TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into capturing data on family violence perpetrators in Victoria

Melbourne—Monday 19 August 2024

MEMBERS

Ella George – Chair

Annabelle Cleeland – Deputy Chair

Chris Couzens

Chris Crewther

Cindy McLeish

Meng Heang Tak

Jackson Taylor

WITNESSES

Renée Blight, Safeguarding, Strategy and Reform Practice Lead, Peninsula Health; and

Amanda Morris, Statewide Lead, Metropolitan Sector, Strengthening Hospital Responses to Family Violence, and

Sharan Ermel, Statewide Lead, Regional Sector, Strengthening Hospital Responses to Family Violence, Bendigo Health.

The CHAIR: Good morning. We will now resume the public hearing of the Committee. My name is Ella George, and I am the Chair of the Legislative Assembly's Legal and Social Issues Committee.

I begin today by acknowledging the traditional owners of the land on which we are meeting, the Wurundjeri Woi Wurrung people of the Kulin nation. I pay my respects to their elders past, present and future and extend that respect to First Nations people across Victoria.

I am joined today by my colleagues Jackson Taylor, the Member for Bayswater; Meng Heang Tak, the Member for Clarinda; Christine Couzens, the Member for Geelong; and Chris Crewther, the Member for Mornington. Annabelle Cleeland, the Deputy Chair and Member for Euroa, will be back with us in a moment.

The Committee recognises that evidence given to this inquiry may be distressing, and we urge people to reach out for support. You can contact Lifeline on 13 11 14, 1800RESPECT, or the Blue Knot helpline on 1300 657 380.

All evidence given today is being recorded by Hansard and broadcast live. While all evidence taken by the Committee is protected by parliamentary privilege, comments repeated outside this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of today's transcript to check, together with any questions taken on notice. Verified transcripts, responses to questions taken on notice and other documents provided during the hearing will be published on the Committee's website.

I am now pleased to welcome Renée Blight, Safeguarding, Strategy and Reform Practice Lead for Social Work, from Peninsula Health; Amanda Morris, Statewide Lead, Metropolitan Sector, Strengthening Hospital Responses to Family Violence in the statewide leadership team; and Sharan Ermel, Statewide Lead, Regional Sector, Strengthening Hospital Responses to Family Violence statewide leadership team. Thank you very much for joining us today. I invite you to make an opening statement of 5 to 10 minutes, and this will be followed by questions from members. Thank you.

Amanda MORRIS: Good morning, everyone. Thank you so much for the opportunity to speak to you today. I am Amanda Morris. I am here in my capacity as the Strengthening Hospital Responses to Family Violence Statewide Lead for the metropolitan sector. I will probably refer to this as SHRFV. I lead the SHRFV initiative at the Royal Women's Hospital and provide mentorship, consultation and capacity building for the Victorian public hospital and health service with a focus on metro hospitals and support for rural hospitals alongside Bendigo Health. I also lead the family violence services at the Royal Women's Hospital and work in partnership with the University of Melbourne on research and evidence-based implementation and evaluation of several components of SHRFV and Commonwealth-funded services. I have been working in the family violence sector since 2018, following a career of 10-plus years in social work and community services in both Canada and Australia.

In 2014 and 2015 the Victorian Government funded the Royal Women's Hospital and Bendigo Health in collaboration with Our Watch to develop and implement a framework for embedding the practice of identifying and responding to family violence experienced by patients. The Strengthening Hospital Responses to Family Violence model was developed to provide a systemwide approach, which is now being applied by hospitals across Victoria. Based on international best practice, the model has two overarching principles and five key implementation elements for a staged approach, which are applicable to any Victorian health setting committed to improving its response to family violence. The submission has been prepared by Bendigo Health and the Royal Women's Hospital, who jointly provide statewide leadership for the Victorian public hospital sector. Following funding to Bendigo Health in 2023, SHRFV working with adults who use family violence emerging practice statewide lead roles undertake consultation and work to identify the MARAM alignment implementation requirements around working with adults who use family violence, develop and adapt relevant resources and support the metropolitan and rural and regional health services with this emerging practice change.

This is my colleague Sharan Ermel from Bendigo Health, who I will allow to introduce herself and speak to the works.

Sharan ERMEL: Thank you. Good morning, everyone. Thank you to my colleague Amanda Morris for her introductory remarks. I am Sharan Ermel. I am here in my capacity as the SHRFV Statewide Lead for the rural and regional sector. Apologies for the very long job titles. I am based at Bendigo Health on beautiful Dja Dja Wurrung country. I would like to pay my respects to the Elders past, present and emerging on that land and across Victoria where we all work. I am a registered nurse and have been involved in the SHRFV initiative since the very early days in 2014. Currently I work closely with Amanda Morris; my colleague Jenny Harris, who has joined me in the role to support 58 rural and regional health services to align and embed not only SHRFV but the MARAM framework and practice guidance; and my colleagues Delwyn Riordan and Susan George, who share the role of the working with adults who use family violence emerging practice leads.

Over the past 10 years the SHRFV initiative has evolved—initially it was established to identify and respond to patients experiencing family violence—to include staff who are actually experiencing family violence and now more recently to identify adults who are using family violence, as the MARAM practice guidance has become available. The work that has been undertaken by SHRFV was recognised as part of the Royal Commission into Family Violence, and recommendation 95 was that the government would support hospitals to roll out the SHRFV initiative across the state over the five-year period. And of course since then in 2021 hospital and health service workforces became prescribed entities under the MARAM framework and the *Family Violence Protection Act* and are compelled to align with the family violence information-sharing and child information sharing schemes. I would like to acknowledge that as these services are primarily recognised as universal organisations under the schemes, for most of health that we represent here it is really staff at that identification level. There are some pockets of staff who may sit at the intermediate level of MARAM.

Whilst our role is to support and guide hospitals and health services in this important work, we do not hold authority to ensure that they comply with all legislative requirements, and our remit has been to engage with those staff who are undertaking the work, not those ultimately responsible for compliance with the legislation at each site.

Thank you for the opportunity to further explore the submission that has been collectively prepared by the SHRFV statewide leads. I would like to now introduce our SHRFV colleague based at Peninsula Health, Renée Blight, who is representing Peninsula Health and their own submission.

Renée BLIGHT: Lovely. Thank you. Thank you so much for having me this morning. I do appreciate the opportunity. My name is Renée Blight. I am again another lengthy title—Safeguarding Strategy and Reform Practice Lead—but essentially I am a lead social worker within Peninsula Health working in the area of family violence and child safeguarding. I am here alongside Meghan O'Brien, the head of social work, because our submission is based on our local experiences and practices at our health network, and we do operate within the SHRFV program. Thank you for your acknowledgement at the beginning. I just want to extend that to the land on which I work, which is of the Bunurong and Boon Wurrung people of the Kulin nation, and extend that acknowledgement and respect to First Nations people throughout Victoria.

The SHRFV program commenced in 2018 at Peninsula Health, and again, it is looking at capacity building and aligning to MARAM within our workforce. Within social work we decided a few years ago to collect our own data on family violence in interactions or cases with our social workers within the emergency department, acute hospital and subacute, which is your rehab and aged care facilities, because we recognised that there is a lot of rich data that is sitting there that will otherwise not be captured because we do not have that availability within our current datasets. It is de-identified, but we do look at different characteristics around gender, relationships between the victim-survivor and person using violence and also impacts on children and older people. Again, thank you for this opportunity. I look forward to contributing in further detail.

The CHAIR: Great. Thank you, Renée, Amanda and Sharan, for your opening statements. I will start with some questions. What are the current data inconsistencies in hospitals, health services and emergency departments' records in regard to family violence?

Sharan ERMEL: What are the data inconsistencies? I think hospitals across the state—and we are talking about hospitals the size of Peninsula Health up to Monash Health and 20,000-plus staff there down to much smaller hospitals and multipurpose services such as Omeo, NCN Health up in the Hume region and things like that that go right down to 60-odd staff—there is large variation in the size of these hospitals and the mix of services and staff within those hospitals. There is a great deal of difference in the level of expertise at these

sites. I think the previous witness—in the session with VDL, Victorian data linkage, the professor who was here—spoke to a lot of the administration data that is collected in hospitals, and from our experience there is some inconsistency there, because it is primarily administrative data that is collected. There are only a small number of sites that are collecting any more extensive data that have that capacity, such as Peninsula Health, St V's—St Vincent's Hospital collects some data, but it is all post admission and post incident.

Hospitals and health services across the state are at varying stages of MARAM maturity, and many remain paper-based with paper-based medical records. There are a number of sites that have electronic medical records, but they are inconsistent in their format, and there is not a lot of communication between the varying databases. Some hospitals that have got electronic medical records or electronic patient records may have four to six different databases that collect different information from different services. Mental health have a very particular data platform that they collect data into, as do inpatient or outpatient services, so there is a lot of inconsistency there. With the varying levels of MARAM maturity, the uptake of the MARAM tools within health is varied, so that has reduced the opportunity for consistent data collection.

I think one of the key things is that we have got to define what data we are actually asking for too. It is one thing to be able to count people who present and gender and their descriptors, but if we are asking to be able to collect information about perpetrators—people who use violence—we need to be able to identify them, and we need to be able to identify them accurately. So that is why we have a lot of the inconsistency.

The CHAIR: Thank you. From your perspective, what can the Victorian Government do in practice to improve consistency of data collection across the health system?

Renée BLIGHT: When we think of inconsistency I would almost see it as a gap—that our collection of victim-survivor information is somewhat there but it usually relates to a physical assault, and if there is not a physical assault then that generally would not be picked up in our datasets. As we know, family violence is more than just physical assaults, and there are many different ways of abuse being perpetrated that would not be captured within that. Then conversely, when we are looking at people who use violence there are very, very few codes that would be able to capture that.

Our services are building and improving our abilities and training to identify people who use violence and work with them in a respectful way, looking at change but also risk and safety management, but we do not have the codes to be able to capture that, and a lot of our people that we see are not in contact with the police or other institutions or services. So that information is not being captured at all, particularly when we think of elder abuse, where police are very rarely involved—there can be overriding levels of shame and embarrassment and loyalty and love towards family members that can limit police or other corrections involvement. And so again we are missing that information that can be really valuable for programs and services to assist victim-survivors, children, older people and the person using violence themselves.

Sharan ERMEL: I think, as Renée has said about the codes, there are a number of ICD-10—International Classification of Diseases—codes in the Australian manual that are applied by coding staff in health information services across the state, but whilst there is direction on how those codes should be applied to an episode of care, there can be variation in which codes are used and how they are interpreted.

In 2019 there was a proposal put forward for a minimum dataset for VEMD—the Victorian emergency manual data? I apologise for my use of acronyms and not knowing what they mean when I need to pull them out. I was not involved in the proposal put forward—I will say that—but it had the promise of being able to then identify who the victim-survivor was and what role the patient had: were they the victim-survivor or were they the perpetrator? And there was a third one, which I can refer to when I look at my notes. But at that point in time it was put on hold, because there was the feeling that the data collection or the data elements were not aligned with MARAM, that it would add an increased data collection burden on staff and the data that was entered primarily goes into the administration system and so is not accessible to clinical staff or other staff. So being able to pull that information out so it was actually useful was really quite limited.

Amanda MORRIS: I have nothing further to add.

Sharan ERMEL: What we would want, and this is probably an experience-based opinion, is some sort of guidance, clear concise guidance, on how to apply codes if we cannot expand or incorporate a minimum

dataset. I think the advice has been that an expansion into injury surveillance data—having more relevant injury surveillance data capture and that ICD-10 code application for admitted patients—would be ideal.

Amanda MORRIS: Now I have something to add. I think, just to close that response: working closely with us in our capacity as statewide leadership to just complete a gap analysis, because what is within our remit is capability and capacity building for staff. That can translate into practice and being able to undertake the appropriate work.

The CHAIR: Thank you. Chris.

Chris CREWTHER: Thank you, Chair. Firstly, thank you, Amanda and Sharan, for your submission as well as the work you do with SHRFV. I think I have got the acronym pronounced correctly. Thank you also, Renée, for your work with Peninsula Health—which covers part of my electorate in Mornington as well, so there is a local connection there—and for your submission as well. My question is for Peninsula Health. Peninsula Health notes that the themes from health data collection are not shared with specialist family violence services and that health services do not contribute to or view CIP data, and I quote:

> … providing a nominated Health Services Lead access to the CIP and –

ability to –

> share relevant data as permitted by legislation … will add to the vital information held … to manage family violence risk.

Can you expand on what this would look like in practice?

Renée BLIGHT: Yes, absolutely. Thank you. The central information point is a database that is shared and held between Orange Door, child protection services and specialist family violence services, and that contains quite detailed and really valuable information regarding current family violence risk. When we are working with high-risk cases of family violence we obviously have the ability under the family violence information-sharing scheme to reach out to agencies to request relevant information and receive that to inform our risk management, but that process, whilst it is really valuable, can be slow sometimes, and there can be barriers into that timely access to really crucial information.

I feel like if there was a model similar to the RAMP representation—RAMP is the risk assessment management panels, where key providers such as health and hospitals sit within that panel and are able to hear and share classified or very important information regarding family violence risk. If that similar model was applied to key positions within health—I mean, to be frank, my position would sit within that, and I know that other positions, colleagues within other health services, would have similar roles, where it is contained and you maintain that integrity of that important data, but we are given access so we are actually able to inform our own risk management, particularly when we are thinking of our work within the emergency department and within mental health. It can be very fast-paced, and the information that we need we actually do need to access quite quickly. So having that model I think maintains the security of that information by keeping it to one or two key roles, but it does provide that link to perform that risk management function.

Chris CREWTHER: Thank you. Just a follow-up for any witness, are you aware if either hospitals or health would like access to the CIP?

Amanda MORRIS: Yes. It certainly, as Renée mentioned, can be a bit of a barrier. In reverse, we do get asked to contribute information under the information-sharing schemes as well. We are considered ISEs, and in some hospitals and health services we do have specialist family violence services who are RAEs in their own regard too, but the process is not circular, so it is very difficult for us to manage risk and understand patterns of behaviour that could potentially contribute further to the CIP.

Sharan ERMEL: I was going to say, yes, I am aware of hospitals that have actually successfully sought information, or a hospital that has successfully sought information, from the CIP, and it has proven to be quite valuable.

Chris CREWTHER: Thank you, and obviously that is another piece of pronunciation I have got incorrect as well with the CIPs. Thank you, Chair.

The CHAIR: Thank you, Chris. Jackson.

Jackson TAYLOR: Thank you, Chair. Good morning. Thank you all for coming today. What further support could the Victorian Government provide to public health services, hospitals and emergency departments with the obligations under MARAM, FVISS and CISS?

Sharan ERMEL: I have got a list. Very much off the cuff, but it is about having, as Peninsula Health said in their submission, a role that would sit on a RAMP—that central point. I think health services and hospitals are very jealous of the AOD and mental health sectors that have the specialist family violence adviser roles. Having a role such as that that could actually sit within a hospital, perhaps on an EFT basis, that could provide secondary consultation, practice uplifts, and capacity and capability building within health would be ideal. Given that the public health services across Victoria employ in excess of probably 150,000 people, there are a lot of staff to increase capacity and capability.

What else? Education that is targeted, concise and fit for purpose for health services and that does not create a burden but builds on the practice, knowledge and expertise of the clinicians within hospitals. How far do I go?

Amanda MORRIS: I might jump in, as you jumped in with education. I think bidirectional education would be wonderful as well too, because hospitals sort of sit alongside specialist family violence services, but we also are sitting on quite a bit of data to help mitigate risk as well too, but it is a specialty in its own right. We would love to have maybe more considered and consistent and collaborative practice under the context of the Royal Commission as well too, so having opportunities like this—like today and more frequent opportunities alongside people like yourselves as well too—to escalate the understanding, comprehension and importance of gaps as well as benefits.

Renée BLIGHT: I agree that an internal resource to help implement their MARAM and information-sharing schemes but also as that resource for staff, because staff often feel uncertain about what they can and cannot document or what alerts they can put on. They are fearful that it will be incorrect or that it is overstepping what they are allowed to place on files, so having that internal support, that expertise to be able to reach out and to receive that guidance is really valuable. We did have that with SHRFV in hospitals across the state, but that funding for each individual hospital is no longer, so hospitals have sort of nominated their own internal leads. But then you risk that inconsistency where maybe some hospitals have that resource, whereas others do not.

Jackson TAYLOR: Thanks. And then just a quick follow-up: what processes are needed to support hospitals to capture at-risk relevant information of people using family violence? How can the Victorian Government support hospitals and health services to embed these in hospitals?

Amanda MORRIS: My response is rather high level, so I can start. I think it comes back to clear guidelines for hospitals and health services for the coding. That can contribute to more consistency and collaboration, and more capacity building. Jump in?

Sharan ERMEL: My Bendigo colleagues who are in the emerging practice lead roles, Delwyn Riordan and Sue, can probably speak to this, but it is about being able to embed consistent tools—education, so that staff can actually identify who people using violence are—that can be incorporated in a way that they are universal and can identify the risk that is present and be able to communicate that. Delwyn, do you want to come and say something? Has that answered the question?

Jackson TAYLOR: It is your answer so, yes.

Sharan ERMEL: Has it answered your question though? So I think that consistency, and I think health has been much maligned, you know. We have seen it really hit over the last few years not only by COVID but by fires and cyberattacks and floods. We have a myriad of different ways that we capture information, so a lot of hospitals still have paper-based records, and we have that move to electronic medical records in a lot of the larger hospitals, but there is no consistency. So that consistent approach to be able to capture and record that information will make it sharable.

Renée BLIGHT: And the two things that I would want is, similarly, the codes, that dataset to be available, so then that data can actually be entered and be captured. The other is perhaps guidance or a requirement. It is not often that you ask people, ask government to require something of them, but I would like to see a requirement that health services do record de-identified data; it does not need to be extensive. And maybe

having some kind of system—user-friendly, that is secure—to be able to do that, so we are capturing that across health services. Because with our own internal data capture that we are doing proactively, we have been able to identify that elder abuse counts for a quarter of the family violence incidents that we are involved with, which is a higher representation than what is often portrayed in other forms of statistics. And we are also seeing more older people as the person using violence, but we are seeing intergenerational violence as well, where it may be an adult child perpetrating abuse towards their older family member. That information would just be lost if we did not have that, so I think having some sort of requirement that health services do capture that information will provide such rich information to be able to build appropriate services and programs.

Jackson TAYLOR: Thank you very much. Thank you, Chair.

The CHAIR: Thank you. Annabelle.

Annabelle CLEELAND: Renée, I just wanted to clarify something. You said that the—I am going to try and pronounce the acronym appropriately—SHRFV-funded representative in hospitals was no longer funded. When did that occur?

Renée BLIGHT: That was just at the beginning of this financial year, so 1 July. It was always a time-limited initiative, being top heavy in its funding and then to be tapered down, so it was always going to be a discrete program. But we found that as the initiative was implemented and the work was being undertaken, in my opinion, it is not something that you just place in a health service and then leave; it actually needs ongoing nurturing, development and support. So we are very thankful that we have our statewide leads continuing, but the funding for individual health networks has finished.

Annabelle CLEELAND: How many roles were there?

Renée BLIGHT: It depended on the health service and often their size, but it may have been two or three EFT for the larger hospitals, maybe under one for the smaller hospitals.

Sharan ERMEL: I was going to say I can speak to that because the SHRFV initiative was initially funded as a result of the Royal Commission, and that funding was for a period of five years. I will take on notice the precise figure—it was around $34 million—but it was front end loaded, and unfortunately at that point in time the MARAM guidance rollout and the availability of the tools and practice guidance were delayed. Of course we have only in the last couple of years had the adults using family violence practice guidance available, and the training for that was only released last year. So the SHRFV model as it was rolled out provided leads in a number of metropolitan sites and larger rural sites, but it was never funded to each individual health service across the state. It was a hub-and-spoke model that was funded, so the likes of Bendigo Health at that point in time supported five cluster sites, and with the model that we had at Bendigo we then provided a small amount of money to those cluster sites. It was about 0.1 of a position at the likes of say Heathcote Health or Dhelkaya Health at that point, but as the funding retracted, the ability of the lead sites to provide additional funding for their cluster sites reduced and then it became in-kind support.

Annabelle CLEELAND: I think it was about 0.3 for Heathcote Health, as I understand. So the responsibilities of those have now been absorbed by hospitals if they have got capacity or not been conducted otherwise?

Sharan ERMEL: If they have had capacity, yes. It now sits often with maybe quality, but with the pivot of health with COVID it has really taken a real hit.

Annabelle CLEELAND: Just on the capabilities of MARAM: when it was introduced, was there a level of support for training to be adopted, or was that self-motivated between services?

Renée BLIGHT: That is a good question.

Annabelle CLEELAND: My supplementary would be: what has to happen to standardise it a bit better?

Sharan ERMEL: I think it probably was very much taken on by the hospitals themselves. Some sites have successfully incorporated family violence training as mandatory for their workforces, and even the term ‘mandatory’ has different connotations in different hospitals across the state, which is quite interesting. It can be either required or mandatory. But that has not been universally adopted across the state. At Bendigo Health we

have been able to incorporate very limited content into our orientation package that is very high level, ‘This is what family violence is, this is where you find resources’, but the other training that has been made available has been very, ‘Here—here are the courses; enrol and do them’, and has been primarily e-learning modules that we have had available. While Bendigo Health had some funding available, we actually had Jenny Harris, who is here in her new capacity, being able to provide some face-to-face training, so that is just one example at a hospital of how we have been able to do the training.

Annabelle CLEELAND: Individually adopted, really.

Sharan ERMEL: Yes, very much individually adopted.

Amanda MORRIS: And governed, I would say. Individually governed it is. It is a best practice model, so some sites really consider it, as Sharan said, as recommended learning, and some sites consider it as mandatory as well. But yeah, it is certainly individually governed based on the legislation.

The CHAIR: Thank you. Christine.

Chris COUZENS: Thank you all for your time today. We really appreciate it. I have just got a quick one for clarification. Renée, you talked about the fact that Peninsula Health is collecting their own data. My question is around: how are you using that data, if you are? And is there training provided to staff who are collecting that data?

Renée BLIGHT: Yes, so it is collected by our social workers within the social work department. So they, as part of their orientation and our annual training and support regarding family violence, are supported and trained in how to enter that and collect that. I mean, it is reasonably straightforward but probably the main emphasis is on them remembering to do that, because it is not part of their daily work as such. The way that we use it is that my small team and I collate it yearly as part of our auditing process, more in themes—so, you know, the gender of the victim-survivor, the gender of the person using violence, whether children have been involved. And so it is more sort of that broad group information that is then presented locally to our department, but we also present it up to our governance committee, which is the Safer Communities Committee—that is what we call it. And that is executive led, where we have representation across management of the health network, including mental health, emergency and health information management, and we look at our systems and processes and findings around different safeguarding and communities. So I report that up to them and we can then make some local suggestions about what services may be required that we have capacity to alter, what training. So we have been doing a lot more mental health and AOD training around recognising impacts upon children, particularly as often the child is not their client, it is the adult, and then conversely the impacts upon older people. So those are the sorts of interventions and support that we would not necessarily be putting into place if we did not have that data. We would probably be thinking more traditional forms of family violence, which when your mind goes to it you think of cisgender, intimate partner violence, middle of life age—and that certainly occurs, absolutely, but I think with the information that we are able to collect about what we are seeing locally we are able to be a lot more targeted in our support for our staff.

Chris COUZENS: And does that include young people, Aboriginal communities?

Renée BLIGHT: Yes. Yes, we have the Aboriginal health unit, and so we would work with them as well around supporting their staff. I know that often they access higher level training for themselves as well around the cultural safety of applying MARAM and the information sharing scheme, and then we incorporate that into our own training. So we really try to emphasise the different considerations that we need to make for different communities, because it is not a cookie-cutter, one-size-fits-all approach, and sometimes that means that our training doubles in length, because we are thinking of different scenarios. But I would much rather that than to do a condensed, narrow version of training or support that overlooks broader considerations that are really vital.

Chris COUZENS: Thank you.

Sharan ERMEL: Can I add to that? I believe that Karen Todd from Barwon Health presented earlier this week, and I know that Barwon Health have worked very closely with the Aboriginal health team in developing training and very inclusive approaches as well.

Chris COUZENS: Thank you.

The CHAIR: Thank you. Heang.

Meng Heang TAK: Thank you, Chair. Thank you for your presentations. My short question is to Amanda. How should data on people using family violence be stored by hospitals and health services securely?

Amanda MORRIS: That is a good question.

Meng Heang TAK: I heard part of your submission was about it, I remember.

Renée BLIGHT: I think that when you are looking at individual databases you need to ensure that they are only accessed by who is supposed to be accessing them, that it is not in a computer shared drive or something of the like that can be accessed by others. A lot of information sits within the medical record; that can be a little bit lost sometimes when you are trying to extract themes and information. Again, we need to make sure that we have systems in place that prevent the misuse of access. That is a whole area of consideration in itself, because at Peninsula Health we have 7,000 employees, and with the rates of family violence in the community it is not unheard of to assume that we have some people on staff potentially that are themselves using violence in their own lives. We need to really make sure that we have systems in place; that maybe there are regular audits, particularly if it is an electronic medical record, of who is accessing that information; that it is relevant to that area that the person has entered, meaning, say, the emergency department or mental health; and that somebody that is working in a completely different area has not accessed that file—or does it even go a step further in restricting in restricting access? I know Alfred Health have a separate e-folder for family violence information, and potentially that can be something where you are granted access depending on your role rather than it just being open to all employees of the health sector.

Amanda MORRIS: I think it is a difficult question to respond to from varying levels, but I think from an overarching, possibly statewide perspective—not to speak for Sharan. As Renée has rightly mentioned, it sounds more like the electronic medical record is probably the safest way to go, noting that many hospitals are at varying stages of implementation. We still have hospitals that are paper based, and that depends on resourcing, it could depend on funding or various reasons. I think it sounds like we need to come to an agreement or a revision on what platform is the safest moving forward for hospitals, noting that many hospitals are multidisciplinary in their own right as well.

Sharan ERMEL: And I think the additional issue that we have in health is often the person using violence is not the patient, so it is where that additional information is recorded. It is not just about collecting data about numbers of people using violence, but it is about that collection of risk-relevant information and how that can be shared and accessed and shared when it is requested by a risk assessment entity, an RAE.

Meng Heang TAK: Thank you. Thank you, Chair.

The CHAIR: Thank you. Thank you to Renée, Amanda and Sharan for appearing before the Committee today and the evidence that you have provided. We are greatly appreciative of the time and effort you have taken in appearing for before us today and also for your submissions.

The Committee will now take a short break before our next witness.

Witnesses withdrew.