T R A N S C R I P T

INTEGRITY AND OVERSIGHT COMMITTEE

Inquiry into the Operation of the *Freedom of Information Act 1982*

Melbourne – Wednesday 13 March 2024

MEMBERS

Dr Tim Read – Chair
Hon Kim Wells – Deputy Chair
Ryan Batchelor
Jade Benham
Eden Foster
Paul Mercurio
Rachel Payne
Belinda Wilson

WITNESS

Andrew Mariadason, Legal Counsel and Manager, Medico-Legal Services, Royal Melbourne Hospital.

The CHAIR: I declare open this public hearing for the Integrity and Oversight Committee's inquiry into the operation of the *Freedom of Information Act*.

I would like to welcome the public gallery and any members of the public watching the broadcast, and I also acknowledge my colleagues participating today: from my left, Deputy Chair Kim Wells; I am Tim Read, the Chair; on my right, Ryan Batchelor; then Eden Foster and Paul Mercurio.

On behalf of the Committee I acknowledge First Nations people, the traditional owners of the land, which has served as a significant meeting place for the First People of Victoria. I acknowledge and pay respect to the elders of First Nations in Victoria past and present and welcome any elders and members of communities who may visit or participate in the public hearing today.

To Mr Mariadason, before you give your evidence there are some formal things I have to cover, so please bear with me.

Evidence taken by the Committee is generally protected by parliamentary privilege. You are protected against any action for what you say here today. If you repeat the same things anywhere else, including on social media, those comments will not be protected by this privilege. Any deliberately false evidence or misleading of the Committee may be considered a contempt of Parliament.

All evidence given today is being recorded by Hansard and you will be provided with a proof version of the transcript for you to check once available. Verified transcripts will be placed on the Committee's website. Broadcasting or recording of this hearing by anyone other than Hansard is not permitted.

I welcome Mr Andrew Mariadason from the Royal Melbourne Hospital. Thanks very much for coming in. Do you have any brief opening comments?

Andrew MARIADASON: Just some introductory comments about my role and the role of freedom of information at the hospital.

The CHAIR: Thank you.

Andrew MARIADASON: Thank you, Chair. Thank you, members of the Committee, for the opportunity to assist with your inquiry. My name is Andrew Mariadason. I am employed by the Royal Melbourne Hospital [RMH] as Legal Counsel and Manager of Medico-Legal Services. My professional address is Level 6, 635 Elizabeth Street, Melbourne. The medico-legal service at the RMH is responsible for managing and administering the Freedom-of-Information [FOI] applications for the RMH. The medico-legal function, including our FOI team, reports into the Chief Legal Officer at the Royal Melbourne Hospital. I have been informed that the Committee is keen to hear about six broad topics referable to the RMH, and if it assists the Committee, I can certainly turn to each of those and provide some preliminary commentary.

The CHAIR: Thank you.

Andrew MARIADASON: Thank you. I am indebted to you. So the first topic is Topic 1, and that is a query around the kinds of FOI requests that the Royal Melbourne Hospital receives and how it provides access to health-related information. Freedom-of-Information requests to the Royal Melbourne are predominantly made by legal firms acting as agents or on behalf of Royal Melbourne Hospital patients, and Victorian statutory entities such as the Transport Accident Commission [TAC] and WorkSafe Victoria. The TAC and WorkSafe routinely seek clinical records in relation to matters arising from motor vehicle or workplace accidents, and as one of Victoria's two adult major trauma centres, the RMH service is one of the busiest in the country, so we see a lot of requests from TAC and WorkSafe. Private health and other private insurance companies request information by FOI, and then of course patients of the Royal Melbourne health service, and on occasion their next of kin in the context of the patient having deceased, request FOI material and from time to time, but far more rarely, Victorian State entities and other entities such as media. Those are effectively the predominant applicants that we see.

Overwhelmingly, FOI requests relate to patient health information, so that is the medical record collected during a patient's inpatient admission or specialist outpatient consults or emergency attendances. When I talk about the medical record I am talking about medical nursing and allied health progress notes, care plans, observation charts, medical records, medication records, pathology, radiology, clinical photographs, operation reports, mental health records (given our role as a provider of mental health services in the western and northern regions) and clinical correspondence as well. Valid requests overwhelmingly result in documents being released in full. We do have documents that are part-released, which means that redactions are applied to the documents, but those redactions are fairly tightly confined. Typically, they relate to personal-affairs information, so for instance we might redact out the mobile number of a clinician who is involved in the care of the patient. That mobile number is often on the clinical record to allow continuity of care or another clinician to contact them during that episode of care. Or we redact confidential information provided by third parties which is gained as collateral by the clinicians during an episode of care. That is some brief commentary in relation to Topic 1. I am happy to move on or field questions from the Committee referable to that.

The CHAIR: That is pretty much your question.

Paul MERCURIO: That is pretty much my question, but I do have one. You said that valid requests are released in full. Can you give us an idea of what a valid request is?

Andrew MARIADASON: Most definitely. A valid request is where there is a written request with an accompanying application fee from the applicant, and it is a request which is targeted and permits us to know what it is that they are looking for. For instance, a valid request might be that they want the medical record referable to an attendance or an episode of care between January of 2024 and February of 2024 if there was an inpatient admission. We would then collate the records referable to that request. That is easily discernible, the application fee has been paid, it is in writing and meets all the prerequisites of the FOI legislation.

Paul MERCURIO: And then can you take us through what an invalid request is?

Andrew MARIADASON: An invalid request may lack specificity about the request itself. So we might receive an application which says, 'Please provide me with information referable to my claim against the Royal Melbourne Hospital.' We may not be able to readily and easily discern from that request what precisely they are looking for. Or they may send an application form in without payment of the application fee, the statutory fee, or those types of things. We tend to work with the applicant to validate the invalid request and then progress through the FOI chain.

Paul MERCURIO: Thank you.

Ryan BATCHELOR: Would I be right in suggesting that most of the applications from lawyers, the statutory – so WorkSafe and the TAC – and/or private insurance would be done at the request or behest of the patient or as part of a claim the patient is making and therefore have their express or implied consent to the application being made?

Andrew MARIADASON: That is correct, Member, in large part. There are probably two ways of looking at that. One is what is perhaps most easily defined as a personal request, which is an application by the patient or their agent, and their agent is typically a legal firm. So the episode of care has finished and they are looking to interrogate the clinical records about what may have occurred during that episode of care. That is what we term a personal request, so the lawyer or the patient –

Ryan BATCHELOR: Would that be for medical negligence purposes?

Andrew MARIADASON: Oftentimes we consider it to be for a medico-legal purpose, so a medical negligence claim. It is quite [a] different request to what we consider ROI, which is release of information, which is often to help the continuum of care. The other cases are non-personal cases, so that is where TAC, after a road trauma, or WorkSafe seek records for the purposes of the management of their claim by the patient in a different context. So the patient may have been injured at work and then hospitalised at the Royal Melbourne, and WorkSafe needs those records in order to progress the WorkSafe case. They have their own statutory, regulatory processes whereby, in effect, if you make a claim for TAC or WorkSafe compensation you imply, or sometimes you sign a form saying, that the TAC or WorkSafe is permitted to then collect collateral information referable to that process.

Ryan BATCHELOR: So it is rare in the bulk of your cases that it is occurring without the express or implied consent of the referenced patient.

Andrew MARIADASON: Rare. In fact that is the first thing that we check for. Going back to the Member's commentary around a valid application, we are checking for consent from the patient, or their next of kin in the event of a patient's death, or some form of authorisation or evidence to suggest that they are either impliedly or explicitly consenting to this process.

Ryan BATCHELOR: You may not have it now, but, on notice, do you know roughly what the broad percentages would be for those different types of claims?

Andrew MARIADASON: I did look at OVIC's annual report from 2022–23. Roughly speaking, and again this is ballpark figures, it was probably a 55 to 45 split in terms of personal versus non-personal requests.

Ryan BATCHELOR: That is fine.

Andrew MARIADASON: Yes, I can take that on notice.

The CHAIR: Thank you very much. The Royal Melbourne has had an electronic medical records system for a few years at least –

Andrew MARIADASON: Indeed, Chair.

The CHAIR: and, as I understand it, it has got a portal for patients to look at least parts of their medical record. Has that made any difference to FOI claims? Now that patients can look at their record, are you getting fewer FOI claims? And regardless of the portal, does having an electronic medical record make it easier to get the information out to people through FOI?

Andrew MARIADASON: Thank you, Chair. I will try to address those in the sequence that you gave to me. Empirically, no. The access to a portal and the EMR – the electronic medical record – has not seen a diminution in the number of claims, or applications I should say, that we get under FOI. When I did some analysis around that, prior to attending before the Committee, the statistical analysis suggested that we were in the last three years at least seeing an 8 per cent annual increase, year-on-year, in terms of the number of FOI applications that people make. I understand that that is in keeping with the trends that OVIC – the Office of the Victorian Information Commissioner – has seen in terms of a gradual increase in the gradient of applications going up. We introduced the electronic medical record for the Parkville precinct, which is for the Royal Melbourne, the Peter MacCallum, the Royal Women's and the Royal Children's Hospital, in or about August 2020, and that has not seen a significant diminution in FOI applications that are being made.

Turning to the second question, about the impact of the EMR, if I can put it that way: following on from the comment that I made about it being a precinct-wide EMR, it certainly has contributed to significant improvements in the way RMH delivers care in a clinical context. Clinicians now have access to the patient's most up-to-date information at all times. There is equipment, such as mobile workstations, handheld devices and barcode scanners, and quite up-to-date, sophisticated equipment to help them deliver and record care, and certainly to support the best clinical decision-making, which is prompted by warnings, alerts, reminders and the like in the electronic medical record. It has certainly assisted our ROI – release of information – approach: the process relating to the release of health information, test results, diagnostic results and pathological results to another doctor, for instance, for continuing medical care. The release of discharge summaries to a GP is quite easy now in the context of the EMR, and certainly the Health Hub provides secure mobile and web applications. Patients can certainly have now a lot of engagement and are empowered in terms of their connection to the health care that is provided, but my sense is that the Health Hub, the EMR all support continuity of clinical care while we are intraclinical care. The FOI process is often used for when the clinical care is finished and people are looking – turning to the Committee members' earlier commentary – around getting information referable to what happened retrospectively and perhaps discerning and interrogating that. One of the challenges that has arisen from the electronic medical record, as good as it is, is that it has resulted in a lot more information. From the point of view of the Freedom of Information perhaps, and this is a bit anecdotal, when you had paper records and illegible scribbles – and that is with respect to doctors –

Ryan BATCHELOR: You do not need to provide respect to doctors.

Andrew MARIADASON: there were probably a hundred pages of clinical records, referable progress notes and radiological and pathological investigations. Now we are looking at a tripling or quadrupling of the number of pages because of EMR, because effectively it records every time a clinician has a point of contact with the record. So it has seen a significant increase in the numbers of pages.

The CHAIR: Okay. Eden Foster might have a question.

Eden FOSTER: Yes, I do. Thank you, Andrew. From a health care perspective, do you have any concerns about a potential transition in Victoria to a push model that promotes proactive and informal release, and are there any risks associated with that from that health care perspective?

Andrew MARIADASON: I think the Royal Melbourne Hospital's position is that early and efficient exchange of clinical information or release of clinical information is important. The pause that we have there, and the question that we have, is whether the push model, which is premised on proactive and informal release with formal requests being the last resort, is necessarily going to make it easier both for applicants and for hospitals, which churn out a lot of information. And we are just concerned to ensure against a prevailing view, which might be a by-product of the push model, that health care records, which innately are the patient's record – so looking at it from the patient-centric view, 'That's my record and I am entitled to it, and I am entitled to it quickly, efficiently, easily, at low cost and unfettered in some respects.' And we have some concerns about that particular push model – not that these concerns are insurmountable, but they remain something that help inform the decision-making of the Committee.

We think that the pull model, the FOI process at the moment, places important responsibilities on the applicant at the outset of the process. They need to provide a valid request, which we spoke about, and then there is an impost, which is the application fee that they pay, which makes them think about the fact 'Do I really want these records?' – not that that is a determinative factor, but it is a factor nonetheless. And then there is the process of engaging in re-scoping to be clear about time lines and statutory-based time lines. These all add what we consider to be very important rigour to the process, and the push model may turn the sentiment away from that sort of rigour.

Secondly, even if a push model of proactive and informal release is adopted, from our point of view we will still be required to go through the very careful analysis that takes place in the pull model as to whether information can be released or withheld in certain circumstances. We say that it is important that these exceptions and exemptions that appear in the *Freedom of Information Act* need to be very carefully considered in a very nuanced way. I will just quickly go through some of the exemptions which might inform the Committee. So we have an exemption at the moment where we do not disclose personal affairs information of third parties if there is a public interest in doing so, and that is staff, next of kin, government agencies, people that we engage with in the episode of care. Also, if information is communicated in confidence and it is contrary to the public interest to be released, then that is an important caveat on what gets released. Oftentimes, to give a clinical example, especially in a mental health scenario, the hospital has been asked to get involved in the care of a patient by next of kin and the patient themselves is not happy about this. They do not feel as though they need to have the care or to have an episode of care with the hospital, but their next of kin does feel this. It is important then that we protect the next of kin in the process of disclosure if a patient then later on says, 'Well, I want to see my clinical records.' We are concerned about important things like the relationship then between the patient and the next of kin and sometimes more serious issues around retaliatory conduct and the like.

So there are very important statutory fetters that arise in relation to FOI. There is a protection for draft documents and documents created for internal investigations. There are from time to time adverse clinical events that occur at hospitals, and these need to be fully, carefully and in a very candid way explored within the hospital. We want to ensure that clinicians feel a sense of assurance and protection from the FOI legislation and that they can do that without necessarily being released in an all-encompassing way. Then there are other secrecy provisions and Acts. For instance, our mental health clinicians will engage frequently with child protection or other statutory bodies. It is very important we have recourse to make sure that those sorts of interactions are protected, and the FOI gives us that scope. Finally, public hospitals and all public entities do not need to produce if the request is so large that it is going to redirect important functions of the hospital generally to managing the FOI request, so that is an important re-scoping provision that we have to talk these matters through.

My concern is around whether the push model tends to push all of that and ignore all of that. I know that there are restrictions on how information can be shared under the *Health Records Act*, but these are still important things for us to ventilate with the Committee. Finally, turning to those issues that I was just discussing, we probably feel as though we are going to have the same amount of work that needs to be done, for instance, to protect the next of kin of a patient that attends, with a push model. Conceptually, from the push model you might derive expectations that it is going to be a much cleaner way of going about giving information to third parties, when there are still all of these protective measures that we need to take and we will still probably have those operational requirements and the scarcity of resources in the push model. I hope that addresses, in a very longwinded way, the question, Chair.

The CHAIR: It does. It actually addresses my next question as well, so that is pretty efficient. But I guess there are some clear exemptions here. You would think that when the material is being entered into the medical record – I am particularly thinking about information from a third party – that clinical staff might know or could be taught that that information should be entered into a different part of the medical record. I am thinking about an electronic system now, whereby at the push of a button you could make sure that that material does not appear.

Andrew MARIADASON: I think the Freedom-of-Information legislation and the exemptions and statutory exceptions that apply are quite nuanced and probably require specialists in Freedom of Information to apply their minds to what information should be released as opposed to what information should not be released. There are oftentimes circumstances where a clinician might mark something for FOI without really understanding what that means. Again, that is not a criticism. That is just a by-product of clinicians who are spending a lot of time delivering clinical care.

The CHAIR: They are not trained in the FOI Act.

Andrew MARIADASON: Indeed. So they are perhaps looking at things and their gut tells them 'This is sensitive', but it may not necessarily acquire one of the specific legislative exemptions. So I would be concerned to have a situation where there is a devolution of responsibility to clinicians about what can and cannot get pushed out, which might occur in a push model, because there are fundamentally really important things to protect, like confidential information from third parties or personal affairs information of third parties, and the consulting process that goes on with FOI as well.

The CHAIR: I am assuming from your answer that in the existing EMR at the Royal Melbourne there is no attempt to quarantine certain types of information within the system the way it is currently used.

Andrew MARIADASON: That is correct. The process of FOI means that our FOI staff export information from the EMR into PDF, and then the process of review of those PDF documents is performed by FOI staff trained in the various exemptions and exceptions that apply in the Act, so that responsibility does not sit with the clinical staff.

The CHAIR: So they go through every page of –

Andrew MARIADASON: Indeed.

The CHAIR: My goodness! Okay, thank you. Ryan Batchelor.

Ryan BATCHELOR: I think I get what you were asking, and I think I get the answer – so I am okay.

The CHAIR: All right.

Ryan BATCHELOR: You were asking basically could there be sensitive material flagged in the EMR to make the process more efficient. And I understand the –

The CHAIR: It is not as easy as that to understand.

Ryan BATCHELOR: That makes perfect sense.

The CHAIR: Unless you want to answer it?

Andrew MARIADASON: Sorry, if I may. Sensitive information is certainly flagged, but it is sensitive information from a clinical lens, so aggression risks and concerns about occupational violence and those sorts of things. Vulnerability risks and those sorts of things are flagged, and clinicians are applying their strong clinical experience – 'I'm not comfortable with that, so I might mark that as 4, sensitive' – but ultimately the decision is then made by the FOI operatives. I hope that assists.

Ryan BATCHELOR: It does. Do you have any other schemes that you provide access to information to? Is all your information access done through the FOI Act and its provisions or are there other statutory or informal release schemes that you use, and any commentary on those versus the formal statutory process?

Andrew MARIADASON: I think it is fair to say that the FOI scheme, which is adopted for FOI applications, is far smaller than the ROI scheme, the release of information. Many thousands of consultations, attendances and procedures are happening each year, and in order to support continuity of care we release information, managing the caveats in release under section 141 of the *Health Services Act*, which is our fundamental confidentiality provision. We will release, oftentimes, discharge summaries, which in fact are not done by the FOI team; they are done by the health information services team, or the HIS team. So a GP will ask for information and we will release that to support continuity of care, and we do oftentimes look at other approaches to voluntarily give information, perhaps outside the FOI scheme, to support the prompt provision of information.

Ryan BATCHELOR: Sorry, just on that, would the ROI-type arrangement generally be to other registered medical practitioners?

Andrew MARIADASON: Correct. That is true, because that is in order to support the continuum of care. That might mean exchange between hospitals that are engaged in the episode of care, because sometimes there is multihospital involvement or GPs. That is probably the more routine situation, where a GP who has referred the patient to the RMH then gets the discharge summary.

Ryan BATCHELOR: But other than that and FOI –

Andrew MARIADASON: Well, then there is the portal. They are pretty much the fundamental premises upon which we release information, and the FOI then covers requests for other types of information.

The CHAIR: Thank you. Let us go to Kim Wells.

Kim WELLS: Thank you. From an administrative perspective, what are the benefits of the statutory release scheme for health-related information under the *Health Records Act*?

Andrew MARIADASON: This was a challenging question to work through.

Kim WELLS: It took me ages to put it together.

Andrew MARIADASON: The benefits of the statutory release scheme under the *Health Records Act* – there is a lot of equivalency between freedom of information and health records, and there are equally provisions that apply exemptions and exceptions for confidentiality and serious risk under the *Health Records Act*, so I see good utility in certainly engaging in this process of seeing whether there is a way of using the *Health Records Act* to support the release of information. I think that there are some mechanisms in place in the Freedom-of-Information process which are important. For instance, in the *Health Records Act* I do not believe there is scope for re-scoping of information. So for instance we might have an instance where an applicant says to us, 'I want my clinical records for my episodes of care at the Royal Melbourne for the last five years.' We look at that, and we discern that there are about 5000 pages of clinical records for the episodes of care. Sometimes it is a dialysis patient for instance and they are coming routinely and regularly, and their pages might be tens of thousands of pages strong. So in the *Health Records Act* I do not believe that we have a situation where we can engage with the applicant to talk through in a structured way and say, 'Can we re-scope this?' as we do in the FOI. Maybe that is something to think through in terms of legislative reform. But those re-scoping exercises are important because they help manage our workload but also are probably helpful in an applicant/management point of view. So there are those sorts of things, but in terms of the benefit of the statutory release scheme, in my view, careful scrutiny needs to be considered about some of these exemptions

and exceptions that we were talking about earlier and how public health services manage that in the push model, which is a bit more challenging.

Kim WELLS: The Committee has received evidence that access to personal health-related information should be separate from the FOI scheme. Do you have a view on that?

Andrew MARIADASON: My view is that at a conceptual level I am concerned to ensure that whatever scheme is put forward for access to health information has the protections and has the rigour applied to applicants that there is in the FOI legislation. If that can be achieved with another type of model, then I will not quarrel with that. But I am here, as I said, to conceptually make sure we are not moving towards a situation where there is an expectation of unfettered access to records. I do not think that serves the patient well, I do not think that serves the next of kin well and I do not think that serves the health services particularly well to have that sort of mantra, if you like, and at an operational level I would again implore that the Committee considers through any change having regard to what goes on at a hospital in terms of release of information when they move to a different type of scheme, because in some respects the same amount of work may still be necessary in a different scheme, it just looks a bit different. So it is important to work through those operationally and conceptually. That is a little bit of a nuanced answer, but hopefully it sort of resonates in the sense that we are resource-poor, and we do deliver a lot of information, and the view that I have is that health services do their very best try to release information, which is very large in quantity and probably does not necessarily have some of that technical nuance that you might get if you are making an FOI application to Premier and Cabinet and all of the other exemptions that might apply in FOI, but we still need to review the records and get them out in a timely way, and we just want to make sure that another iteration of this does not leave the same operational challenges.

The CHAIR: Indeed. Before we ask any more questions is there anything else you think that we should hear while we have got you here?

Andrew MARIADASON: I do not, Chair. I think I have covered it.

The CHAIR: I am sure Committee members will have a couple more questions.

Ryan BATCHELOR: You have expressed your concern about the management of a push model in your evidence. Have you spoken with any of your counterparts in other jurisdictions where they have had more recent moves to change FOI to state level, say, New South Wales? Do you have any commentary on whether the challenges that you face are also experienced in New South Wales, or in Queensland, which has got a slightly different set of arrangements again? Do you have any reflections on other jurisdictions in an Australian context vis-a-vis the challenges that you are expressing?

Andrew MARIADASON: I am afraid I do not, Committee member. I have not had the opportunity to speak to other health services in the northern states, but I am aware of the fact that they have different models. I am not able to comment on the success or otherwise of those particular models. I have spoken at length to colleagues in Victoria around health services. I am not permitted to really speak for them, but I think that there is a general sense that it is a challenging environment and that the push model just needs to be managed in a very nuanced way. It needs to be introduced in a very nuanced way so that we can cover off on the issues that we have been discussing earlier.

The CHAIR: Can I ask about what might be called internal working documents in patients' medical records? They are probably not called that in the hospital, but they might fall under that category. They are not diagnoses, treatments, tests or observations, they are more things like 'I think what's going on here is this process, but it could be this' and 'Are we missing something else?' – that kind of reflective stuff which sometimes might make it into a medical record. What is the process for that sort of material?

Andrew MARIADASON: The same process applies in terms of internal working documents. To perhaps give you an example of an internal working document, it is where there is an adverse patient event or some scenario that occurs and an incident report is generated as a result of that. Someone might have a very significant adverse clinical event which results in a code blue being called, a code blue being a major medical emergency that requires significant resources to go into the treatment of that patient. That might then result in an incident report referable to that clinical event. That clinical event will not typically be stored in the electronic medical record, but if there is a request for that incident report then we would go through the same process of

looking into whether that document in and of itself should be released. So that is an example of an internal working document. Sometimes they are drafts and opinions of people as to why perhaps that code blue occurred or the like, and so we need to go through the same process in terms of release.

The CHAIR: And I think what we are talking about here could apply to, say, a clinical audit meeting or a death audit meeting where people are discussing why someone died and they do not know why and they are having that conversation. But I am thinking broadly about the public interest in keeping that stuff confidential. In the case of a death we do not have to worry about what the patient thinks. But leaving aside personal sensitivities, is there a public interest in withholding that information from disclosure?

Andrew MARIADASON: I think that is a case-by-case assessment that needs to be taking place in relation to that particular issue, and that is the approach that we take from time to time. But I would argue that certainly there is a supportable basis to say that there is a public interest in ensuring that candour is taken or clinicians are afforded the protection of these sorts of measures in the *Freedom of Information Act*. But I certainly accept that with the statutory duty of candour, with open disclosure, those sorts of very important hospital-wide measures that are taken to give more transparency and empower patients are important as well. So I see both sides of the coin. I think though ultimately it is a case-by-case basis, and people should be free to air their opinions about things without necessarily having formulated a view on those and have some sort of protection around those opinions.

Kim WELLS: Can I just pick up something that Tim asked. If my father went in and died and I do an FOI, do I have to specifically ask if there was an incident report raised or do you automatically release that incident report as part of the FOI process?

Andrew MARIADASON: There has to be a request for that incident report.

Kim WELLS: But how would I know to request it if I did not know it happened?

Andrew MARIADASON: That is a fair question. There might be incidences where the EMR reflects the fact that there has been an incident report created in the process of managing it, and typically if there is a death in the hospital, there will be a process of open disclosure that is gone through with the patient's next of kin. So we do have quite rigorous approaches under the statutory duty of candour. If there is an adverse patient event that results in a death, as the Chair was speaking about, there are typically reviews, but the patient's next of kin, I should say, are often brought along that journey early on. But that would have to be a request that is made under FOI specifying –

Kim WELLS: A specified request.

Andrew MARIADASON: That is right.

Kim WELLS: So it is not voluntarily given?

Andrew MARIADASON: No, it is subject to a request.

The CHAIR: I think we would be right in understanding there might be circumstances where there could be material that someone would want to know about but its very existence is not brought to their attention. So that circumstance could occur.

Andrew MARIADASON: That circumstance could occur.

The CHAIR: Apart from incident reports, what might be some other examples of material that sits outside the medical record but might be relevant to someone's past care?

Andrew MARIADASON: You spoke about it, Chair – mortality and morbidity audits. There are incident investigations, root cause analyses and those types of documents as well.

The CHAIR: I have got to wind up in a couple of minutes. I cannot remember how many thousand FOI requests you have – a lot. I am just trying to get a sense of the workload on the hospital from all of these FOI requests. You know, you have got a lot of staff – how big a job is it?

Andrew MARIADASON: I have two full-time FOI officers, roughly speaking – 1.8 EFT – two full-time FOI clerks and a number of casual staff that support the process in terms of managing FOI requests. I think we average, roughly speaking, about 300 a month. In large part we have got good processes to make sure that we are getting the reading done and the provision of information in a timely way, but it is a challenge from a resource point of view.

The CHAIR: And these staff are going through thousands and thousands of pages looking for material that for the reasons we have discussed is not safe to be released.

Andrew MARIADASON: Yes. For instance, some of the thousands of pages may be comprised of pathology reports, so I think self-evidently they require a less discerning eye –

The CHAIR: It is a quick flick.

Andrew MARIADASON: than perhaps a review of the progress notes or when you are looking at specific social work consultations or those sorts of things – or radiology. We are trying, where we can, to release efficiently and quickly, so they might not get the same review that the progress notes would get, because it is pathological information which comprises lots of pages. Or we might look to re-scope the request and say, 'Look, of the thousands of pages, many of them are pathology. Do you really want this?' And the applicant may say, 'No, in fact that's not what I need it for.' So then we would carve out that information and reduce the scope of the information.

The CHAIR: I think we are out of time, so I am going to take the opportunity to thank Andrew Mariadason very much.

Ryan BATCHELOR: I should just put on the record: obviously my partner is a medical practitioner, though not at your hospital. But my register of interests does disclose her employment, in case anyone thought that might be a conflict of interest.

The CHAIR: Very good. Thanks for that, and I will just thank Andrew Mariadason again for a very informative presentation. Thank you.

Andrew MARIADASON: Thank you.

The CHAIR: We will suspend the hearing for 5 minutes and resume shortly.

Witness withdrew.