THE HEALTH LEGISLATION AMENDMENT BILL 1996

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The Bulletin reflects the legislation as introduced. The *Queensland Legislation Annotations*, prepared by the Office of the Queensland Parliamentary Counsel, or the *Bills Update*, produced by the Table Office of the Queensland Parliament, should be consulted to determine whether the Bill has been enacted and if so, whether the legislation as enacted reflects amendments in Committee. Readers are also directed to the relevant *Alert Digest* of the Scrutiny of Legislation Committee of the Queensland Parliament.

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CONTENTS

1. PURPOSE .......................................................................................................................... 1

2. AMENDMENTS TO THE HEALTH ACT 1937 ......................................................... 2
   2.1 BACKGROUND TO AMENDMENTS TO THE HEALTH ACT 1937 .............. 2
   2.2 PAINT ....................................................................................................................... 4
      2.2.1 Use, Manufacture and Sale of Certain Paint................................................. 6
      2.2.2 Labelling of Paint ......................................................................................... 8
      2.2.3 Enforcement Powers .................................................................................... 9
   2.3 USE OF PESTICIDES .......................................................................................... 9

3 AMENDMENTS TO THE NURSING ACT 1992 ....................................................... 11
   3.1 THE QUEENSLAND NURSING COUNCIL ...................................................... 11
      3.1.1 Qualifications for Registration or Enrolment ......................................... 12
   3.2 THE PROFESSIONAL CONDUCT COMMITTEE ......................................... 12
   3.3 CODE OF CONDUCT ......................................................................................... 13
      3.3.1 Contraventions of the Code of Conduct .................................................... 13
   3.4 IMMEDIATE SUSPENSION OF REGISTRATION OR ENROLMENT ....... 14
   3.5 CANCELLATION OF REGISTRATION OR ENROLMENT ......................... 16
   3.6 ANNUAL LICENCE CERTIFICATE FEE ......................................................... 16
   3.7 AMENDMENTS CONCERNING OFFENCES AND CHARGES ..................... 17

BIBLIOGRAPHY .................................................................................................................. 20

APPENDIX A ..................................................................................................................... 20
APPENDIX B ..................................................................................................................... 21
APPENDIX C ..................................................................................................................... 22
APPENDIX D ..................................................................................................................... 23
1. PURPOSE

The Health Legislation Amendment Bill 1996 will amend the following pieces of legislation:

- Dental Act 1971 (Qld);
- Health Act 1937 (Qld);
- Hospitals Foundation Act 1982 (Qld);
- Medical Act 1939 (Qld); and
- Nursing Act 1992 (Qld).

Most of the amendments to the Dental Act 1971, Medical Act 1939, Health Act 1937 and Hospitals Foundations Act 1982 are mechanical. These changes include the amendment to the Hospitals Foundations Act 1982 to enable the establishment of a body corporate constituting a hospital foundation and amendments to the Dental Act 1971 and Medical Act 1939 to provide that dental and medical companies incorporated in Australia, but operating in Queensland, will now be subject to the provisions of the Act.
The Medical Act 1939 will also be amended to allow validation of specialist’s registration and the appointment of a medical practitioner as president of the Medical Board instead of the Chief Health Officer.

This bulletin will only consider some of the proposed amendments to the Health Act 1937 (Health Act) and the Nursing Act 1992 (Nursing Act). These are:

- Amendments to the Health Act in relation to the use of certain paints and pesticides; and
- Amendments to the Nursing Act in relation to
  - the passing of resolutions by the Queensland Nursing Council;
  - qualifications for registration and enrolment as a nurse;
  - procedures for investigations to be conducted as a result of alleged contraventions of the Code of Conduct;
  - procedures in relation to the immediate suspension of registration or enrolment;
  - the circumstances where registration or enrolment may be cancelled and those where such cancelled registration or enrolment may be restored;
  - rules in relation to the payment of the annual licence certificate fee; and
  - miscellaneous matters in relation to offences under the Act.

2. AMENDMENTS TO THE HEALTH ACT 1937

This Bill proposes several amendments to Part 4 - Drugs and Other Articles - of the Health Act. These amendments include the incorporation of some parts of the Standard for Uniform Scheduling of Drugs and Poisons in relation to paint as well as amendments to certain offences regarding the use of pesticides.

2.1 BACKGROUND TO AMENDMENTS TO THE HEALTH ACT 1937

In 1993 a Reference Committee was established by the Chief Health Officer to oversee the review of the Health Act. It is interesting to note that in the introduction to a Discussion Paper concerning this review (which was published by the Department of Health in September 1995), the committee concluded that Part 4 of that Act - Drugs and Other Articles should be reviewed for development as separate legislation in its own right.¹

That Discussion Paper set out a “number of significant issues that are emerging which need to be identified, understood and embodied in any discussion on the future direction of legislation concerning drugs, poisons and therapeutic goods.” These included the issue of uniformity between state, national and international legislation.\(^2\) It was noted that Queensland has already adopted, by reference, particular standards and codes of practice under the Health Act. (For example section 102 of the Health Act refers to the Drugs Standard Adopting Act 1976 (Qld) which adopts the current British pharmaceutical codex and British veterinary codex.) Queensland has also adopted the national **Standard for Uniform Scheduling of Drugs and Poisons** (which outlines national scheduling, labelling and packaging of drugs and poisons) under the Queensland Poisons Regulations 1973. It was concluded that uniformity between Queensland and other States at a national and international level would be beneficial as perceptions and meanings of terms would be clearer, it would allow for a unified approach from manufacturers, suppliers and users and it would ensure that legislation in Queensland is beneficial and relevant.\(^3\) The paper called for submissions on the extent to which Queensland legislation should be consistent with national and international perspectives and trends and on whether Queensland has any issues that require departure from national trends.\(^4\)

The other issue relevant to amendments made by this Bill which is also referred to in the Discussion Paper is that of penalties. It was pointed out that the maximum penalties in the Health Act range from 20 - 80 penalty units ($1500 to $6000)\(^5\) while serious offences under the Environmental Protection Act 1994 attract maximum penalties such as 4165 penalty units ($312,375) or five years imprisonment and offences under the Fisheries Act 1994 range from 300 penalty units ($22,500) to 2000 penalty units ($150,000). The paper concluded that

> The broadest possible options should be available to provide the Court with alternatives to impose penalties on convicted persons. These options should include placing persons under professional health care, community service, monetary fines, the ability to publish offenders’ names, imprisonment for serious offences or suspension or cancellation of authorities.\(^6\)

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\(^3\) *Review of the Health Act 1937: Drugs, Poisons and Therapeutic Goods*, p 11.


\(^5\) *Penalties and Sentences Act 1992*, (Qld) s 5.

2.2 **PAINT**

The Bill introduces a **new Division 3A** into the Act to update the provisions relating to poisoning and contamination from paint including the health effects of lead in paint.

The following extract comes from an article in the *Master Painters’ News* which adapted a booklet issued by the Environment Protection Agency (NSW):

*Paints containing lead were used extensively on interior and exterior surfaces of houses built between 1860 and 1950.*

*In Queensland in 1922, restrictions were placed on the use of paint containing soluble white lead in areas frequented by children.*

*In 1956 lead carbonate as a pigment was prohibited in Queensland. These restrictions do not mean that Queensland houses are free of paint containing lead.*

*Lead-based paint was manufactured up until the 1960s, with diminishing quantities from 1950s onwards. Houses built before 1970 are likely to have surfaces coated in paint containing lead.*

*In 1965 the National Health and Medical Research Councils’ recommended maximum lead level in domestic paints was 1 per cent. In 1992, it was reduced to 0.25 per cent.*

*In 1995, The Australian Health Ministers Advisory Council recommended that the maximum lead content in household paint be reduced to 0.1 per cent. The recommendation will take effect from 1 December 1997.*

According to a booklet published by the Environment Protection Agency (New South Wales) (which provides basic information on the risks associated with paint containing lead):

*Lead particles can be inhaled or swallowed and then accumulated in the body throughout a person’s lifetime. The lead, which is not excreted, is mainly stored in the bones and teeth. Some is present in the blood and soft tissues.*

*Severe lead poisoning is uncommon in Australia. However, a single exposure to high concentrations of lead, such as eating a leaded-paint flake the size of a five-cent piece, can cause significantly elevated blood levels for some weeks.*

*Studies suggest that relatively low levels of lead in the blood can adversely affect the intellectual development and behaviour of young children …*

*… Young children absorb the lead by touching contaminated dust or soil and then putting their fingers or toys in their mouths. They can absorb up to 50 per cent of

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the lead entering their bodies whereas adults absorb about 10 per cent. As the nervous system of children under five is still developing, this higher absorption rate is of particular concern.

During pregnancy, lead may cross from the mother to the baby through the placenta. There is some evidence that elevated blood-lead levels in the mother might affect the development of the nervous system of the baby and increase the risk of a premature birth.8

An extract from the Workshop Manual for the Lead Paint Management Training Programme written by Professor Brian Gulson and Fred Salome which was offered in 1996 by Macquarie University Graduate School of the Environment and which was published in the Winter 1995 edition of LEAD Action News further considers the distribution and effects of lead. The authors point out that

Lead is a cumulative poison. Unlike acute poisons, such as chemicals that can kill quickly by attacking the lungs, lead poisoning happens slowly.9

This extract is attached to this bulletin as Appendix A along with an article published in the Summer 1996 edition of LEAD Action News entitled ‘Lead in paint on toddler’s cot led to her death’. (Appendix B).

The Bill will repeal current sections dealing with the use, manufacture, sale and labelling of certain paint and replace it with the provisions incorporating Appendix P to the Standard for the Uniform Scheduling of Drugs and Poisons (the standard). The standard was originally developed by the National Health and Medical Research Council and was adopted and published by the Australian Health Ministers’ Advisory Council in July 1985. Appendix P of the standard is entitled the Uniform Paint Standard and includes a definition of paint as follows:

… without limiting the ordinary meaning, includes any substance used or intended to be used for application as a colouring or protective coating to any surface but does not include graphic material.

This is the same as the definition contained within the Health Act except that the Health Act definition does not exclude graphic material, but goes on to include

… oil paint, water paint, enamel, distemper, and any tinting substance for use in the composition of any paint or for adding to any paint …

The definition of paint in the Health Act has not been repealed by the Bill.

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Neither the Bill nor Appendix P deal with the issue of the removal of lead-based paint from structures. In September 1995, the Master Painters’ & Signwriters’ Association of Queensland responded to publicity concerning a Brisbane-based painting contractor who, in the removal of lead-based paint from a home, allegedly spread lead-based dust into the home and yard of a neighbour, by publishing a set of guidelines for the safe removal of lead based paint. A newspaper article considering this issue is attached at Appendix C.

2.2.1 Use, Manufacture and Sale of Certain Paint

The Bill will amend the Health Act by repealing section 127 which specifies prohibitions on certain uses of certain paints. Contravention of this section renders a person liable to a penalty ranging from 5 to 20 penalty units ($375 to $1500).\(^{10}\)

This section will be replaced by new section 129F which provides that “a person manufacturing, selling, supplying or using paint must comply with the standard”. The standard is defined in new section 129E as the “appendix P of the uniform standard” which in turn is defined as the “Standard for the Uniform Scheduling of Drugs and Poisons compiled by the Australian Health Ministers’ Advisory Council”. The maximum penalty for a breach of this section will be the same as that for a breach of section 127 - 20 penalty units ($1500).

Paragraph 2 of Appendix P completely prohibits the manufacture, use or sale of paint containing basic lead carbonate, (except, on certain conditions, paint for application as mirror backing). Section 127(1), which prohibits the manufacture, sale or use of any paint containing basic carbonate white lead, is the same except it does not permit the exception in relation to mirror backings.

The other prohibitions under Appendix P differ in two major ways from the current situation as prescribed by section 127. Firstly, there are differences in the type of paint which will be prohibited and secondly there are differences in the prohibited purposes for which this paint may be used.

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\(^{10}\) Penalties and Sentences Act 1992 (Qld), s 5.
**Prohibited Paint**

Section 127(2) prohibits the use of paint containing more than prescribed portions of lead, arsenic, antimony, cadmium, selenium or mercury.

**Paragraphs 3 and 4 of Appendix P** distinguish **First Schedule Paint** and **Third Schedule Paint**.

**First Schedule Paint** is defined as paint which contains specified portions of antimony, barium, cadmium, chromium or selenium. Apart from barium and chromium these chemicals are all currently dealt with in the prohibition set out in section 127(2). Section 127(2) also includes arsenic and mercury which are not included in any definition of prohibited paints in **Appendix P**.

**Third Schedule Paint** is defined as paint containing specified proportions of lead which is also dealt with in section 127.

**Paragraph 6 of Appendix P** also completely prohibits the manufacture, sale and use of paint containing insecticides. This is not currently dealt with under the Health Act.

**Purposes for which this Paint will be Prohibited**

Section 127(2) provides that a person may not “use or put” prohibited paints on certain places. **Appendix P** goes further in that in prohibits the “manufacture, sale supply or use” of certain paints for certain purposes.

Section 127(2) prohibits the use or placement of prohibited paint on:

(a) the roof of a house or other building or structure whatsoever; or

(b) any exterior portion, other than the roof, of any house or other building whatsoever; or

(c) any fence, wall, post or gate whatsoever; or

(d) any interior portion whatsoever of a house; or

(e) any furniture whatsoever.
**Paragraph 3 of Appendix P** prohibits the manufacture, sale supply or use of First Schedule Paint for the following purposes which go further than those under section 127(2):

1) for the roof or for any surface to be used for the collection or storage of potable water;

2) for furniture; or

3) for any fence, wall, post, gate or building (interior or exterior) other than a building which is used exclusively for industrial purposes or mining or any oil terminal; or

4) for any premises used for the manufacture, processing, preparation, packing or serving of products intended for human or animal consumption.

The prohibitions in relation to First Schedule Paints also apply to the manufacture, sale, supply or use of Third Schedule (lead based) paints. **Paragraph 4 of Appendix P** prescribes these and further prohibitions on the use of Third Schedule (lead based) paints. Firstly, the exception in relation to buildings used exclusively for industrial purposes or mining or any oil terminals does not apply to these paints and therefore the use, sale and manufacture of Third Schedule (lead based) paints will also be prohibited for these structures. Secondly, Third Schedule (lead based) paints are also not to be used, sold or manufactured for bridges, pylons, pipelines, storage tanks, or similar structures. Finally, the manufacture, sale supply or use of Third Schedule (lead based) paints is also prohibited for “equipment or utensils” used for the manufacture, processing preparation, packing or serving of products intended for human or animal consumption.

**Paragraph 5 of Appendix P** also completely prohibits the manufacture, sale and use of paint for application to toys unless the paint complies with specifications in Part 3 of Australian Standard 1647 for Children’s Toys (Safety Requirements).

### 2.2.2 Labelling of Paint

Section 128 of the Health Act will also be repealed. Section 128(1) requires that a label “which complies in all respects with what is prescribed under the regulations” must be “attached to every package of paint packed or enclosed for sale”. Section 128(2) prohibits the sale of any paint unless it is labelled according to the regulations. There are no current regulations prescribed in relation to the labelling of paint, the last set having lapsed in 1988.
This section will be replaced by paragraph 7 of Appendix P which provides that a person must not sell or supply a paint or tinter unless it is labelled according to the requirements set out in paragraphs 8 to 14 of the Appendix. These include general requirements as to the language, size and colour of labels for any paint as well as specific requirements of wording for First, Second and Third Schedule Paint. (Second Schedule Paint is defined as paint containing specified proportions of ethylene glycol monoalkyl ethers, methylene chloride, toluene, and xylene.)

2.2.3 Enforcement Powers

Section 127(4) of the Health Act gives “any officer” the power to remove for examination or analysis samples of any paint. The chief health officer is also empowered to require the owner or person using or applying prohibited paint to clean down and remove that paint (section 127(6)). Failure to comply with such a notice renders a person liable to a fine of between 5 and 20 penalty units ($375 to $1500) and if the failure continues for longer than 14 days to a maximum daily penalty of 4 penalty units ($300) (section 127(7)).

The Bill will repeal these provisions and replace them with new section 129G which permits an officer (defined in section 160 as the chief health officer, the officers of the chief health officer and officers of the local government) to take for examination or analysis a sample of paint. New section 129H empowers the chief health officer to issue a notice to comply to either a person contravening the standard referred to in section 129F or to the owner of the house, premises, structure or furniture. The notice must state the act or omission constituting the alleged contravention, the action required by the person to rectify the alleged contravention and the day by which such action must be taken. The maximum penalty for non-compliance is 20 penalty units. There is no provision similar to section 127(7) permitting continued accrual of penalty units.

2.3 USE OF PESTICIDES

The Bill amends the offence provisions in relation to pest control operators who are defined as persons who for payment or reward use “pesticides in or about premises for the purpose of controlling, destroying or preventing the growth or development of insects, arachnida or vermin” but not persons who use “pesticides for agricultural, horticultural or pastoral purposes”. Pesticides are defined by the Act as including “any insecticide, rodenticide, arachnidicide, pulicide, weedicide or fungicide”.

Section 131K(1) of the Act provides that only licensed persons can “hold himself or herself out” as pest control operators.
Section 131K(2) creates offences as follows:

A person shall not use pesticides unless

(a) in using the same the person is not a pest control operator; or
(b) in using the same the person is operating under the personal supervision and in the presence of a person who is a licensee.

The Bill replaces this section with new section 131K(2) which provides that

A pest control operator must not use a pesticide unless the pest control operator is a licensee.

with the exception created by new section 131K(3) namely that

Section 131K(2) will not apply to a pest control operator who uses a pesticide in the presence, and under the personal supervision of a licensee.

So although unlicensed pest control operators are prevented from “holding himself or herself out” as pest control operators, as long as a licensed person is supervising the operation of pest control, non-licensed persons may actually use pesticides and effectively operate as pest control operators. New section 131K(4) places certain restrictions on the supervision process to require that the non-licensed operator is over the age of 18 years and the licensed supervisor “is present during, and personally supervises, the use or preparation”.

No penalties are currently specified for offences in relation to pesticides. The Bill will introduce a maximum penalty for the breach of sections 131K(1), (2) and (4) of 20 penalty units which has the value of $1500.
3 AMENDMENTS TO THE NURSING ACT 1992

Arguably the most significant effect of the Bill will be the amendments to the Nursing Act 1992. These include amendments regarding the functions and powers of the Queensland Nursing Council and the Professional Conduct Committee, particularly in relation to the registration or enrolment and suspension of nurses.

3.1 THE QUEENSLAND NURSING COUNCIL

The Queensland Nursing Council (the Council) was established pursuant to section 6 of the Nursing Act 1992 (Nursing Act) replacing the Nurses Registration Board of Queensland. The functions of the Council are set out in section 7 of that Act and its purpose was described in 1995 by the then Minister for Health, the Hon Peter Beattie as

… ensuring that appropriate standards of nursing practice are achieved and maintained and that an integrated system of consumer protection is in place in Queensland.\(^{11}\)

The amendments in the Bill give the Council greater flexibility in decision making by providing (in clause 37) that the Council may permit its members to participate in meetings

… by telephone, closed-circuit television or another form of communication.

Further flexibility is ensured by new section 16A (clause 38) which provides that the council can resolve matters without a meeting if at least a majority of members sign a document containing a statement that they are in favour of that resolution. The resolution can be passed in this fashion by members signing separate documents containing the statement in identical terms. Furthermore the resolution need not be signed by those members on the same day. The resolution is deemed to have been passed at a meeting of the Council held on the day on which the last of those members sign the document.

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3.1.1 Qualifications for Registration or Enrolment

One of the most important functions of the Council is to decide whether an applicant has satisfactorily met the educational and general requirements set out in sections 54(1) and (2) respectively so as to be qualified to be a registered nurse or an enrolled nurse. The applicant also has the onus to meet the further requirements set out in section 54(3) of being in a satisfactory state of health and having sufficient command of both oral and written English. Clause 42 of the Bill will now define these requirements as compulsory but non-exclusive elements of a general requirement that the person be “competent and fit to practise nursing”.

Like the other requirements the applicant has the onus to satisfy the Council of this requirement.

3.2 THE PROFESSIONAL CONDUCT COMMITTEE

Part 5 of the Act establishes the Professional Conduct Committee (the Committee) which, pursuant to section 85 is empowered to hear any charge that is referred to it under the Act and to take appropriate action in relation to such hearings.

This Bill will amend section 87 of the Act to increase the membership of the Committee from six registered nurses nominated by the Council, of whom three are to be chosen by the Council from a panel of names submitted by associations representing nurses, to 12 registered nurses of whom six are to be chosen by the Council from the panel of names. The membership will also be increased so that instead of the Committee also comprising of one person representing persons who use services provided by the nursing profession there will now be three such persons.

The Committee is, pursuant to section 96(1), currently constituted for particular proceedings by the chairperson and four other persons, three of whom must be nurses, however section 96(2) provides that “for the exercise of powers in relation to the hearing of a proceeding, or for purposes other than the hearing and determination of a proceeding”, the Committee may be constituted by the chairperson alone.

This section will be amended by the insertion of a new section 96(3) which will limit the powers of the committee when constituted by the chairperson alone. These include just about all decisions as to the procedure and evidentiary content of a hearing.
3.3 **CODE OF CONDUCT**

The Nursing Act does not actually set out grounds for disciplinary action or complaint such as those previously set out in section 31 of the Nursing Act 1976. Instead, Division 2 of Part 5 of the Nursing Act provides for a **code of conduct** which, pursuant to section 99, may be prescribed by the council “[F]or the purposes of providing practical guidance to nurses, midwives and other persons authorised to practise nursing”. Contravention of this code of conduct is the basis for disciplinary action.\(^2\)

No code of conduct has, however, yet been prescribed as it was initially envisaged that the Council would wait, “in the interests of consistency for nurses and midwives practising in Australia, for the development of a national code of conduct”\(^3\) by the Australian Nursing Council Inc. This code, entitled the Code of Professional Conduct for Nurses in Australia, was published in July 1995, however the Council received legal advice to the effect that this code cannot be used pursuant to the Queensland Act. The Council is therefore to develop its own code.

### 3.3.1 Contraventions of the Code of Conduct

Division 3 of Part 5 deals with contraventions of the code of conduct. Section 102 of the Act provides that “a person aggrieved by the conduct of a nurse, a midwife or another person authorised to practise nursing may complain in writing to the council of the conduct”. Section 102(2) provides that the “Council may cause an investigation to be conducted into the conduct of a nurse, midwife or another person authorised to practise nursing on the ground of contravention of the code of conduct” and section 103(1) provides that such an investigation may be undertaken by an inspector. Appendix D to this bulletin provides details of complaints received by the Council pursuant to this section during 1994 and 1995.

This section is to be repealed and replaced by **new section 103(1)** which states that as well as an investigation into conduct as a result of a complaint under section 102, an inspector can also conduct an investigation into the immediate suspension of the registration or enrolment of a nurse under section 67(1). These investigations are currently referred to the **Professional Conduct Committee** for determination (see section 3.4 below). The Bill will also make the following amendments to the way in which the inspector can conduct such investigations:

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The inspector will now be obliged to give “the person an opportunity during the course of the investigation to make formal submissions” (new section 103(4)(a)).

in the case of complaints under section 102(1), the inspector is obliged to give the person particulars of the complaint (new section 103(4)(b)). No such obligation exists in relation to an investigation into an immediate suspension under section 67.

the executive officer currently has the discretion to direct the respondent to such a complaint to undergo an assessment by the Health Assessment Advisory Panel under Division 5 of part 5 of the Act if the executive officer suspects, on reasonable grounds, that that person suffers from an addiction to alcohol or “another condition”. The Bill will amend this section by amplifying this second circumstance as “another condition that impairs the person’s ability to practise nursing or midwifery” (new section 103(6)).

Section 104 permits the Council to prefer a charge “against a person alleging a contravention of the code of conduct” and to “refer the matter to the Committee for hearing and determination” if the Council is satisfied that

(a) the complaint is based on the ground of contravention of the code of conduct, and

(b) there is substance to the complaint.

A new section 104A will be inserted by the Bill to incorporate the investigation of immediate suspension of a nurse. The new section provides that if a charge is preferred by the Council against a suspended nurse pursuant to section 67(5), the council must “immediately refer the matter to the committee for hearing and determination”.

3.4 IMMEDIATE SUSPENSION OF REGISTRATION OR ENROLMENT

Pursuant to section 67 of the Act, the Council has power to immediately suspend a nurse’s enrolment or registration if “the council is satisfied that the ability of a nurse to continue to practise nursing is seriously impaired to such an extent that a patient’s health or safety could be at risk”.

According to an article entitled ‘Managing a concern about a drug-related condition of a nurse’ in the Queensland Nursing Forum which is published by the
Queensland Nursing Council, criteria used by the council

... in deciding whether patient health and safety are at risk include whether the nurse is, for example

giving the patient only part of the drug and self administering the remaining portion;

substituting placebos for ordered medications for patients and then self administering the ordered drug;

affected by the drugs to the extent that their judgement is impaired; and/or

seeking and accepting appropriate assistance in dealing with the problem.¹⁴

Section 67(4) of the Act currently provides that if the Council does immediately suspend a nurse then the Council “must immediately refer the matter to the Professional Conduct Committee for determination”. Clause 50 of the Bill repeals this part of that section and will provide that instead of such a referral the Council is simply to “have the matter investigated”.

Consequential amendments are made as to the Council’s powers upon receipt of the investigator’s report. New section 67(5) provides that the Council must immediately either lift the suspension or prefer a charge against the suspended nurse alleging a contravention of the code of conduct (see section 3.3.1 above).

New section 67(6) provides that if a charge is preferred under subsection (5) the suspension applies “until the determination of the matter referred to the committee for hearing and determination under section 104(4)”. The committee is defined by the Act to be the Professional Conduct Committee (see section 3.2 above).

Section 104 permits the Council to prefer a charge “against a person alleging a contravention of the code of conduct” and to “refer the matter to the Committee for hearing and determination” if the Council is satisfied that

(a) the complaint is based on the ground of contravention of the code of conduct; and

(b) there is substance to the complaint.

A new section 104A will be inserted by the Bill to incorporate the investigation of immediate suspension of a nurse. The new section provides that if a charge is preferred by the Council against a suspended nurse pursuant to section 67(5), the Council must “immediately refer the matter to the committee for hearing and determination”.

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3.5 CANCELLATION OF REGISTRATION OR ENROLMENT

Section 70 of the Act provides that the Council may cancel the registration or enrolment of a nurse in certain circumstances including where a person has applied in writing to have their registration or enrolment cancelled (section 70(1)(b)), where the enrolment or registration has been cancelled by the law of another state or territory (section 70(1)(c)) and where a person ceases to have the relevant qualifications (section 70(1)(d)). Section 70(1)(c) will be amended to include the situation where a nurse’s registration or enrolment has been cancelled by a foreign country. The Bill also amends section 70(2) by extending the existing power of the Council to suspend the registration or enrolment of a nurse who has been suspended under the law of another state or territory to include the situation where a nurse has been suspended under the law of a foreign country.

Section 72(1) of the Act specifies that in certain cases the Council may not restore the registration or enrolment of a nurse unless the Council gives a particular direction in accordance with section 72(2). These cases include where the registration or enrolment was cancelled at the written request of a person under section 70(1)(b). Section 72(1) will be amended to delete the reference to section 70(1)(b) which means that the Council will not be able to restore the registration or enrolment which has been cancelled at the written request of a person under section 70(1)(b). The section will also be amended to permit the reregistration of a nurse whose registration was cancelled under the now repealed section 31 of the Nursing Act 1976 which permitted cancellation of registration where, for example, a nurse had been convicted of an indictable offence.

3.6 ANNUAL LICENCE CERTIFICATE FEE

Section 74 of the Act applies to the payment of the prescribed fee for an annual licence certificate (to be referred to as the annual licence certificate fee) to be paid by nurses and midwives. The new section is redrafted along similar lines to the current section providing for cancellation of registration, enrolment or authorisation if this fee is not paid within a certain time (clause 54). The effect of the amendments can be summarised as follows:

- the Act currently provides that payment for an initial certificate for a nurse must be made within 7 days of enrolment or registration. This is deleted and payment for both nurses and midwives must be made within a payment period which is to be prescribed under a by-law.
- Under the Act the Council is obliged to reregister, re-enrol or reauthorise a nurse or midwife after cancellation for failure to pay the fee if an application is made within 3 months and if the Council is satisfied that the applicant practised nursing or midwifery during the last 5 years prior to cancellation.
(known as a **recency of practice** criterion). This will be amended in three ways:

- the 3 month time limit will no longer apply and applications can be made at any time.
- there is a new requirement that the Council must also be satisfied that the applicant is qualified to be registered, enrolled or authorised.
- although the Council is still obliged to re-register, re-enrol or reauthorise an applicant if satisfied that the applicant practised nursing or midwifery during the 5 years prior to suspension, the Council now has the discretion to still “reregister, re-enrol or reauthorise the applicant subject to the conditions of practice it considers appropriate” even if the Council is not satisfied that the applicant has practised nursing or midwifery during the 5 years before the application.

The **recency of practice** eligibility criterion was raised and developed as an issue in discussions on the proposed nursing legislation which became the Nursing Act. The requirement of recency of practice was said to have been included because of ongoing changes within the health care system and changes within nursing.\(^\text{15}\) The Nursing Act specifies recency of practice as a requirement of:

- qualification for registration or enrolment under section 54;
- any application for restoration of registration or authority to practise under section 74(5)(b);
- any application for renewal of an annual licence certificate under section 75(2)(b)(i); and
- the endorsement by the Council of an annual licence certificate of a nurse authorising their practice as a midwife or psychiatric nurse under sections 76(2) and (3).

The relaxation of this criterion by the amendment to section 74(5)(b) is not mirrored in any of these other sections.

### 3.7 Amendments Concerning Offences and Charges

Section 137(1) which sets out the decisions and orders of the Council which can be appealed will be amended to include the decision to cancel a person’s registration or enrolment (**Clause 64**).

---

Section 145, which provides that offences under the Act may be prosecuted in a summary way under the *Justices Act 1886*, will be amended by Clause 65 to include **new section 145(1A)** which will provide that such proceedings must be commenced

1. **a)** within 1 year after the commission of the offence; or
2. **b)** within 1 year after the offence comes to the complainant’s knowledge, but within 2 years after the commission of the offence.

Presumably the wording of this section would cover circumstances where, in the absence of a plea of guilty, such proceedings could only be for the alleged commission of an offence.
BIBLIOGRAPHY

MONOGRAPHS


ARTICLES


LEGISLATION

• *Health Act 1937* (Qld)
• *Nursing Act 1992* (Qld)
• *Penalties and Sentences Act 1992*, (Qld)
APPENDIX A

Distribution and Effects of Lead

by Prof. Brian Galson and Fred Salome

The following is an extract from the Workshop Manual for the Lead Control and Management training programme being offered in 1996 by Macquarie University Graduate School of the Environment in conjunction with CTI Consultants. The authors have granted permission for this section to be reproduced.

After lead is absorbed from the gastrointestinal tract or the lungs, it enters the bloodstream. At first, lead attaches to proteins in the blood that carry it to different tissues or organ systems in the body. Blood has a fluid portion, called plasma, and a cellular portion. The cellular portion is made up of red blood cells (or erythrocytes) and white blood cells. Most of the lead present in the blood is bound to the red blood cell.

Doctors can tell how much lead a person has been exposed to by measuring the amount of lead in the blood. These amounts are reported as a quantity per unit of volume (usually micrograms [µg] per decilitre.)

Lead is distributed to many tissues and organ systems of the body. It’s important to remember that lead cannot be destroyed or changed to something else in the body. The amount of lead stored in the body has been described as the “body burden” of lead. Among adults over 95% of the total body stores of lead are found in bone. For children about 70% of lead is stored in bone. This lead is not simply stored away in bone forever, but moves in and out as the body functions normally. For example, as children grow their bones restructure to permit normal shapes as they develop.

The amount of lead in important organs such as the brain, the blood forming system and the kidney are signs of the damage produced by lead accumulation. Several factors must be looked at in order to find the harmful health effects produced by lead:

- How much lead is present in the organ system?
- How long has the lead been present?
- Is the organ system at a time in its development when it can be affected by lead?

Lead is a cumulative poison. Unlike acute poisons, such as chemicals that can kill quickly by attacking the lungs, lead poisoning happens slowly. The lead that is taken in daily, mounts up in the tissues, especially the bones. Blood lead levels mainly show recent exposure (for example, the past few months of exposure) however, lead that is removed from bone is also present in the blood. It is quite possible that a person can have higher amounts of lead in his or her body than looking at the blood-lead level would tell us. Because bone is not easily available for measurement of lead, the usual way to tell how much lead exposure a person has had is by chemically measuring the level in the blood.

The body gets rid of lead in the urine and through the gastrointestinal tract. However, many people (and most occupationally exposed workers) are unable to get rid of as much lead as they take in. That is why the “body burden” of lead increases over the decades. Until late in life, most persons are steadily getting more and more lead in their tissues. Only among the elderly, for example those 70 to 80 years old, does the body lead burden begin to get less.

Sometimes bone releases its lead. This may be when the person has a disease, for example osteoporosis, or sometimes during pregnancy and lactation. During pregnancy lead is transferred from the mother to the developing infant. Because lead freely crosses the placenta, the mother’s blood lead
amounts determine how much lead reaches the fetus. The infant's blood lead at birth is about 85-90% as high as the mother's blood lead level. The tissues of the developing fetus, including the brain, take in lead during gestation. The lead taken in during this time has special importance because the developing brain is extremely vulnerable to the harmful effects of lead.

Damage does not occur to one organ system (for example, the nervous system) while not harming other organs at the same time. In humans, the central nervous system, especially of developing infants and very young children, is affected by lower amounts of lead than are other organs such as the kidneys. For this reason much of the focus of recent studies on the effects of lead has been on the harmful neurological effects of lead.

Nervous System Effects of Lead

It has only been understood during the past decade just how much the nervous system is affected by lead. That means, earlier recommendations on "safe" amounts of lead in blood were dangerously close to levels now considered very likely to cause mental retardation in children. Because the past ten years has been a period of very rapid change in understanding of the toxicity of lead, much that has been written (either older pamphlets, medical articles, guidelines for occupational health, etc.) is out of date as to harmful effects that occur at low levels of lead exposure. In the 1950's blood lead levels ≥ 60 μg/dL concerned medical care providers. By the 1980's this level was lowered to 25 μg/dL. The Centers for Disease Control has recently (October, 1991) reduced the level at which interventions are recommended to 10 μg/dL (see section on NHANES III).

In 1990, the US Public Health Service established the national goal of eliminating, by the year 2000, all occupational exposures that result in worker blood lead levels greater than 25 μg/dL (DHHS, 1990). The mean blood lead level for males in the United States during the period from 1976-1980 was 16 μg/dL and this has now decreased in 1988-1991 to 4 μg/dL in the latest National Health and Nutrition Examination Survey (NHANES III). In addition, the American Conference of Governmental Industrial Hygienists has proposed that worker blood lead levels be controlled to 20 μg/dL.

Effects in Adults

At very high lead exposures adults also can develop what is called "acute lead encephalopathy." This can occur suddenly. Warning signs include irritability, headaches and hallucinations, and dizziness. With very high exposures the person could go into convulsions, paralysis and even die. Blood lead levels that cause these effects are well above 150 μg/dL among adults. A more typical picture of nervous system damage in the adult shows harmful effects of lead on various nerves such as the motor nerves. This damage, in advanced cases, results in "wrist drop" or "foot drop" (the inability to maintain the hand or foot in a normal position due to weakness of muscle tone because of nerve damage).

At lower exposures asymptomatic (without symptoms) effects on the peripheral nerves occur. This means that changes are present that are detectable only by special diagnostic techniques. Workers having blood lead levels lower than 70 μg lead/dL have been found to have slowed movement of nerve impulses. In adults exposed to lower amounts of lead, some changes typically reported are increased occurrence of fatigue and short-term memory loss, decreased functioning of the nervous system for activities that depend on visual intelligence, and visual-motor co-ordination.
Effects in Infants and Children

The clinically evident effects of lead on the nervous system differ for children and adults. For children, blood lead concentrations of about 100 to 150 μg/dL and higher are associated with severe damage (encephalopathy). When this happens there is swelling of the brain. This increased pressure severely limits the brain’s functioning. Before chelation therapy (administration by injection of organic acids that bind or chelate lead, so that it can be eliminated) was begun in the 1980s, lead poisoning this severe resulted in about a 65% rate of death for children. In current practice, these cases are rare. When properly diagnosed and appropriate chelation therapy used, the death rate is considered to be about 1 or 2%. Although lead exposures this high are rare in the United States today, they are encountered in industrialising countries that have not tried to control lead exposures. Children surviving an episode of lead encephalopathy frequently have permanent brain damage, including retardation and severe behavioural disorders.

Effects on the Blood-forming System

Lead impairs the synthesis (formation) of a substance called “heme” which is extremely important to human life because it carries oxygen to tissues of the body. Lead interferes with the production of this substance at several different steps. Lead-exposed persons can develop anemia. In adults, anemia is usually seen in severe chronic lead poisoning and blood lead levels of 70 μg/dL and higher are usually found.

Lead has a more severe effect on the blood-forming system in iron-deficient people. Generally young children and women of child-bearing age are much more likely to be iron deficient than are adult men. Because the combination of iron deficiency and lead exposure causes more severe effects on the blood-forming system than either condition alone, women and children tend to show more severe effects. These occur at lower blood lead levels in women and children than in men.

Effects on the Kidney

High exposures to lead that produce acute lead poisoning can damage the kidney in both adults and children. One of the functions of the kidney is to absorb certain substances which are filtered through the kidney. Lead interferes with these functions by altering the metabolism of the kidney. After lead levels are reduced the kidney is able to again do these functions. However, if the lead exposures in childhood continue for a long time and at high amounts, children may show kidney disease later in life as adults. Chronic nephropathy (kidney disease) in lead workers is now recognised as a separate disease. Chronically lead-poisoned workers can show elevated blood urea nitrogen. So far there is relatively little information on the renal (kidney) effects of exposure to relatively low levels of lead among either children or adults.

Hypertension

Long-term, high exposures to lead have been reported to be linked with high blood pressure and stroke. One researcher has followed two groups of workers occupationally exposed to lead (4,519 battery plant workers and 2,360 lead production workers from smelters) for a number of years. Both groups of workers have significantly more deaths than would be expected by hypertensive disease and chronic renal disease.

Reproductive Effects

Female workers with high lead exposures and the wives of male lead workers have a higher rate of miscarriages. Male workers with elevated lead exposures (e.g., blood lead levels of 50 μg/dL) have more abnormal sperm cells and lower sperm counts.
APPENDIX B


Lead in paint on toddler’s cot led to her death

The following article is reprinted with lead permission from the Ashburton Guardian, New Zealand (16/12/91).

A terrifying Mid Canterbury [New Zealand] toddler chewed enough lead-based paint from her renovated cot to die from lead poisoning, Ashburton Coroner Laurence Cooney has been told.

Twelve-month-old Cody Marie Mann ingested 8.1 square centimetres of the paint and the undercoat and died of a condition so rare several doctors failed to diagnose it.

A Christchurch pathologist who found high levels of lead in Cody’s body after her death asked police to investigate because the chemical concentration was so abnormal.

Dr Cooney said Cody’s mother, Katrina Mann, sought all the right advice when her baby was ill and could not be blamed for the death.

Miss Mann told Dr Cooney at yesterday’s inquest Cody was born on August 15, 1992, and was a happy and contented baby.
About May this year she began sleeping in a cot repainted by her parents, Michael McCormick, with a plastic-type paint recommended for the job. The cot was between 30 and 40 years old.

When Cody developed two teeth she began to chew the top rails of the cot, which the couple then coated with fabric as a deterrent.

Miss Mann mentioned it to her planet nurse and to her general practitioner.

"I was assured that although this was not good for Cody, it certainly was not going to cause too much harm."

Cody’s health began to deteriorate in late July. The previously healthy baby became clingy and vomited her food.

"I contacted my GP on about August 14 and I was told it was normal for a child of that age. I presume because she was teething at the time,"

"I was told to bring her back if the sickness continued."

Unhappy with the advice, Miss Mann sought a second opinion nine days later. This doctor diagnosed an infection and prescribed antibiotics.

Cody remained silent since that night and was admitted to Ashburton Hospital for observation the next day.

When the suspected urinary tract infection worsened she was transferred to Christchurch Public Hospital where she died on August 28, 1999. It was too late to treat her by the time lead poisoning was diagnosed.

Health protection officer Steve Hill said he was asked to investigate the case when lead poisoning was suspected as the cause of death.

He tested the interior and exterior of a house formerly occupied by the family at Princes Street in Ashburton and their present Mayfield home.

Mr Hill said Cody had chewed through up to four layers of paint, some of which was lead based.

The total areas measured about 8.1 square centimetres.

From that paint the toddler could have ingested up to 3.4 grams of lead, of which 40%, or 1.3 grams, would have been able to be absorbed by her body.

He said analysis of Cody’s hair showed lead levels climbed from two to 80 micrograms in the last two months of her life, corresponding with the onset of teething and her chewing the cot rails.

Mr Hill said he was also concerned about a high level of lead found in 20 feet of the 30-year-old painted weatherboard house at Mayfield.

He said lead was still used in some pigmentation and as a drying agent.

Some paints came with labels warning they should not be used on children’s toys.

Christchurch medical officer of health clinical advisor Dr John Holmes said lead poison cases were well documented, but rare.

"I am not aware of another case like this."

He said lead poisoning could be treated but the levels found in Cody were very high.

"The people I have spoken to have never seen anything like this."

Dr Holmes said exposure to low levels of lead caused retardation and a general slowing down.

He said the Public Health Commission was keen to study lead levels in New Zealand communities over its concern about environmental lead levels and lead in petrol.

Mr Crane said Miss Mann had done everything a mother could to find out what was wrong with her baby and fix it.

He said he hoped Cody’s death would not be in vain and that other parents would be aware of the potential hazard associated with ingesting lead.
APPENDIX C

This Appendix contains the following articles:

A NEIGHBOURHOOD renovation job could lead to brain damage in your child.

Lead is highly toxic, particularly for children.

In high concentrations it can kill, but even low level exposure has been shown to cause brain damage, behavioural and other problems in children.

The use of lead-based paint is now banned, yet Australia has no legislation regulating the way people remove lead-based paint.

Political complacency and community ignorance about the dangers associated with removing lead-based paint are allowing both do-it-yourself renovators and professional painters to get away with dangerous practices.

A recent case in Brisbane highlighted the issue.

The Doonan family fled their New Farm home this month after it was coated in paint dust blown in from next door.

The century-old Queenslander next door was being sanded down by a professional painting company in preparation for painting.

No precautions were taken to contain the paint dust which was shown in later tests by the Division of Workplace Health and Safety to contain up to 15 per cent lead.

Since then, Heather and George Doonan, along with four-month-old Seamus, five-year-old Roisin, seven-year-old Laura, nephew Storm, 12, niece Tari, 16, and friend Dana, 18, have been lugging themselves from motel room to motel room, competing at times for vacancies with Ekka visitors.

To decontaminate their home of lead will probably cost the Doonan family more than $20,000.

Cleaning contractors have been scouring their home inside and out, working to Department of Workplace Health and Safety guidelines for cleaning lead-contaminated houses.

Mr Doonan said the bill for the cleaners alone would be $9000-$10,000.

And that doesn't include the cost of tearing up their grass, hauling away the top soil and probably replacing all their carpets.

It doesn't include hotel bills, clothes washing bills and replacement of items, like the vacuum cleaner, that have had to be thrown away.

And it certainly doesn't include the fear, the conflict and the hassles.

While it is going to be very expensive - and who pays will probably depend on a court case - Mr and Mrs Doonan said they were most concerned that lead contamination was happening throughout Brisbane constantly.

Peter Sloga, the painting contractor involved, said he did not know of any dangers associated with sanding old paint.

He said he didn't consider it his responsibility to check before sanding if a paint contained lead.
Last year, the Division of Workplace Health and Safety in Queensland issued guidelines for the safe removal of lead-based paint.

Acting director of inspection and advisory services in the division, Gary Chaplin, said the guidelines had been disseminated to all painters through painters' and builders' associations.

According to the guidelines, safe methods for removing lead-based paint include wet hand sanding, chemical stripping (although it has its own dangers) and using a hot air gun.

Unsafe methods include dry sanding, torch or open flame burning and waterblasting.

However, according to Queensland state manager of the Master Painters' Association, Sue De Simone, using safe methods can be "thousands of dollars" more expensive than using unsafe methods, such as dry sanding.

Ms De Simone said people often hired the painter giving the cheapest quote without questioning their method of paint removal because they were unaware of the risks of removing old paint.

Trace element analyst Graeme Waller said any house built before 1970 probably had at least parts of it coated in lead-based paint.

"The older the house, the more lead," he said.

Decontamination of the Doonan's home may still not solve their problem.

Mrs Doonan said the house from which the paint was removed had been cleaned out and the paint dust washed into the yard.

The owner of the house was not interested in removing the contaminated soil and was planning to sell the house, she said.

Wind would blow the fine lead dust particles around the neighbourhood, and recontaminate the Doonan property, she feared.

Opposite the house is a primary school.

Professor Brian Gulson, a professorial fellow at Macquarie University, has been studying lead contamination in Sydney houses.

He has found cases where people have paid tens of thousands of dollars to decontaminate their houses, only to find that their children's blood lead levels had not decreased.

"Somebody down the street may have been renovating and dust just gets in the air and blows around everywhere - lead dust can go kilometres," he said.

In Queensland, the power of the Division of Workplace Health and Safety to prevent the use of unsafe methods of paint removal is limited.

If a complaint is made to the division, inspectors can test for lead in the paint dust and issue a prohibition notice to the painter.

This notice remains in effect until the painter cleans up the paint dust and changes the method of paint removal on that particular site.

While death from lead poisoning is rare nowadays, a host of studies have shown that even low exposure to lead can have devastating consequences on health.

Children, pregnant women and their unborn children are particularly vulnerable to the effects of lead.

Children absorb up to 50 per cent of lead ingested, compared with 10 to 15 per cent in adults.
And with their propensity to put everything in their mouths, young children tend to ingest a lot of lead from the environment.

Humans can also absorb lead through the lungs and skin.

Lead is an enzyme poison, which accumulates in the body.

It interferes with energy metabolism in cells and with the formation of haemoglobin in red blood cells, causing damage to almost every organ in the body.

Developing nervous tissue in children is particularly susceptible to damage from lead, with studies showing the greater the lead concentration in children's blood, the lower their IQ.

Other problems include poor language skills, behavioural problems, decreased growth and impaired hearing.

There is evidence that lead may cause attention deficit disorder, estimated to affect five to 10 per cent of children.

The National Health and Medical Research Council last year reduced the "acceptable" level of blood lead to 10 micrograms per decilitre (ug/dl) from 25 ug/dl.

A just-completed national survey of 1600 Australian children between one and four years found that seven per cent had blood lead levels greater than 10 ug/dl of blood.

Exact figures will not be available until September or October when a full report on this survey will be released.

The decreasing use of leaded petrol has been effective in lowering airborne lead levels.

However, Mr Waller said while petrol emissions increased blood lead levels in most people, the greatest danger actually lay with lead-based paint.

"When you look at lead from motor vehicle emissions along a major road where you might be getting 70,000 vehicles a day, 1000 to 1500 parts per million (ppm) of lead in the soil adjacent to the road is about the maximum you're going to get," he said.

"But if you sample the soil adjacent to an old house that's had relatively high level lead paint on it, then 30,000 ppm is not uncommon."

Blood lead levels are indicative only of recent exposure to lead because in blood, lead has a half life of only about 30 days.

Lead accumulates in the body, particularly in the bones from where it may resorb back into the blood throughout life, and so bone lead levels may provide a long-term assessment of lead exposure.

Queensland University of Technology professor Brian Thomas is half way through a study of the resorption of lead from bones during pregnancy and breast-feeding.

He said a previous study of people aged over 60 found that there was a correlation between their levels of bone lead and the type of houses they had lived in as children.

National co-ordinator of The Lead Group, Elizabeth O'Brien, said their information service received about five calls a month from people whose homes were contaminated by lead because of renovations in neighbouring houses.

But she said there were probably hundreds more cases where people were not aware that their neighbour's renovation, or their own, was endangering them.
SEVERAL Queensland nurses face suspension or having their powers severely limited for alleged drug abuse while working.

Queensland Nursing Council executive officer Jim O'Dempsey confirmed yesterday that "a number of charges" had been set down for hearing by the professional conduct committee in August and September.

He declined to say how many related to substance use or abuse.

The Sunday Mail understands a senior nurse from a Brisbane hospital was deregistered when the committee last met in April.

The nurse apparently used tranquilisers to keep her energy levels high at work and after hours.

Mr O'Dempsey refused to discuss individual cases - describing them as confidential - but said "no more than two" nurses had been suspended from duty in the 1995-96 year for drug use.

He said there had been about 40 complaints in the past financial year relating to alleged misconduct by nurses, but would not elaborate on how many of those were specifically about drug abuse.

The council received five "reports of concern" about the condition of nurses relating to substance abuse in the period July 1, 1994, to June 30, 1995, and Mr O'Dempsey said the number was about the same in the past year.

He said between 10-15 nurses had been put on limited registration for misconduct.

Again, he would not say how many were drug-related, but it could be assumed that at least a third had been censured for abuse.

Limited registration meant withdrawing a nurse's access or ability to administer certain drugs and poisons; requiring them to undergo a rehabilitation program with a psychiatrist; and face a review in one or two years.

They were also regularly and randomly urine-tested.

Up to 60 Queensland doctors are known to be drugs users, but there has been concern about the number of nurses turning to narcotics, such as Serapax and Valium, or opiates such as morphine and pethidine.

The nursing council has stepped up an education campaign.

"The numbers [of abusers] are actually decreasing," Mr O'Dempsey said.

"This council has taken very pro-active steps in advising the profession with regard to the risks of exposure to dangerous drugs.

"People, like nurses, doctors and dentists, are industrially exposed to drugs."
They are more at risk than someone [in another profession] not exposed.

He believed nurses were more aware of the problems now.

That campaign began with a lengthy report in the Queensland Nursing

Forum magazine last December, entitled "Managing a Concern about a Drug-Related Condition of a Nurse".

"In considering how best to deal with concerns about the conditions of such nurses, council has determined that where the nurse's health rather than their conduct is the focus of the concern, a rehabilitative approach is most appropriate.

Three points are significant in this decision: "Society has invested in the educational preparation of the nurse for practice and there is a continuing need for nursing skills."

"An impaired nurse needs support and assistance, not punishment. "Nurses should be able to retain their chosen career as long as patient health and safety is not at risk.".

The report featured two Queensland case studies: a nurse using morphine and pethidine who had progressed well on a rehabilitation program; a drug-addicted nurse who refused to admit to her pethidine habit and, because patients were put at risk, faced suspension.

The implications of drug-taking for nursing practice and a guide to notifying the council about a suspected offender were also included.

Mr O'Dempsey said that while rehabilitation was the key point, the council would never allow a nurse to endanger a patient.

"If we believed that, because of a nurse's condition, a patient's health or safety were at risk, then we would withdraw the licence to practise.".

He confirmed that some nurses on limited registration were working in hospitals in the state, but were closely monitored by their employers.

Mr O'Dempsey said the council would consider an application for restoration of registration only if a nurse could prove they had overcome a drug problem.
APPENDIX D

COMPLAINTS TO THE QUEENSLAND NURSING COUNCIL FROM PERSONS AGGRIEVED BY THE CONDUCT OF A NURSE, MIDWIFE OR ANOTHER PERSON AUTHORISED TO PRACTISE NURSING TO JUNE 1995.


### TABLE 1: NUMBER OF COMPLAINTS RECEIVED

<table>
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<th>YEAR</th>
<th>COMPLAINTS RECEIVED</th>
<th>NUMBER</th>
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<th>% of Total</th>
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<td>20</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td></td>
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<td>Jan-Jun 1994</td>
<td></td>
<td>3</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>Jul-Dec 1994</td>
<td></td>
<td>16</td>
<td>32.6%</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan-Mar 1995</td>
<td></td>
<td>3</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>Apr-Jun 1995</td>
<td></td>
<td>7</td>
<td>14.2%</td>
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</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>49</td>
<td>100%</td>
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### TABLE 2: TYPE OF COMPLAINTS

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<th>YEAR</th>
<th>Sexual Misconduct</th>
<th>Inappropriate Relationship</th>
<th>Health Concern</th>
<th>Assault</th>
<th>Substance use/abuse</th>
<th>Incompetence</th>
<th>Other</th>
<th>TOTAL</th>
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</thead>
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<tr>
<td>1994</td>
<td>7</td>
<td></td>
<td>6</td>
<td>1</td>
<td>15</td>
<td>3</td>
<td>7</td>
<td>39</td>
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<td></td>
<td>17.9%</td>
<td></td>
<td>15.4%</td>
<td>2.6%</td>
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<td>7.7%</td>
<td>17.9%</td>
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<td></td>
<td>11.5%</td>
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<td>15.4%</td>
<td>30.8%</td>
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TOTAL | 39 | 100% | 26 | 100% |
### TABLE 3: SOURCE OF COMPLAINTS

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<th>Source of Complaints</th>
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<tr>
<td>Chief Health Officer/ Environmental Health</td>
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<td>2</td>
</tr>
<tr>
<td>Health Rights Commissioner</td>
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<td>2</td>
</tr>
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<td><strong>TOTAL</strong></td>
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### TABLE 4: REGISTRATION STATUS OF NURSES SUBJECT OF COMPLAINTS BY AREA OF PRACTICE AND GENDER

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<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
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<td>NA</td>
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<td>0</td>
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<table>
<thead>
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<th>General</th>
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<th>Midwifery</th>
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