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Heroin Overdoses and Duty of Care

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This paper discusses the legal concept of "duty of care" in the context of witnessing heroin overdose. Heroin users are encouraged never to inject alone so that in the event of an overdose, medical assistance may be immediately called. However, results from the recent National Drug Strategy Household Survey indicate that a significant proportion of overdose witnesses do not call for an ambulance or for other medical help. Reasons given include an unwillingness to get involved and fear of police involvement. The latter is attributable partly to fear of prosecution on drugs charges or on outstanding warrants, and partly to witnesses' concerns over legal liability in the event of the user's death.

It is noted that there is no general duty to provide or call for assistance, but that such a duty may arise from particular circumstances or relationships. Theoretically, a duty of care may be breached by failure to call for assistance or by negligently administering assistance. However, the practical likelihood of criminal prosecution of a witness for the death of an injecting drug user is, in all but the most exceptional of circumstances, minimal. The appropriate public policy message is that the legal risks to overdose witnesses in calling for assistance are far outweighed by the medical risks to the user of not doing so.

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Heroin is the most popular injected drug in Australia. One study found it was the "last drug injected" by over half (52%) the injecting drug users in 1998, and by two in five (44%) users in 1995 (McKetin et al. 2000). The most severe acute consequence of using heroin is death by overdose, often as a result of polydrug combinations rather than heroin alone. The number of heroin overdose deaths in Australia has been increasing since the 1970s, and has more than doubled since 1990. Population-adjusted figures show a similar increase, from 40 overdose deaths per million population in 1990, to 87 deaths per million population in 1998 (McKetin et al. 2000). In 1998 alone, 737 Australians aged 15 to 44 years died from opiate overdoses.

Injecting drug users are encouraged to never inject alone and to "taste" (that is, use a small amount of newly sourced heroin) before injecting in quantity. If overdose does occur, they are encouraged, as are non-injecting members of the general public, to immediately call for an ambulance or for other medical assistance (New South Wales Police Service 2000, p. 4; SA Overdose Prevention Campaign 2000, p. 7). Attendances by ambulance personnel to overdoses are almost universally successful if the calls are made early enough. In the Australian Capital Territory in 1999–2000, for example, ambulance officers attended approximately 490 overdoses, of which 478 were successfully resuscitated, often (but not always) using Narcan (Williams, Bryant & Hennessy 2001). It is the exception rather than the rule in most jurisdictions for overdose victims to receive further

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medical attention following ambulance attendance. Overdose victims in the Australian Capital Territory are virtually never transported to hospital, however, in Western Australia the reverse is true.

To assist in overcoming injecting drug users' reluctance to seek medical assistance due to the possible involvement of police, police agencies in Australia do not routinely attend overdoses (Dietze et al. 2000, p. 30). In general, they only attend:

- if requested to do so by medical personnel (to assist with crowd control or for the protection of ambulance officers);
- if a death has occurred, or
- if they were the first on the scene.

Nonetheless, many injecting drug users and many non-injecting witnesses to overdose choose not to call for medical assistance. The question arises if there is a duty of care to call for an ambulance or other medical assistance when witnessing an overdose. Are persons under a legal obligation to seek medical attention for others whom they reasonably believe are overdosing?

This paper is divided into three parts. The first part presents results from a national survey of Australians which canvassed (among other items of interest) reporting behaviours of witnesses to heroin overdoses and reasons why some of those overdoses were not reported to ambulance or other medical professionals for assistance. The second part of the paper describes the legal consequences of not calling for medical assistance. The third part discusses policy implications.

Data and Sample

The overdose data used in this paper are based on the most recent National Drug Strategy Household Survey, which was conducted in 1998. The survey included questions on personal experiences of heroin overdoses and reporting behaviours (whether overdoses were reported and, if not, reasons why). Over 10,000 respondents aged 14 years or older participated in the survey. To improve the reliability of estimates, the sample was stratified by sex, age and geographic region, and then weighted to the estimated 1998 resident population for each stratum to produce an aggregated distribution proportional to the national population. Further details on the survey methodology can be found in Williams (1999), Australian Institute of Health and Welfare (1999) and Roy Morgan Research (1999).

Witnesses to Heroin Overdoses

Heroin belongs to the class of drugs known as analgesics or, in lay terms, painkillers. It is most commonly taken by injection and induces a surge of pleasure (a "rush") which gives way to a state of gratification (Department of Human Services and Health 1994). In large or high-purity doses it can depress the respiratory and central nervous systems to such an extent that unconsciousness, coma or death may result. Unconsciousness accompanied by depressed breathing characterises most "overdoses". In 1998, over 80,000 males and over 100,000 females witnessed at least one heroin overdose (Table 1). (These estimates are extrapolated from the population weighting procedure employed for the 10,030 survey participants.) While the number of witnesses to overdoses might seem high to the uninitiated, the National Drug Strategy Household Survey estimated that in the same year there were close to 110,000 injecting drug users (AIHW 1999). Over half of all heroin injectors have experienced an overdose, and more than one-third overdosed in 1999–2000 (Williams, Bryant & Hennessy 2001).

The vast majority of witnesses to overdose witnessed between one and four overdoses in the 12 months prior to the survey in 1998. Injecting drug users were overwhelmingly more likely than non-injecting persons to witness an overdose, with less than two per cent of non-injectors witnessing an overdose in the previous 12 months.

Likelihood of Calling for Medical Assistance

Approximately two-thirds (64.2%) of all persons who had witnessed heroin overdoses in the 12 months leading up to the survey *always* called for ambulance or other medical assistance (Table 2). Female witnesses (67.6%) were slightly more likely than male witnesses (61.7%) to always call for assistance.

About one in eight witnesses (12.0%) *sometimes* called for medical assistance and one in

Table 1: *Estimated number of witnesses to heroin overdoses, by sex, Australia 1998*

Number of times witnessed overdoses	Males	Females	Injecting drug users	Non-injecting witnesses
	Number		(%)	
1–4	58,423	86,942	15.9	0.9
5–9	18,579	14,741	1.4	0.3
10–14	2,340	5,284	2.8	0.0
15+	2,391	1,382	6.8	0.6
Total	81,733	112,349	26.8	1.7

Source: 1998 National Drug Strategy Household Survey unit record file

Table 2: *Whether ambulance or other assistance sought when witnessing heroin overdose, by sex, Australia, 1998 (%)*

Call for ambulance, other health assistance?	Males	Females	Injecting drug users	Non-injecting witnesses	All Persons
Yes, always	61.7	67.6	49.7	65.9	64.2
Yes, sometimes	10.3	14.3	35.5	10.3	12.0
No, never	28.0	18.1	14.8	23.8	23.7

Source: 1998 National Drug Strategy Household Survey unit record file

four witnesses (23.7%) *never* called for assistance, with male witnesses (28.0%) more likely than female witnesses (18.1%) to never call for medical assistance. Interestingly, while two-thirds of non-injecting witnesses (65.9%) *always* called for assistance compared to less than half of injecting witnesses (49.7%), almost twice as many non-injecting witnesses (23.8%) as injecting drug user witnesses (14.8%) *never* called for assistance.

Table 3: *Reasons for not calling for assistance, Australia, 1998 (%)*

Reason	Males	Females	Injecting drug users	Non-injecting witnesses	Persons
I/we were too inebriated/intoxicated	15.9	3.6	0.0	14.4	11.9
I/we didn't want to get involved	17.8	29.6	20.9	22.7	21.7
I/we were capable of handling the overdose	28.0	63.4	53.9	35.8	39.6
I/we were afraid the police would get involved	28.2	41.5	41.1	32.0	32.6
Other reason	43.6	14.5	5.5	41.2	34.0

Notes: Base equals all respondents who did not always call for ambulance, health assistance
More than one response allowed
Source: 1998 National Drug Strategy Household Survey unit record file

Why Witnesses of Heroin Overdoses do not Always Request Assistance

Approximately one in five (21.7%) witnesses to heroin overdoses who did not call for medical assistance did not do so because they "didn't want to get involved"; another third (39.6%) thought they were "capable of handling the overdose" (Table 3). Female witnesses (63.4%) were more likely than male witnesses (28.0%) to nominate "capability".

One in three witnesses (32.6%) who did not call for medical assistance did not call because they "were afraid the police would get involved". Again, female witnesses who did not call for assistance (41.5%) were more likely than male witnesses (28.2%) who did not call to be "afraid" of police involvement. When only injecting drug user witnesses who did not call for medical assistance are considered, over half (53.9%) indicated "they were capable of handling the overdose" as a reason, and two in five (41.1%) indicated that they feared police involvement.

In a 1998 South Australian study of non-fatal overdose among heroin users, fear of police involvement was also found to be a significant factor for delay in calling for assistance (McGregor et al. 1998). Specific fears identified as secondary reasons were concerns regarding outstanding warrants (31%) and fear of manslaughter charges (33%). In order to assess whether such fears are well founded, it is necessary to consider both the applicable law and police practices in the context of injecting drug user overdose.

Duty of Care

There is no general legal duty to rescue a person from danger, to prevent harm occurring to a person, or to render assistance to a person in need. This (to some, surprising) state of affairs is often summarised in the claim that the law imposes *no duty to be a Good Samaritan* (Kift 1997; Ratcliffe 1966; Menlowe & McCall Smith 1993). It follows that the law does not normally punish people who fail to rescue, prevent harm or give assistance to others, no matter how morally reprehensible their conduct may be.

Of course, there are exceptions to the general rule. While legal liability does not normally arise from what are termed "pure omissions", the common law has traditionally recognised certain circumstances or relationships as giving rise to a legal duty of care. Breach of such a duty may attract legal liability for any resulting harm (including criminal liability for death). Cases in which failure to act has resulted in criminal prosecution include:

i. the failure of a parent to prevent the death of a child—*Russell* [1933] VLR 59 and *Lowe* [1973] QB 702;

ii. inadequate care provided by persons who voluntarily assume the responsibility of caring for someone—*Stone and Dobinson* [1977] 1 QB 354 and *Taktak* (1988) 14 NSWLR 226; and

iii. the failure of a person to prevent harm resulting from a dangerous situation created by that person—*Miller* [1982] 2 AC 161.

Where someone is present at a heroin overdose, or is in a position to call for assistance, the circumstances *may* fall into one or more of the above categories.

Specific duties may also be imposed by legislation. Some jurisdictions define homicide offences in a way which includes omissions as well as acts causing death, for example, the *Crimes Act 1900* (NSW), section 18, and the *Criminal Code* (Tas), section 153. The criminal codes of several States and the Northern Territory also set out specific duties relating to the preservation of human life, care of children, and dangerous acts or things:

- *Criminal Law Consolidation Act 1935* (SA), ss 29–30;
- *Criminal Code* (Qld), ss 285–290;
- *Criminal Code* (Tas), ss 144–152;
- *Criminal Code* (WA), ss 262–267; and
- *Criminal Code* (NT), ss 149–154.

Interestingly, section 155 of the Northern Territory code creates an offence of failure to rescue:

> Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously

> fails to do so is guilty of a crime and is liable to imprisonment for seven years.

This rare "Good Samaritan provision" was considered by the Northern Territory Supreme Court in *Salmon* (1994) 70 A Crim R 536, where an appeal against the conviction of a hit-and-run driver under section 155 was allowed on the basis that the failure to stop was explicable as "blind panic" rather than a callous decision (Leader-Elliott 1996). Such a provision could conceivably apply in the situation where a witness to a heroin overdose failed to call for medical assistance purely out of self-interest, such as fear of prosecution on drugs charges.

Standard of Care

The existence of a legal duty of care does not by itself convey what standard of care is required to be observed. Courts assess negligence by reference to the standard that would be observed by the "reasonable person" in similar circumstances. For trained professionals such as medical personnel, the standard is that of the ordinary similarly skilled person in similar circumstances: *Rogers v Whitaker* (1992) 175 CLR 479.

In the case of injecting drug users, it is unlikely that anyone apart from trained medical personnel could reasonably be expected to give active medical assistance. The required standard of care for an ordinary witness to an overdosing injecting drug user is unlikely to extend beyond calling for medical assistance (usually telephoning for an ambulance), and not obstructing or hindering the delivery of that assistance. However, an untrained person who does attempt to provide medical assistance and causes harm in the process runs the risk of being judged against the standard of a medical professional. While the danger of causing injury to an overdosing injecting drug user may be small if all that is attempted is to clear airways and to put the person in a "recovery" position, there are potential dangers in the administration of further substances in an attempt to assist recovery. This issue takes on added importance against proposals for relatives and friends of injecting drug users to be given prescriptions of resuscitation drugs such as naloxone (also known as "Narcan") for administration in the event of overdose (Steele 1998; Lenton & Hargreaves 2000; ANCD 2000). Ambulance officers have expressed concern that naloxone may actually cause fatalities if administered to the wrong persons, such as those not actually experiencing overdose, or those who are unconscious due to multiple drug use (ABC Radio National 2000). Further, it has been suggested that peer administration of naloxone would undermine other prevention strategies, with some research indicating increased likelihood of failure to call an ambulance (Lenton & Hargreaves 2000, p. 262).

It is important to stress that for criminal liability to be imposed, breach of a duty of care must fall a *very* long way short of the standard of the reasonable person in the circumstances (*Taktak* (1988) 14 NSWLR 226). The test accepted in Australia in relation to manslaughter by criminal negligence is set out in the case of *Nydam* [1977] VR 430:

> In order to establish manslaughter by criminal negligence, it is sufficient if the prosecution shows that the act which caused the death was done by the accused consciously and voluntarily, without any intention of causing death or grievous bodily harm but in circumstances which involved such a great falling short of the standard of care which a reasonable man would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment.

For civil liability (in an action brought by surviving dependants), the plaintiff must prove on a balance of probabilities that the defendant's negligence caused the death (*Haber v Walker* [1963] VR 339). Such actions are normally commenced only against defendants with significant capacity to pay damages, or who have some form of liability insurance.

Questions of civil and criminal liability have been more comprehensively investigated in relation to proposals for supervised injecting facilities (Cica 1995; Bronitt 1995).

Criminal Liability for Heroin Overdose

Courts have on numerous occasions held that manslaughter can be committed through the administration of drugs. Most often, this arises when one person injects another with an illegal drug, such as heroin, with fatal consequences. To do so without the consent of the person injected, or with the intention of causing death or bodily harm, clearly constitutes a criminal act which may, in rare cases, be prosecuted as murder. Injection of heroin, even with the consent of the person being injected, has been held by the English Court of Appeal to constitute an "unlawful and dangerous act" sufficient to ground a manslaughter conviction: *Cato* [1976] 1 WLR 110. Similarly, manslaughter by criminal negligence can be committed by administering drugs: *Taylor* (1983) 9 A Crim R 358 (in which a mother, acting on medical advice given over the phone, was convicted for mistakenly giving her six-year-old child a lethal dose of a sedative). It is not unrealistic, therefore, to expect a manslaughter charge where one person administers heroin to another who subsequently dies from overdose (Darke, Ross & Hall 1996, p. 416).

However, the likelihood of criminal prosecution is considerably less in other circumstances. Where one person merely supplies drugs which are subsequently injected with fatal

results, the voluntary act of self-administration is usually regarded as an intervening event which breaks the causal chain leading from the act of supply to the death: *Dalby* [1982] 1 All ER 916. It is only where there is some further act of involvement or encouragement in the lethal overdose, such as preparing the heroin mixture and handing it to the injecting user, that a manslaughter conviction is likely to be upheld: *Kennedy* [1998] EWCA 3411.

Legal Implications of not Calling for Assistance

Mere failure to call for an ambulance to assist an overdosing injecting drug user who dies is highly unlikely to result in a prosecution for murder or manslaughter. The difficulties in proving that such failure amounts to criminal negligence are formidable, as shown by the few cases in which the issue has arisen.

In *Taktak* (1988) 14 NSWLR 226, the defendant was initially convicted of manslaughter on the basis that he voluntarily assumed the care of a 15-year-old heroin user who died from an overdose. Critical to the conviction was the fact that the defendant had, by taking the victim to a flat and covering her with a jacket and blanket, effectively removed her from a situation in which other persons could have assisted or obtained assistance. The New South Wales Court of Criminal Appeal accepted that this imposed a duty of care on the defendant, but disagreed that the level of culpability was sufficient to sustain the conviction of manslaughter by criminal negligence. The appeal was allowed, and the conviction quashed.

In *Khan* [1997] EWCA 945, the English Court of Appeal overturned the manslaughter convictions of two heroin dealers who had supplied a 15-year-old inexperienced user with heroin at their apartment. She orally ingested a large amount of the drug and went into a coma. The defendants left without calling for the medical assistance the girl clearly required, and later returned to dispose of the body and surrounding evidence. Noting that the defendants' behaviour "was about as callous and repugnant as it is possible to imagine", the Court nonetheless ruled that the manslaughter convictions could not be upheld in the absence of a duty of care arising in the circumstances.

In the recent Australian case of *Madhavi Rao* [1999] ACTSC 132, the accused was tried as an accomplice to the lethal injection of a victim with heroin. In the absence of evidence of significant accessorial involvement in the homicide, the prosecution sought to establish manslaughter on the alternative basis that the accused had failed to obtain medical treatment or assistance for the victim. However, this was rejected by the trial judge as there was no evidence that the victim had exhibited symptoms requiring urgent medical intervention at a time which might have placed the accused under a duty to seek such assistance. On a "reference appeal" by the prosecution seeking to clarify the question of duty of care, the Federal Court rejected the appeal as incompetent because the trial judge had not ruled on the question: *R v MR* [2000] FCA 1127.

Discussion and Policy Implications

It is clear that from a harm minimisation perspective, which is the central plank to the National Drug Strategic Framework (MCDS 1998), and from the available epidemiological evidence, witnesses to heroin overdose should *always* call for medical assistance. It is also clear, however, that despite 15 years (1985–2000) of this message being promulgated through the National Campaign Against Drug Abuse, the National Drug Strategy and, more recently, the National Drug Strategic Framework, over one-third of witnesses to overdoses will not seek medical assistance for a variety of reasons. The first obstacle which appears amenable to change is the perception among the one in three witnesses who do not report, and particularly among fellow injecting drug user witnesses, that police will become involved.

State and Territory police agencies are to be congratulated on their professional relationship with injecting drug users and their restraint and willingness to observe the "better good" in not routinely attending overdoses. They are active in promoting this policy in the general community and among injecting drug users. Ambulance services also reinforce the message at every opportunity (New South Wales Police Service 2000; Queensland Ambulance Service 2000). Among injecting drug users, however, their most recent interaction with police prior to witnessing an overdose was likely to have been in relation to a use/possess or deal/traffic matter (most injecting drug users also deal in illicit drugs to support their habit). These experiences are sometimes unpleasant, which may partly explain their fear of police involvement. The recent introduction of police drug diversion programs, which channel drug users into education and treatment instead of into the criminal justice system, might change the way in which injecting drug users experience the processing by police of drug-specific charges. Police might also give consideration, when attending non-fatal overdoses, to checking bona fides or outstanding warrants of witnesses only in exceptional circumstances.

For the one in eight witnesses who were themselves too inebriated or intoxicated at the time of an overdose to call for assistance, existing health

messages about safe injecting practices are obviously not getting through. Further research into this apparent failure is warranted.

For the one-third of witness who thought they were capable of handling the overdose (and particularly the two-thirds of injecting drug user witnesses who gave this reason), and for the one in five who just did not want to get involved, clear and consistent messages on the medical dangers associated with such (in)action need to be given again and again, by health and law enforcement authorities alike.

From a legal standpoint, failure to call for assistance is unlikely to give rise to civil or criminal liability. Fears of manslaughter charges arising from merely witnessing an injecting drug user overdose are (in all but exceptional circumstances) unwarranted, and provide little excuse for failing to respond. Even where the particular circumstances are such that the law recognises a duty to assist, prosecution for such failure is one of the less likely outcomes.

The appropriate public policy response may be to inform injecting drug users and those who might be witnesses to an injecting drug user overdose that the legal risks in calling for assistance are minimal and are far outweighed by the medical risks of not doing so. It is important that this message be consistently delivered by police, health professionals, social services personnel and others who come into regular contact with injecting drug users. In the event that a turnaround in willingness to call for medical attention does not occur in the short to medium term, even after the adoption of these measures, consideration might be given to legislative reform. The Northern Territory's "Good Samaritan provision", which in effect obliges bystanders to render, or call for, assistance to those in need if they are capable of doing so, provides one possible model.

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