Attachment D – Submissions template

Public consultation: Review of the Criminal history registration standard and other work to improve public safety in health regulation

The Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards are inviting stakeholders to have their say as part of our review of the *Criminal history registration standard* (the criminal history standard). There are 19 specific questions we'd like you to consider below (with an additional question 20 most relevant for jurisdictional stakeholders). All questions are optional, and you are welcome to respond to any you find relevant, or that you have a view on.

Your feedback will help us to understand what changes should be made to the criminal history standard and will provide information to improve our other work.

Please email your submission to AhpraConsultation@ahpra.gov.au

The submission deadline is close of business **14 September 2023**

How do we use the information you provide?

The survey is voluntary. All survey information collected will be treated confidentially and anonymously. Data collected will only be used for the purposes described above.

We may publish data from this survey in all internal documents and any published reports. When we do this, we ensure that any personal or identifiable information is removed.

We do not share your personal information associated with our surveys with any party outside of Ahpra except as required by law.

The information you provide will be handled in accordance with Ahpra's privacy policy.

If you have any questions, you can contact AhpraConsultation@ahpra.gov.au or telephone us on **1300 419 495.**

Publication of submissions

We publish submissions at our discretion. We generally publish submissions on our website to encourage discussion and inform the community and stakeholders about consultation responses. Please let us know if you do not want your submission published.

We will not publish on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

We can accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. A request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or if you want us to treat all or part of it as confidential.

Published submissions will include the names of the individuals and/or the organisations that made the submission unless confidentiality is expressly requested.

Initial questions

To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☒ Organisation

Name of organisation: Sexual Assault Services Victoria

Contact email: [redacted]

☒ Myself

Name: [redacted]

Contact email: [redacted]

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ A member of the public?

☒ Other: Peak body for Victorian specialised sexual assault services

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Focus area one – The Criminal history registration standard

Question 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?

Your answer:

A number of the 'factors' are not appropriate for determining the relevance of criminal conduct to a person's registration status. This means that the factors do not get the balance right.

Factor 1. The nature and gravity of the offence or alleged offence and its relevance to health practice. *The more serious the offence or alleged offence and the greater its relevance to health practice, the more weight that the Board will assign to it.*

The seriousness of an offence will sometimes but may not always inform whether conduct in question is consistent with being a fit and proper person to hold registration. For example, there are sexual offences that are categorised under law as less serious, summary offences, that would nevertheless be highly problematic in the context of registration as a health practitioner. Examples in the *Summary Offences Act 1966* (Vic) include sexual exposure (s 19) and observation of genital or anal region of another person (s 41A).

All sexual offences cause a type of fear, trauma and psychological distress that is unique from other types of person-based offending. Sexual offending of any level speaks to a person's (usually a man's) problematic attitude about their own status and position of power in respect to another person (usually a woman and women generally or other vulnerable people).

A person that has, even just once, committed a less serious (but still highly damaging) sexual offence such as exposing themselves or unlawfully taking a video of a person's genital or anal region has demonstrated that they are willing to exert power and fear over another person for the purpose of their own status and sexual gratification.

Given that doctor-patient relationships involve the latter being in a physically and/or emotionally vulnerable position, any level of sexual offending by an applicant or health practitioner demonstrates an attitude that is inconsistent with being a fit and proper person to be registered for health practice. Whether there has since been attempts to take accountability for sexual offending and to reform problematic attitudes, is a separate and subsequent question.

As such, there should not be a default approach of affording greater relevance and weight to more serious offences, particularly in the case of sexual offences. The analysis should be whether the offence in question demonstrates behaviour that makes the person unfit for registration as a health practitioner. The answer to this question may be more clear cut with serious offences; however, equal analysis needs to be undertaken to all sexual offences as to whether the behaviour is consistent with registration as a health practitioner.

Factor 1 could be rephrased to: "the nature of the offence and its relevance to health practice", with the accompanying note stating words to the effect that "offences that hold greater relevance to health practice will be assigned more weight by the Board".

Factor 2. The period of time since the health practitioner committed, or allegedly committed, the offence. *The Board will generally place greater weight on more recent offences.*

This factor should be removed. The passage of time alone does not demonstrate remorse or a willingness to reform problematic behaviours and attitudes.

Factor 3. Whether a finding of guilt or a conviction was recorded for the offence or a charge for the offence is still pending. *In considering the relevance of criminal history information, the Board is to have regard to the type of criminal history information provided. The following types of criminal history information are to be considered, in descending order of relevance.*

a. *Convictions*
b. *Findings of guilt*
c. *Pending charges*
d. *Non conviction charge; that is, charges that have been resolved otherwise than by a conviction or finding of guilt, taking into account the availability and source of contextual information which may explain why a non-conviction charge did not result in a conviction or finding of guilt*.

All underlined material should be removed, or removed for other offences but retained for sexual offences.

Whether or not there was a conviction or finding of guilt does not always attest to whether a person is fit and proper for the purpose of registration as a health practitioner.

If someone is convicted or found guilty of an offence, this demonstrates that there was enough evidence available for a person to be found guilty of that offence, beyond reasonable doubt. If a person is found guilty or convicted, it is appropriate for the Board to rely on this finding that the conduct constituting the offence occurred, without having to reinvestigate that issue.

If a person is acquitted or found not guilty of a particular offence, this does not automatically mean that the conduct in question is less relevant to whether a person is fit and proper for registration. It simply means that either the person's conduct did not amount to a particular offence or that the evidence available did not persuade a judge or jury beyond reasonable doubt. In such cases the Board needs to investigate the behaviour that was the subject of charges to determine whether that behaviour limits the person's fitness to be registered. It should not place less weight on the behaviour because the person was acquitted of a particular offence.

This is particularly important in cases of sexual offending, which is notorious for its difficulty to prove. Sexual offending often happens in private and proving it can come down to the individual accounts of each party, delivered in the context of a judicial process that is highly traumatic for victim survivors.

Further, if a charge is still pending, this should not delay an investigation by the Board. This is because police and the OPP can take many months if not years in their investigations and decisions on whether or not to progress with charges. It is critical that protection of the public be pursued by the Board in the meantime.

The underlined material should be removed and could be replaced with words to the following effect: "If a person has been found guilty or convicted of a criminal offence, the Board can rely on this outcome in finding that the conduct in question occurred. If a person has been charged with but acquitted of an offence, the Board needs to consider whether the alleged conduct occurred and its relevance to health practice".

The guidance note should provide accompanying information about the difficulties in proving sexual offence matters in particular.

Factor 4. The sentence imposed for the offence. *The weight the Board will place on the sentence will generally increase as the significance of the sentence increases, including any custodial period imposed. The Board will also consider any mitigating factors raised in sentencing, where available, including rehabilitation.*

This factor is problematic in the context of sexual offences. Sentences imposed by courts reflect the level of severity of the offence against the worst levels of offending. The Board should not be looking to benchmark fitness to be registered against a scale that accounts for the very worst behaviour in relation to sexual offences. The behaviour in question should be assessed against the behavioural standard expected of a health practitioner. Factor four could be removed.

Factor 5. The ages of the health practitioner and of any victim at the time the health practitioner committed, or allegedly committed, the offence. *The Board may place less weight on offences committed when the applicant is younger, and particularly under 18 years of age. The Board may place more weight on offences involving victims under 18 years of age or other vulnerable persons.*

With many criminal offences engaged in as a child or young person, it will be fair to assess that the behaviour stemmed from their developmental immaturity or the social or family circumstances they were experiencing at the time. People often look back at a range of conduct they engaged in when they were younger and recognise that it was not acceptable.

If an applicant has engaged in harmful sexual behaviour as a child or young person (under 18), the assessment will be less straight forward. Specific guidance on this issue should be consulted on and developed for the purpose of Factor 5.

Factor 6. Whether the conduct that constituted the offence or to which the charge relates has been decriminalized since the health practitioner committed, or allegedly committed, the offence. *The Board will generally place less or no weight on offences that have been decriminalized since the health practitioner committed, or allegedly committed, the offence.*

This factor seems reasonable and is appropriate, for example, where a person has had an abortion that was previously considered unlawful.

Factor 7. The heath practitioner's behaviour since he or she committed, or allegedly committed, the offence. *Indications that the offence was an aberration and evidence of good conduct or rehabilitation since the commission, or alleged commission of the offence, will tend to be a mitigating factor. However, indications that the offence is part of a pattern of behaviour will tend to have the opposite effect.*

This factor should be accompanied by specific guidance on behaviours that involved sexual offending. Applicants and health practitioners should be required to demonstrate extensive understanding of the causes of their sexual offending, and complete reformation of any previously problematic or misogynistic attitudes. Given the majority of instances of sexual offending are not reported, arguments that sexual offending was an aberration are problematic.

Factor 8. The likelihood of future threat to a patient of the health practitioner. *The Board is likely to place significant weight on the likelihood of future threat to a patient or client of the health practitioner.*

This is an important factor that will take account of evidence relevant to factor 7.

Factor 9. Any information given by the health practitioner. *Any information provided by the health practitioner such as an explanation or mitigating factors will be reviewed by the Board and taken into account in considering the health practitioner's criminal history.*

This is an important factor to ensure procedural fairness. The Board will weigh the relevance of the information to the person's fitness for registration.

Factor 10. Any other matter the Board considers relevant. *The Board may take into account any other matter that it considers relevant to the application or notification. A Board will not require an applicant or registered health practitioner to provide further information that may prejudice their personal situation pending charges and the Board must not draw any adverse inference as a result of the fact that information has not been provided.*

Factor 10 addresses issues that are not easy to balance. The applicant or health practitioner may have information that is directly relevant to their fitness to practice that may also be disadvantageous to them during a police investigation. This factor requires specific consultation with relevant stakeholders.

Question 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?
Your answer: Please see our responses to Question 1.
Question 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?
Your answer: The information contained in the current standard does not currently articulate a broad statement of the standards of behaviour expected from applicants and existing health practitioners. A preamble to the factors could articulate this.
Question 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?
Your answer: Please see our response to Question 1.
Question 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?
Your answer: Please see our response to Questions 1 and 3.
Question 6 Is there anything else you would like to tell us about the *Criminal history registration standard*?
Your answer: Not at this stage of the consultation.

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

Question 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?

Your answer:

We support this information being published. It will increase community confidence in the system and provide important transparency.

Question 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?

Your answer:

In Attachment B:

Point 1. We agree with point 1 regarding the primacy of public protection.

Point 2. We disagree in the context of sexual offending with point 2 regarding a default position that more serious offences are afforded more weight, for the reasons we articulate above.

Point 3 regarding "the nature of the offence" could be expressed more clearly. It could be rephrased with words to the effect that "a reference to 'the nature of the offence' relates to the *type* of offending, for example, whether the offence was a property related offence or an offence against a person.

Point 4. As we note above, we do not believe there should be a default position in relation to sexual offending that more serious offences are afforded more weight. As such, point four could be removed or modified with specific reference to sexual offending being an exception. If it is retained, it could be expressed more clearly. For example, it could be rephrased with words to the effect that "a reference to the 'gravity' of an offence relates to the seriousness of the offending or alleged offending".

Point 5. We disagree with point 5 regarding the seriousness of the offending, when applied to sexual offending, for the reasons we articulate above. We suggest that the focus be on the extent to which the offence in question is relevant to fitness to be registered as a health practitioner.

Point 6. We agree with point 6, that there will be some offences that are incompatible with fitness to be registered as a health practitioner.

Point 7. We strongly agree with point 7, including that sexual offences are particularly serious in the context of health practice, as well as offences against vulnerable groups.

Point 8. We suggest removing the line that says "while an individual case of these offences may not seem relevant.." A possible rephrasing of this point could be:

- In the context of sexual violence, multiple serious or lesser offences may indicate a pattern of behaviour that may also need close consideration in decision making. Multiple sexual offences may indicate a pattern of behaviour that may compromise the ability and suitability of a practitioner to practise safely and appropriately.

Point 9. This point needs to be entirely re-written. The passage of time alone, in the context of sexual offending, does not demonstrate that a person has reformed. In relation to sexual

offending, there needs to be firm evidence of behaviour and attitude change during the relevant time period.

Point 10 needs to be removed for the reasons articulated above.

Point 11. We support guidance around the relevance of colonization on the criminal history of Aboriginal and Torres Strait Islander peoples. Consultation on this point should take place with First Nations agencies.

Point 12. We support point 12 and recommend that specific guidance be consulted on and developed in circumstances where the applicant or health practitioner has engaged in harmful sexual behaviour as a young person.

Point 13. We agree with point 13 regarding demonstrated positive behaviour since the offending.

Point 14. We agree with point 14 regarding demonstrated concerning behaviours and attitudes since the offending.

Points 15-17. As discussed in our response to Question 1, we disagree, in the context of sexual offending, with an approach that places more relevance on a finding of guilt / conviction. These points should be rephrased so that the guidance makes clear that, in some contexts, for example in relation to sexual offending, (a) a finding of guilt or conviction can be relied upon by the Board that the conduct in question took place; and (b) Where are person has been found not guilty or acquitted of an offence, the behaviour that led to the charges will be investigated by the Board to see if it otherwise impacts their fitness to be registered as a health practitioner. There should be specific guidance developed regarding the complexities in proving sexual assault offences beyond a reasonable doubt, in particular.

Points 18-22. As discussed in our response to Question 1, in the context of sexual offending, we disagree with an approach that weighs a person's fitness to be registered against the sentence imposed. As discussed above, sentences imposed by courts reflect the level of severity of the offence against the worst levels of offending. In the context of sexual offending, the Board should not be looking to benchmark fitness to be registered against a scale that accounts for the very worst behaviour. The behaviour in question should be assessed against the behavioural standard expected of a health practitioner. Guidance around the relevance of sentences should be rephrased to reflect this. We recognise that Point 22 attempts to reflect this to a certain degree.

Points 23-24. We generally agree with the guidance regarding vulnerable groups and the abuse of trust, as articulated in these points.

Points 25 and 26. We generally agree with these points regarding decriminalised offences and offences that are unlawful overseas but not in Australia.

Points 27 and 28. We generally agree with these guiding points on future threats to patient and public safety.

Question 9

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

Your answer:

The criminal history standard is an important framework for determining fitness to be registered as a health practitioner.

Equally important are the processes applicable to situations where problematic behaviour has not been the subject of criminal charges. For example, most sexual assaults are not reported to police, for reasons related to fear, shame, trauma and lack of confidence in the justice system. These matters

need to be treated just as seriously by the Board as those that are reported to police. The same sexual assault related guidelines need to be in place for Board decision makers that are considering alleged instances of sexual assault that were not reported to police.

Question 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.

Your answer:

We do not hold a firm view on this at this stage of the consultation. It is common sense that there are some crimes that are inherently incompatible with fitness to be registered as a health practitioner, including murder, offences related to child sexual exploitation and sexual assault. However, there is some discomfort in placing certain offences within the Category B, second tier list, that "may or may not" be presumed to be incompatible. One example that doesn't sit well in Category B is family violence. Family violence takes many forms across a spectrum of physical, sexual and emotional abuse. Family violence related offences are complex to categorise in this way because Ahpra does not want to inadvertently signal that family violence related offences are anything but incredibly serious and damaging.

One approach to only have one category, being Category A.

Question 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.

Your answer:

Please see our response to Question 10.

Question 12

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

Your answer:

We have no further feedback at this stage of the consultation.

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

Question 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?

Your answer:

We are aware of this.

Question 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.

Your answer:

Yes. It is important for community confidence that reinstatement decisions are transparent. It is also important that there is information available that allows people to make a decision on whether the reinstated health practitioner is somebody they feel comfortable seeking services from.

Many victim survivors of sexual assault and other community members would not want to seek a health service from somebody who had previously been suspended due to a sexual offence.

Question 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?

Your answer:

We have no further feedback at this stage of the consultation.

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

Question 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 the consultation paper.)

Your answer:

We commend Ahpra for asking this important question. There are health practitioners who sexually assault their patients. Equally, there are health practitioners who sexually harass and assault colleagues. For example, we know that senior male medical staff sexually assault junior female colleagues. While reports of these events are becoming more frequent, it is likely that this has been a pervasive, under-reported issue for a long time. This is because most women do not report their experience of sexual assault to police. When sexual assault occurs in the context of a workplace, there is a further disincentive for women to report, because they fear backlash from their professional

community should their report of sexual assault "ruin" the career of a well-respected professional. This is particularly the case in the context of a highly hierarchical medical profession where senior men hold significant personal status and institutional power.

Below are ideas that we are happy to consult with you on further.

1. **Prevention.** Extensive work needs to be undertaken within the medical profession in particular on gender equity. Major cultural shifts are required across the profession so that the underlying enabling norms related to sexual assault are undone. This work is critical to the safety and wellbeing of all medical staff and patients.

2. **Support to report.** Most women (about 87 per cent) do not report their experience of sexual assault to police. This is for many reasons, including shame, the fear of not being believed, and the fear of being subjected to a long justice process that is well known for re-traumatising victim survivors of sexual assault. Further, as noted above, many female medical professionals feel that they cannot report sexual assault committed against them by a senior medical colleague for fear of ruining their own life and reputation in doing so. It is safe to assume that there would be many instances of sexual harassment and assault within the profession that currently goes unreported to the Board.

   There should therefore be an option for health professionals and patients to report their experience of sexual assault to a specialised body, that is equipped to support them through the reporting process within the context of the health profession. This would help to ensure that sexual misconduct is identified within the profession. In instances where sexual assault has not been reported to police, and the criminal history registration statement may not be engaged, a parallel process needs to be available for assessing suitability for registration. Whether a survivor reports to police and/or another body should be a decision of that survivor, with all options offered to survivors.

   The existence of an established, specialised body would hopefully contribute to the cultural shift towards gender equity in the health profession.

   The health profession could look to the report by former Sex Discrimination Commissioner, Ms Kate Jenkins, *Set the standard, Report on the Independent Review into Commonwealth Parliamentary Workplaces to Government.*

3. **Referrals to specialised sexual assault services.** Sexual assault counselling is a specialised, trauma-informed service. All people reporting sexual assault against a health professional should be referred to specialist support.

4. **Advocacy to reform tribunal processes to better protect the privacy and wellbeing of victim survivors.** Victorian Courts are subject to procedural rules that afford a level of protection to victim survivors of sexual assault during criminal proceedings. These procedures are important yet have much room for improvement, as identified in the Victorian Law Reform Commission's 2021 report on *Improving the Justice System Response to Sexual Offences.* VCAT is not subject to such procedures and we hear about victim survivors being significantly, further traumatised as a result of being a part of VCAT proceedings against health professionals alleged to have engaged in sexual misconduct. This process needs urgent reform, if not overhaul.

Question 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?

Your answer:

We have no further feedback at this stage of the consultation.

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

Question 18

Are the areas of research outlined appropriate?

Your answer:

We agree with the proposed research areas. Additional areas for research are:

1. Appropriate bodies for receiving complaints against health practitioners for sexual misconduct.
2. Research on appropriate supports and procedural protections for victim survivors of alleged sexual assault during registration related hearings, including at VCAT.

Question 19

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

Your answer

We have no further feedback at this stage of the consultation.

Additional question

This question is most relevant to jurisdictional stakeholders:

Question 20

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

Your answer:

We have no direct insight into this question.