Australian Nursing and Midwifery Federation submission

Ahpra and the National Boards Public consultation for the review of the Criminal history registration standard and other work to improve public safety

28 September 2023

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 322,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide feedback to Ahpra and the National Boards public consultation for the review of the *Criminal history registration standard* and other work to improve public safety.

CONSULTATION QUESTIONS

Focus area one – The Criminal history registration standard

1. **The *Criminal history registration standard* (Attachment A) outlines the things decision-makers need to balance when deciding whether someone with a criminal history should be or stay registered such as the relevance of the offence to practice, the time elapsed and any positive actions taken by the individual since the offence or alleged offence. All decisions are aimed at ensuring only registered health practitioners who are safe and suitable people are registered to practise in the health profession.**
   Do you think the criminal history standard gets this balance right?
   If you think the *Criminal history registration standard* does not get this balance right, what do you think should change to fix this?

   The ANMF believes that in general, the balance of maintaining public safety, and treating health practitioners fairly in regards to their criminal history is appropriate. However, a registration standard is meant to define the requirements a practitioner needs to meet for registration. The content of the *Criminal history registration standard* is in the form of a guideline for decision makers about how they will balance various considerations. The ANMF submits that this content should be removed from the Standard and included in an accompanying guideline.

   The ANMF notes that there is no direction on the impact if pending charges are withdrawn. We suggest that an explanation of the process that occurs when charges are withdrawn is included. For example, if granting of registration has been delayed to consider/investigate a pending charge and the charge is withdrawn, then the Standard should be clear that no further consideration should be given to a charge which has been withdrawn and any record of this removed.

   In relation to Standard 3.d. “non-conviction charges”, the Standard fails to clearly delineate the difference between a “finding of guilt without conviction” and a completed “diversion program” in which the accused is “discharged” without a finding of guilt recorded. The National Law defines criminal history as:

   > *(b)* ***every plea of guilty or finding of guilt*** *by a court of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law and whether or not a conviction is recorded for the offence;* (emphasis added)

   A person who has completed a diversion program in Victoria, for example, is not considered to have pled guilty nor has there been a finding of guilt.

There is no protection given over the information and documents sought by Ahpra under the *Criminal history registration standard* such that these would be protected from subpoena, summons or being adduced into evidence in any criminal proceedings. Such a protection would protect the public and the rights of the accused practitioner.

In addition, there should be clarity within the Standard on how those applying for registration will be supported through the process, to avoid possible re-traumatisation by the regulator.

2. **Do you think the information in the current *Criminal history registration standard* is appropriate when deciding if an applicant or registered health practitioner's criminal history is relevant to their practice? If not, what would you change?**

   No, as stated above, fundamental rights and fairness need to be an express consideration and real protection needs to be given to information provided where the outcome is pending in a criminal matter.

   The ANMF suggests the following amendments:

   - The current standard should apply to student registration, in order that a student with an incompatible criminal history not undertake education leading to registration only to find on completion of their qualification that their application for registration as a practitioner will not meet the *Criminal history registration standard*; and
   - There should be a nationally consistent threshold for an "offence". For example, in Queensland and Tasmania, under poor definitions of thresholds, practitioners are required to notify Ahpra on their annual renewal if they have paid the fine for a parking ticket (which meets the QLD/TAS definition of conviction). Other states do not maintain this standard.

3. **Do you think the information in the current *Criminal history registration standard* is clear about how decisions on whether an applicant or registered health practitioner's criminal history is relevant to their practice are made? If you think it is not clear, what aspects need further explanation?**

   The current *Criminal history registration standard* would be made clearer with the addition of Attachments B and C. If these attachments were incorporated into the current Standard, the document would be more intuitive. In addition, the decision-making process could be more transparent by publishing the outcomes of previous criminal history checks.

The current *Criminal history registration standard* can cause confusion amongst practitioners. This is because there remains an inconsistency between health practitioners' obligations in respect of making a declaration under the *Criminal history registration standard* at registration renewal time and practitioners' obligations to give notice of relevant events under section 130 of the National Law in respect of criminal history during a registration period. Under section 130, a practitioner must give notice when:

- charged with a scheduled medicine offence;
- charged with an offence punishable by 12 months imprisonment or more;
- found guilty of a scheduled medicine offence;
- found guilty of an offence punishable by imprisonment, whether in a participating jurisdiction or elsewhere.

As a result of the inconsistency there is an obligation to disclose only certain criminal matters to the Boards during a period of registration while there is an obligation to declare virtually all criminal matters at registration renewal time. It therefore appears that Ahpra and the National Boards, in applying the *Criminal history registration standard*, are in many instances scrutinising and investigating practitioners for criminal conduct or alleged criminal conduct below the threshold that was of concern to the legislators in enacting (and recently amending) section 130 of the National Law.

4. **Is there anything you think should be removed from the current *Criminal history registration standard?* If so, what do you think should be removed?**

   The *Criminal history registration standard* should not take into consideration or should place minimal weight on previous findings of guilt that have been deemed under applicable legislation to be 'spent' convictions. Not allowing practitioners to move on from their past indiscretions and subjecting them to Ahpra investigations about previous conduct is demoralising and damaging to potential practitioners.

   The ambiguity in the definition of "non-conviction charges" discussed above should be addressed.

5. **Is there anything you think is missing from the 10 factors outlined in the current *Criminal history registration standard?* If so, what do you think should be added?**

   Yes, there should be a standalone protection of the accused practitioners' rights that are guaranteed in our system of justice. We know that our criminal justice system incarcerates minorities at a disproportionate level. Care should be taken to ensure that the *Criminal history registration standard* does not support systemic discrimination where Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) practitioners are being disproportionately refused registration. It is noted that the paper discusses a guideline about this but would request it be extended to, or one be created for, CALD practitioners also.

Under factor 3, “non-conviction charges” should carry a presumption to grant registration, unless there is evidence of a direct connection between the finding of guilt and the practice of the profession. A “direct connection” for example meaning the finding of guilt without conviction for offences committed in the course of practice.

There should also be guidance around vexatious complainants and charges in the context of domestic violence or relationships with coercive control.

6. **Is there anything else you would like to tell us about the *Criminal history registration standard*?**

Greater detail is required to outline how the Standard will be appropriately implemented. For example, although the consideration of the disproportionate representation of Aboriginal and Torres Strait Islander peoples within Australia’s criminal justice system is appropriate, greater detail is required regarding how to engage with this criminal history in a culturally safe way. This may include preferred methods of communication, or reducing costs related to the application and assessment of these decisions.

The summary in the current Standard should be amended to better reflect the points made in Attachment B, or Attachment B should be permanently incorporated into the published Standard.

More focus needs to be given to the practice or actions the practitioner has taken in response to an offence and their attitude moving forward. The real risk to the public needs to be considered and articulated not a “just in case” approach, which is what presently exists.

Focus area two – More information about decision-making about serious misconduct and/or an applicant or registered health practitioner’s criminal history

7. **Do you support Ahpra and National Boards publishing information to explain more about the factors in the *Criminal history registration standard* and how decision-makers might consider them when making decisions? Please refer to the example in Attachment B. If not, please explain why?**

Yes, the ANMF supports this approach. The publishing of the guidance document does go some way to help applicants for registration understand the matters that will be taken into consideration when decisions are made by the Boards.

However, Attachment B has very troubling examples of decision-making that should be subject to appeal and review if passed. These are:

> *16. However, if the alleged offending is serious and indicates a pattern of behaviour it may be that a decision is made before the charges are heard.*
>
> *17. Similarly, where the nature of the conduct or behaviour is serious and considered to pose a risk to the public, a decision may be made regardless of the fact there has been no conviction or no finding of guilt.*

The use of tendency and coincidence evidence in this way is fraught with bias and assumptions. The use of the nature of an offence alone being enough to refuse registration will act to exclude some registrants who have, often unsubstantiated, accusations made of a sexual or assault nature. The decision-makers who hold no legal qualification are able to make life changing decisions before any conviction is laid, based on whichever charge the police officer decided to lay.

8. **Is the information in Attachment B enough information about how decisions are made about practitioners or applicants with a criminal history? If not, what is missing?**

Attachment B is confusing and seems to be trying to cast as wide a net as possible. It states "a penalty imposed at the upper end of the range of sentencing options would indicate that the offence was considered more serious" and then that "a sentence imposed is, however, not a definitive guide to the seriousness of the offence or its relevance to practice". Instead of allowing some consideration that the person may pose less of a risk, Attachment B warns that "Decision-makers should not assume that a non-custodial sentence imposed in criminal proceedings implies an offence is not serious in the context of health practice". This does not strike a balance at all. There should be a clearer outline for practitioners of the factors that may mitigate the offence for example, having counselling, a learning plan and safety nets in place. Where offences occur at work, the systemic issues such as staffing, training and psychosocial hazards should be considerations in any decision-making process.

Accountability measures/processes are not clearly articulated or defined in the decision-making process. In order to track potential inconsistencies, the ANMF recommends a straightforward infographic is incorporated into the next version. Another way to help prospective registrants understand the decision-making process would be to publish summaries of negative decisions. Decisions made by the Boards to refuse registration could be published on the Ahpra website much in the way Panel decisions are published, with personal details of unsuccessful applicants anonymised. There should also be an explanation of the decision-making process that led to the final outcome. This would demonstrate and provide a better understanding of the Boards' decision-making processes and provide for accountability and transparency around the Boards' application of the registration standards including the *Criminal history registration standard.*

9. **Is there anything else you would like to tell us about the information set out in Attachment B?**

   The ANMF suggests that paragraph 1 of Attachment B should be made clearer, to ensure that all the guiding principles are addressed, and that workers' rights to work are upheld. Paragraph 17 also requires clarification to ensure full consideration of the effects pending charges may have on health practitioners.

   There is no guidance around practitioners who are dealt with through alternative sentencing such as section 32 or mental health orders, drug court, traffic offender programs, circular sentencing or other alternative means. These sentences are intended to be less punitive although loss of registration based on the charge rather than the outcome renders that intention unlikely.

10. **Thinking about the examples of categories of offences in Attachment C, do you think this is a good way to approach decision-making about applicants and registered health practitioners with criminal history? If you think this is a good approach, please explain why. If you do not agree with this approach, please explain why not.**

    In respect of the proposed approach, we note that this reflects the approach taken in assessing working with children checks and NDIS worker screening in the various jurisdictions. If this approach were to be taken under the *Criminal history registration standard,* very clear lists would be required to be included detailing the relevant offences under each category, in accordance with the applicable legislation and/or criminal codes in force in each jurisdiction. This means that if a Board refused to register a person on the basis of a finding of guilt in a Category A offence, the exact offence relied upon under the relevant jurisdiction to refuse registration would need to be specified. Similarly, if the Boards were to invite the applicant to show cause as to why they should not be refused registration because of a charge or finding of guilt related to a Category B offence, then the *Criminal history registration standard* would need to be very clear about the status of the offence relied upon under the criminal law/code of the relevant jurisdiction.

    The ANMF believes this is an appropriate way to approach decision-making. It would leave prospective applicants under no misapprehension as to severity and weight placed on each type of offence. The use of different categories for different offences would clearly demonstrate that offences relating to traffic, minor drug offences, and nuisance would hold little to no weight compared to offences listed in Categories A and B.

    It is the ANMF's view that each category would need to detail a comprehensive list of the applicable offences. A draft itemisation of the criminal offences to be included under each category would need to be put out for further consultation before offence Categories A, B and C were incorporated into the *Criminal history registration standard.*

11. **Do you think there are some offences that should stop anyone practising as a registered health practitioner, regardless of the circumstances of the offence, the time since the offence, and any remorse, rehabilitation, or other actions the individual has taken since the time of the offence? Please provide a brief explanation of your answer. If you answered yes, please explain what you think the offences are.**

    The ANMF is unable to respond to this appropriately without further information on how assessments will take place (including, but not limited to, who will have decision-making capacity and what qualifications, training, and experience they hold). In general, the capacity for human error in this circumstance may be too high, and removing the possibility of careful review by a Tribunal board may too strongly and negatively impact the health field. The context and circumstances are always relevant and there should be case by case consideration each time.

12. **Is there anything else you would like to tell us about the possible approach to categorising offences set out in Attachment C?**

    The approach of categorising offences mirrors the categorisation of offences adopted in worker screening legislation in each jurisdiction. Many practitioners who work with children or in the NDIS are already subject to the overlapping and duplication under the *Criminal history registration standard* and state-based worker screening legislation. In Victoria, teachers registered with the Victorian Institute of Teaching are spared the duplication of regulation. They are not required to have Working with Children Checks. Ahpra and the Boards must find a way of harmonising their categorisation of offences with the different state and territory jurisdictions screening regimes to avoid unnecessary duplication, delay and the distress this causes practitioners.

Focus area three – Publishing more information about decisions that are made about serious misconduct by registered health practitioners

13. **Were you aware that disciplinary decisions by tribunals about registered practitioners were published to Ahpra and National Board websites and are linked to an individual practitioner's listing on the public register?**

    Yes. This can, at times, prevent the practitioner from returning to practice. The consequence is indefinitely punitive and leads in effect to a lifetime ban not only for employment as a health practitioner but also in other unrelated jobs. Where the decision of the Tribunal is intended to be protective not punitive, similar to a reprimand being lifted, there should be a process by which an application can be made to unlink a decision or publish when a person is allowed to return to practice and why they are allowed to return.

14. **Do you think decisions made to return a practitioner to practice after their registration has been cancelled or suspended (reinstatement decisions) for serious misconduct should be published where the law allows? Please explain your answer.**

Reinstatement decisions should not automatically be made public. Rather, they should be considered on a public interest basis, and publication should be determined by a court or a Tribunal body.

It may help build confidence that the practitioner has met the concerns of the Tribunal, complied with orders, and all the protective factors are outlined. Deterrence is often stated as a factor considered in making protective orders against a practitioner. Publishing reinstatement decisions to the same websites would demonstrate that practitioners can learn, grow and change.

15. **Is there anything else you would like to tell us about the approach to publishing information about registered health practitioners with a history of serious misconduct?**

Currently registered health practitioners who have had an adverse Tribunal decision made against them have a hyperlink to the full decision added to their profile on the public register. The length of time that this decision remains on the register is not regulated. It appears that it is Ahpra's practice to leave the hyperlink on the practitioner's public register profile in perpetuity. The effect of publishing the decision in this manner has a disproportionate effect on health practitioners such as nurses and midwives who generally practice as employees when compared with practitioners who are self-employed, for example medical practitioners.

Many practitioners who have adverse findings hyperlinked to their public register profile find it difficult, if not impossible, to gain employment because of the hyperlink to the Tribunal decision. Prospective employers are dissuaded from employing these practitioners because of the reputational risk of those using their service accessing the adverse decision through the public register, years later.

This is not only prejudicial to the practitioner, it usurps the role of the Tribunal. Tribunals carefully consider and calibrate the sanctions they apply to practitioners' registrations following findings of professional misconduct and unprofessional conduct. For instance, a Tribunal may impose a sanction of 8 months' suspension on a practitioner for engaging in sexual harassment of colleagues. The purpose of such a sanction is general and specific deterrence of practitioners engaging in such conduct in the workplace. The effect of publishing the hyperlink to the decision on the practitioner's public register profile in the case of an employee nurse, renders that practitioner practically unemployable indefinitely, despite the intention of the Tribunal which determined the appropriate sanction.

Rather than leaving the decision about publishing hyperlinks to Tribunal decisions to the Boards, under section 225(p) of the National Law, the National Law should require the Tribunal to specify the length of time the hyperlink and other information about the decision such as the reprimand is published on the public register.

The ANMF would like to ensure that any information published is in accordance with section 226 of the *Health Practitioner Regulation National Law Act 2009*:

> 1. A National Board may decide that information relating to a registered health practitioner is not to be recorded in a National Register or Specialists Register in which the practitioner's name is included if—
> (a) the practitioner asks the Board not to include the information in the register; and
> (b) the Board reasonably believes the inclusion of the information in the register would present a serious risk to the health or safety of the practitioner.

Focus area four – Support for people who experience professional misconduct by a registered health practitioner

16. What do you think Ahpra and National Boards can do to support individuals involved in the regulatory process who are affected by sexual misconduct by a registered health practitioner? (For examples, see paragraph 47 of this paper).

Ahpra as an investigative body and decision-maker needs to remain independent of complainants, however, they should refer complainants and practitioners who have been accused of misconduct to support services.

Once identified, Ahpra must connect relevant individuals with current services and professional supports, such as respect.gov.au, lifeline, and local legal aid commissions. Victims should be provided a greater voice in the Tribunal, being offered the opportunity to verbally raise the impact of the misconduct on their life and well-being.

17. Is there anything else you would like to tell us about how we can support individuals affected by a registered health practitioner's professional misconduct?

The ANMF would like to raise concerns that the focus of support is on the notifier, and ignores support that may be required by the health practitioner. In our member's experiences complainants may be vexatious or perpetrators of domestic violence themselves. Support should be given to all involved where the presumption of innocence is upheld until proven otherwise. Publishing available services for the health practitioner, such as Nurse and Midwife support, will help to reduce recidivism.

Focus area five – Related work under the blueprint for reform, including research about professional misconduct

18. Are the areas of research outlined appropriate?

We suggest more in-depth consultation on how shared governance will be established with Aboriginal and Torres Strait Islander bodies.

All research needs to be publicly available so that education can be developed, and active steps taken to bring attention to issues and trends for further research.

19. Are there any other areas of research that could help inform the review? If so, what areas would you suggest?

The following areas of research could be considered:

- Research investigating the consistency of professional misconduct decisions by Tribunals between the different jurisdictions, to ensure that there is consistency in the findings and the sanctions applied across the different jurisdictions;
- Research into the consistency in findings and sanctions made across the different professions, for example a study comparing the outcome in matters brought by the Medical Board and the Nursing and Midwifery Board; and
- Research examining the practical effects on the professional careers of practitioners with findings of professional misconduct recorded against them. This study could examine the role of gender or race in determining the career outcomes for practitioners found guilty of professional misconduct.

Additional question (This question is most relevant to jurisdictional stakeholders):

20. Are there opportunities to improve how Ahpra and relevant bodies in each jurisdiction share data about criminal conduct to help strengthen public safety?

There is room for significant improvement. Ahpra should continue to build relationships and information-sharing capabilities with the other bodies that subject health practitioners to fit-for-work checks and investigative processes to ensure swift processing of matters. To streamline the application process, duplication of investigation processes should be avoided as much as is possible.

In addition, we know that nurses and midwives (and many other health practitioners) associate their profession with their identity. This strong identification causes a psychological risk to the practitioner when they fear losing their registration, and lengthy investigations and stand-down processes further cause significant mental health injury. It is a worker's right to participate in employment. We acknowledge the importance of these investigations, but the processes must be conducted in a timely manner and with appropriate supports in place for the health practitioner's emotional and social health and wellbeing. Health practitioners rightly work in a highly regulated environment, designed to protect people receiving care. It is reasonable to forecast that in an environment fraught with punitive, lengthy, and unnecessary investigative processes, health practitioners may leave the profession while others may be deterred from joining.

For greater transparency, the training that is provided to decision-makers in order to assess criminal history and other matters should be published.

CONCLUSION

Thank you for the the opportunity to provide feedback to Ahpra and the National Boards public consultation for the review of the *Criminal history registration standard* and other work to improve public safety. The ANMF believes that in general, the balance of maintaining public safety, and treating health practitioners fairly in regards to their criminal history is appropriate in the revised standard. However, the content of the *Criminal history registration standard* is currently in the form of a guideline for decision-makers rather than as a registration standards to define the requirements a practitioner needs to meet for registration. The ANMF submits that this content should be removed from the Standard and included in an accompanying guideline. Extensive feedback is provided to ensure fair, equitable, transparent and consistent decision-making processes and to reduce duplication of criminal history and fit-for-work checking processes for the benefit of health practitioners and those for whom they provide health and aged care.