

Part II: Civil Liability for the Administration of Medication in Emergencies

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Introduction

Part I of this article critically analysed the Education Department's guidelines on the administration of medication in non-emergency situations while Part II considers these same arguments in the context of the administration of medication in emergency situations.

A medical emergency is a sudden and unexpected occurrence which can involve severe suffering or threat to the life of another. Schools in this study reported that the most common medical emergencies include anaphylactic fits, hypoglycaemic episodes and severe asthma attacks (students who are vulnerable to such conditions are referred to as 'high-risk students'). In all these emergencies, the life of a student may depend on the quick recognition by staff of relevant symptoms and consequent administration of medication.

In an attempt to 'provide an adequate system to ensure that no child is exposed to any unnecessary risk of injury',¹ the guidelines require schools to develop emergency action plans for students with medical conditions.² The rationale behind this requirement is that schools should 'address all known contingencies before they occur and to ensure that all staff members are aware of their responsibilities should a medical emergency eventuate'.³ Despite the merit of this requirement, the guidelines have not addressed a number of inherent risks that may arise in emergencies.

Duty of Care

Ordinary members of the community do not have a duty to rescue others regardless of how little effort or danger is involved in achieving that rescue.⁴ However, some 'special' relationships, such as school authority/teacher and student, create a positive obligation to rescue.⁵ Although no Australian case definitively states that school authorities and staff have a duty to rescue students, the 'special' nature of their relationship would seem to create a positive obligation to rescue. It appears self-evident that their general duty of care to 'protect students against risks of injury'⁶ includes coming to the rescue of students in peril.⁷ Undoubtedly, the duty extends to administering medication in an emergency. Given that the death of a student is more probable in an emergency, staff cannot refuse to administer medication and, given the lack of time, are unlikely to be able to delegate this task.

Breach of the Duty of Care

Standard of Care

When ordinary members of the community assist in an emergency errors in judgment or execution that normally give rise to liability are likely to be excused, as rescuers are not expected to exhibit the high level of prudence and competence expected in less stressful situations.⁸ A rescuer's standard of care is therefore judged against what is reasonably expected in an *emergency*, without the benefit of hindsight.⁹ However, the courts generally do not interpret 'reasonableness' strictly, because it is considered against the exigencies of the moment.¹⁰ The lower standard afforded to rescuers reflects a strong public policy of condoning heroic acts so as not to discourage others tempted to effect a rescue.¹¹ In any event, rescue victims are generally reluctant to sue rescuers, as they are usually grateful for any assistance provided.¹²

Where a special relationship exists between the rescuer and the victim, such as school authority/teacher and student, a higher standard of care is likely to be imposed. Consequently, what is 'reasonable' in the circumstances of an emergency is likely to be given a stricter interpretation, despite the exigencies of the emergency, although not quite as strict as that in non-emergency situations. Arguably, higher *expectations* are placed on school staff to effect a successful rescue in an emergency requiring medication than in any other emergency situation where rescuers have a 'special' relationship with their victim. These expectations stem, first, from the fact that, unlike rescues attempted by lay persons, the assistance rendered in a school emergency is not gratuitous but rather the result of an affirmative duty of care. Given that the law *requires* parents to send their children to school, parents not only expect school staff to attempt rescues they also expect those attempts to be successful. Second, there is a greater awareness of the risk of injury in a school emergency as parents have usually informed the staff of the student's condition and the appropriate action to take. Arguably, these expectations not only raise the standard of care expected from staff in an emergency but also increase the likelihood that victims will sue.

Nevertheless, although staff are unlikely to be given much leeway in an emergency, there are circumstances in which considerable leeway may be given. For example, if an untrained teacher is compelled to give an adrenalin injection to a student having an anaphylactic fit, because no trained person is available, the teacher may avoid liability. The legal principles that usually apply to lay persons performing expert tasks are unlikely to apply in this situation because if no attempt to give the injection is made death is certain. Essentially, the 'saving of life or limb justifies taking considerable risk'.¹³ In any event, rather than the teacher, the school authority and principal are likely to be liable for failing to develop an effective emergency action plan.¹⁴

However, the situation is different if an untrained teacher insists on giving the injection in the place of a readily available trained person. In that situation the court is likely to impose the standard of care expected from a person with special skill, since the untrained teacher has effectively held himself or herself out as having that skill.¹⁵

The guidelines provide¹⁶ that where medical help is unavailable and untrained staff give an injection, they will only be legally covered by the Education Department if they:

1. Check the label, dosage and identity of the student prior to giving the injection;

2. Are acting within the agreed emergency plan;
3. Do not impede the assistance of a qualified person; and
4. Receive adequate instructions from a qualified person or parent prior to giving the injection.

While the first three of these conditions are reasonable in an emergency similar to that outlined above, the fourth condition is unrealistic. There is simply no time to get these instructions as a student with anaphylaxis can become unconscious within three minutes. Most classrooms do not have telephones and it may be more dangerous for the teacher to leave the student alone while obtaining instructions. In any event, the court is more likely to be concerned with the negligence of the school authority and principal in failing to ensure that a properly trained staff member was available.¹⁷ The 2001 draft guidelines appear to acknowledge the problems with the fourth condition and now provide that staff must 'seek medical advice or assistance immediately *after* the emergency situation'.¹⁸

Foreseeability of Risk

Allowing untrained staff to supervise high-risk students, having high-risk students in large classes with only one teacher, and storing emergency medication too far away from high-risk students creates obvious risks of injury that cannot be dismissed as 'far fetched and fanciful'.

Probability and Gravity of Risk

(a) Untrained staff supervising high-risk students

Clearly, there are grave risks associated with placing a high-risk student in the care of an untrained teacher who is unaware of the symptoms or actions to be taken in an emergency. The situation is analogous to allowing a teacher who cannot swim to supervise a swimming class, since the teacher would not be able to rescue a drowning student.¹⁹ Similarly if a teacher does not know what to do if a student has an anaphylactic fit or does not recognise the symptoms, death or serious injury is highly probable.

(b) High-risk students in large classes

It is inherently risky to put a high-risk student in a class of approximately 28²⁰ or more students with only one teacher supervising. Even if the teacher is trained to recognise particular symptoms indicative of an emergency, he or she may not immediately realise that a student is in danger because his or her attention may be elsewhere in the classroom. One teacher reported that she had a child with severe diabetes in her class who frequently had hypoglycaemic episodes. The student did not have the ability to know when she was about to have a hypoglycaemic episode and, therefore, could not alert the teacher to danger. Consequently, the student would sometimes slip into unconsciousness, and, if left for too long without glucose and oxygen to the brain, ran the risk of sustaining brain damage.

(c) Storage

Despite the earlier arguments regarding the risks associated with storing medication in the classroom,²¹ different considerations apply for high-risk students because they need to have

immediately accessible medication. If medication is not closely located to high-risk students, and an emergency occurs, they may be seriously injured or die.

Reasonable Precautions

(a) Training

All staff need to be trained in recognising symptoms indicative of an emergency which requires, prompt action to be taken. A select group of trained staff is insufficient as they may not always be available. Time spent locating trained staff is dangerous given that some high-risk students need immediate treatment to prevent death or serious injury. A well organised emergency action plan should nominate specific staff members to act in an emergency, but also provide that, if they cannot be located immediately, another trained staff member should act.

In recognition of the need for training regarding emergency situations, the January 2001 draft guidelines state that 'all staff should be trained in anaphylaxis prevention, recognition and management' and include a three step first aid management plan and information as to symptoms to be aware of.²² It is likely therefore that principals are required to regulate staff training in this regard. In one school, the principal ensured staff competence regarding anaphylaxis management by organising regular practice sessions in which staff injected oranges with an epipen.²³ Although the guidelines comprehensively prescribe training requirements for anaphylaxis management they do not contain similar requirements regarding other equally potentially life threatening illnesses, such as asthma, epilepsy, diabetes and hypoglycaemia. If the school authority is to discharge its duty of care effectively with regard to administering medication in emergencies, it must not only require schools to develop emergency action plans, but also provide schools with information about *all* illnesses that could potentially become emergencies²⁴ and require *all* staff to obtain practical training on the action to take in an emergency should the plan fail. These may be onerous requirements for principals and staff but, given the magnitude of the risk associated with staff not having this training and the relatively low cost of obtaining it,²⁵ the court is likely to consider that it is a reasonable precaution. The June 2001 draft guidelines appear to acknowledge this requirement as information on asthma and diabetes has now been included in the guidelines.²⁶

(b) High-risk students in large classes

It may be difficult to take precautions against this risk as the *Disability Discrimination Act (1992) (Cth)* may come into effect if disabled students are segregated from other students.²⁷ However, the risk could be reduced by placing high-risk students in a clearly visible position in the classroom, such as at the front of the class. Although this precaution may cause embarrassment and loss of dignity to high-risk students, the risk of death or injury will likely outweigh these concerns.

(c) Storage of emergency medication

The guidelines state that, if students require immediate access to their medication, an 'arrangement must be made with the school'.²⁸ However, they fail to provide how such an arrangement should be facilitated. Some schools address the issue by storing medication outside the classroom but as close as possible to the student (e.g. the principal's office). Other schools have developed a 'token system' whereby all staff carry different coloured tokens, each colour indicative of the particular emergency and the medication required. In an emergency the staff member gives the token to an

able student who runs to the front office. Staff in the front office obtain the medication and then run with the student to the emergency. Although there is merit in these practices, their success depends on the immediate recognition of a student's symptoms; if the symptoms are not immediately recognised the time spent obtaining medication may prove fatal. It may therefore be more appropriate for high-risk students to carry their medication with them at all times²⁹ or to store it in the classroom. Although this creates risks for other students in the class, who may gain access to this medication, these may be necessary risks given the even greater risk of death or serious injury to the high-risk student.³⁰

Conclusion

Having highlighted the risks and problems associated with administering medication in schools, it may be useful to, first, summarise the proposed guideline reforms that have been discussed in Parts I and II of the article and, second, raise some options for alleviating staff liability for erroneous medication administration, particularly in emergency situations.

Guideline Reforms

The guidelines go some way to discharging the school authority's duty to provide a safe and effective medication administration system.³¹ For example, they provide strict protocol for medication administration,³² include examples of medication request forms to be filled out by parents and doctors³³ and provide recommendations regarding the development of emergency action plans.³⁴ However, the guidelines are not as comprehensive as they could be and unnecessarily expose staff to potential liability and students to potential injury. These risks would be further minimised if the guidelines were reformed in the following ways:

1. A clear statement that teachers and principals have a duty to administer medication and therefore *cannot* refuse to administer medication (although the guidelines may provide a statement that delegation to another responsible staff member is permissible in non-emergency situations);
2. A clear statement as to how staff are to *administer* medication. For example, schools must:
 - (i) Locate students if they do not collect their medication from the central location;
 - (ii) Supervise students while they ingest their medication;
 - (iii) Contact parents if students refuse to take their medication;
3. Classroom administration of medication in non-emergency situations should be prohibited. Schools should be required to have medication administered from a central location by at least two nominated persons;
4. *All* staff should be trained to administer medication in emergency situations. Those staff members who will be administering medication in non-emergency situations (i.e. from a central location) should also be trained. Furthermore, the guidelines should contain comprehensive information about the prevention, recognition and management of *all* common student illnesses;

5. *All* non-emergency medication should be stored in the front office (in accordance with suggestion three) regardless of whether it is to be self-administered or not;
6. Parents, guardians or, at the very least, a responsible adult should be required to bring medication into the school, not the student;
7. Unsupervised self-administration of medication should be prohibited.
8. Emergency medication should be kept proximate to the student at all times in the classroom and taken with the student if he or she leaves

Minimising Liability

The duty incumbent on staff to administer medication is exceptionally onerous particularly given the already difficult roles they have and the fact that administering medication has, in recent times, become more complicated. If the guidelines are modified such that staff can delegate their duty of care to administer medication to a central administration system, liability arising from erroneous administration in non-emergency situations is likely to be greatly reduced. However, in emergencies, delegation may not be possible, given the lack of time. Consequently, staff may have no choice but to administer medication and, given the taxing exigencies of an emergency, there is certainly the potential for errors to be made and liability to ensue. Furthermore, the standard of care is likely to be even higher for trained staff. Given these factors, the potential liability staff face in these circumstances should be either partially or wholly alleviated.

However, it is important to ensure that the predominant objective of tort law - to compensate the injured party³⁵ - is not undermined. A balance must be struck between alleviating the liability of staff and compensating injured students. Something that would undoubtedly promote this objective would be the introduction of a government-funded school injuries compensation scheme, which would work in a similar way to workers' compensation schemes.³⁶ The system would provide automatic compensation to injured students, proportionate to the extent of their injuries, regardless of fault. For reasons of fairness, the injuries compensable under this system would include all injuries sustained by students while at school rather than simply those sustained as a result of a medication error.³⁷

(a) Immunity Legislation

Legal proceedings could not be instituted against staff members if immunity legislation were enacted in conjunction with a school injuries compensation scheme. Given that the Education Department is, in most cases, vicariously liable for the negligence of staff, the Education Department is, for all practical purposes, solely liable to pay compensation regardless of whether immunity legislation is in place or not. The purpose of immunity legislation is therefore not predominantly to alleviate staff from paying compensation, but to circumvent their exposure to the court process. Staff expressed concern that, if sued, their professional reputation would suffer, because a court case could take quite some time, thereby necessitating absence from work. Furthermore, school injury cases tend to attract a lot of negative publicity and hostility from parents.³⁸ Moreover, the trauma of litigation and a finding that a staff member has been negligent

has the potential to undermine the confidence of staff who act in similar future emergency situations.

In some Australian states, immunity legislation has been enacted for the negligent acts or omissions of persons with medical expertise, such as doctors, in emergency situations that occur outside working hours.³⁹ These persons are not generally legally obliged to voluntarily assist in these circumstances⁴⁰ and, prior to the introduction of immunity legislation, the potential for liability if an error was made was a major disincentive for them to act. Clearly, the rationale for enacting immunity legislation is to encourage persons with medical expertise to assist in emergencies, given that they are best equipped to deal with them.

If immunity legislation were enacted for school staff the rationale would be entirely different. It would acknowledge the degree of difficulty and stress they face in emergencies as a result of the fact that; (1) they generally have very limited, if any, medical training; (2) any training they have raises the standard of care they may be held to; (3) they are *required* to act in emergency situations which occur at schools; (4) their primary role is to teach and hence they do not use the limited medical training frequently, unlike medical personnel; and (5) should an error be made the potential for liability is high given that the circumstances of a school emergency are, to some extent, expected (e.g. emergency action plans, parents warning the school of potential medical emergencies).

In the United States, Connecticut has enacted immunity legislation for school personnel which provides that if they 'render emergency care by the administration of *medication by injection* to a student in need thereof, they shall not be liable to the student assisted for civil damages for any injuries which result from negligent acts or omissions in providing that emergency assistance'.⁴¹ It further provides that immunity will *only* be granted if school personnel have specialised training with regard to giving an injection. By specifying the need for training, the section seems to acknowledge that a higher standard of care attaches to trained persons, thus they can more easily breach their duty, and consequently they need immunity most. By contrast, there is no need for immunity legislation for untrained school personnel who give injections in life or death situations since, in any event, they are unlikely to be held liable under general common law principles. Furthermore, by limiting the immunity to persons giving injections, the section recognises that giving injections is an inherently dangerous procedure with a wide margin for error as opposed to merely administering tablets in an emergency where the margin for error and the risk of injury to the student is small. To this extent, the Connecticut immunity legislation for school personnel may be an ideal model for Australia.

It seems clear that school authorities and delegates have a duty to administer medication to students. The guidelines have attempted to provide clarity to staff in administering medication and to alleviate their concerns with this duty. However, some of the guidelines unintentionally create confusion and unnecessarily expose the school authority and its delegates to potential liability. Although the risk of staff administering medication erroneously can never be entirely eliminated, if the guidelines are reformed to reflect the above suggestions, the risk of error and liability is likely to be greatly reduced.

Endnotes

* This article is based on the thesis submitted by Jenny Thrum in partial fulfilment of the LLB (Hons) degree, School of Law, University of Western Australia

1. *Commonwealth v Introvigne* (1982) 150 CLR 258, 274 (Murphy J).
2. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 7,12; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 9,12; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 10, 13.
3. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 12; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 13.
4. *Hargrave v Goldman* (1963) 110 CLR 40, 66 (Windeyer J); *Quinn v Hill* [1957] VR 439, 446; *Home Office v Dorset Yacht Club* [1970] AC 1004, 1027; *Donoghue v Stevenson* [1932] AC 562, 580 (Lord Atkin); *Jaensch v Coffey* (1984) 155 CLR 549, 579 (Deane J). However, if the danger is caused by a person who then fails to go to the rescue, leading in turn to the injury or death of the victim, that person may well have a duty to rescue: *Wagner v International RR* 133 NE 437 (1921). Similarly, a rescuer may owe a duty of care once a rescue attempt has been embarked upon. The duty is to ensure that the actions of the rescuer do not increase the risk to victims or bring others into danger: *OLL Ltd v Secretary for the Home Department* [1997] 3 All ER 897.
5. *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 502 per Deane J, *Horsley v Maclaren (The Ogopogo)* (1971) 22 DLR (3d) 545 (SCC).
6. *Richards v State of Victoria* [1969] VR 136, 140 (Winneke CJ).
7. *Commonwealth v Introvigne* (1982) 150 CLR 258; *McCallion v Dodd* [1966] NZLR 710, 721 (North P); *Moddejonge v Hurron County Board of Education* [1972] 2 OR 437.
8. L Crowley-Smith, 'The duty to rescue unveiled: a need to indemnify Good Samaritan health care professionals in Australia?' (1998) 4(4) *Journal of Law and Medicine* 352, 356; N Gray and J Edelman, 'Developing the law of Omissions: A Common Law Duty to Rescue?' (1998) 6 *Torts Law Journal*, 256.
9. *Ward v TE Hopkins & Son Ltd* [1959] 3 All ER 225 (CA), 244 (Willmer LJ); *Horsley v Maclaren (The Ogopogo)* (1971) 22 DLR (3d) 545, 559 (Laskin J).
10. *Ward v TE Hopkins & Son Ltd* [1959] 3 All ER 225, 244 (Willmer LJ).
11. LBC, *Laws of Australia*, vol 33 Negligence, '2 Duty of Care' [33-69].
12. Mitchell McInnes, 'Good Samaritan Statutes: A Summary and Analysis', (1992) 26(2) *University of British Columbia Law Review*, 239.
13. *Watt v Hertfordshire County Council* [1954] 1 WLR 835, 838 (Denning LJ).
14. Aside from the common law, s.53 of the Nurses Act 1992 (WA) is also likely to apply in this situation. It provides that –
Notwithstanding anything in this Act, a person does not commit an offence against this Act if the person, whether or not for remuneration, provides such first aid or medical attention as is necessary to save a human life or to relieve human suffering in a medical emergency where it is not possible or practicable for a medical practitioner, or a nurse qualified to provide the first aid or medical attention to do so.
15. *Rogers v Whitaker* (1992) 175 CLR 479.

16. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 12.
17. *Australian Capital Territory Schools Authority v El Sheik* (2000) Aust Torts Reports ¶81-577.
18. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 21; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 23.
19. As in *Moddejonge et al. v Huron County Board of Education et al.* [1972] 2 OR 437.
20. It was found that the average class size in most primary schools was 28 students.
21. See 2.2.3(c) in Part One of this Article.
22. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 39
23. An epipen is a device shaped like a pen which is jabbed into the upper leg or buttocks of the student for the purpose of releasing Adrenalin into the body to combat the symptoms of anaphylaxis.
24. For an example of how other state Education Departments have dealt with this issue, see the Tasmanian guidelines which provide comprehensive information to all schools on life threatening disabilities.
25. As discussed in footnote 72 in Part I of this article, public hospitals and community support groups provide this training either freely or at a very low cost - some parents of children with these illnesses had also volunteered to teach school staff about the action they must take in a medical emergency. Furthermore, the time that would be needed to be set aside for this training would not be unreasonably high since it could be obtained by the staff during the five days of professional development time they are allowed each year.
26. Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 42-43, 45-51.
27. *Disability Discrimination Act 1992 (Cth)*, s.22(2)(c).
28. Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 16; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 17.
29. For example, in a 'bum bag' which is a small bag that clips around a student's waist with a small zipped pouch.
30. In other words, the utility of the risk may justify taking it: *Daborn v Bath Tramways* [1946] 2 All ER 333, 336; *Mercer v Commissioner of Road Transport* (1936) 56 CLR 580, 589.
31. *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258, 274 (Murphy J).
32. For example, written authority from student's parent or guardian, medication to be properly labelled and sent only in minimum quantities, administration only in accordance with instructions or advice of a medical authority: Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 6, 11; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 10, 15-16; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 11, 16-18.
33. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 9, 10; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 24-26; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 27-28.

34. Administration of Medication Policy and Procedures, Education Department of Western Australia, 1997, 12-13; Student Health Care Draft Guidelines January 2001, Education Department of Western Australia, 21; Student Health Care Draft Guidelines June 2001, Education Department of Western Australia, 23.
35. JG Fleming, *The Law of Torts* 9th edn (North Ryde NSW: LBC Information Services, 1998), 5.
36. Andrew Wake, 'Unpredictable Children and the School's Duty of Care' (Paper presented at the 3rd Australian and New Zealand Education Law Association Conference, Brisbane, 1994) 154; Ian M Ramsay and Ann R Shorten, *Education and the Law* (Sydney: Butterworths, 1996), 196-197; Peter G Heffey, 'The Duty of Schools and Teachers to Protect Pupils from Injury', (1985) 11 *Monash University Law Review*, 1-64, 63-64; Gordon Avenell, 'The demise of *in loco parentis*', (1990) 12(4) *The Practising Administrator*, 16-19,38. A partial example of a school injuries compensation scheme has been developed in NSW: *Sporting Injuries Insurance (Amendment) Act 1984 (NSW)*. Similarly, since 1974, New Zealand has had a comprehensive system of exclusive compensation, replacing tort recovery not only for traffic and industrial accidents but for all 'personal injury by accident'. This latter phrase has been interpreted *very* broadly to cover a wide range of accidents.
37. Those who have suggested the introduction of a student compensation scheme (see footnote 36) have, in any event, argued that the scheme should have a wide application, as is the practice with the workers compensation scheme.
38. See also 'letters to the editor' (2000) 29 *Western Teacher* 4 (letter written by W. Powell, former principal) whereby some of these concerns are highlighted.
39. *Law Reform Act 1995 (Qld)*, s.16; *Ambulance Services Act 1990 (NSW)*, s.26.
40. However, the decision of the Court of Appeal of New South Wales in *Lowns v Woods* (1996) Aust Torts Reports ¶81-376, has introduced a duty which compels physicians to render medical aid to imperilled strangers.
41. Title 52. Civil Actions, Chapter 925 Statutory Rights of Action and Defences, Conn.Gen.Stat § 52-557b (1997).