriate", in the sense of beneficial, to have more security staff on the floor. His evidence supported a finding that there would have been a benefit from this system, which was relevant to, without itself proving, a finding that the system should have been provided.

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33 AR 1766-1767.

[55] For these reasons, none of the criticisms of her Honour's critical finding can be accepted. For the purposes of s 305B and s 305C of the *Workers' Compensation and Rehabilitation Act* 2003 (Qld)[34], and for the reasons given by her Honour, the evidence established that a reasonable person in the position of the appellant would have taken this precaution. This was likely to have been beneficial in avoiding or minimising the relevant risk, and on the evidence it was unlikely to have been problematic or prohibitively expensive in its operation.

[56] The remaining ground of appeal[35] is an argument about causation. It is submitted that the requirement of s 305D(1)(a) of the WCRA was not satisfied.

[57] The argument is effectively a repetition of one made under the previous ground, namely that the system would be ineffective because the patient would not know that a security officer would be present until the door was opened. It is said that given this patient's predilection to escape, there is no reason to think that he would not have tried to escape on this occasion in any event, and with the same consequence of an injury to the respondent.

[58] This argument cannot be accepted. As discussed earlier, the system itself would be something which would be likely to become known to patients, such as this one, with a particular propensity to escape. And in any case, had a security officer been present as the door was being opened, and had the patient persisted in trying to escape on seeing the officer there, it is the officer who would have had the burden of physically confining and controlling the patient, instead of that having to be done, in the first place, by the respondent.

Conclusion and orders

[59] I would order that the appeal be dismissed with costs.

[60] **MULLINS AJA:** I agree with McMurdo JA.

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34 The WCRA.

35 Ground 2(d)(ii) in the Notice of Appeal.