QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*Health Ombudsman v Fletcher* [2021] QCAT 4
PARTIES:	**DIRECTOR OF PROCEEDINGS ON BEHALF OF THE HEALTH OMBUDSMAN** (applicant) **v** **BELINDA LEANNE FLETCHER** (respondent)
APPLICATION NO/S:	OCR317-18
MATTER TYPE:	Occupational regulation matters
DELIVERED ON:	19 January 2021
HEARING DATE:	1 – 2 October 2020
HEARD AT:	Brisbane
DECISION OF:	Judicial Member D J McGill SC Assisted by: Ms Laura Dyer Dr Kim Forrester Mr Paul Murdoch
ORDERS:	**1. The Tribunal decides that such of the conduct of the respondent alleged in the amended referral, as was admitted by the respondent, or was found by the Tribunal, collectively amounted to professional misconduct.** **2. The respondent is reprimanded.** **3. The suspension imposed by the Health Ombudsman on 26 October 2016 is set aside.** **4. The registration of the respondent is cancelled.** **5. The respondent is disqualified from applying for registration as a health practitioner for a period of twelve months from the date of this decision.** **6. The parties are to bear their own costs of this proceeding.**
CATCHWORDS:	PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – NURSES – DISCIPLINARY

PROCEEDINGS – professional misconduct - registered nurse working in correctional facility – inmate with head injury – failure to monitor adequately – failure to transfer to hospital – sanction – effect of suspension on registration

Health Ombudsman Act 2013, s 10, s 103(1)(a), s 104, s 107, s 109
Health Practitioner Regulation National Law (Qld) s 56, s 148, s 207.

Chen v Health Care Complaints Commission [2017] NSWCA 186
Health Ombudsman v Arora [2019] QCAT 200
Health Ombudsman v Field [2019] QCAT 243
Health Ombudsman v Kennedy [2019] QCAT 319
Medical Board of Australia v Alkazali [2017] VCAT 286
Medical Board of Australia v Cukier [2017] VCAT 109
Medical Board of Australia v Duck [2017] WASAT 28
Medical Board of Australia v Waldron [2017] QCAT 443
Medical Board of Australia v Wong [2015] QCAT 439
Medical Board of Australia v XY [2018] QCA 95
Nursing and Midwifery Board of Australia v Finlay [2018] QCAT 275
Nursing and Midwifery Board of Australia v Gibbons [2014] QCAT 412
Nursing and Midwifery Board of Australia v Manton [2014] QCAT 400
Psychology Board of Australia v Wakelin [2014] QCAT 516

APPEARANCES & REPRESENTATION:	
Applicant:	A R Forbes of Turks Legal
Respondent:	S Robb, instructed by Robert & Kane

REASONS FOR DECISION

[1] This is a referral by the applicant of disciplinary proceedings against the respondent under the *Health Ombudsman Act* 2013 s 103(1)(a), s 104. In accordance with the Act I sat with assessors Ms L Dyer, Dr K E Forrester and Mr P Murdoch.[1]

[2] The respondent is and was at relevant times a registered nurse, and hence a registered health practitioner for the purposes of the *Health Practitioner Regulation National Law* (Qld) ("the National Law"). The applicant alleges that the respondent engaged in professional misconduct in that, while working as a registered nurse in a correctional facility, she did not properly assess and document the condition of a prisoner who had suffered a head injury, did not intervene when he was being

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1 *Health Ombudsman Act* 2013 s 126. For their function, see s 127.

inappropriately dealt with by others, and did not take steps to have the prisoner removed to a hospital in a more timely way.

[3] The respondent was legally represented in the proceeding, and the parties filed a statement of agreed and disputed facts. Most of the facts were agreed, but some were in issue.[2] A number of affidavits and other material were put before the Tribunal, and three witnesses gave oral evidence and were cross-examined: Ms Vale, another registered nurse working at the facility that day; the applicant's expert witness; and the respondent. This matter was heard the day after a similar proceeding involving Ms Vale was heard and decided. That matter proceeded on a set of agreed facts, which were not in all respects the same as the facts on which this matter has been decided. The two matters have been decided separately, each on the basis of the evidence and submissions in that matter only.

Facts

[4] The facts are taken from the statement of agreed facts, and other material before the Tribunal. Where there is a conflict of evidence, that is discussed and dealt with. The respondent was first registered as a registered nurse in March 2012. She spent a graduate year at a country hospital, and then began work as a clinical nurse at a correctional facility. She was no stranger to the facility, as she had worked there for eight years as a corrective service officer ("CSO") prior to completing her nursing training: p 2-18.

[5] On 8 October 2016 the respondent was one of five nurses on duty at the facility, being rostered to work from 7 am to 7 pm.[3] It was a Saturday, so there was no Nurse Unit Manager on duty, although there was one available on call.[4] Each nurse was rostered to a particular position, the respondent in the position called Desk Nurse. She had designated duties in that position, such as collecting pathology specimens and administering Schedule 8 drugs as prescribed, but the position was not particularly busy. The applicant alleged that she had the role of shift coordinator, but the respondent denied this and, as there was little evidence to support this, it is not accepted.[5] She was however the one among those on duty with the longest experience of working as a nurse at the facility, except for one other who had a little more experience,[6] and a combination of this and her prior experience at the facility would have given her some practical authority.

[6] At about 8.30 am a prisoner from the protection unit was hit on the head with a mop bucket in an exercise yard, and the respondent was notified. She attended with a gurney and equipment, together with another nurse and a CSO, and found Nurse Vale already there. Nurse Vale had been on a medication round in the protection unit when she was told of the incident, and was closer to the prisoner.[7] The prisoner

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2 At the beginning of the hearing the applicant sought to withdraw from the agreement in respect of two of the facts. In one case this was not opposed and was allowed; in the other it was opposed, and was not allowed, for reasons given at the time.

3 One of the five came on duty only at midday.

4 Interview with Stewart p 42.

5 The Nurse Unit Manager gave inconsistent evidence about this: Affidavit para 13, hearing book ("HB") p 325; statement 13 June 2017 para 10, HB p 329.

6 Transcript p 2-16. He started at about the end of 2013 (HB p 83), she in early 2014: HB p 912.

7 Transcript p 1-13.

was able to tell the respondent his name, and to get up. He was placed on the gurney and taken to the treatment room in the health centre at the facility.[8]

[7] At the health centre the prisoner told the respondent that his head was sore, and that he did not have any pain relief medication. The respondent put an icepack on his head, and then took his blood pressure, pulse and oxygen levels which were recorded by Nurse Vale, who also checked his pupils. His Glasgow Coma Scale was then 15.[9] Nurse Vale rang the local hospital, and advised that the prisoner had grazes to the head and on the knee and shoulder, was alert and talking, and was complaining of headache. She was told to keep him under observation, and analgesia was authorised. After the necessary form was completed, the respondent administered the analgesia to the prisoner.

[8] At about 9.12 am the prisoner was moved to a bed in a two bed room in the health centre, called the medical unit, where he stayed, with observations taken by others.[10] The respondent next saw him at about 11 am when she entered that room, and found Nurse Vale cleaning the prisoner, as apparently he had vomited. At that stage he was lying on the floor beside the bed, crouched over, and did not seem to be making any spontaneous movements, so far as can be seen on the video footage of the scene, which was played to the Tribunal.[11] The respondent stood at the foot of the prisoner, and it was suggested by the applicant that at one point she put her foot on the prisoner,[12] but she could not recall that (p 1-78) and it does not clearly appear on the video. At one stage she bent over him, but did not appear to do anything useful. The Nurse Unit Manager, on seeing the footage, said that the prisoner was obviously unwell, and should have been transferred to hospital at that stage.[13]

[9] Nurse Vale and a CSO lifted the prisoner onto the foot of the bed, without any visible assistance from the prisoner. Later he was dragged up the bed, again without any obvious assistance from him. On the video he looks as though he could be unconscious. The bed rails were raised, an indication of a major change in his condition since 9 am.[14] Nurse Vale took his blood pressure and oxygen levels, and the respondent appeared to be looking closely at the prisoner, but both then left the room. There was no visible indication that either of them took any neurological observations.[15] At one stage the respondent appeared to place her hand on the side of the prisoner's face.[16] She was not able to recall what the purpose of this was.[17]

[10] An expert in nursing said that in this incident the respondent had failed to recognise the signs that the prisoner was deteriorating as a result of the head injury, and that

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8 Nurse Vale described him as alert, oriented and able to walk: transcript p 1-14. A CSO described him as groggy and not saying a lot: affidavit of Kurtz 12-9-19 paragraph 10(h), HB p 523.

9 Statement of Nurse Kroning 17-11-16 para 16, HB p 548.

10 He was able to walk in himself: Video; Expert Transcript p 1-43.

11 Nurse Vale described him as non-compliant with her at that time, and said she asked the respondent to do the neurological examination: transcript p 1-18, 19. She said she did no later neurological examination on the prisoner.

12 Evidence of expert, transcript p 1-45.

13 Statement of 13 June 2017 para 33; HB p 333.

14 Evidence of expert, transcript p 1-46.

15 A CSO who was present said that all that they did was shine a light in his eyes, try to get him to talk and take his blood pressure: statement of Richards 28-7-17 para 18, HB p 734. See also evidence of expert, transcript p 1-47.

16 Evidence of expert, transcript p 1-46. If this was part of a test of neurological status, it showed that she considered more detailed assessment in a hospital appropriate.

17 Transcript p 1-79. See also report of expert p 14.

this was substantially less than the minimum acceptable standard for a nurse with her experience and qualifications.[18] She said that the direct observation the respondent made of the prisoner should have led to a conclusion that he was deteriorating and required urgent medical attention. She should have intervened to ensure the safety of the patient and facilitated his immediate transfer to hospital.[19] The respondent said that the only deterioration she detected was that he had vomited, which she understood was self-induced: p 1-82.

[11] At about 12.50 pm the respondent followed Nurse Vale to the prisoner's bedside; they were accompanied by two CSOs. The prisoner was lying across the foot of the bed with his legs against the wall. Nurse Vale took his observations, and then the respondent spent about half a minute looking closely at him. Again there was no visible indication that either of them took any neurological observations,[20] and the video showed no obvious spontaneous movements of the prisoner. The four of them then left the room.

[12] The expert in nursing said that in this incident the respondent had failed to recognise the signs that the prisoner was deteriorating as a result of the head injury, had failed to undertake a full and comprehensive neurological assessment of the prisoner, or ensure that one was taken, and that this was substantially less than the minimum acceptable standard for a nurse with her experience and qualifications.[21] The respondent admitted in evidence that this was not appropriate care for a person with a head injury: p 2-12. She denied that her inaction was because she believed that the prisoner was faking his symptoms: p 2-13.

[13] The progress notes contain an entry marked 1 pm, which the respondent admitted she wrote, confirming the prisoner had essentially normal observations, including a Glasgow Coma Scale of 15, and that he was cleared to return to his cell.[22] The respondent claimed she wrote this note at the direction of Nurse Vale; Nurse Vale denied this. For the purpose of this matter, it is agreed that Nurse Vale asked the respondent to make the entry.[23] The respondent admitted that in retrospect the content of the note was wrong, at least in some respects: p 1-73. She said that she did not know at the time that the note was wrong: p 1-75. The expert in nursing called by the applicant said that it was obvious from the video that the note was wrong, and that the prisoner looked in the video to be seriously unwell.[24] I accept the expert's evidence; for what it is worth, he looked seriously unwell to me.

[14] The respondent was at the desk when two CSOs were taking the prisoner from the Medical Unit back to his cell, which involved taking him through the health centre, past the respondent's desk. At one stage he was lying on the floor, the CSOs picked

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18 Letter of expert 26 October 2019 p 2; HB p 278. See also report p 10, HB p 289; transcript p 1-47.

19 Report of expert p 12, p 13; HB p 291, p 292. The respondent accepted she had an obligation to ensure the safety of the prisoner: p 1-80; but she said she did not then realize that she had that obligation (p 1-82) because she was not the primary care nurse: p 1-84.

20 See also evidence of expert, transcript p 1-49. The respondent admitted that a proper assessment was not undertaken at this time: p 1-85

21 Letter of expert p 2; HB p 278. As she explained, in her report pp 15, 16, it is clear from the video that a complete neurological assessment was not carried out. See also transcript p 1-50. Again, immediate transfer to hospital was indicated: expert report p 17.

22 The respondent said she could not recall whether at the time she agreed with that decision: p 1-75. If she did not, she did nothing about it.

23 Statement of agreed facts para 40. CSOs stated that Nurse Vale had said at times that the prisoner was faking.

24 Transcript p 1-50, 51: "grossly inaccurate". See also expert's report, p 2.

him up, held him against the wall, and then walked him forward with an officer on each side.[25] It is agreed between the parties that the respondent saw the prisoner struggling with the CSOs.[26] Another nurse suggested the use of a wheelchair, and obtained one, and the prisoner was placed on it, and waited in the reception area for a short time until the CSOs took him back to his cell. This was seen on video played to the Tribunal. I did not notice any spontaneous movement of the prisoner during this video.[27] He was certainly not struggling at that time. His appearance was quite inconsistent with his appearance around 9 am, or with the condition recorded in the note at 1 pm. A CSO who observed this thought he looked unwell, noticed odd leg movements and said it looked as though he was resisting being returned to his cell; there were comments among the CSOs that he may have been faking his symptoms, but this was because he had been conscious after the initial injury.[28] That is, because his condition had visibly deteriorated. The respondent denied that she believed he was faking, and said that she failed to detect that he was sick: p 2-14. She could not explain why she failed to detect his symptoms: p 2-15.

[15] At about 3 pm, after the prisoner had been returned to his cell, a CSO reported to the nurses that the prisoner had been incontinent of urine.[29] Neither the respondent nor the other nurses investigated his condition at that time. At 4.40 pm a "code blue" was called for the prisoner. The respondent and another nurse went to his cell, and found Nurse Vale there; she had been doing another medication run in the protection unit at the time and was close to the cell.[30] A number of CSOs were also present. The prisoner was lying on his back across his bed, sweating profusely. The respondent rubbed his sternum and he did not respond; she observed that he was breathing, that he was hot to the touch and that he had been incontinent of urine, so that his pants were wet.

[16] The respondent sent a CSO to obtain an icepack from the CSOs station, and when it was obtained, placed it on his groin.[31] She denied that she did this to test whether he was faking his symptoms, and claimed that it was done as an efficient way to reduce his temperature, because of the presence of large blood vessels in the groin. I do not accept that evidence, for a number of reasons. The groin area was already wet, and the expert witness said that that was not an appropriate way to cool him down.[32] A more appropriate location for an icepack would have been the chest or armpit area. Further, he was obviously in need of urgent transfer to the hospital, yet it appears

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25 This was a further occasion when she failed to observe or recognize that his condition had deteriorated, such that it was unsafe for him to return to his cell. This was also said by the expert to be substantially less than the minimum acceptable standard: expert's report p 2.

26 One of the CSOs described him as "floppy" at this time: statement of Richards para 23, HB p 735.

27 Nurse Woolley said that the prisoner moved his foot onto the plate, and his hand to his mouth, after he was placed in the wheelchair: Interview 9-12-16 page 52, HB p 459. When he tested his eyes, his pupils were equal and reacting: ibid p 55. A CSO described him as thrashing his arms about before he was put in the wheelchair: affidavit of Kurtz paragraph 17(h), HB p 527.

28 Signed statement of Joughin dated 15 December 2017. Another CSO said he was shaking and having spasms, and did not look healthy, or like he was faking: Affidavit of Birkett 28-8-19 p 2, HB p 308. The expert said that from the video the prisoner was not fit to return to his cell, and that this was another occasion when the obvious step of transfer to hospital was not taken: report pp 19, 20.

29 Affidavit of Kurtz paragraph 21(a), hearing book p 528: he was very worried about the prisoner by this stage, but the nurses did not seem concerned.

30 She was on a medication run when she was asked to look at the prisoner: transcript p 1-27.

31 Transcript p 2-8, p 2-16. CSOs who observed the incident said it was places on his genitals: affidavit of Birkett p 5, HB p 311; affidavit of Kurtz para 25(d), HB p 530.

32 Expert report p 22, HB p 301; transcript p 1-53, 54. She was also critical of other failures to provide proper care.

that nothing was done to put that in motion until after the icepack was applied, and no response had been elicited. The respondent claimed that it was necessary to obtain permission from a senior officer to move the prisoner from his cell, but that could have been obtained by a CSO using a radio and would have taken only a matter of seconds, particularly if presented as urgent.[33] The only plausible explanation for the use of the icepack in this way was to test if he was faking.

[17] Nurse Vale said that the respondent had said at the time that that was the purpose of the test.[34] Another nurse, who had waited with the trolley at the foot of the stairs for a time and came into the cell after this was over, said that the respondent said to him that the ice did not work.[35] There was also evidence from CSOs that the nurses at this time were discussing whether he was faking his symptoms.[36] I accept the evidence of Nurse Vale on this. The respondent's evidence on this is just not credible, for the reasons I have set out. Indeed, this is a significant factor in relation to the credibility of the respondent generally. The other nurse said the prisoner's condition had obviously deteriorated since he was returned to his cell.[37]

[18] After the test it was decided to move the prisoner to the health centre. This involved carrying him down some stairs, and for that purpose he was wrapped in a sheet and carried down the stairs to a gurney. This was identified as not good practice because of the risk of spinal injury, but in the circumstances it was probably the quickest available option. When that occurred, the respondent clipped up a restraint on the prisoner as he lay on the gurney, and tightened it vigorously, which amounted to rough handling and a substantial deviation from safe nursing practice.[38] On returning to the health centre the respondent telephoned the supervisor of the facility to advise that transfer to hospital was required, and then went to attend another "code blue" which had been called, leaving another nurse to talk to QAS.[39] The respondent said that when she first telephoned 000 for an ambulance, the call was not answered;[40] I do not accept this evidence. It was another nurse, who was not as aware of the circumstances as the respondent, who spoke by telephone to QAS, and not until about fifteen minutes after the prisoner came to the health centre.[41] The ambulance attended in a few minutes, but the respondent did not brief the paramedics, that being left to another nurse.[42]

[19] The expert said that when the respondent attended the cell she failed to respond appropriately to a medical emergency, and that it was inappropriate for her to have

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33 Transcript p 2-8. A CSO who was there said that there was a distinct lack of urgency in the cell, and the nurses did not appear to be doing much: affidavit of Kurtz paragraph 25(h), HB p 530.

34 Nurse Vale transcript p 1-22; p 1-27; the respondent was not cross-examined about this.

35 Interview with Nurse Woolley 9-12-16 p 70, 71, HB p 477, 478. He had previously told her, as a funny story, of an incident long before where another nurse had exposed fakery by ice on the genitals: p 66, HB p 473.

36 Statement of Groth dated 27 June 2017 para 32; Affidavit of Birkett 28 August 2019 p 5, 6, HB p 311, 312, who said that Nurse Vale also said she thought he was faking.

37 Interview with Nurse Woolley 9-12-16 p 71, HB p 478.

38 Expert report p 23, HB p 302.

39 The expert was also critical of this delegation: report p 24, HB p 303.

40 Statement of agreed facts para 63(b).

41 Interview with Nurse Woolley p 78, HB p 485: he was not familiar with the procedure to call an ambulance to the correctional facility. There was no good reason not to have a CSO call an ambulance while the prisoner was being moved to the health centre, or to call as soon as the nurses returned to the health centre.

42 According to a note from the hospital, it took an hour before the correctional facility officials would allow the ambulance to leave, which if true was a disgrace: Clinical summary, HB p 1008.

delegated the task of contacting the QAS to another nurse, and that both decisions and actions fell substantially below the minimum acceptable standard for a nurse with her experience and qualifications.[43] The expert said that the progress notes of the respondent were inadequate in respect of clinical details, and that the retrospective note she wrote the next day also failed to correct that deficiency, and that this fell substantially below the minimum acceptable standard for a nurse with her experience and qualifications.[44]

[20] The following day the same set of nurses were rostered on again, including the respondent. During the morning the respondent spoke by phone to the Nurse Unit Manager who asked for retrospective notes of the incident to be written. Such a set of notes was produced, although this occurred by the five nurses getting together and contributing to a note which the respondent recorded, and they all signed.[45] On 26 October 2016 the registration of the responded was suspended by the applicant under s 58 of the Act. That decision was confirmed on 9 December 2016, and the suspension remains in place.

[21] It emerged that the prisoner had suffered a subdural haematoma. He was evacuated for an emergency craniotomy, and was left with brain damage. He remained in hospital until March 2017, and on discharge had basic language skills, and was mobile, but required supervision for safety; he was not cleared to drive, or to swim unsupervised, and was not to consume alcohol for two years.[46] From this I infer that the brain damage was significant. There is no medical evidence that the severity of his condition was caused by the delay in his receiving proper care, but I expect it is reasonable to infer that his condition was made worse by that delay.

Analysis

[22] It is obvious enough that, at least by 11 am on 8 October 2016, the prisoner was largely, if not essentially unresponsive. His condition was clearly deteriorating, and when he was seen by the respondent in the room at the health centre at about 11 am his condition had obviously deteriorated from 9 am. The whole point of keeping him under observation after a head injury was to monitor his condition for any signs of neurological deterioration, which in fact did occur. In those circumstances, it was appropriate for his condition to be reported to the hospital at least, and probably for him to be transferred to the hospital. That was not done. It seems to me that there are only three possible explanations for that: a belief that the prisoner was faking his apparent condition; an indifference to the condition of the prisoner; and a failure to appreciate the significance of the apparent condition of the prisoner.

[23] It appears to me that the obvious explanation for the respondent's behaviour was that she believed he was faking his symptoms. It is understandable that someone with about ten years experience of dealing with prisoners would become somewhat cynical about their complaints; for all I know, such cynicism could be justified, and

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43 Report of expert p 2; HB p 279. See also transcript p 1-63.

44 Ibid. The respondent claimed that when writing the retrospective note she just wrote down what people told her to say; she now accepted that that note was false in parts: p 2-11.

45 As an exercise in gathering evidence about what had really happened the previous day, this was quite inappropriate. Each nurse should have provided a separate statement. That it was the respondent who actually wrote the note is a further indication of the practical authority of the respondent within this group of nurses. See also affidavit of Nurse Woolley 6-9-19 para 33, HB p 406, interview of Woolley p 98, HB p 505.

46 Discharge summary 7-3-17, HB p 969.

it may be common for prisoners, or at least some prisoners, to feign illness. There was no evidence that this prisoner had a history of such behaviour. However, there was no basis for doubt that he had suffered a genuine head injury, and although it appeared superficial, the possibility that it was more serious existed. A registered nurse should have been conscious of this; it was the whole point of keeping him under observation.

[24] Although his vital signs had not deteriorated,[47] there were other symptoms which obviously had. At 9 am he was able to stand on his own, but by 11 am he was not getting up and standing on his own, unless he was faking; yet the respondent said that she did not see that as an aspect of deterioration in his condition: p 1-83. She could not explain this failure, but claimed it was not because she believed he was putting on an act. The recorded neurological observations were clearly false. It is obvious from the video that neither the respondent nor Nurse Vale took all the details recorded in the notes of his neurological state at 11 am. The recorded observations could only have been based on an assumed faking of symptoms.[48]

[25] The respondent was told by a CSO that the prisoner had made himself vomit by putting his fingers down his throat.[49] That is not necessarily an indication of faking symptoms; a person with nausea may well want to get it over with, in the hope that he would feel better afterwards.[50] Being unresponsive and uncooperative, and even struggling with CSOs, could easily be the result of genuine illness. In any case, the apparent condition was never shown to be fabricated, and in those circumstances, the correct approach was a precautionary one, and the prisoner should have been transferred to hospital.[51]

[26] The argument was advanced that Nurse Vale had responsibility for the prisoner, because her position included responsibility for prisoners in the protection unit, and in the room where this prisoner was within the health centre. There are problems with that argument. First, the better evidence was that no particular nurse was overall in charge in a formal way that day, and as I have noted the respondent had some practical authority. That she went into the room where the prisoner was at 11 am and shortly before 1 pm indicates that she was to some extent involved in the care of the prisoner, and her demeanour on the video was largely that of a supervisor.[52] She could have insisted that the prisoner be transferred to hospital,[53] and if Nurse Vale obstructed that, she could have telephoned the Nurse Unit Manager, or the hospital. She accepted that she was the person in the best position to assess the prisoner when he was being moved back to his cell, and could have directed that he remain in the medical centre, but did not.[54]

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47 I note that a deterioration was recorded as soon as someone other than Nurse Vale took them.

48 Nurse Vale said that she asked the respondent to take them and believed she did and recorded what the respondent said: transcript p 1-26. The respondent denied this: transcript p 1-72, 1-85. I consider the truth is that neither of them took proper neurological observations, and the notes were fabricated.

49 A CSO said that he saw him do this: affidavit of Carige 5-9-19 para 10, HB p 384. Another CSO said that she saw this on the monitoring CCTV: affidavit of Richards 2-10-19 para 8(b), HB p 729.

50 Evidence of expert p 1-38: this should have been assessed as part of the overall picture.

51 Evidence of expert p 1-53.

52 That was also the impression of a CSO: statement of Carige 11-7-17 para 36, HB p 393. The respondent offered no explanation for why she was in the room then: transcript p 1-86.

53 Under cross-examination she accepted that, on the basis of what she observed around 11 am, the prisoner should have been transferred to hospital: p 1-82.

54 Transcript p 1-86. She claimed that she did not at the time appreciate that it was open to her to reverse what she said was Nurse Vale's decision.

[27] There was another conflict of evidence here: Nurse Vale said that she wanted to transfer the prisoner to the hospital at an earlier time, but the respondent had said that he was faking, and she did not stand up to the respondent because she was intimidated by her.[55] Having seen them both, on the video and giving evidence in person before the Tribunal, this explanation is plausible: Nurse Vale was a much older, and smaller, woman, and her demeanour in the videos is of someone just doing her job; the respondent is still young, much larger and displayed a confident demeanour in the video.[56] The visible behaviour of the respondent that day in the video was entirely consistent with a belief that the prisoner was faking his condition. Although the respondent denied that she thought at the time that the prisoner was faking his presentation, I do not regard such evidence as credible, and I reject it. I accept that the true situation is that at the time the respondent believed that the prisoner was faking his condition, and it was for that reason that she did not take steps to have him transferred to hospital.[57]

[28] Her position would hardly be better however if I had concluded that one of the other explanations I posed earlier was the true one. If she was indifferent to the condition of the prisoner, that was quite inconsistent with her duty as a nurse. Whatever he had done, he was entitled to proper health care while he was in prison, and if the respondent was deliberately neglecting him, she was in gross breach of the duty of a nurse to a patient. If she had failed to notice that his conditions had deteriorated, as she claimed in evidence, she is either incredibly unobservant or hopelessly incompetent. In the videos he certainly looks quite unwell.[58] In the circumstances I find her evidence just impossible to accept. She could not have been so incompetent.

[29] One of the facts alleged by the respondent and disputed by the applicant was that the respondent did not witness the prisoner display any symptoms consistent with a head injury. She knew he had had a head injury, and she could see that (unless he was faking his symptoms) he had become seriously unwell. The obvious conclusion was that his signs and symptoms were evidence of the head injury, but even if that was not the case, he certainly had something which required hospital assessment and treatment. Even if he might have been faking, on a precautionary basis he should have been sent to hospital for medical assessment.

[30] I should also mention another matter, which was a matter of practice rather than a factor relevant to the respondent's credibility. Although the respondent had filed an affidavit in the Tribunal, it did not contain her account of the events that day, so that it did not function as her evidence in chief. It did exhibit a letter written on her behalf by solicitors, which was said to have been written on her instructions, and which she said she saw and settled, but she did not verify on oath even that limited version.[59] In the witness box she still did not give comprehensive evidence in chief. It is not as though her version was already in evidence in the form of an interview

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55 Affidavit of Vale 25-9-19 para 48, HB p 584; interview 9-12-16 p 41, HB p 625; transcript p 1-28.

56 The Nurse Unit Manager described the respondent as a forward and assertive woman: Affidavit 2 September 2019 para 12, HB p 325. One of the other nurses said that when she started she felt intimidation from the respondent: interview Nurse Kroning 15-6-17 p 23, HB p 573. There was no evidence that the respondent was dominated or intimidated by Nurse Vale.

57 There was other evidence from CSOs that Nurse Vale had also said that the prisoner was faking. In this matter I do not need to decide whether she really had that belief. It may be that in fact Nurse Vale also believed at the time that he was faking, and that encouraged the respondent in her belief.

58 To me, to the expert witness and to the assessors.

59 The letter was essentially a submission and did not give a detailed account of her actions that day.

with investigators from the applicant; although interviewed by them, the respondent declined to answer questions about her conduct that day concerning the prisoner, or even the conduct of others that day.[60] One effect of that approach was to allow her maximum flexibility in cross-examination.[61] This is hardly the behaviour of a practitioner who is being frank with the Tribunal.

The referral

[31] The matters relied on were in paragraphs 60 to 75 of the amended referral filed 28 February 2020, although paragraph 60 was not pressed by the applicant.

[32] There were a number of findings sought by the applicant, although not all of the factual allegations in the referral were pressed. The question of the scope of the general duties of a nurse was not contentious at the hearing, although there was some dispute about the application of those duties in the particular circumstances. A number of findings follow from the reasons stated above, in the narrative of events.

[33] When the respondent was present while observations were taken of the prisoner at about 11 am, and shortly before 1 pm, the respondent failed to conduct, or ensure that there was conducted, a comprehensive and systematic physical and neurological assessment, and a pain assessment. There was no assessment of limb power, or ability to respond to verbal commands. The respondent also failed to ensure that the neurological examination was properly recorded in the progress notes. There was no record of any pupil reaction on those occasions, and other details were not recorded. The respondent failed to place the prisoner, or ensure that the prisoner was placed, on a bed in an appropriate position for conducting the assessment. The respondent failed properly to monitor the prisoner's health status, and to respond appropriately to the deterioration in the condition of the prisoner, in that she failed to advocate, and to arrange, the transfer of the prisoner to the hospital.[62]

[34] When the respondent saw the prisoner being moved through the Health Centre on the way back to his cell, the respondent failed to monitor properly the health status of the prisoner, and to respond appropriately to the deterioration in his condition since 9 am, failed to conduct a proper neurological examination and document the findings, failed to direct the CSOs to leave the prisoner in the Medical Unit, and failed to arrange transfer of the prisoner to the hospital.[63]

[35] The respondent conceded that the prisoner in fact had a serious head injury at that time. The respondent failed to asses the prisoner as having, or as potentially having, a high-risk head injury at that time.[64] This is because the respondent knew or ought to have known that the prisoner had been holding or rubbing his head, had originally sought pain killers, had a deteriorating neurological condition, did not remain lying properly on his bed, moved in a strange way on his bed and on the floor, was unable to stand or walk, and had vomited, whether or not self-induced. When the

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60 Transcript of interview 12-12-16, p 27, 29, HB p 931, 933.

61 I recognize that this may have been a tactic adopted by her lawyers. I do not draw any inference against her just because she declined to answer questions in the interview, something she did not do before the Tribunal; but the whole approach struck me as decidedly odd.

62 Amended referral paragraph 61(a) – (c), (e), (f) and (k); paragraph 62(a) – (c); paragraph 63(a), (b); paragraph 64 (a)-(e).

63 Amended referral paragraphs 65(a) – (d); paragraph 66.

64 Amended referral paragraphs 67, 68, 69.

respondent knew that he had vomited, she failed to position the prisoner so as to protect his airway, and did not place him in the recovery position.[65]

[36] The Tribunal does not find that the respondent placed her foot on the prisoner while he was on the floor, since the video evidence of this is not clear, and the Tribunal does not find that the respondent applied downward pressure when she put her hand on his head, as that is also not clear from the video, but accepts that there was no clinical purpose in her having touched him in this way.[66]

[37] The Tribunal finds that the respondent caused an icepack to be obtained and placed it on the groin area of the prisoner without clinical purpose, and in order to detect if he was faking his symptoms.[67] This was inappropriate treatment, and probably delayed the transfer of the prisoner to hospital. The respondent argued that this finding was not open, on the basis that the amended referral alleged in para 44(a) that the respondent observed that the prisoner was unconscious, and that this was not consistent with the agreed facts. But the allegation that the icepack was placed on his genitals was squarely raised, and the whole question of a belief that the prisoner was faking was litigated at the hearing, and I do not consider that I am constrained in making this finding by either the terms of the referral, or the terms of the agreed facts.[68]

[38] The Tribunal finds also that the respondent's conduct led to a delay in the prisoner's receiving proper treatment for his head injury, and in that way compromised his health, and caused, or risked causing, further injury to him.

Characterisation of conduct

[39] The Tribunal is aware of the definition of professional misconduct in the National Law. The respondent in her amended response to the referral admitted that her conduct amounted to professional misconduct, in respect of:

(a) Failure to recognize the prisoner's acute clinical deterioration at about 11 am, at about 1 pm, and at about 2 pm;

(b) Her actions in assessing the prisoner's pain at about 9 am;

(c) Her incorrect recording of the time when oral analgesia was administered to the prisoner at 8 am, rather than 9 am.

[40] The applicant however presses for a finding of professional misconduct on a wider basis, and submits that there are several other respects in which matters found by the Tribunal demonstrated collectively professional misconduct on a wider basis, and of a more serious nature. The findings made by the Tribunal referred to above are all relevant to an assessment of the overall conduct of the respondent in respect of the prisoner. The Tribunal accepts the evidence of the expert witness, that in several respects the conduct of the respondent fell substantially below the appropriate standard of a clinical nurse, and indeed fell below the standard expected of a nurse at entry level to the profession.

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65 Amended referral paragraphs 48; 70(a), (b).

66 Amended referral paragraph 72.

67 Amended referral paragraph 73.

68 Paragraph 57(c) and (d) of the statement of agreed facts reflect the dispute over why the ice pack was placed.

[41] A belief that a patient is faking his symptoms is not a justification for withholding appropriate care. Given the history known to the respondent, he could well have been suffering from a significant head injury, and in such circumstances a deterioration in his neurological signs was at least a possibility. There was nothing about the behaviour of the prisoner visible on the video shown to the Tribunal which demonstrated faking rather a real head injury. Further there was surveillance video available for the whole time when the prisoner was in the medical unit. This was not available to the nurses, but it was available to a CSO, and the respondent could have enquired of the CSO about his behaviour at other times. Even at the point when he was being taken back to his cell, the respondent made no attempt to investigate his true condition. The obvious explanation for that behaviour is a firm belief in faking symptoms, but even in those circumstances, the appropriate course was a precautionary transfer to hospital, where a more detailed investigation could be undertaken.

[42] I am wary about the role Nurse Vale played on that day. Although she claimed she wanted to have the prisoner transferred to hospital at an early stage, but was overruled by the respondent, who intimidated her, it was also open for her to have consulted the Nurse Unit Manager, or the hospital, either of which would I expect have led to a transfer to hospital. Even if Nurse Vale was also supporting the theory that he was faking his symptoms, she was not the respondent's superior, and the respondent still had a personal duty to care for the prisoner, even if that meant going above Nurse Vale's head. Even if the respondent was relying on Nurse Vale, or taking support from her position, I do not consider that that excuses her failure to provide proper care to the prisoner.

[43] A finding that the respondent believed that the prisoner was faking his symptoms means that a number of the submissions of the applicant, based on a different analysis of the situation, are irrelevant, and need not be dealt with. But the Tribunal accepts that, as a result of her belief, the respondent displayed a very serious error of judgment, in failing to recognize the possibility of error, and in failing to apply a precautionary approach, and that this demonstrated a lack of caring or compassion, and heartlessness in her attitude to the prisoner. This was shown even when he was being taken back to the health centre from his cell, by her rough handling of him on the gurney.

[44] In the circumstances, the Tribunal decides that the respondent's conduct, in respect of the prisoner, constituted professional misconduct, on the basis of such of the conduct alleged in the amended referral as was conceded by the respondent in her response to the amended referral, or is covered by the findings of fact made.

Sanction

[45] In imposing a sanction, the health and safety of the public are paramount.[69] Disciplinary proceedings are protective, not punitive in nature.[70] Relevant considerations include both personal and general deterrence, the maintenance of professional standards and the maintenance of public confidence.[71] Insight and

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69 *Health Ombudsman Act* 2013, s 4(1).

70 *Legal Services Commissioner v Madden (No 2)* [2009] 1 Qd R 149 at [122].

71 *Health Care Complaints Commission v Do* [2014] NSWCA 307 at [35]; *Health Ombudsman v Kimpton* [2018] QCAT 405 at [79].

remorse on the part of the respondent are also relevant. [72] What matters is the fitness to practice of the respondent at the time of the hearing.[73]

[46] One matter which is relevant to sanction is that the Tribunal's finding that the respondent believed at the time that the prisoner was faking his symptoms was arrived at despite the respondent having denied this on oath. To make an adverse finding in such circumstances is a serious step, and I am conscious of its serious nature, which I have taken into account in deciding whether to make that finding.[74] It follows that the respondent lied in her evidence to the Tribunal, a matter which is relevant to her character, and considerations of insight and remorse, matters which are relevant to deciding the appropriate sanction.[75]

[47] The respondent was suspended promptly by her employer, and her registration was later suspended. She has not worked as a nurse since she was suspended by her employer, and has now been away from nursing for over four years. Evidently she still wants to make a career in nursing, and during the period of her suspension she has completed numerous courses to improve her skills as a nurse. The substantial question is whether, in view of her conduct as found by the Tribunal, and in the light of her lack of frankness with the Tribunal, it can be said that she is now not a fit and proper person to be registered as a nurse.

Previous decisions

[48] The applicant did not rely on any particular earlier decision as providing useful guidance to the Tribunal, although some decisions were mentioned. Only one is worth discussing. In *Nursing and Midwifery Board of Australia v Gibbons* [2014] QCAT 412 a registered nurse, who was responsible for a patient who was experiencing low oxygen saturation levels, failed to provide proper supervision of the patient, and failed to refer him to a medical practitioner, despite serious drops in the oxygen saturation levels. The patient had aspiration pneumonia, which had not been detected earlier, and died as a result of the lack of proper treatment. There had been also failings by others, but the Tribunal found that the practitioner's failure to recognise the urgent need for medical intervention meant that he had displayed a seriously unacceptable level of incompetence and lack of patient care: [31].

[49] By the time the matter came before the Tribunal, where the parties joined in seeking particular orders, the practitioner had been away from nursing for more than nine years, and the Tribunal had no information about whether he had any desire or intention to return. The Tribunal reprimanded him, and imposed conditions that any future application for registration required specified courses of education and counselling, and provision of reports showing insight and competence. It also imposed conditions on any future registration, requiring supervision, a logbook and notifications to aid surveillance by the Board, and prohibiting him from working for an agency, as sought by the parties.

[50] The respondent referred to *Nursing and Midwifery Board of Australia v Finlay* [2018] QCAT 275, where proceedings were brought against a nurse in respect of a

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72 *Medical Board of Australia v Blomeley* [2018] QCAT 163 at [140] – [143].

73 *Pharmacy Board of Australia v Thomas* [2011] QCAT 637 at [31].

74 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

75 Compare *Psychology Board of Australia v Wakelin* [2014] QCAT 516 at [21], [25], [27], concerning giving false denials to investigators. See also *Health Ombudsman v Field* [2018] QCAT 416 at [43]; *Health Ombudsman v Arora* [2019] QCAT 200 at [28].

large number of failings in dealing with 34 patients over a period of some months, in that her documentation was inadequate, she had failed to refer patients to doctors, she had administered medication without medical authorisation, and otherwise dealt with patients in a way requiring medical approval, including in one case carrying out a procedure that should have been done by a doctor. In one case she documented a medical approval which had not occurred. There was a potential for harm to patients, but in fact no patient was harmed by her actions, which distinguishes this decision. These matters were not contested. The Tribunal found that each instance of unprofessional conduct together amounted to professional misconduct: [18].

[51] There were various mitigating circumstances, and the practitioner had subsequently been working for some years under supervision conditions, without further problems. She was reprimanded, and subject to mentoring conditions, to be reviewed after twelve months. That was a situation where the nurse was in effect relieving the burden on an overworked doctor, and did not do any harm to any patient. The doctor generally approved later of what she had done. The decision is not comparable.

[52] The respondent also referred to *Nursing and Midwifery Board of Australia v Manton* [2014] QCAT 400, a case involving the nurse who had the shift before *Gibbons* (*supra*), and who had also failed to monitor the patient and refer his deterioration to a medical practitioner. During the relevant period the deterioration was not as great, and the case was regarded as less serious than *Gibbons*. Again, by the time the matter was dealt with, the respondent had been away from nursing for six years. The respondent had given an undertaking to undergo further education, and counselling, prior to any future application for registration, and on this basis the sanction was a reprimand.

[53] The respondent also referred to the decision in the matter of *Vale*,[76] and submitted that there should be some parity between the sanction imposed on Nurse Vale and the sanction imposed on the respondent. I do not agree; there are important differences between them. First, Nurse Vale gave a full account of what she said happened on that day to the applicant's investigators, and in her proceeding the applicant did not dispute the accuracy of what she said then. The matter proceeded on the basis of joint submissions, and Nurse Vale appeared to be contrite and remorseful at the hearing. That matter proceeded on the basis that Nurse Vale had wanted to transfer the prisoner to hospital from as early as 11 am, but the respondent had asserted that he was faking his symptoms, and Nurse Vale was intimidated by the respondent, and went along with her for that reason. Those facts were accepted by the applicant, and the Tribunal did not have all of the evidence available to it in this matter, including the evidence from CSOs that Nurse Vale also expressed the view that the prisoner was faking his symptoms. Overall, that matter was presented by both parties in a different light from the situation revealed by the findings above.

[54] There was no suggestion in this case that the respondent was intimidated by Nurse Vale, although her position was in effect that she deferred to Nurse Vale because she regarded Nurse Vale as having the primary care of the prisoner. I regard that approach as an error and as an inadequate excuse for her failure of care. The respondent's conduct would have been even worse if Nurse Vale had suggested a transfer to hospital, and the respondent had quashed that suggestion, but in all the circumstances I am not prepared to make that finding. However, it was certainly

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76 *Health Ombudsman v Vale* [2020] QCAT 363.

open to the respondent to have taken the initiative with the care of the prisoner, and she did not do so.

[55] I am also not prepared to find that Nurse Vale recorded the results of neurological assessments made at her request by the respondent. It is quite clear from the video evidence that when they went into the room shortly before 1 pm, essentially together, neither undertook a proper neurological assessment, and since they were both in there together, both knew that one had not been undertaken. It follows that the respondent knew at the time that the note that the respondent wrote, timed at 1 pm, was false. In that situation, it does not matter whether it was written at the instance of Nurse Vale or not. She either took the decision or at least went along with it, and it does not matter which. The respondent wrote a false note, which was the basis of the inappropriate return of the prisoner to his cell. It was for this reason that she did not intervene in the disgraceful process by which he was returned to his cell.

Discussion

[56] This case involves a persistent failure to provide proper care to a patient who was clearly in need of it, which manifested a troubling level of indifference on the part of the respondent. The unfortunate consequences suffered by the prisoner illustrate the importance of the provision of proper nursing care in a correctional facility, where medical attention is not as readily available as it would be, for example, in a hospital, and where a prisoner cannot seek that attention directly. This serves to underline the seriousness of the lack of patient care displayed by the respondent. There are considerations of general deterrence, to emphasise to all nurses working in correctional facilities the importance of their responsibility for the health and wellbeing of the prisoners in the facilities, and of the adoption of a precautionary approach when there is a possibility of a serious condition. That is particularly important if the situation is such that the process of securing urgent medical attention for a prisoner is likely to be delayed by the procedures of the facility.

[57] In this case, there is little indication of remorse, and a lack of insight into the wrongfulness of the conduct; to the contrary, the respondent's attitude has been defensive throughout. She refused to answer questions about the events of that day when spoken to by the applicant's investigators, her initial response to the referral put many things in issue which were subsequently conceded or found against her, and she lied to the Tribunal in her evidence. In the light of the expert evidence, and the other material before the Tribunal, the conduct of the respondent overall was substantially below the standard reasonably expected of a registered health practitioner of an equivalent level or training or experience.

[58] I also consider that the conduct, seen in the light of her subsequent behaviour, is conduct inconsistent with the respondent being a fit and proper person to hold registration in the profession. In order to cancel the respondent's registration, it is necessary for the Tribunal to decide that the respondent is not a fit and proper person to be registered as a nurse.[77] That is to be decided as at the date of hearing.[78] The important distinction between suspension and cancellation of registration is that, in the latter case, it is necessary for the respondent on seeking registration to

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77 *Medical Board of Australia v Wong* [2015] QCAT 439 at [84]; *Medical Board of Australia v Duck* [2017] WASAT 28 at [33], [34]; *Medical Board of Australia v Alkazali* [2017] VCAT 286 at [74].

78 *Medical Board of Australia v Cukier* [2017] VCAT 109; *Field* (*supra*) at [36].

demonstrate that she is then a fit and proper person to be registered as a nurse.[79] Further, it is then open to the Board to impose conditions on any new registration.

[59] A number of matters relevant to a finding that a practitioner is not a fit and proper person to be registered were identified in *Health Ombudsman v Field* [2019] QCAT 243 at [36].[80] In this case, the dishonesty at the hearing suggests a defect in character rather than an error of judgment. The relevant conduct, although an isolated incident, extended over a period of hours, so that the respondent had plenty of time to think about how she ought to be behaving. Further, the failure of care on the relevant occasion was substantial, and showed an inadequate level of professional care and competence.

[60] The material shows that, as at October 2016, the respondent was not a fit and proper person to be registered as a health practitioner. In view of her evidence at the hearing, that remains the situation, notwithstanding the courses that the respondent has since undertaken, and her admissions that she can now recognise some deficiencies in her conduct that day. Her evidence during the hearing was however inadequate to demonstrate proper insight into her failings, and, in view of the findings earlier, the reliability of that evidence is doubtful. It remains appropriate to find that the respondent is still now not a fit and proper person to be registered as a nurse. Further, the Tribunal cannot be confident that at any particular time in the future the respondent will be again a fit and proper person to be registered. Accordingly, it is appropriate to cancel her registration.

Respondent's registration status

[61] Counsel for the respondent submitted that the respondent's registration could not be cancelled, because she had not renewed her registration after it was suspended by the applicant, and accordingly it had expired, under the National Law s 56. The duration of registration is dealt with under the National Law s 56, which provides in s 56(2)(b) that, if a health practitioner is registered, the registration expires at the end of the last day of the registration period. That occurred in May 2017, and since she did not apply to renew her registration under the National Law, there was no longer any registration to cancel, or for that matter to suspend. Reliance was placed on *Nursing and Midwifery Board of Australia v Gibbons* [2014] QCAT 41 and *Medical Board of Australia v Waldron* [2017] QCAT 443.

[62] The *Health Ombudsman Act* 2013 provides in s 10 that it is to operate in conjunction with the National Law, and in s 10(4), that the relevant National Boards are to give effect to decisions of the applicant under the Act. Hence when the applicant suspended the registration of the respondent, and advised the National Board of its decision, the National Board gave effect to that decision by suspending the registration of the respondent under the National Law. That brought into operation the terms of s 207 of the National Law, dealing with the effect of suspension, which provides:

> If a person's registration as a health practitioner or student is suspended under this Law the person is taken during the period of suspension not to be registered under this Law, other than for the purposes of this Part.

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79 *Chen v Health Care Complaints Commission* [2017] NSWCA 186 at [21]. Uncertainly as to what may happen in the future may support a decision to cancel registration.

80 Referencing *McBride v Walton* [1994] NSWCA 199 at [34].

[63] When the Board acts as required by the 2013 Act to give effect to the decision of the applicant, that means that the respondent's registration was suspended by the Board under the National Law for the purposes of s 207. As a result she is taken to be not registered under the National Law, which means that she cannot renew her registration under Division 9 of Part 7 of the National Law, and it also means that s 56(2)(b) does not apply to her registration, because that section applies to a practitioner who has registration. Because the person is still taken to be registered for the purposes of Part 8, notifications and disciplinary matters can be dealt with as if the practitioner is registered.

[64] In this case the applicant acted following a notification by the respondent's employer, and the National Law provides in s 148, which is within Part 8, that notifications are to be dealt with under the *Health Ombudsman Act* 2013. Clearly the two pieces of legislation were intended to be read together, and to work together, and as a result the effect of s 148 is that the action taken by the applicant, and this Tribunal, is treated as occurring for the purposes of Part 8 of the National law. Hence the respondent is still registered for the purposes of this proceeding, and it remains open to the Tribunal to cancel, or for that matter to suspend further, her registration.

[65] *Gibbons* (*supra*) does not assist the respondent's argument, as that was not a case where the practitioner's registration had been suspended. *Waldron* (*supra*) is also not directly on point, being a case where the suspension occurred under the National Law, and, with respect, I consider that the reasoning in that decision was wrong, in that it failed to give full effect to the terms of s 207 of the National Law. I note that an appeal against that decision was allowed by consent, and the Court substituted an order consistent with the subsistence of the registration, although without itself considering the point independently, on the basis that the parties agreed that there had been an error of law in this respect: *Medical Board of Australia v XY* [2018] QCA 95.

[66] If I am wrong in this analysis, and s 10 does not bring s 207 into operation, I consider that the same effect follows anyway, on the basis that the 2013 Act provides for the suspension of registration, which in the absence of legislative exposition has its usual meaning, that the registration continues in existence but ceases to be operative. That is the effect of the order of suspension made by the applicant, and the registration therefore remains in force pursuant to the 2013 Act, which as a later statute, takes effect, if necessary, by way of implied amendment to the National Law. So the respondent remains registered for the purpose of this proceeding.

Conclusion

[67] It remains necessary to determine whether any, and what, preclusion period should be applied to the respondent. In view of the finding that she remains not a fit and proper person to be registered, some preclusion period is appropriate, but it is also relevant to take into account that she has not been practicing for over four years. In the circumstances, I consider that it would be appropriate for her to be disqualified from applying for registration for a further period of twelve months. It will be a matter for the Board to decide whether she is then a fit and proper person to be registered.

[68] The respondent submitted that any delay in allowing her to apply for registration would cause her difficulties in respect of recency of practice requirements for

registration.[81] In view of the evidence of the expert as to the quality of the care displayed by the respondent in this matter, I consider that completion of some form of refresher course would be beneficial, in helping the respondent to raise to a reasonable level her performance as a nurse. This is not a reason not to impose a preclusion period on the respondent.

[69] The Tribunal cannot impose conditions on any future registration of the respondent; that will be a matter for the Board. Nevertheless, I consider that the Board, if satisfied that the respondent should be registered, should impose on the respondent a condition that she not work in a correctional facility, a condition the Tribunal imposed on Nurse Vale.

[70] I have had the benefit of the assistance of the assessors in this matter. Accordingly the decision of the Tribunal is that:

1. The Tribunal decides that such of the conduct of the respondent alleged in the amended referral, as was admitted by the respondent, or was found by the Tribunal, collectively amounted to professional misconduct.
2. The respondent is reprimanded.
3. The suspension imposed by the Health Ombudsman on 26 October 2016 is set aside.
4. The registration of the respondent is cancelled.
5. The respondent is disqualified from applying for registration as a health practitioner for a period of twelve months from the date of this decision.
6. The parties are to bear their own costs of this proceeding.

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[81] Citing *Health Ombudsman v Kennedy* [2019] QCAT 319 at [57].