SUPREME COURT OF QUEENSLAND

CITATION:	*Batiste v State of Queensland* [2001] QCA 275
PARTIES:	**CHARLES STEPHEN BATISTE** (plaintiff/respondent) **v** **STATE OF QUEENSLAND** (defendant/appellant)
FILE NOS:	Appeal No 8769 of 2000 SC No 6547 of 1999
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	20 July 2001
DELIVERED AT:	Brisbane
HEARING DATE:	12 June 2001
JUDGES:	McMurdo P, Thomas JA, Muir J Separate reasons for judgment of each member of the court; McMurdo P and Thomas JA concurring as to the order made, Muir J dissenting
ORDER:	**Appeal dismissed with costs**
CATCHWORDS:	TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – DAMAGE – CAUSATION – GENERALLY – where plaintiff nurse suffered injury when psychiatric patient became aggressive - whether defendant's failure to warn ward staff of patient's impending arrival and to ensure staff were present to greet and calm patient caused the injury –– whether trial judge erred in drawing inference that the incident would not have occurred if usual patient transfer system were followed – whether *Betts v Whittingslowe* applied correctly TORTS – NEGLIGENCE – PROOF OF NEGLIGENCE – GENERALLY – where conflicting evidence as to usual system of patient transfer – whether conclusion that failure to have staff to greet and calm the patient would have prevented the injury was supported by the evidence *Bendix Mintex Pty Ltd v Barnes* (1997) 42 NSWLR 307, cited *Bennett v Minister of Community Welfare* (1992) 176 CLR

408, discussed
Betts v Whittingslowe (1945) 71 CLR 637, discussed, applied
Chappel v Hart (1998) 195 CLR 232, discussed
Cook on Gas Products Pty Ltd v Kelly [1999] NSWCA 270; CA 41055 of 1998, 26 July 1999, cited
Hawthorne v Thiess Contractors Pty Ltd [2001] QCA 233; Appeal No 5605 of 2000, 8 June 2001, considered
Hill-Douglas v Beverley [1998] QCA 435; Appeal No 2829 of 1998, discussed
Jones v Dunkel (1959) 101 CLR 298, cited
Luxton v Vines (1952) 85 CLR 352, cited
March v Stramare (E & MH) Pty Ltd (1991) 171 CLR 506, approved
Naxakis v West General Hospital (1999) 197 CLR 269, discussed
Seltsam Pty Ltd v McGuiness (2000) 49 NSWLR 262, approved
Sutherland Shire Council v Heyman (1985) 157 CLR 424, cited
Vyner v Waldenberg Bros Ltd (1946) 61 TLR 545, referred to
Wylie v ANI Corporation Ltd [2000] QCA 314; Appeal No 4092 of 1999, 4 August 2000, referred to

COUNSEL: P A Keane QC S-G, with him R C Morton, for the appellant
H B Fraser QC, with him J A McDougall, for the respondent

SOLICITORS: Corrs Chambers Westgarth for the appellant
Murphy Schmidt for the respondent

[1] **McMURDO P:** I agree with the reasons for judgment and the order proposed by Thomas JA.

[2] **THOMAS JA:** The respondent, an employee at the Psychiatric Unit of the Prince Charles Hospital, successfully sued his employer for damages for negligence. This is an appeal against the finding of liability. Its basis is that the learned trial judge erred in finding that any act or omission by the appellant caused the respondent's injury.

[3] At the material time the respondent was one of a group of five nurses whose task was to escort a mentally disturbed patient from Ward 6 to Ward 7 of the Psychiatric Unit. His primary objective was to keep the patient calm, and each member of the team was in a position to apply physical restraint should this become necessary. The patient was escorted into Ward 7. While in the reception area outside the nursing station the patient became agitated. The respondent (whose duty was to control the patient's left arm) "tightened his grip" but the patient violently threw himself backwards into a chair. This stretched the respondent's arm and he suffered a posterior dislocation of the left shoulder.

[4] The evidence is canvassed in detail in the reasons of Muir J which I have had the advantage of reading.

Issues

[5] Two questions arise on this appeal: firstly whether the learned trial judge misdirected herself in relying upon a selected passage from *Betts v Whittingslowe*[1] and secondly whether it was reasonably open to hold that causation was established.

Reliance on *Betts v Whittingslowe*: principles of causation

[6] Her Honour attributed the following statement to Dixon J (as he then was):

> "Breach of duty coupled with an accident of the kind that might thereby be caused is enough to justify an inference, in the absence, of any sufficient reason to the contrary, that in fact the accident did occur owing to the act or omission amounting to the breach."

[7] That was part only of a sentence in which Dixon J pondered the ambit of a Court of Appeal decision namely *Vyner v Waldenberg Bros Limited*[2], a case concerned with a statutory rule of absolute duty. Indeed Dixon J's sentence commenced with the words "it is not necessary to enquire whether their Lordships meant more than that the …" and ended with the words "… of statutory duty". *Betts v Whittingslowe* was itself a case of breach of an imperative statutory duty, namely duty to "securely fence … all dangerous parts and to cause all fencing and safeguards to be maintained in an efficient state …". It was a pre-apportionment act decision, and contributory negligence would have amounted to a defence. There was no other competing inference, such as intentional self-injury, inconsistent with liability on the part of the defendant. Dixon J followed the above statement with the comment:

> "In the circumstances of this case that proposition is enough. For, in my opinion, the facts warrant no other inference inconsistent with liability on the part of the defendant."

In such a context it is hardly surprising that his Honour found it acceptable to link the accident to the breach "in the absence of any sufficient reason to the contrary".

[8] On one view of it the comment simply enjoins judges when faced with breaches of such duties to consider whether there are any other competing causes for the accident that has occurred, and if there is no sufficient reason to the contrary, to find that the breach of duty caused the accident. I do not think that any particular problem arises from such an approach, even if it is taken to be also applicable to other kinds of breach of duty. Of greater concern to me is the level of contribution that may be regarded as sufficient to justify regarding a breach of duty as the cause when there *are* other reasonable competing inferences. In some recent cases[3] it has been suggested that some recent statements by High Court judges justify the view that only a slight degree of connection will suffice. However I reject this. It is not consistent with the approach required by *March v Stramare (E & MH) Pty Ltd*[4] to seek to define such matters. To do so would involve a definition of commonsense, which, according to *March v Stramare*, is to prevail in such matters, and which is not in my view susceptible to a priori definition.

---

1 (1945) 71 CLR 637, 649.

2 (1945) 61 TLR 545.

3 *Hawthorne v Thiess Contractors Pty Ltd* [2001] QCA 223, paras [10] et seq; cf *Wylie v ANI Corporation Ltd* [2000] QCA 314, paras [43] et seq.

4 (1990-1991) 171 CLR 506.

[9] It is true however that some recent decisions[5] concerned with medical negligence contain statements suggesting that certain acts which expose a patient to a mere increase of risk of injury may reasonably be held to have caused the injury. On this topic I entirely agree with the comments of Spiegelman CJ in *Seltsam Pty Ltd v McGuiness*[6] which focus upon the issue whether an increased risk *did* cause or materially contribute to the injury actually suffered.

> "There is a tension between the suggestion that any increased risk is sufficient to constitute a "material contribution", and the clear line of authority that a mere possibility is not sufficient to establish causation for legal purposes. The latter is too well-established to be qualified by the former. The reconciliation between the two kinds of references is to be found in the fact that, as in *Chappel v Hart* and in the cases that suggest the former, the actual risk had materialised. The "possibility" or "risk" that X might cause Y had in fact eventuated, not in the sense that X happened and Y had also happened, but that it was undisputed that Y had happened *because* of X."

[10] For present purposes it is not necessary to discuss statements made in *Chappel v Hart*[7] and *Naxakis v Western General Hospital*[8] in the context of the particular problems on causation that emerge in medical negligence cases when a doctor fails to give a patient an opportunity that the patient might or might not have taken to avoid a particular risk. Those cases are now repeatedly referred to as supporting a low bench mark for the level of contribution necessary to establish causation when competing causes exist[9] but I do not understand any new general theories of causation in tort and contract to have been laid down in *Chappel* or in *Naxakis* other than in respect of cases where those special problems arise. It remains the law that it is still necessary for a plaintiff to prove that a defendant's conduct materially contributed to the sustaining of the injury. This principle which forms part of the ratio of *March v Stramare (E & MH) Pty Ltd*[10] has not been questioned in any subsequent case.

[11] In my view although her Honour's citation of *Betts v Whittingslowe* was incomplete, I do not think that it discloses any error of law. The real question is whether her Honour adequately adverted to other competing causes and whether on the facts of the case it was reasonably open to find that any act or omission on the part of the hospital was the cause of the respondent's accident.

Adequacy of respondent's case to prove causation

[12] The particulars of negligence upon which the respondent succeeded were the following:

- failing to warn or sufficiently warn the staff of Ward 7 of the impending arrival of the patient at the ward;

---

5 *Chappel v Hart* (1998) 195 CLR 232; *Naxakis v Western General Hospital* (1999) 73 ALJR 782, 787, 797, 807; 197 CLR 269, 279, 296, 312.

6 (2000) 49 NSWLR 262, 280; Davies JA agreed with Spiegelman CJ.

7 (1998) 195 CLR 232.

8 (1999) 73 ALJR 782, 787, 797, 807; 197 CLR 269, 279, 296, 312.

9 *Hawthorne v Thiess Contractors Pty Ltd* [2001] QCA 223 para [10].

10 (1990-1991) 171 CLR 506.

- failing to ensure that staff were present in Ward 7 to greet and calm the patient upon his arrival there so as to prevent him panicking and becoming violent.

Her Honour made specific findings in those terms.

[13] It was not part of the respondent's case that some different system ought to have been in force. The case depended on proof that departure from the usual system brought about the adverse consequences. As the reasons of Muir J demonstrate, there was a good deal of variation in the evidence as to what the usual system involved, but there was no doubt that it involved the giving of advance notice to the nursing station in Ward 7 before transferring such a patient, and the making of arrangements within that ward for a nominated person to welcome the patient and engage him in conversation upon his arrival. There was no particular place where the meeting was to occur, but there is evidence that it was supposed to happen near the entrance of Ward 7 or at any time prior to production of the patient at the reception area. Muir J's reasons also demonstrate that there is no proper basis for holding that Ward 7 would be expected to assemble a similar team of escorts to take over from the original group of escorts. Such a suggestion was made by the respondent, but it does not seem sensible, and in any event, the great majority of the evidence was contrary to any such requirement.

[14] Her Honour found, and there was adequate evidence to support the finding, that no warning was given of the impending arrival of the patient, and that consequently no arrangements had been made to have staff present in Ward 7 to greet and calm the patient. The system was not rigid, and a certain amount of variation would be expected to occur according to the exigencies. There was no finding, nor would it have been feasible to make one, as to how many additional staff should be present when the escort team arrived. If necessary the persons responsible for reception could call upon the services of the original escort team until a secure transfer had been effected. It was also part of the system that before the transfer took place an area of Ward 7 would be locked so that other patients or personnel other than staff would not be present in the transfer area. That requirement was also not complied with. However during presentation of the respondent's case his counsel intimated to the court that breach of that particular requirement was not relied on because it was not suggested that its breach contributed to the occurrence of the incident. It was however a relevant part of the system.

[15] The system of course never had a chance to function because of the rather fundamental breach by Ward 6 officers of failing to advise the host ward that a new guest would be arriving. In the absence of such a warning one would hardly be surprised at chaotic results.

[16] Against this background it seems to me that the fact that the transfer miscarried as it did is not surprising, and the respondent's account of it (accepted by her Honour) was quite credible. Denomination of a person from Ward 7 to speak to the patient, put his mind at ease and to take whatever steps were necessary to ensure safety could be seen as an important step, the absence of which could be calculated to create a situation of instability and danger. That seems to have been what happened. It was precisely such a danger that materialised. Nurse Jones' evidence included a reference to what would happen when a patient was perceived to be potentially aggressive (as Ward 7 should have been advised in relation to this

particular patient). It hardly needs to be said that a time would need to be nominated, the ward would need to be closed as that time approached, and someone would be ready to receive and direct the patient into a new environment.

[17] Mr Keane QC for the appellant placed considerable emphasis upon a submission that there was no fixed time or place for the greeting, so that even if due notice had been given, it might well be that the greeting would not have occurred until after the patient had been seated in a chair such as the one involved in the incident. However whilst that is a possibility, I think it is a mere outside possibility by reason of the respondent's evidence which was accepted by her Honour. The respondent, whose duties included that of the "talker" in the escort party passed through the airlock without incident and then along the corridor leading to the reception area. He saw patients and some staff members and noticed that there had been no lock-down. He likened the task to carrying a stick of dynamite. His evidence includes the following:

> "We are walking up the hallway and looking for people. No one that I can see acknowledged [us] at that time. I was still talking to the patient, keeping him under control. He probably didn't realise that things were too different at that stage … than … what they should be. … I was going to … the nursing office. This is because that is where facilities are … We took them straight up and kept them in the foyer area … because there is always a nurse there – to be greeted … There was a staff member … on my wing and I realised that something had to be done here. So I couldn't really say 'What the hell is going on?' I said 'Oh where would you like us to go now? Could you find out where you would like us to go now?', words to that effect, giving them the hint to go and find someone to sort the situation out … they said they would go off and to do that … by that time we had arrived in front of, or near the glass nursing station and we stopped, we chatted a few words to the patient. 'We are just standing here for a moment. I'm sure someone will be with you in just a second. The doctor will be here.' … Within a very short number of seconds he seemed to become agitated … He was saying 'What is going on here?', you know. It started to become more so and then we were preparing to do whatever was needed to be done. He looked … straight at me and just said 'Well f… you.' "

At that point the patient threw himself backwards into a chair and the respondent sustained his injury.

[18] The evidence of Dr Shand, also accepted by her Honour included his opinion that the absence of anyone to greet the patient introduced a note of objective uncertainty. If the patient was already on edge and frightened he would become more so because of that uncertainty.

[19] I think it was open to her Honour to conclude that had the necessary notice been given and the usual system activated, the worrying features and instability that started to attend the exercise would not have arisen. The obvious lack of any reception in Ward 7 of the patient's impending arrival introduced hesitancy and a changed atmosphere which triggered the incident. The appellant failed to follow its usual procedure which would probably have resulted in engaging the patient's attention, keeping him moving and not giving him time to think about what was

happening. It is true that there are arguable competing causes that arise for consideration in this case, including the possibility that the eventual greeting would not have commenced until after the incident had occurred. However for the reasons I have stated it seems far more likely that the failure to observe the usual system produced the loss of control of the situation and caused the incident to happen.

[20] I therefore conclude that her Honour's findings and conclusions were reasonably open on the evidence.

[21] The appeal should be dismissed with costs.

[22] **MUIR J:** The respondent suffered an injury to his left shoulder when, employed as a psychiatric nurse employed in the Winston Noble Psychiatric Unit within the Prince Charles Hospital, he was participating in the transfer of a patient to the unit's locked psychiatric ward ("Ward 7"). As a result of that relatively minor injury, the appellant suffered post traumatic stress disorder which, combined with his shoulder injury, effectively rendered him unable to work as a psychiatric nurse.

[23] The respondent commenced proceedings in the District Court against the appellant claiming damages arising out of an unspecified cause of action. The proceeding was transferred to the Supreme Court and after a trial, judgment was given for the respondent in the sum of $501,412.

[24] The appellant appeals against the judgment in respect of liability only. On the hearing of the appeal, two grounds were argued. The first was that the learned primary judge had erred in law by, in reliance on a passage from the judgment of Dixon J in *Betts v Whittingslowe* [11], drawing the inference that the incident which led to the respondent's injury would not have taken place had the hospital's system of work in respect of transfer of patients been followed. The second ground of appeal challenged the factual finding that failure to warn the staff in Ward 7 of the patient's impending arrival was causative of the respondent's injury.

The central findings of the primary judge on causation

[25] It is convenient to set out that part of the primary judge's reasons dealing expressly with the question of causation –

> "**Causation**
>
> [11] Regardless of whether there should have been a reception team as such, the plain fact is that the staff in Ward 7 were not expecting Patient G and so no preparations of the kind described by Nurse Wilson had been made for his arrival. There was a foreseeable risk that a patient such as Patient G would become aggressive in the circumstances. He did become aggressive, and the plaintiff was injured as a result. I infer that had preparations of the kind described by Nurse Wilson been taken, it is more probable than not that the incident would not have occurred.
>
> [12] In *Betts v Whittingslowe* (1945) 71 CLR 637 at 649 Dixon J said –

[11] (1945) 71 CLR 637 at 649.

> 'Breach of duty coupled with an accident of the kind that might thereby be caused is enough to justify an inference, in the absence of any sufficient reason to the contrary, that in fact the accident did occur owing to the act or omission amounting to the breach.'

> Insofar as the present case rests on a failure to warn, the plaintiff has satisfied the further requirement of proving that it is more probable than not that had the warning been given, the injury would not have been suffered: *Hill-Douglas v Beverley* [1998] QCA 435; *Hallmark-Mitex Pty Ltd v Rybarczyk* CA No 11009 of 1997, 4 September 1998; *Chappel v Hart* (1998) 195 CLR 232; *Seltsam Pty Ltd v McGuiness* NSW CA No 40456/97 & 40463/97, 7 March 2000.

[13] I find that the plaintiff's injury resulted from the defendant's –

1. failure to ensure that staff were present in Ward 7 to greet and calm the patient upon his arrival there so as to prevent him panicking and becoming violent; and
2. failing to warn or sufficiently warn the staff of Ward 7 of the impending arrival of the patient at the ward.

(Statement of claim para 6(c) and (d))."

The argument based on *Betts v Whittingslowe*

[26] Mr Keane QC, who led Mr Morton for the appellant, argued that the primary judge treated the passage from Dixon J's judgment in *Betts v Whittingslowe* set out in paragraph 12 of the reasons as requiring an approach to causation which identifies steps which the appellant should have taken but did not, and which would have lessened the risk, and which concludes that the subsequent manifestation of the risk is, of itself, enough to warrant the conclusion that the failure to take the steps caused the ensuing injury.

[27] It was submitted that the passage from *Betts v Whittingslowe* quoted by her Honour was part of a larger passage which it is necessary to examine in order to place Dixon J's observations in their appropriate context. That larger passage is as follows[12] –

> "A further consequence follows, however, from the conclusion that the imperative requirement of the statute that a dangerous part of the machinery should be securely fenced or guarded was not fulfilled. In *Vyner v. Waldenberg Bros. Ltd.* (1945) 61 T.L.R. 545, an accident had occurred to an employee working at a circular saw, but how it really happened no one knew. It appeared, however, that the riving knife at the back of the saw did not conform with the statutory regulations for safety. *Scott* L.J., in delivering the judgment of himself, *Mackinnon* and *Morton* L.J.J., laid down the rule as follows:- 'If there is a definite breach of a safety provision imposed on the occupier of a factory, and a workman is injured in a way

---

12 At 648-649.

> which could result from the breach, the onus of proof shifts on to the employer to show that the breach was not the cause. We think that that principle lies at the very basis of statutory rules of absolute duty.'(1945) 61 T.L.R., at p. 546. It is not necessary to inquire whether their Lordships meant more than that the breach of duty coupled with an accident of the kind that might thereby be caused is enough to justify an inference, in the absence of any sufficient reason to the contrary, that in fact the accident did not occur owing to the act or omission amounting to the breach of statutory duty. *In the circumstances of this case that proposition is enough. For, in my opinion, the facts warrant no other inference inconsistent with liability on the part of the defendant*." (emphasis supplied)

[28] It was contended that her Honour's approach to causation, although consistent with the views expressed in the following passage from the judgment of McHugh J in *Chappel v Hart*,[13] is erroneous –

> "Before the defendant will be held responsible for the plaintiff's injury, the plaintiff must prove that the defendant's conduct materially contributed to the plaintiff suffering that injury. (*Bonnington Castings Ltd v Wardlaw* [1956] AC 613 at 614; *Duyvelshaff v Cathcart & Ritchie Ltd* (1973) 47 ALJR 410 at 417; 1 ALR 125 at 138; *Tubemakers of Australia Ltd v Fernandez* (1976) 50 ALJR 720 at 724; 10 ALR 303 at 310-311; *March v Stramare* (1991) 171 CLR 506 at 514.) In the absence of a statute or undertaking to the contrary, therefore, it would seem logical to hold a person causally liable for a wrongful act or omission only when it increases ("increases" in this context includes "creates") the risk of injury to another person. If a wrongful act or omission results in an increased risk of injury to the plaintiff and that risk eventuates, the defendant's conduct has materially contributed to the injury that the plaintiff suffers whether or not other factors also contributed to that injury occurring. If, however, the defendant's conduct does not increase the risk of injury to the plaintiff, the defendant cannot be said to have materially contributed to the injury suffered by the plaintiff. That being so, whether the claim is in contract or tort, the fact that the risk eventuated at a particular time or place by reason of the conduct of the defendant does not itself materially contribute to the plaintiff's injury unless the fact of that particular time or place increased the risk of the injury occurring."

[29] The appellant's submission on the proper approach to causation may be summarised as follows –

Betts v Whittingslowe, *Chappel v Hart* and *Naxakis* were all cases where the failure to take the relevant precaution against the identified risk was the only potential cause of the eventuation of the injury complained of. Those cases and the principles stated in them do not apply where, as in this case, there are many potential causes of the event leading to the injury and, thus, where it cannot be said that had the

---

13 (1998) 195 CLR 232 at 244-245.

relevant precaution been taken that, of necessity, would have prevented the suffering of injury.

The approach of the majority in *Seltsam Pty Ltd v McGuiness*[14] correctly reflects the reasons of Dixon J in *Betts v Whittingslowe.* Particular reliance was placed on the following passage from the judgment of Spiegelman CJ[15] –

> "The issue in the present case is whether an increased risk *did* cause or materially contribute to the injury actually suffered.
> There is a tension between the suggestion that an increased risk is sufficient to constitute a 'material contribution', and the clear line of authority that a mere possibility is not sufficient to establish causation for legal purposes. The latter is too well-established to be qualified by the former. The reconciliation between the two kinds of references is to be found in the fact that, as in *Chappel v Hart* and in the cases that suggest the former, the actual risk had materialised. The 'possibility' or 'risk' that X might cause Y had in fact eventuated, not in the sense that X happened and Y had also happened, but that it was undisputed that Y had happened *because* of X."

The Queensland Court of Appeal in *Hill-Douglas v Beverley*[16] was correct in limiting the principle relied on by the respondent in that case to medical negligence claims. The principle was as follows[17] –

> "Once a plaintiff demonstrates that a breach of duty has occurred which is closely followed by damage, a prima facie causal connection will have been established. It is then for the defendant to show, by evidence and argument, that the plaintiff should not recover damages."

[30] Because of the view I take of the facts and of the continuing authority of the *Betts v Whittingslowe* principle, it is unnecessary for me to embark on a discussion of the differing approaches to causation taken in *Seltsam Pty Ltd v McGuiness* and *Hill-Douglas v Beverley*.

[31] In *Naxakis v West General Hospital*[18], Gaudron J referred, with approval, to a passage from the judgment of McHugh J in *Chappel v Hart*, stating[19] –

> "For the purposes of the allocation of legal responsibility, "[i]f a wrongful act or omission results in an increased risk of injury to the plaintiff and that risk eventuates, the defendant's conduct has materially contributed to the injury that the plaintiff suffers whether or not other factors also contributed to that injury occurring." (*Chappel v Hart* (1998) 195 CLR 232 per McHugh J.) And in that situation, the trier of fact - in this case, a jury - is entitled to conclude that the act or omission caused the injury in question unless the defendant establishes that the conduct had no effect at all or that the

---

14 (2000) 49 NSWLR 262.
15 At 280.
16 [1998] QCA 435; Appeal No 2829 of 1998, 18 December 1998.
17 At paragraph 40.
18 (1999) 197 CLR 269.
19 At 279.

> risk would have eventuated and resulted in the damage in question in any event. (See *Bennett v Minister of Community Welfare* (1992) 176 CLR 408 at 420-421 and the cases there cited. See also *Chappel v Hart* (1998) 195 CLR 232 at 237-238, per Gaudron J, at 247-248, per McHugh J, at 257-259 per Gummow J, at 272-273, per Kirby J.)

[32] It appears from the foregoing and from other passages in her reasons, particularly at paragraph 36, that Gaudron J regarded McHugh J's formulation of principle as not departing in substance from Dixon J's statement of principle in *Betts v Whittingslowe* or, for that matter, from the broad principles expounded in cases such as *March v Stramare (E & MH) Pty Ltd* [20] and *Bennett v Minister of Community Welfare*.[21] Nor in my view did Callinan J, who referred to the same passage from McHugh J's judgment with approval,[22] regard his Honour as departing from the *Betts v Whittingslowe* formulation.

[33] Kirby J, also in *Naxakis*,[23] referred the *Betts v Whittingslowe* principle with approval whilst essaying his own re-statement of it –

> "Where, as here, a plaintiff demonstrates that it was open to a jury to conclude that the respondents were in breach of their duty of care to him and this breach was closely followed by his damage, a prima facie causal link is established. It may be displaced and it may be rejected; but it cannot be ignored in considering a motion for judgment for the defendant for want of evidence. (*Betts v Whittingslowe* (1945) 71 CLR 637 at 649.)"

[34] To return to *Chappel v Hart*, Gummow J,[24] referred, with approval, to a passage from Gaudron J's judgment in *Bennett v Minister of Community Welfare* [25] in which her Honour said[26] –

> "And although it is sometimes necessary for a plaintiff to lead evidence as to what would or would not have happened if a particular common law duty had been performed …, *generally speaking*, if an injury occurs within an area of foreseeable risk, then, in the absence of evidence that the breach had no effect …, or that the injury would have occurred even if the duty had been performed …, it will be taken that the breach of the common law duty caused or materially contributed to the injury. However, the question whether some supervening event broke a chain of causation which began with or which relates back to an omission or a failure to perform a positive duty, is one that can only be answered by having regard to what would or would not have happened if the duty had been performed. It is only by undertaking that exercise that it is possible to say whether the breach was 'still operating' or…, continued to be causally significant when the harm was suffered."[27] (emphasis supplied)

---

20 (1991) 171 CLR 506.
21 (1992) 176 CLR 408 at 412-413.
22 At paragraphs 127 and 128.
23 At paragraph 76.
24 At 257.
25 (1992) 176 CLR 408.
26 At 420-421.
27 Footnotes have been omitted.

[35] Immediately prior to that passage Gaudron J had said[28] –

> "In practice, it is not always necessary to enquire what would have happened in the circumstances under consideration had a positive duty been performed. Thus, in the case of a statutory duty, a 'breach of duty coupled with an accident of the kind that might thereby be caused is enough to justify an inference, in the absence of any sufficient reason to the contrary, that in fact the accident did occur owing to the act or omission amounting to the breach of statutory duty' (*Betts v. Whittingslowe* (1945), 71 C.L.R. 637, at p. 649 per Dixon J.)"

[36] Mr Fraser QC, who lead Mr McDougall for the respondent, submitted that Dixon J's dictum in *Betts v Whittingslowe* remained authoritative and had been treated in judgments in *Chappel v Hart* and *Naxakis v West General Hospital* as applicable to breaches of a common law duty of care. The correctness of that submission is borne out in the above discussion and by *Sutherland Shire Council v Heyman*,[29] *Bendix Mintex Pty Ltd v Barnes*[30] and *Cook on Gas Products Pty Ltd v Kelly*.[31]

[37] The principle expressed by Dixon J in *Betts v Whittingslowe* is that set out in the primary judge's reasons. It is concerned with questions of onus of proof and has its own in-built qualifications or limitations, permitting an inference of causation to be drawn only "in the absence of any sufficient reason to the contrary". I am unable to accept the submission that the words emphasised in paragraph [6], following the passage quoted by her Honour, are part of the principle. Those words concern the application of the principle to the facts of the case.

[38] Paragraph 11 of the reasons, if taken in isolation, justifies the criticism set out in paragraph [26] above. When regard is had to paragraph 10 of the reasons, however, it will be seen that her Honour has attributed the patient's aggression to uncertainty caused by a perceived failure of the transfer process. Paragraph 10 contains these findings –

> "I accept the evidence of another psychiatrist, Dr Shand, on this topic. He observed that the absence of anyone to greet the patient introduced a note of objective uncertainty, and that if the patient were already on edge and frightened by his perception of what was happening to him, he would be more so because of that uncertainty. Someone with Patient G's disorders would be more likely than, say, a psychotic patient, to respond positively to a plan of action which involved engaging his attention, keeping him moving and not giving him time to think about what was happening and showing by inference that force was available if necessary."

[39] Consequently, it does not seem to me that her Honour's approach to the application of the *Betts v Whittingslowe* principle was one which ignored the need to look for the existence of any reason which would negate the inference which she was entitled, but not obliged, to draw from the facts. To my mind, the critical issue on

---

28 At 420.
29 (1985) 157 CLR 424 at 467.
30 (1997) 42 NSWLR 307 at 315-316.
31 [1999] NSWCA 270; CA 41055 of 1998, 26 July 1999, at paragraph 12.

this appeal is whether on the facts of this case there was any real scope for the application of the *Betts v Whittingslowe* principle, which is concerned with questions of onus of proof, and the related question of whether the inferences drawn by her Honour were open on the facts. It is those matters which are now addressed.

Statement of non-contentious facts

[40] Before attempting an analysis of the evidence concerning the incident itself it is useful to record some non-contentious background to the incident.

[41] The plaintiff, at the time of the incident, was 37 years of age. He had had many years experience as a psychiatric nurse. He had worked in the Winston Noble Psychiatric Unit, including in Ward 7, for about 2 years prior to the incident. On the evening of the incident, he was working in Ward 5 when he and another nurse in that ward, Nurse Jones, were requested to assist in escorting a patient from Ward 6 to Ward 7. On arrival at Ward 6 he was told that the patient to be transferred was ex-army, "capable of handling himself" and had expressed homicidal sentiments concerning his wife.

[42] The escort party, consisting of the respondent, Jones and three other male nurses formed up. In accordance with normal procedure, four members of the party were assigned a specific role. The respondent was to take the patient's left arm, Jones the plaintiff's right, and two others were designated "leg men". In the event that the patient showed signs of untoward physical activity, on a pre-arranged signal, those four men would move to secure him. The respondent was also designated as "the talker" with the role of conversing with the patient so as to keep him calm and mentally occupied.

[43] The respondent and Jones in their designated positions were to maintain hold of the patient's arms until the staff at Ward 7 had taken custody of him or until it was otherwise considered safe to abandon that precaution.

[44] The patient was a 27 year old man, 188 cm in height, weighing 73 kilograms. He was admitted to the Winston Noble Unit after threatening to kill his wife and to commit suicide. In the unit he had told another patient that he had a knife and a pocket knife had been discovered under his pillow. These factors led to the decision to transfer him to Ward 7.

[45] On the commencement of the transfer operation, the respondent and Jones each took hold of one of the patient's arms, placing one hand on the patient's wrist and the other hand slightly above the patient's elbow and, with the respondent and Jones maintaining their restraint on the patient, the 5-man escort party conducted the patient from Ward 6 across an oval to Ward 7. There they went through a compartment described in evidence as "the airlock", the purpose of which was to provide a secure entry to the ward through two locked doors. It was customary for patients to be searched in this area. Once through the airlock, the escort party and the patient turned left, walked down a corridor and then turned right and walked along another leg of the corridor towards the ward's nursing station.

[46] No plan of the layout of the relevant part of Ward 7 went into evidence and its dimensions and configuration were not clearly explained. It seems that the nursing station is in a room at the end of the corridor, on the right of the entrance to the

corridor and is separated from a reception area by a glass partition. The area, which I have referred to as the reception, is an area opposite the nursing station, on the left of the entrance to the corridor, in which chairs were placed for the use of patients. The nursing station and the reception area are in the same room. The respondent described the room as "the main foyer/reception, receiving area of Ward 7".

[47] The staff in Ward 7 had not been alerted to expect the arrival of the patient. Nurse Wilson, the nurse in charge of Ward 7 on the evening of 4 September 1993, said that had she been alerted to the impending arrival of the patient –

> "I would have cleared an area. We have a corridor with doors we can shut off, and the patient can be brought into that area when there's no other patients there at all. Some staff should have been there. That would be it."

[48] Her Honour accepted that evidence and there is no challenge to the finding in this regard.

Evidence of the respondent, Nurse Jones, Nurse Wilson and Nurse Post on the protocol or practice for the reception of patients being transferred to Ward 7 from another ward

[49] **Nurse Post** was an experienced psychiatric nurse who, in around 1991, had been actively engaged in Workplace Health and Safety matters relating to the Winston Noble Unit. Prior to July 1991, he had been the nurse in charge of the night shift. He swore that, at relevant times, there was a system in place for the reception of patients in Ward 7 which involved these components –

(a) The locking off of the reception area and nurses' station from the remainder of the ward. That appears to have involved the locking of doors leading from the reception area so as to isolate it and exclude patients from it;

(b) Ensuring that "as many staff as physically possible" were in the reception area awaiting the patient's arrival;

(c) The nomination by the nurse in charge of the shift at the time of reception of a person to speak to the patient so as to put the patient's mind at ease and to take whatever steps were necessary to ensure safety.

[50] He did not state that the standard procedure required the charge nurse or her delegate to make contact in a particular place or in accordance with any particular timing or procedure. His evidence was to the effect that the practice was for a transfer party to be met promptly on arrival in Ward 7 but not that it be met before or whilst still moving into the ward.

[51] He accepted that the role of the "talker" in the transfer party was to continue to engage the patient's attention until the charge nurse or the charge nurse's delegate in Ward 7 took over that function. He said that Ward 7 staff should be present in a non-threatening way "in close proximity without barriers between the patient and their escort team and themselves".

[52] In part of his evidence, he said that there should be four persons in the reception committee. In the light of earlier evidence he may have meant to say "at least four". He did not provide any basis for this opinion unless it is to be found in his

understanding that a safe environment on transfer was created by the presence of Ward 7 staff in addition to those in the escort team and that "the more the better". The evidence of no other witness supported his evidence that the practice was that as many staff members "as physically possible" should be ready to receive a patient.

[53] He accepted that patients who are angry or frustrated on entering Ward 7 might react "in a challenging way", and, in effect, that the presence of an obvious reception group or committee at the patient's point of arrival might also trigger such a reaction. He accepted that there were "lots of things" which could "set off" psychiatric patients going into Ward 7. He accepted also that the procedure to be followed in Ward 7 on the reception of a patient might vary from patient to patient.

[54] **The respondent,** who had more experience of nursing in Ward 7 than any other nurse on duty at the time of the incident, said that in his experience the staff in Ward 7 would be notified of an impending transfer and would go through a type of drill in which the respective roles of each member of the receiving team would be identified. There would be a lock-down of the ward before the patient's arrival. On entry into the reception of Ward 7, the transferee would be in the midst of the "thoroughly organised" receiving group "already numbered off" with a talker nominated to –

> "Talk to the person, explain what is going on and by the sheer volume of numbers the person – some people may say it is intimidated. They feel secure in that there are a lot of people there. They are very friendly to the person, but they are firm and friendly in saying, 'this is the procedure. This is what we are going to do' … so it is a smooth flow of the continuous operation. It is a key part of it."

There was "always a nurse (in the reception area) to be greeted".

[55] It is often difficult to discern whether the respondent was giving evidence about a protocol or established system or opinion evidence as to the most desirable way in which to effect a transfer. The foregoing evidence appeared to me to come within the former category.

[56] He accepted, in cross-examination, that what was done on any particular transfer by way of a reception group was a matter for the Ward 7 charge nurse.

[57] Also in the course of cross-examination he said that "If you have got good season(ed) team members of 7, they understand the smooth transfer and will go up and be at the doors (of the air-lock) or send someone up for you at least". This evidence and the evidence of a "thoroughly organised receiving group" who had been "numbered off" receives no support from any other witness.

[58] **Nurse Jones**, an experienced psychiatric nurse, first registered as such in 1984, said that the procedure followed on receiving patients in Ward 7 depended on the type of patient concerned. Where a patient was perceived to be potentially aggressive "… they would close the ward down, move the tables and chairs around, and be ready. And the people that took the patient over, sort of handed over to the Ward 7 staff that were … there."

[59] To effect entry into the ward, a member of the escort team would open the doors to the airlock. A nominated person in Ward 7 would welcome the patient and engage the patient in conversation, informing him of what is then to take place. He said at one point in his evidence that "… the greeting is supposed to be there and then, walking down the corridor" but he accepted that the greeting might take place after the escort party had seated the patient in a chair in the reception. Much would depend on the patient and the circumstances at the time. As a matter of standard procedure, there would be more than one person in and about the reception area of Ward 7. He ascribed no immediate role to any of these persons apart from the person designated to greet the patient.

[60] He agreed that it was not unusual for patients to "get upset, fearful and frustrated, walking into Ward 7". He accepted that whatever practice existed did not involve having four or five Ward 7 nursing staff standing around reception.

[61] **Nurse Wilson** gave the evidence set out in paragraph [47]. There was no hint in her evidence of the carefully planned reception operation spoken of by the respondent.

The evidence of the respondent, Nurse Jones, Nurse Wilson and Nurse Post of events surrounding the incident

[62] **Nurse Wilson** also gave brief evidence about the incident itself. She recalls sitting in the nursing station, hearing a loud voice (which she accepted was the patient's) and looking down the corridor where she saw the patient arriving with the escort party. She left the nurses' station to meet the escort party in the reception and heard the respondent call out. She looked immediately in the direction of the voice and saw the patient seated in a chair. She agreed that it all happened very quickly. She recorded on the patient's chart "… Struggling on entering ward … nurse injured while this occurred …".

[63] Nurse Wilson gave no evidence about whether, if she had been aware of the impending arrival of the patient, the patient would nevertheless have remained for some time in reception or concerning the point at which the escort party would have been relieved of responsibility for the patient.

[64] **Nurse Jones'** evidence of the events leading up to the incident are as follows. He sensed the patient becoming tense and restless going into the ward and he heard him saying "'fuck' all the time". On arriving at or near the reception area he saw staff inside the nurses' station. There was no one outside the nurses' station waiting to greet the escort party.

[65] He does not recall any patients being present. He said the escort party was proceeding to take the patient to a chair in order to sit him down when the patient made an exclamation and "sort of went to sit back down again – Oh, you know, pulled towards the chairs … it was brief and really hard to see it coming". At this time people in Ward 7 were "sort of, like, 10 feet away or so, you know, of the escort party, like, they were quick to come in and they, you know, grabbed the patient and sat him down in the chair …".

[66] He was uncertain about whether the patient had actually sat down in a chair and had got back up again prior to the incident or whether "we were going towards the chair and almost got there". In a signed statement given in August 1995, he had said –

> "I remember we sat the patient down on a chair over the right, inside the door while someone summonsed ward staff".

[67] He said that if the incident had not occurred the patient would have been seated by the escort party on a chair in reception but, as things turned out, "we didn't get to that".

[68] **The respondent** said in evidence in chief that the transfer party proceeded to Ward 7 and passed through the airlock without incident. The group turned to the left, walked down the corridor and took a right turn into length of the corridor leading to the reception area. He saw patients and a number of staff members and noticed that there had been no lock-down. He kept talking to the patient as the group approached the nurses' station where he said to a Ward 7 nurse words to the effect "Where would you like us to go now?". The party then stopped for a moment "in front of, or near the nursing station". He said a few words to the patient and "within a very short number of seconds" the patient seemed to become agitated, exclaimed and threw himself backwards into a chair.

[69] In cross-examination it was put to him that he could easily have spoken to the patient about what was going to happen. He responded that given the opportunity, he could have done so but that he did not get the chance to do it because the incident happened so quickly. He did not dispute that he had told his treating psychiatrist, Dr Shand, sometime prior to 8 July 2000, that he was unsure whether before he sustained his injury he had sat the patient down or reassured him about sitting down. He said that at the time of speaking to Dr Shand he was a bit confused but under Dr Shand's directions, he "continually remember(ed) exactly what I remember of the night and that is why I say I did not remember sitting him down. I remember presenting to the office, I remember a sudden situation, I remember the patient throwing himself down". In that part of his evidence accepted by the primary judge he spoke of arriving "in front of or near the nursing station" after speaking to a Ward 7 nurse.

[70] He was asked "Was it as you reached that area (the end of the part of the corridor which runs into the nurses' station and reception area), that the incident occurred? Is that what you are saying - - It seems to me that's when it went snap." That answer may well conflict with the respondent's evidence in chief unless it is taken as affirming that the incident occurred almost instantaneously upon arrival in the reception area.

[71] The following exchange in cross-examination bears upon what would have happened had Ward 7 been forewarned of the patient's arrival –

> "Let's assume all had gone according to plan, okay, you would have remained the talker. Let's assume there had been no incident, right, you would have remained the talker until you'd been relieved of your escort duties? - - That would depend on the – at the moment the charge nurse met you and spoke to you, that's – they would give you the signal as to which way they wanted it to go. If they wanted you to stay with the patient and talk to them, fine. If they wanted to take over the situation, fine. You would work under their direction.

> "But until you got some indication that the charge nurse wanted you to hand over the patient or cease your duties as the talker, that's what you remained doing?-- Either that or defer to the senior rank that was with you."

That evidence accords with the evidence of Nurses Post and Jones that as a matter of practice the escort party may not relinquish control of the patient on arrival in the reception of Ward 7 and that the "talker" would continue in his role until relieved.

Dr Shand's evidence

[72] Dr Shand, who gave expert evidence on behalf of the respondent, had given the following advice in a telephone conference with the respondent's solicitors –

> ". With this patient's history, the potential for violence seems to have been there.
> . Transfer of patients to locked wards heightens the potential for a violent reaction to the impending confinement.
> . Obviously the intention of the protocol is to reassure the patient by those methods – greeting them, reassuring them, engaging them, being in control of the situation, and a 'show of strength'.
> . *On balance, if the patient reacted well to verbal engagements and the escort to the locked ward, a proper greeting protocol would have passed possession of him smoothly.*
> . When there was no-one to greet the patient, it introduced a note of objective uncertainty, and if the patient was already on edge and frightened or at his perception of what was happening to him, he would be more so because of that uncertainty.
> . He was trained in psychiatric hospitals in the late 60's and was involved with the Psychiatric Department of St Vincent's Hospital until 4 or 5 years ago. Even back in the 60's, when they got such a patient, they would organise a battle plan carefully." (emphasis supplied)

[73] The advice was transcribed and admitted into evidence.

[74] In cross-examination, he accepted that on an inward transfer of a psychiatric patient an important feature in controlling the patient's behaviour is a show of strength by hospital staff and that four experienced male psychiatric nurses would be adequate for that task. In re-examination, when asked if the presence of four or five male nurses was sufficient, "where there had been a breakdown in the procedure and there was no one to meet and greet," he answered "apparently not because he broke free". He agreed in cross-examination that the arrival of a patient such as the patient in the reception area of a secured ward might trigger a physical reaction on the patient's part when he realises he is in custody. He also agreed that the patient's exclamation and action in sitting down was consistent with the act of a patient who knew he was going to be confined.

[75] He accepted that the part of the greeting protocol requiring the engaging of the patient's attention, being friendly and relaxed, using the patient's name and making introductions could be attended to by the escort party until the patient was handed over. He conceded also that the part of the protocol which involved keeping the patient moving and not giving him time to think about what was happening, had to come to a end at some time. One of the premises on which his evidence appears to have been based was that there was a procedure in existence under which patients such as the patient would be taken through reception to the patient's room without stopping. That assumption is not supported by the evidence.

The primary judge's findings of events immediately preceding and at the time of the incident and on credibility.

[76] The primary judge accepted the respondent's evidence of what happened at about the time of the incident and the findings are recorded as follows in paragraph 9 of the reasons –

> "He was keeping up his role as 'talker'. As they approached the nursing station, he said to a staff member who was on his wing words to the effect of 'Where would you like us to go now? Could you find out where you would like us to go now?' to give staff the hint to go and find someone to sort out the situation. By then they had arrived in front of or near the nursing station. They stopped and chatted a few words to the patient. In a very short space of time he seemed to become agitated, saying 'What is going on here?' - but not sufficiently for the plaintiff to call a take-down (i.e. to instruct the other escorts to descend on the patient taking hold of his arms and legs according to their prearranged positions). The patient started to become more agitated and the escorts were preparing to do whatever was necessary when the patient looked straight at the plaintiff, said 'Fuck you!' at the same time throwing his left arm slightly up and then down very fast and throwing himself backwards into a chair."

[77] In that part of her reasons dealing with the respondent's psychiatric injury, her Honour noted that the respondent was "clearly unreliable in the history he gave the psychiatrists" and then remarked –

> "He had a tendency to be tangential in his responses to questioning. I do not regard these factors as necessarily pointing to deliberate untruthfulness; rather, they were features of his mental state."

[78] Part of Nurse Wilson's evidence was referred to with express approval. Part of the evidence of Nurse Jones and of Nurse Post was accepted, by implication also. Her Honour made express reference to part of Nurse Jones' evidence set out in paragraph [64] hereof, stating, "he felt the patient becoming apprehensive as they entered Ward 7." Her Honour accepted the evidence of Dr Shand in relation to the consequences of failing to implement a practice of greeting patients as identified by the respondent in preference to that of Dr Nothling, the psychiatrist called by the appellant. No express findings were made about the general reliability of any witness other than the respondent.

The appellant's submissions on the factual aspects of causation

[79] The appellant submits that there was no sufficient basis for inferring that it was more probable than not that, if there had been other members of staff present and alerted to the transfer in addition to the escort party, the patient would have behaved in any different fashion. In that regard the appellant refers to the evidence of Dr Shand to the effect that a patient might react when he realises he is in custody and Dr Nothling's evidence to the effect that the incident was at least equally consistent with the patient's realising that he was in Ward 7 and could not talk his way out of it. Thus, it is submitted, no causal relationship was demonstrated between the failure on the part of Nurse Wilson to take the relevant precautions and the injury suffered by the respondent.

[80] It is further submitted that the conclusion that "failure to ensure that staff were present in Ward 7 to greet and calm the patient upon his arrival there so as to prevent him panicking and becoming violent" had also caused the respondent's injury is not supported by the evidence because –

(a) The time for a Ward 7 staff member to "greet and calm" the patient had not arrived at the time of the incident;

(b) There was no evidence that the "greeting" should take place immediately upon arrival at the nurses' station or that any momentary delay in that respect would have any effect on the patient's behaviour. (In this regard the appellant relied on evidence of Dr Nothling that it was "perfectly proper procedure for the patient, having been taken into the ward, to be asked to sit in a chair");

(c) Nurse Jones gave evidence that in ordinary circumstances the patient would have been sat down on one of the chairs opposite the nurses' station until someone from Ward 7 came over and met the patient;

(d) Nurse Wilson gave evidence that she came out of the nurses' station when she heard the noises from down the corridor. She did not have time to say anything to the patient;

(e) The purpose of talking to the patient is to engage his attention, to distract him and to make him feel at ease and there is no reason why this could not be done by the "talker" in the escort party. That this is so was accepted by Dr Shand, Dr Nothling, Nurse Jones and Nurse Post. The respondent, who was very experienced was quite capable of fulfilling this function and was doing so at the time of the incident.

[81] Having regard to those matters, it is submitted, there is no reason to think that had Nurse Wilson or any other member of Ward 7 staff spoken to the patient, their words would have changed anything.

[82] As for the "proper greeting" protocol identified by Dr Shand, the appellant submitted that each element of it had been met.

[83] There was ample evidence that many matters may trigger an incident such as the one under consideration and there was no evidence from either Dr Shand or Dr Nothling that what provoked the patient's behaviour, more probably than not, was the absence of a reception committee or a "greeter".

[84] It was further submitted that the proposition that Ward 7 staff saying calming things to the patient would have soothed him whereas the respondent in fulfilling his role in the escort party was unable to do so is illogical. In that regard it was said that a patient would not know whether a nurse was or was not a member of Ward 7 staff.

[85] A member of the escort party could be a Ward 7 staff member and in those circumstances there would be no reason why that person could not fulfil the role of "greeter". The respondent came from Ward 6 and there was nothing to suggest that the patient knew he was not from Ward 7. Finally in this regard, it is submitted that the respondent had considerable experience in Ward 7 and could easily have talked sensibly to the patient in the same way as any member of the Ward 7 staff was likely to have spoken.

Conclusions on causation

[86] Her Honour concluded that had Nurse Wilson been warned of the patient's impending arrival preparations would have been made and, had they been made, "it is more probable than not that the incident would not have occurred". Her Honour does not expressly identify the preparations she had in mind but on Nurse Wilson's evidence, they amounted to the lock-down of the ward and arranging for some staff to be in the reception area. As her Honour refrained from finding that "there should have been a reception team as such", her conclusions on liability are not based on the absence of a reception team of the nature of that asserted by the respondent.

[87] Nurse Wilson was not asked to explain what she meant by "clearing an area', presumably because counsel understood her to be referring to the reception area. It is by no means clear though that Nurse Wilson's arrangements would have necessitated having staff present in the reception area outside the nurses' station which is within the reception area.

[88] It was no part of the respondent's case that there should have been a "lock-down" of the ward. The absence of lock-down was not pleaded and, in the course of the respondent's evidence in chief, her Honour enquired of Mr McDougall –

> "Is that part of your case, the fact that there had been no lock-down?"

[89] Mr McDougall replied –

> "No. Well, there was no lock-down – that's not necessarily causative of the incident though. What we say is causative of the incident is that there is no greeting and reception area, which is how Dr Shand refers to it, so as to make the transition from the escort party to the Ward 7 staff run smoothly. In other words, the patient should have been kept moving, engaged by the nurse in charge, spoken to, reassured, and handed over to the reception party, and kept moving to where he was to be taken and eventually medicated, which is what occurred."

[90] It was pleaded in the statement of claim that –

> "The plaintiff's injury was caused by the defendant particulars of which are as follows:
>
> …

(c) failing to ensure that staff were present in ward 7 to greet and calm the patient upon his arrival there so as to prevent him panicking and becoming violent

(d) failing to warn or sufficient warn the staff of ward 7 of the impending arrival of the patient at the ward."

Paragraph 4 of the statement of claim alleged –

> "Upon arrival at ward 7, there were no staff present to greet and calm the patient and the patient became unsettled and violently threw himself into a chair."

For good measure, the pleading was amended to add paragraph 3A which provided –

> "Prior to the patient's arrival at ward 7, no warning or no sufficient warning was given to the staff of ward 7 of the impending arrival of the patient so as to enable the staff to greet and calm the patient."

[91] It is, I suppose, implicit in the pleading that had warning of the impending arrival of the patient been given, a greeting procedure would have been put in place which would have averted the incident. The statement of claim makes no allegation about the existence of a protocol or safe system of work in that regard which was breached. Nevertheless, evidence was led in the respondent's case with a view to establishing such a protocol or system. No finding, however, was made of the existence of such a system or, consequently, of failure to follow it. It is likely that this was because of the pronounced lack of consensus between witnesses as to the content of any such system.

[92] Once failure to "lock-down" is disregarded, as it must be, a finding of negligence would need to arise out of a breach of a duty of care resulting from the absence from the reception area of a person appointed to greet the escort party, and the absence of other forewarned members of the nursing staff of Ward 7, coupled with the failure to follow a procedure which would have resulted in "engaging (the patient's) attention, keeping him moving and not giving him time to think about what was happening and showing by inference that force was available if necessary".

[93] The evidence discloses that some Ward 7 staff were, in fact, in and about the reception area when the escort party arrived. Furthermore, the evidence does not support the conclusion that any member of the Ward 7 staff other than the charge nurse or her delegate would be likely to have had a relevant role to play in the time between the escort party's entry into the reception area and the incident.

[94] The failure to greet in the manner referred to earlier is likely to have had a causative effect only if the incident occurred at a time after which the greeting would probably have occurred had notice been given of the patient's impending arrival. Furthermore, subject to any possible application of the principle in *Betts v Whittingslowe*, the respondent needed to establish that had such a greeting process been employed, the incident probably would not have occurred.

[95] The primary judge, accepting the respondent's evidence on the point, found that the incident occurred immediately after a brief verbal exchange between the respondent and a Ward 7 nurse. That finding is not inconsistent with the evidence of Nurse

Jones and Nurse Wilson that the patient was becoming restless whilst approaching the reception area.

[96] Neither psychiatrist was asked to express an opinion on the facts as I have just outlined them, or for that matter, on the facts ultimately found by the primary judge. Dr Shand's evidence was based in part on the existence of a "protocol" which "would have passed possession of (the patient) smoothly" and which would have resulted in the patient being taken through reception to his room without stopping. He concluded that the absence of a person to greet the patient "introduced a note of objective uncertainty" but the factual basis on which the opinion was expressed was not explained. It appears to have been assumed by him that the incident occurred after the time at which the Ward 7 staff, had they known of the impending arrival of the patient, would have commenced some form of interaction with the patient. Also, significant parts of his evidence were based on the erroneous premise that Ward 7 was a locked ward at relevant times and, as noted earlier, on the belief that existing procedures required such a patient to be taken directly to his or her room without stopping in reception. For these reasons, Dr Shand's evidence is of limited evidentiary value.

[97] I do not accept that the evidence justifies the conclusion that the incident occurred after the time at which a Ward 7 nurse, in the ordinary course of events would have made contact with the patient as part of a pre-arranged reception process. As has been seen, Nurse Wilson's evidence does not assist the respondent in this regard and nor does the evidence of Nurse Jones. It does not follow from acceptance of the need for a greeting, reassurance, a smooth transfer and the like that the transfer could be done only in one way or that, to minimise a physical reaction by the patient, an approach by the charge nurse or his or her delegate must be simultaneous with entry of the escort party into the ward. Flow and continuity could surely be maintained, for a brief period at least, by an expert escort party of five keeping the patient occupied.

[98] The respondent's own evidence was to the effect that in the normal course of events the escort party might be requested by the charge nurse to maintain control of the patient for a period. In such circumstances, a normal expectation would be for the "talker" to remain in that role and indeed, Nurse Jones and the respondent said as much.

[99] The evidence of the nurses who gave evidence, other than the respondent, points to a practice, if that is the correct expression, for the reception of patients in Ward 7 which was less formal and more *ad hoc* than the respondent asserted. In the absence of written rules or directives, one would expect the procedure adopted in a given case to be affected by matters such as: the identity and practices of the charge nurse; the charge nurse's perception of the patient and the other demands on Ward 7 staff at the time of the transfer. This variability in practice, which was not the subject of criticism, does not assist the respondent in proving causation.

[100] Her Honour accepted the respondent's evidence of what happened at and about the time of the incident. That evidence, which was not challenged on appeal, is that the escort party –

> "… stopped and chatted a few words with the patient. In a very short space of time he seemed to become agitated, saying 'what is going

> on here?' before becoming more agitated and throwing himself into a chair."

[101] On the respondent's version of events, if there was a break in continuity or a change in atmosphere which acted on the patient, it was only for a matter of seconds. That may be enough, of course, to establish liability if the inference can be drawn that the events in Ward 7, which had their genesis in a failure to notify the charge nurse of the patient's impending arrival, brought about uncertainty, hesitancy or a changed atmosphere which triggered the incident. There may also be scope for the application of the *Betts v Whittingslowe* principle in the absence of facts or circumstances militating against the drawing of an inference favourable to the respondent.

[102] The respondent does not swear to becoming disconcerted or to acting in such a way as to transmit uncertainty to the patient. His evidence suggests the contrary –

> "As we walked up the foyer it was quite obvious that things were not as they should be. .. You are carrying a stick of dynamite and you have to keep that under control, and we were walking up the hallway and looking for people. No-one that I can see acknowledged at that time.
>
> I was just still talking to the patient, keeping him under control … *I was still talking to the patient, keeping him under control. He probably didn't realise that things were too different at that stage and possibly what – than possibly what they should be.* As we came – I was going to centre around – what is usual practice – the nursing office. This is because that is where facilities are – as I have said, medication rooms and single rooms. Now, it is not my duty to march a person into a single room unless I am authorised and ordered to do so. So we took them straight up and kept them in the foyer area at which stage it would – it can, of course, be expected – because there is always a nurse there – to be greeted."
>
> Did you say anything at this stage to someone other than the patient?—Yes, there was a staff member sort of on my wing and I realised that something had to be done here. So I couldn't really say, "What the hell is going on?" I said, "Oh, where would you like us to go now?", words to that effect, giving them the hint to go and find someone to sort the situation out. They said they would go off and do that." (emphasis supplied)

[103] Furthermore the evidence does not suggest that the respondent or any other member of the escort party did something to trigger the patient's actions. The respondent, as one would expect, continued to perform his role as talker so as to attempt to keep the patient occupied and at ease. As the appellant points out, the respondent had more experience of Ward 7 procedures than any other nurse present and was well able to fulfil any calming function which needed to be performed. Four other trained nurses were with him, three with pre-assigned roles. Although the respondent said that his expectation was that the ward would be "shut down" prior to the arrival of the escort party, a "shut down" was not an invariable practice. He was very experienced and the capacity of the escort party to control and manage the patient was never in doubt. As the patient, presumably, was ignorant of the normal operational procedures for transfers to Ward 7, it was unlikely that he would sense

from the matters spoken of by the respondent that there was anything amiss in Ward 7.

[104] On the basis of the facts as found, there was a brief exchange between the respondent and a Ward 7 nurse to which the patient could have attached no relevant significance. Having regard to the matters already discussed, that exchange and the matters surrounding it do not appear to have been likely to have caused the incident. On the other hand, both psychiatrists were of the view that a great many matters might trigger an upset in a person in the patient's disposition. Nurses Jones, Nurse Post and the respondent also gave evidence generally to this effect.

[105] The evidence of Nurse Post and Nurse Jones is that the patient was showing signs of distress on entering into the reception area. The evidence of Nurse Jones in this regard was part of the primary judge's findings and is supported by the evidence of Nurse Wilson. Both psychiatrists expressed opinions to the effect that that the patient's exclamation and sitting down were consistent with the actions of a patient who knew that he had been presented with a change of habitation over which he had no control. A cornerstone of the respondent's case, based on evidence by Dr Shand and the respondent himself, was the need for a continuous progression of events so as to effect a smooth transfer of custody of the patient. It seems likely that the concept of locking down the ward was, in part at least, to have a secure area in which the escort party could hand over custody. Once inside that area there would not appear to be any particular need for the transfer operation to keep flowing in the sense of continuous physical movement and it appears to have been normal procedure for an escort party to wait in reception with the patient and to keep custody of him whilst so doing.

[106] Dr Shand gave no evidence to the effect that it would be contrary to sound practice for an escort party, particularly one comprising five trained male nurses, to retain custody and general responsibility for the patient being transferred in the reception area of the receiving ward for an appreciable period. As was noted earlier, he through it acceptable for an escort party to retain custody of the patient and to continue with the "talker" role after arrival in the receiving ward.

[107] Dr Nothling gave evidence that in his experience a patient being transferred to a secure ward was not usually met by a receiving team as such. His opinion was that, in practice, an escort party usually would not relinquish custody of the patient immediately on arrival in a receiving ward. He rejected the notion that it was desirable to have a reception group on the basis that "It doesn't work in the practical world, and secondly, it might quite frighten many of the patients". Also, in his experience, unless the charge nurse had been warned to expect a violent patient, he or she would tend to "be writing some notes (in the nurses' station) … but she wouldn't come rushing out straightaway".

[108] Having regard to the evidence that the actions of patients of the nature of the subject patient are unpredictable and that emotional outbursts or physical actions may be triggered by a wide range of things, it is difficult to conclude that had there been a pre-arranged greeting by Nurse Wilson or her delegate things would probably have turned out differently. That is particularly so if regard is had to the fact that an experienced psychiatric nurse was exerting a calming influence at the time of the incident.

[109] Neither psychiatrist expressed an opinion about the desirability or likely efficacy of intervention by the charge nurse once the patient, under the control and supervision of the escort party, manifested signs of distress or anxiety. Indeed, there is no reason to suppose that the greeting process, spoken of by Dr Shand as part of a technique directed to preventing a patient from becoming unsettled, was necessarily appropriate, at least without adaptation, where the incoming patient had become unsettled immediately on arrival. More specifically, there is no evidence which suggests that Nurse Wilson or any delegate she may have appointed would have been more effective than the respondent in exerting a calming influence on the patient who was showing signs of distress or anxiety before or immediately upon entering the reception area. A reaction by a patient in connection with his or her transfer to Ward 7 was a likely enough eventuality and that is why the patient was escorted to the ward by five trained nurses in the manner already discussed. That was an appropriate precaution to take in the circumstances.

[110] The evidence relied on by the respondent to establish causation is thus deficient in a number of critical respects. At best for the respondent the facts give rise to conflicting inferences of equal degrees of probability so that the choice between them is merely a matter of conjecture or surmise. In such circumstances, a finding of liability is not open.[32]

[111] In these circumstances, it is not permissible to resort to the principle in *Betts v Whittingslowe* in order to draw the inference that, on the balance of probabilities, the incident was caused by the failure to alert the charge nurse in Ward 7 of the patient's impending arrival which, in turn, lead to the failure to implement a greeting process in Ward 7.

[112] In my view, the more compelling inference to be drawn from the facts is that the incident resulted from an increase in the patient's level of anxiety as a result of his transfer to a new environment and that, even if Nurse Wilson had been warned of the patient's impending arrival, a Ward 7 staff member would not have "greeted" the patient prior to the incident or the incident would not have been averted by any greeting.

[113] I would allow the appeal, set aside the judgment below and order that the respondent pay the appellant's costs of the action, including of the appeal, to be assessed on the standard basis.

---

[32] *Jones v Dunkel* (1959) 101 CLR 298 at 304-305 and *Luxton v Vines* (1952) 85 CLR 352 at 358.