Office of the Information Commissioner
Queensland

Decision and Reasons for Decision

Application Number: **220051**

Applicant: **The Courier Mail**

Respondent: **Department of Health**

Decision Date: **22 February 2011**

Catchwords: **ADMINISTRATIVE LAW - RIGHT TO INFORMATION - REFUSAL OF ACCESS - EXEMPT INFORMATION - LAW ENFORCEMENT OR PUBLIC SAFETY INFORMATION - documents reviewing deaths in hospital emergency departments - whether the process for reviewing deaths is a system or procedure for the protection of persons, property or environment - whether disclosure could reasonably be expected to prejudice the system or procedure - whether information is exempt under schedule 3, section 10(1)(i) of the *Right to Information Act 2009* (Qld) - whether access to information can be refused under section 47(3)(a) of the *Right to Information Act 2009* (Qld)**

ADMINISTRATIVE LAW - RIGHT TO INFORMATION - REFUSAL OF ACCESS - PUBLIC INTEREST - documents reviewing deaths in hospital emergency departments - applicant did not seek access to information which would identify patients, family members, associates or clinicians participating in the process of reviewing deaths - whether disclosure would reveal personal information - whether disclosure, would, on balance, be contrary to the public interest - whether access to information can be refused under section 47(3)(b) and schedule 4 of the *Right to Information Act 2009* (Qld)

Contents

REASONS FOR DECISION

Summary

1. The applicant applied to the Department of Health[1] (**QH**) for access to documents relating to emergency departments for specified periods that:

   (i) reviewed in-unit deaths;
   (ii) reviewed pregnancy miscarriages; and
   (iii) showed investigations into performance relating to patients in the triage category of resuscitation who were not seen immediately.

2. Following discussions with QH, the applicant reduced the scope of the application by:

   - limiting the application to particular hospitals across a reduced time period; and
   - clarifying that it did not seek access to identifying information in the documents.

3. In its decision dated 5 November 2009 (**Decision**), QH refused access to 234 pages of information relating to emergency department deaths in QH hospitals[2] on the basis that:

   - the information was exempt on the basis that disclosure could reasonably be expected to prejudice a system or procedure for the protection of persons, property or the environment; and
   - disclosure of the information would, on balance, be contrary to the public interest.

4. The documents located by QH related to deaths in emergency units at the nominated hospitals. On external review, QH submitted that disclosing any information in the documents would prejudice the confidentiality of the process for reviewing deaths (**Death Review Process**) and reduce the willingness of clinicians to participate meaningfully in the process. QH also raised strong concerns about the disclosure of personal and private information of patients, families, associates and clinicians contained in the documents.

5. I set aside QH's decision and find that QH should give access to the documents, in de-identified form, because such disclosure would not disclose exempt information and would not, on balance, be contrary to the public interest.

Background

6. Significant procedural steps relating to the application and external review process are set out in Appendix 1.

Reviewable decision

7. The decision under external review is the Decision referred to above at paragraph 3.

Information in Issue

8. QH's Decision refused access to 234 pages in their entirety. However, certain information in those pages is outside the scope of this review on one of the following bases:

[1] Also known as Queensland Health.
[2] Whilst the applicant sought access to documents from four hospitals, one hospital did not locate any documents responding to the terms of the access application. See paragraph (d) in Appendix 1.

- it does not fall within the terms of the access application (**Out of Scope Information**); or
- it comprises identifying information relating to patients, family members, associates or clinicians to which the applicant does not seek access in this review (**Identifying Information**).[3]

9. Accordingly, the information which is the subject of this external review is the 234 pages identified by QH in its Decision, excluding the Out of Scope and Identifying Information (**Information in Issue**).

Evidence considered

10. In making this decision I have considered:

- access application and external review application
- Decision
- 234 pages to which QH refused access, including the Information in Issue
- file notes of telephone conversations held between OIC staff and the applicant and QH during the external review
- QH's submissions to OIC dated 23 March 2010, including attachments and relevant online publications (as referred to in these reasons for decision)
- *Health Quality and Complaints Commission Act 2006* (Qld) (**HQCC Act**)
- Health Quality and Complaints Commission (**HQCC**) online resources including - *Review of Hospital-related Deaths Standard* and *Fact sheet – Review of deaths*
- relevant provisions of the *Right to Information Act 2009* (Qld) (**RTI Act**) and *Information Privacy Act 2009* (Qld) (**IP Act**); and
- relevant cases and decisions as referred to in these reasons for decision.

The law

11. Access must be given to a document unless it contains exempt information or its disclosure would, on balance, be contrary to the public interest.[4]

12. To the extent a document comprises exempt information or contrary to public interest information, an agency may refuse access to it.[5]

13. However, it is the Parliament's intention that the grounds for refusing access to information are to be interpreted narrowly.[6]

14. In making this decision I have considered whether the Information in Issue:

- is exempt on the basis that disclosure could reasonably be expected to prejudice a system or procedure for the protection of persons, property or the environment[7]; and

[3] The pages containing Out of Scope Information are listed in Appendix 2 and the categories of Identifying Information are listed in Appendix 3. A detailed schedule particularising the Identifying Information to be deleted from the documents in accordance with this decision (**Schedule**) has also been provided to QH with this decision. However, due to the operation of section 108(3) of the *Right to Information Act 2009* (Qld), the Schedule cannot be included as an appendix to this decision, as it would disclose information which QH claims is exempt or contrary to public interest information. Pending any appeal of this decision and following the expiration of any relevant appeal period, a copy of the Schedule will also be provided to the applicant with copies of the documents for release.
[4] Sections 44(1), 48 and 49 of the RTI Act.
[5] Sections 47(3)(a) and 47(3)(b) of the RTI Act.
[6] Section 47(2)(a) of the RTI Act.

- would, on balance, be contrary to the public interest to disclose[8].

Findings

Exempt information

15. QH submits that information in the documents is exempt[9] because its disclosure could reasonably be expected to prejudice a system or procedure for the protection of persons, property or the environment. It submits that the Death Review Process followed by QH comprises a system or procedure for the protection of persons.

16. For information to be exempt because disclosure could prejudice a system or procedure for the protection of persons, property or the environment it must be established that:

    a) an identifiable system or procedure exists
    b) it is a system or procedure for the protection of persons, property or environment; and
    c) disclosure of the information in issue could reasonably be expected to prejudice that system or procedure.[10]

17. These requirements are cumulative. Each requirement must be established to sustain a claim that information is exempt from disclosure under the RTI Act.

(a) Does an identifiable system or procedure exist?

18. Having regard to the information available on QH's website and its submissions, I note that the Death Review Process established and followed by QH forms part of QH's *Clinical Governance Framework*. QH's website states:

> *The Clinical Governance Framework is the web of policies, processes and accountabilities which are directed at improving patient safety and the quality and effectiveness of Queensland Health services.*[11]

19. QH's *Clinical Governance Policy* is central to the *Clinical Governance Framework*. It applies to all components of QH and states:

> *Safeguarding and improving the safety and quality of patient care is the first priority of Queensland Health and will inform all aspects of the work and decisions of constituent units.* [12]

20. The *Clinical Governance Policy* authorises, and is supported by, various QH clinical governance implementation standards including:

    - *Reporting and Review of Deaths*; and
    - *Clinical Audit and Review.*

21. The QH implementation standard for *Reporting and Review of Deaths*[13]:

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[7] Under schedule 3, section 10(1)(i) of the RTI Act.
[8] With reference to the public interest factors in schedule 4 of the RTI Act.
[9] Under section 48 and schedule 3, section 10(1)(i) of the RTI Act.
[10] *Ferrier and Queensland Police Service* (1996) 3 QAR 350 (***Ferrier***) at paragraphs 27 and 36; see also *VHL and Department of Health* (Unreported, Queensland Information Commissioner, 20 February 2009) (***VHL***) at paragraph 40.
[11] See QH's website: http://www.health.qld.gov.au/cpic/quality_strategy/clinical_gov_pol.asp.
[12] See QH's website: http://www.health.qld.gov.au/cpic/quality_strategy/clin_gov_frm_key_pol.asp.
[13] Queensland Health Clinical Governance Implementation Standard 6 *Reporting and Review of Deaths* (v 1.0). Hardcopy provided to OIC by QH with its submissions dated 23 June 2010.

- describes mandatory minimum auditable requirements about roles and responsibilities relating to the reporting and review of deaths in QH; and
- sets out the responsibilities and accountabilities allocated to each role for the review and reporting of deaths.

The standard is sufficiently detailed to include, as appropriate:

- timeframes for some responsibilities
- notes and examples of how to comply; and
- criteria against which performance can be measured.

22. The QH implementation standard for *Clinical Audit and Review*[14]:

- describes the minimum mandatory requirements for clinical audit and review activities by QH clinicians
- sets out the responsibilities and accountabilities allocated to particular roles with respect to clinical audit and review, which may include minimum timeframes for certain actions; and
- identifies "Death Review" as part of the minimum clinical review requirements for units and departments.

23. In relation to death review, the *Clinical Audit and Review* standard specifically requires compliance with QH standards and any external death review processes. This includes QH's *Reporting and Review of Deaths* standard, discussed at paragraph 21 above, and also any healthcare standard issued by the HQCC.[15]

24. HQCC has issued a standard titled *Review of Hospital-related Deaths*[16] which requires a healthcare provider to ensure that all hospital-related deaths are reviewed. Amongst other things this standard:

- describes different categories or levels of review for hospital related deaths; and
- requires a healthcare provider to establish policies and procedures relevant to the categories or levels of review.

25. This HQCC standard has been adopted by QH and forms part of QH's clinical governance framework. By complying with HQCC's standard, QH complies with its duty under section 20(1) of the HQCC Act to establish, maintain and implement reasonable processes to improve the quality of its health services.[17]

26. Having considered QH's Death Review Process set out in its clinical governance implementation standards *Reporting and Review of Deaths* and *Clinical Audit and Review* and HQCC's standard *Review of Hospital-related Deaths*, I am satisfied that:

- the levels of review
- any timeframes for review and reporting
- the allocation of responsibilities and accountabilities between roles and titles; and
- any criteria for measuring performance,

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[14] During this review this standard was available on QH's website at http://www.health.qld.gov.au/cpic/documents/clinaudrevstand_v1.pdf.

[15] The standard specifically refers to HQCC as an example of an external organisation having a Death Review Process.

[16] HQCC's standard *Review of Hospital-related Deaths* in force prior to 1 July 2010, made in accordance with section 22(2)(b) of the HQCC Act. An updated version of this standard was released on 1 July 2010. Its outcomes are substantively the same.

[17] See sections 20(2), 22(1) and 22(2)(b) of the HQCC Act.

described in those standards are sufficiently coherent, organised and comprehensive to establish that a system or procedure exists for the purpose of schedule 3, section 10(1)(i) of the RTI Act.[18]

27. Having established that a system or procedure exists, I will now examine whether the system or procedure is for the protection of persons, property or the environment.

(b) Does QH's Death Review Process comprise a system or procedure for the protection of persons, property or the environment?

28. In deciding whether a system or procedure is for the protection of persons or property, previous decisions of the Information Commissioner have considered the purpose or objects of the system or procedure in question as discerned from various sources such as:

- legislation[19]
- explanatory notes[20]
- an organisation's Charter[21]; and
- submissions about the process in question.[22]

29. QH submits that its Death Review Process comprises a system or procedure for the protection of persons. To support its submissions QH refers to:

- clinical governance information available on its website
- its own *Reporting and Review of Deaths* standard; and
- information about review of hospital related deaths available on the HQCC website.[23]

30. QH's submissions emphasise:

- Recommendations in the *Queensland Health Systems Review—Final Report* (which resulted from an independent review of Queensland's health systems in 2005) aimed at strengthening QH's risk management/clinical governance framework, through the development of processes including death review.

- Provisions in chapter 3 of the HQCC Act that create a duty on QH to maintain health service quality improvement processes and permit HQCC to issue standards that QH can adopt to comply with the duty, including HQCC's *Review of Hospital-related Deaths* standard.

- The mandatory nature and scope of HQCC's *Review of Hospital-related Deaths* standard as explained in HQCC's information sheet about the standard.[24]

31. For the purpose of establishing whether there is a system or procedure for the protection of persons, I have carefully considered and reviewed QH's submissions and the information provided by it in support of those submissions including:

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[18] *Ferrier* at paragraphs 28 and 33.
[19] See *ROSK and Brisbane North Regional Health Authority* (1996) 3 QAR 393 at paragraphs 13-14.
[20] See *VHL* at paragraphs 44.
[21] See *Ferrier* at paragraphs 29-31.
[22] See Decision Summary, *The Courier Mail and Queensland Art Gallery* (Queensland Information Commissioner, Unreported, 18 December 2007).
[23] As set out at paragraph 12 of Appendix to this decision.
[24] As in force prior to 1 July 2010. An updated version of this standard was released on 1 July 2010 by HQCC.

a) Chapter 9 of the *Queensland Health Systems Review—Final Report,* which states at section 9.5.3:

> **9.5.3 Clinical audit and death review**
> *Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria followed by the implementation of change at an individual team or service level. … Death review is a clinical audit process whereby all deaths in a particular hospital are reviewed on a regular basis.*[25]

b) QH's clinical governance implementation standard for *Reporting and Review of Deaths* which states its purpose as:

> *…to ensure robust reporting of deaths as required by legislation and appropriate learning from death reviews to identify deficiencies in care systems and implement strategies aimed at improving quality of care.*[26]

c) HQCC's *Review of Hospital-related Deaths* standard in force prior to 1 July 2010 which required:[27]

> *All deaths that occur within Queensland*
>
> - *in hospitals for both admitted and non-admitted patients and*
> - *in the community if a hospitalisation had occurred within the preceding thirty days of the death*
>
> *are reviewed, and the following checks undertaken:*
>
> 1. *Does the death qualify under the criteria of 'reportable deaths to the Coroner'?*
> 2. *Does the Cause of Death certificate demonstrate integrity?*
> 3. *Have opportunities for improved quality of care been identified and addressed?*

d) Relevant parts of the HQCC Act pursuant to which the *Review of Hospital-related Deaths* standard is issued.[28]

32. After reviewing the above material, I consider that QH's Death Review Process is a process or procedure for the protection of persons. The stated purpose of the Death Review Process is to identify deficiencies in care systems relevant to a death incident or incidents, and to identify opportunities for improved quality of care. Once deficiencies in care systems are identified, QH's standard for *Reporting and Review of Deaths* requires strategies to be implemented that remedy those deficiencies. Similarly, HQCC's standard for *Review of Hospital-related Deaths* requires opportunities for improved quality of care to be identified and then addressed. Given that the Death Review Process is situated within the framework of improving quality of care to patients and requires the implementation of strategies or actions to remedy any identified issues arising out of a death review, I am satisfied that it is a process or procedure for the protection of persons.

33. Having found that QH's Death Review Process is a system or procedure for the protection of persons for the purpose of schedule 3, section 10(1)(i) of the RTI Act, I

[25] *Health Systems Review Final Report* dated September 2005, chapter 9, pages 182 and 183, available on QH's website at: http://www.health.qld.gov.au/health_sys_review/final/.
[26] *Reporting and Review of Deaths* (v 1.0) at paragraph 1.
[27] HQCC's *Review of Hospital-related Deaths* standard in force from 1 July 2010 has outcomes that are substantively the same.
[28] Sections 3(1)(a), 14(b), 20(1), 22(1) and 22(2)(b) of the HQCC Act.

must consider whether disclosure of the Information in Issue could reasonably be expected to prejudice that system or procedure.

(c) Could disclosure of the Information in Issue reasonably be expected to prejudice QH's Death Review Process?

34. QH submits there is a reasonable expectation of prejudice to its Death Review Process resulting from disclosure. In particular, QH submits:

- Even though death reviews are mandated by QH's own policy and in accordance with statutory requirements of the HQCC Act, the conduct of the Death Review Process is entirely reliant on the meaningful participation of clinicians.

- Clinicians understand the process as being a strictly confidential process which is integral to ensuring that they fully engage in the ventilation of issues and the identification of areas for improvement.

- The Death Review Process is conducted in a quality improvement framework with the goal of learning and improvement of safety and quality and makes no inference as to blame or liability. If staff are identified or perceive that their participation will confer a real or perceived risk to them through the public release of the information to the media resulting in unwarranted adverse inferences being drawn about their involvement in a person's death, they will cease to participate in the process.[29]

35. I accept that QH's submissions reflect its concerns as the organisation transitions from a focus on individual clinicians to embedding a focus on clinical teams and systems of care. Nevertheless, the question to be answered is whether disclosure of the Information in Issue could reasonably be expected to prejudice QH's Death Review Process.

36. For the reasons set out below, there is no reasonable basis upon which to expect prejudice to QH's Death Review Process on the bases set out at paragraph 34 as a result of disclosure of the Information in Issue.

37. The following documents, to which QH referred in its submissions:

- HQCC's *Review of Hospital-related Deaths* standard
- HQCC Act
- QH's *Reporting and Review of Deaths* standard

do not refer to the Death Review Process as being a confidential process.

38. Additionally, I have considered the following documents:

- *Clinical Audit and Review* standard;
- *Clinical Governance Policy*, and
- *Roles and Responsibilities* implementation standard

These documents also do not refer to the Death Review Process as being a confidential process. Rather, QH's *Clinical Governance Policy,* which establishes the framework within which QH's Death Review Process is situated, lists transparency and accountability as a fundamental element of QH's approach to clinical governance. Accordingly, QH's submissions that its clinicians understand the Death Review Process

[29] QH submissions dated 23 June 2010, page 3.

to be confidential do not appear to be consistent with the standards, policies and legislation under which the Death Review Process operates. In view of that, I do not consider QH's arguments concerning an understanding of confidentiality on the part of its clinicians provide a basis for a reasonable expectation that the Death Review Process would be prejudiced by disclosure of the Information in Issue. [30]

39. As set out at paragraph 26 of this decision, QH's Death Review Process is a coherent, organised and comprehensive process. It is also mandatory. QH's *Reporting and Review of Deaths* implementation standard applies to all QH employees and contractors and sets out the mandatory minimum auditable requirements for the reporting and review of deaths that apply to roles and responsibilities from clinical staff through to Executive Directors. HQCC's *Review of Hospital-related Deaths* standard is also mandatory in nature and scope. Therefore, I am not persuaded that release of the Information in Issue could result in staff not participating meaningfully in the process. The nature of the process with responsibilities feeding into a hierarchical reporting structure would identify any lack of proper and appropriate participation by particular staff. QH could properly deal with any such issues as part of its performance management process.

40. QH also submits that clinicians will be reluctant to participate in the Death Review Process due to the media coverage that may flow from disclosure. I am not satisfied that disclosure will result in adverse inferences being drawn about the involvement of individual clinicians in particular death incidents because the Identifying Information is excluded from the Information in Issue. Accordingly, any perception that clinical staff will be personally under scrutiny cannot be substantiated in this review.

41. For the reasons set out above I find that disclosure of the Information in Issue could not reasonably be expected to prejudice QH's Death Review Process.

42. In summary, whilst I am satisfied that QH's Death Review Process is a system or procedure for the protection of persons, I find there is no reasonable basis to expect that disclosure of the Information in Issue could prejudice QH's system or procedure of death review. Accordingly, I find that the:

- Information in Issue is not exempt information of the type set out in schedule 3, section 10(1)(i) of the RTI Act; and
- ground for refusing access to information set out in section 47(3)(a) of the RTI Act does not apply in this case.

Public interest

43. QH submits that disclosure of the information in the documents would, on balance, be contrary to the public interest.[31]

44. To decide whether disclosure of the Information in Issue would, on balance, be contrary to the public interest, I must:

- identify any irrelevant factors that apply in relation to the information and disregard them
- identify public interest factors favouring disclosure and nondisclosure that apply in relation to the information
- balance the relevant factors favouring disclosure and nondisclosure; and

[30] Additionally, information that identifies medical staff does not form part of the Information in Issue in this review. Accordingly, there is no reason to expect their meaningful participation in the Death Review Process could be compromised on the basis argued by QH.
[31] Under section 49 of the RTI Act.

- decide whether disclosure of the information would, on balance, be contrary to the public interest.

45. No irrelevant factors arise in this case.

46. In considering factors favouring disclosure of the Information in Issue, I am satisfied that disclosure could reasonably be expected to promote open discussion of public affairs and enhance the Government's accountability.[32] Open discussion and the notion of accountability encourage more effective public administration and service delivery. By allowing the business of government to be examined and discussed the government can be held accountable for its actions.[33] Therefore, to the extent that information reviewing the quality and safety of emergency care in Queensland public hospitals contributes to open discussion about QH's service delivery, in accordance with proper professional standards and its timeliness, access to such information is important.

47. QH submits that its Death Review Process is subject to external oversight, for example by HQCC and the Coroner, and therefore the public interest in accountability is satisfied. However, I consider external oversight by entities such as HQCC and the Coroner is a mechanism that serves rather than satisfies the public interest in QH being accountable for the provision of its health care services. In my view disclosing the details of the reviews of specific emergency department incidents where a death occurred will enhance the accountability of QH. Disclosure will reveal actions taken and factors relevant when delivering emergency public health care, and the precise steps taken when evaluating those actions and factors following a death in an emergency department. Such disclosure enhances QH's accountability because it demonstrates the practical operation of the Death Review Process and sheds light on critical issues arising in emergency departments and how those critical issues are managed.

48. I am also satisfied that disclosure of the Information in Issue could reasonably be expected to contribute to positive and informed debate on important issues or matters of serious interest.[34] The performance of QH emergency departments is an issue of serious interest to the Queensland public.[35] Disclosure of the Information in Issue will provide details of the type and scope of review of specific emergency department incidents. It will better inform the public about review practices when deaths occur in public hospitals and contribute to debate on the performance of QH emergency departments.[36] In this regard I note that the word 'positive' is construed broadly in the context of access to information legislation and encompasses various effects that disclosure might have including enlivening public debate, generating criticism or leading to legal process.[37]

49. In considering factors favouring nondisclosure, QH's decision recognised the public interest in protecting an individual's right to privacy and the privacy of an individual's health matters generally. However, given that family references, medical and personal history and contextual information that might identify or be concerned with the personal details of relatives, friends or associates of each deceased patient are excluded from

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[32] Schedule 4, part 2, item 1 of the RTI Act.
[33] *Australian Capital Television Pty Ltd v The Commonwealth (No. 2)* (1992) 66 ALJR 695 at 743 per McHugh J.
[34] Schedule 4, part 2, item 2 of the RTI Act.
[35] Recognised by the Deputy Premier and Minister for Health, the Honourable Paul Lucas, when announcing the routine release of certain emergency department data: http://www.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=68404.
[36] *Director General, Department of Families, Youth & Community Care and Department of Education; Perriman (Third Party)* (1997) 3 QAR 549 at paragraph 19(b).
[37] *Osland v Secretary to the Department of Justice* (2008) 234 CLR 275 at 321 per Kirby J; *Commonwealth v John Fairfax and Sons Limited and Others* (1980) 147 CLR 39 at 52 per Mason J.

the Information in Issue, disclosure of the Information in Issue does not raise a legitimate public interest in protecting individuals' privacy in this case.

50. The RTI Act also recognises that the disclosure of personal information is a public interest harm whether the person involved is living or dead.[38] Therefore if the Information in Issue contains personal information, this consideration must be taken into account.

51. Personal information as defined under the IP Act is *'information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion'*.[39] This information forms part of the Identifying Information as referred to in paragraph 8 and Appendix 3 of this decision. For example, I consider that:

- the names of any individuals, including medical staff and deceased persons, are information by which their identity is apparent. As the word 'apparent' permits some limited flexibility to take account of the context in which the information is situated, I consider that it is possible to look at a name in the documents and, together with the listed contact details, know or perceive plainly that it is information about a particular individual or deceased person[40]; and

- a deceased person's identity could reasonably be ascertained by cross matching certain information in the documents:
  - address and contact details
  - date of birth
  - medical history including admission history
  - information about the person's injury or health or personal history; and
  - treatment dates including date of death.

52. The process of determining whether an individual's identity can 'reasonably be ascertained' is dependent on the context in which the information is situated. It allows for some resort to external information sources.[41] This information relates to a narrowed pool of QH patients because the documents relate to death incidents in emergency departments from three identified hospitals during a defined period of time. In that context I consider it reasonable that relatives or associates of a deceased person could ascertain that deceased person's identity from the information set out above, whether from the information alone or by cross referencing it with other information within their knowledge or possession.

53. That said, the types of personal information set out at Appendix 3 do not form part of the Information in Issue.[42] Accordingly, in respect of that personal information the public interest factor favouring non-disclosure referred to at paragraph 50 above does not apply in this review.

54. However, to the extent that the personal information of non-medical staff forms part of the Information in Issue – staff names, contact details and job titles – I note that its disclosure is deemed, under the RTI Act, to cause a public interest harm which must be

[38] Schedule 4, part 4, item 6(1) of the RTI Act.
[39] Section 12 of the IP Act.
[40] *WL v La Trobe University* [2005] VCAT 2592 (***WL***) at paragraph 17. See also Burdon M and Telford P, 'The Conceptual Basis of Personal Information in Australian Privacy Law', *Murdoch University Electronic Journal of Law* (2010)17(1) at page 20.
[41] *WL* at paragraphs 45 and 47.
[42] As defined in paragraph 8 of this decision.

balanced against considerations favouring disclosure of the Information in Issue in this review.[43]

55. In QH's decision and its submissions made during this review, QH considers that disclosure could prejudice its auditing procedures. The basis for QH's expectation of prejudice was that its clinical staff, if identified, would not participate meaningfully in future Death Review Processes, which would compromise the efficacy of such processes. QH considers that staff understand the process of death review to be a confidential quality improvement process and that disclosure of the information could undermine confidence in the process leading to areas for improvement not being fully identified and/or issues not being fully ventilated.

56. However, in this review the applicant is not seeking access to information that identifies medical staff. Accordingly, that information does not form part of the Information in Issue.[44] Setting aside the question of whether there would in fact be prejudice to its auditing procedures if QH staff were identified, as medical staff will not be identified in this review there is no reason to expect their meaningful participation in the Death Review Process could be compromised on the basis set out above. This is especially so given that the process of death review is mandatory. Taking all these matters into account I find this consideration does not apply in this review.

57. Similarly, patient confidentiality is not an issue in this review because the applicant is not seeking access to the Identifying Information. Accordingly, disclosure of the Information in Issue will not permit the identification of a person, whether or not deceased, who is receiving or has received a public health sector service (as defined in section 2 of the *Health Services Act 1991* (Qld)).

58. I have not identified any other factors favouring nondisclosure of the Information in Issue in this review.

59. In this review I am satisfied that public interest considerations favouring disclosure of the Information in Issue deserve significant weight given the:

    - performance of QH emergency departments is an issue of ongoing public interest as evidenced by Ministerial media releases and the publication of monthly performance reports by QH[45]; and
    - the material referred to by QH in its submissions demonstrates a history of responding to community concerns about the quality and safety of public hospital services.

60. Given that the Information in Issue excludes the Identifying Information listed in Appendix 3, I am satisfied that the public interest considerations favouring nondisclosure relating to personal information and privacy, as referred to at paragraphs 49 and 50 above, do not carry weight in the circumstances of this review.

61. In relation to the consideration favouring nondisclosure identified at paragraph 54, I must consider the strength of the public interest harm that would result from the disclosure of the personal information of non-medical staff forming part of the Information in Issue. In my view, as the personal information of non-medical staff is wholly related to their routine duties and responsibilities as employees of a public sector

[43] Schedule 4, part 4, item 6 of the RTI Act.
[44] As defined in paragraph 8 of this decision.
[45] See for example, http://www.health.qld.gov.au/performance/default.asp.

entity, I am satisfied that the public interest harm resulting from its disclosure would be of negligible weight.[46]

62. In balancing competing public interest considerations it is the Parliament's intention that the RTI Act be administered with a pro-disclosure bias and I should decide to give access to a document unless giving access would, on balance, be contrary to the public interest.[47]

63. In this review I am satisfied that the significant public interest considerations favouring disclosure outweigh those favouring nondisclosure. Therefore, in this case I am satisfied that:

- disclosure of the Information in Issue would not, on balance, be contrary to the public interest; and
- the ground for refusing access to information set out in section 47(3)(b) of the RTI Act does not apply in this case.

DECISION

64. I set aside the decision under review and find that the Information in Issue should be disclosed to the applicant as it is not exempt information and its disclosure would not, on balance, be contrary to the public interest.

65. I have made this decision as a delegate of the Information Commissioner under section 145 of the RTI Act.

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Clare Smith
Right to Information Commissioner

Date: 22 February 2011

[46] See the OIC guideline titled *Routine personal work information of public servants* available at http://www.oic.qld.gov.au/information-privacy-guidelines.
[47] Section 44 of the RTI Act.

Appendix 1

Significant procedural steps

(a) In an access application received by QH on 30 July 2009, the applicant applied for access to documents related to emergency departments that:

(i) reviewed in-unit deaths from 1 July 2008 to 30 June 2009
(ii) reviewed pregnancy miscarriages during 1 July 2004 to 30 June 2009; and
(iii) showed investigations into performance relating to patients in the triage category of resuscitation who were not seen immediately during the period from 1 July 2007 to 30 June 2009.

(b) Following discussions with QH the applicant reduced the scope of the application to documents related to emergency departments at the following four hospitals:

- Royal Brisbane and Women's Hospital
- Nambour Hospital
- Townsville Hospital
- Gold Coast Hospital

that—

(i) reviewed in-unit deaths from 1 January 2009 to 30 June 2009
(ii) reviewed pregnancy miscarriages during 1 July 2006 to 30 June 2009; and
(iii) showed investigations into performance relating to patients in the triage category of resuscitation who were not seen immediately during the period from 1 July 2007 to 30 June 2009.

(c) By telephone conversation on 2 September 2009 with QH, the applicant agreed not to pursue access to patient identifying information.

(d) By decision letter dated 5 November 2009, QH notified the applicant that it had:

- not identified any responsive documents in relation to the Gold Coast Hospital
- identified 234 pages relating to the remaining three hospitals; and
- decided to refuse access to all 234 pages.

(e) QH's decision refused access to the documents under:

- section 47(3)(a) of the RTI Act, finding the information was exempt under section 48, schedule 3, section 10(1)(i) of the RTI Act because its disclosure could reasonably be expected to prejudice a system or procedure for the protection of persons, property or the environment; and
- section 47(3)(b) of the RTI Act, finding that disclosure of the information would, on balance, be contrary to the public interest under section 49 of the RTI Act.

(f) On 19 November 2009 the applicant applied to OIC for external review of QH's decision.

(g) By letters dated 8 December 2009, OIC informed the applicant and QH that the external review application had been accepted for review.

(h) By letter dated 18 December 2009, QH provided OIC with copies of the documents to which access was refused.

(i) In a telephone conversation on 10 March 2010, the applicant advised OIC that it:

- had, through earlier applications, obtained some information from QH relating to items (ii) and (iii) of the access application[48]
- did not wish OIC to request QH to conduct any further searches for additional documents relating to this review; and
- was seeking access to de-identified versions of the documents that had been located by QH.

(j) By letter dated 17 March 2010, OIC confirmed to the applicant:

- that the review would focus on the documents that were the subject of QH's decision and would not consider any sufficiency of search issues; and
- of its preliminary view that, once de-identified, most of the information could be released.

(k) OIC conveyed its preliminary view that the grounds of refusal relied upon by QH were not made out, to QH by letter dated 24 May 2010 together with copies of the 234 pages from which the Identifying Information had been removed.

(l) On 23 June 2010, QH informed OIC that it did not agree with the preliminary view and provided submissions in support of its case. Part of those submissions directed OIC to:

- Clinical Governance Implementation Standard 6, *Reporting and Review of Deaths*, available on QH's intranet site.

- Information available on QH's website:
  - *Health Systems Review Final Report* dated September 2005, chapter 9 and recommendation 9.10; and
  - information about the *Clinical Governance Framework*.

- Information available on the website of HQCC:
  - *Health Quality and Complaints Commission Act 2006* (Qld), chapter 3
  - *Review of Hospital-related Deaths* standard; and
  - Fact sheet – *Review of deaths.*

(m) On 3 August 2010, OIC informed the applicant that QH had contested the preliminary view and provided OIC with submissions in support of QH's position and that those submissions were being considered by OIC.

(n) By telephone conversation on 19 October 2010, the applicant confirmed with OIC that it was not seeking access to the personal details of patients or their families and associates nor to information that would identify medical staff.

[48] As identified in paragraphs (a) and (b) above.

Appendix 2

Out of Scope Information

Page number	Description of out of scope information	Full or partial page
104	This page contains 10 diary entries for patients. Diary entry 10 relates to the review of an emergency department in-unit death. The remaining nine diary entries do not relate to the review of in-unit deaths or pregnancy miscarriages in emergency departments or investigations into performance in emergency departments.	Part of this page
154 - 169 and 209 - 213	Emails that deal with administrative matters about QH staff providing information to the Coroner. The information in these pages does not review in-unit deaths or pregnancy miscarriages in emergency departments nor show investigations into performance in emergency departments as requested in the applicant's application for external review.	21 full pages
216 - 218	Each page contains the same single line entry that relates to a death in a hospital that is not the subject of the application.	Part of each page

Appendix 3

Identifying Information

Category of information	Description
Name	Patient, family and associates' names
Patient details	Patient address and contact details
Patient age	Patient age including date of birth and words which describe patient age such as 'child', 'elderly', 'infant'
Gender	Gender including words that are gender specific or that describe a gender specific characteristic
Patient number	Patient reference number including Medicare details, URN, MRN, case number, other hospital reference number
Medical history	Patient medical history (both associated with presentation at emergency department and previous presentations)
Details of death	Date, time and place of death
Contextual information	Contextual information about injury or health by which a patient's identity might reasonably be ascertained, including treatment dates
Personal history	Personal history including place of birth, home town, relationship information, race
Family and associate references	Information regarding family or associates by which the patient, family and/or associate's identity might reasonably be ascertained
Staff name	Name of medical staff including contact details, position titles, qualifications