[2016] WASC 336

JURISDICTION	**:**	SUPREME COURT OF WESTERN AUSTRALIA IN CHAMBERS
CITATION	**:**	MORRIS -v- INFORMATION COMMISSIONER AT WA OFFICE [2016] WASC 336
CORAM	**:**	CORBOY J
HEARD	**:**	29 MARCH 2016
DELIVERED	**:**	17 OCTOBER 2016
FILE NO/S	**:**	GDA 17 of 2015
BETWEEN	**:**	ANN MARY MORRIS Appellant AND INFORMATION COMMISSIONER AT WA OFFICE First Respondent ARMADALE HEALTH SERVICE Second Respondent

ON APPEAL FROM:

Jurisdiction	**:**	OFFICE OF THE INFORMATION COMMISSIONER
Coram	**:**	MR S BLUEMMEL
File No	**:**	F 222 of 2015

Catchwords:

Appeal - Amendment of information - Appeal from decision by the Information Commissioner to cease dealing with a complaint

Legislation:

Freedom of Information Act 1992 (WA), pt 3, pt 4

Result:

Appeal dismissed

Category: B

Representation:

Counsel:

Appellant	:	In person
First Respondent	:	Ms S Lloyd
Second Respondent	:	Mr A Mason

Solicitors:

Appellant	:	In person
First Respondent	:	Principal Legal Officer, Office of the Information Commissioner
Second Respondent	:	State Solicitor for Western Australia

Case(s) referred to in judgment(s):

Attorney General (NSW) v X [2000] NSWCA 199; (2000) 49 NSWLR 653
Civil Aviation Safety Authority v Central Aviation Pty Ltd [2009] FCAFC 137; (2009) 179 FCR 554
Collector of Customs v Pozzolanic Enterprises Pty Ltd (1993) 43 FCR 280
Crewdson v Central Sydney Area Health Service [2002] NSWCA 345
Drake v Minister for Immigration and Ethnic Affairs (1979) 46 FLR 409
Francis v Department of Defence [2012] AATA 838; (2012) 59 AAR 35
Haritos v Federal Commissioner of Taxation [2015] FCAFC 92; (2015) 233 FCR 315
Paridis v Settlement Agents Supervisory Board [2007] WASCA 97; (2007) 33 WAR 361
Re Resch and Department of Veterans' Affairs (1986) 9 ALD 380
Sharp Corporation of Australia Pty Ltd v Collector of Customs (1995) 59 FCR 6
Western Australian Planning Commission v Questdale Holdings Pty Ltd [2016] WASCA 32; (2016) 213 LGERA 81

CORBOY J:

The background to the appeal

The second respondent's decisions and the complaint

1 The appellant appeals from a decision made by the Information Commissioner on 17 December 2015 to stop dealing with her complaint on the ground that it lacked substance. The decision was made pursuant to s 67(1) of the *Freedom of Information Act 1992* (WA) (the FOI Act).

2 In June 2015, the appellant requested that medical reports held by the second respondent be amended to delete 'all mental health psychological' diagnoses and 'social competency' references. The request was treated as an application under s 45 of the FOI Act.

3 The second respondent refused the appellant's request but it also advised that the request and accompanying documents would be filed to form part of the appellant's medical records (letter dated 19 June 2015). The appellant applied for an internal review of that decision. The Director of Clinical Health Services conducted the review. She upheld the decision not to amend the appellant's medical records. The appellant was advised of that decision by letter dated 1 July 2015.

4 The appellant made a complaint to the Information Commissioner by letter dated 7 July 2015. The gist of her complaint was that the medical records maintained by the second respondent contained information that was inaccurate or false. The appellant attached to her complaint correspondence with the second respondent and accompanying documents that she contended established that the information recorded in her medical records was false or inaccurate and defamatory.

5 The Information Commissioner advised the appellant by letter dated 7 December 2015 that he had formed a preliminary view that the second respondent's decision not to strike out entries in the appellant's medical record concerning her psychiatric diagnoses and social competency was justified. The appellant was invited to make further submissions on the Information Commissioner's preliminary view.

6 The appellant provided further submissions by an email sent on 16 December 2015. The Information Commissioner replied the following day. He advised that he had considered the appellant's further submissions but remained of the view that the second respondent's

decision was justified. Accordingly, he had decided to stop dealing with the complaint under s 67(1)(b) of the FOI Act as it lacked substance.

The appeal notice

7 The appellant's appeal notice stated her appeal as:

> Appeal for Expungement under the Freedom of Information Act of Incorrect and Unproven Diagnosis: refusal to give a reason for refusal, no proof of claims against me provided, no access to records (3 application areas tried) (Hospital, Commission and Minister), no access to discussion with diagnostician? and full identity not given of such person(s).

8 The appeal notice stated that various documents were attached. The documents were described in the notice, with the description incorporating a commentary on the documents. It is not possible to summarise that part of the appeal notice (which was intended to form part of the appellant's grounds of appeal). Accordingly, a copy of the appeal notice is annexed to these reasons.

9 As will be seen, the appellant submitted to the Information Commissioner that her application only involved a matter of record keeping. However, it was apparent from the documents and submissions that she provided to the second respondent, the Information Commissioner and the court that her ultimate aim was to prove that she had not suffered from any mental illness for the purpose of dealing with various entities such as Centrelink. So, for example, she wrote to the court in the course of the appeal identifying a number of occupations that she considered that she was fit to pursue.

The documents provided in the appeal

10 The Information Commissioner delivered various documents to the court pursuant to O 65 r 11 of the *Rules of the Supreme Court 1971* (the IC Documents). The documents comprised documents that had been provided by the appellant (a bundle marked '1') and correspondence between the Information Commissioner and the appellant and others. The documents formed the basis for the Information Commissioner's decision. The documents were numbered by the Information Commissioner and will be referred to as IC Document 1, IC Document 2 and so on.

11 The appellant provided the Information Commissioner with further documents after making her complaint. The documents were described in a schedule prepared by the Information Commissioner and formed a bundle that was item number 71 in the IC Documents. The documents

were separately numbered within the bundle so that the documents will be referred to as IC Document 71/1, IC Document 71/2 and so on.

12 As has been noted, the appellant delivered a bundle of documents with her appeal notice. The bundle comprised letters from the second respondent advising the appellant of the decisions that had been made on her requests to amend her medical records and for an internal review; correspondence between the appellant and the second respondent regarding her requests; and documents relied on by the appellant to contend that her medical records included information that was false. The appellant also provided a second bundle of documents that reproduced many of the documents that had been filed with the appeal notice but also contained copies of some of her correspondence with the Information Commissioner.

13 As an appeal under the FOI Act is akin to an application for judicial review, I have considered all of the documents that were provided to the court regardless of the form of the documents or how they came to be provided.

14 Finally, it should be noted that the medical records held by the second respondent were not produced to the Information Commissioner or to this court (other than to the extent that some documents, such as doctor's letters and referrals that had been apparently provided to the appellant at some point, were delivered to the Information Commissioner and/or formed part of the bundles of documents filed by the appellant in this court). I infer from the materials provided to the court that the appellant has not seen her medical records and so her applications are based, in part, on what she assumes has been recorded in her medical records. The second respondent advised the Information Commissioner that it held six files of records concerning the appellant.

The appellant's medical 'history'

15 This part of the reasons is drawn from the documents provided to the court by the Information Commissioner and the appellant.

16 The appellant was diagnosed in mid 1989 with tenosynovitis in both arms. The diagnosis was made by Dr De Souza (IC Document 71/2). The appellant accepts that this diagnosis was correctly made. That is apparent from annotations made on a letter by Dr De Souza and from the other documents produced to the court, including the appeal notice. As the Information Commissioner noted in his preliminary decision, the appellant contended that the condition had been successfully treated

within a reasonable time after the diagnosis. As best as I have been able to ascertain from the documents provided to the court and from her submissions, the appellant denies that she has suffered from any other medical condition during the time that she has had an association with the second respondent.

17 In May 1991, the appellant was referred by Dr Poli to the Armadale Clinic for counselling for an anxiety disorder (IC Document 71/6). This appears to be the earliest document produced by the appellant that forms part of the second respondent's medical records.

18 In August 1991, Dr Poli referred the appellant to an occupational therapist with the Commonwealth Rehabilitation Service (IC Document 71/7). The appellant has annotated her copy of the referral at some point to indicate that she disagreed with the referral. There are numerous references in the appellant's documents to inaccurate information held by Commonwealth agencies (most recently, Centrelink). I infer that Dr Poli's referral was the genesis of the appellant's complaints about various Commonwealth agencies holding and acting upon false information concerning her medical history.

19 Dr De Souza subsequently completed a medical certificate for the appellant to receive sickness benefits because of incapacity caused by her tenosynovitis (IC Document 71/8). The appellant has annotated the document to indicate that she did not receive sickness benefits.

20 In December 1993, Dr De Souza certified the appellant as fit to 'try' jobs that required typing to 'some extent' (IC Document 71/9 and IC Document 71/10). The appellant's documents indicate that she was undertaking typing and other courses in 1995 (IC Documents 71/11-13) and that she was certified as fit to work in that year (IC Document 71/14 and IC Document 71/18). The appellant also produced records from insurance companies and WorkCover Western Australia to indicate that, as at 1996, she had not made any claim for workers' compensation. She obtained a record from the Disability Services Commission in 2002 that indicated she had not been registered with, or referred to, the Commission 'for services to persons with an intellectual disability and/or autistic spectrum disorder' (IC Document 71/24).

21 In 2011, Dr Smith, a locum psychiatrist at the Mead Centre, provided an opinion to the Public Trustee on the appellant's testamentary capacity. I infer that the Mead Centre is a facility that is operated by or associated with the second respondent.

22 Dr Smith's opinion was based on a consultation with the appellant and his review of the case notes maintained by the second respondent. His opinion contained a reasonably detailed summary of the case notes, at least so far as they recorded matters relating to the appellant's mental health. The opinion also included comments that were made by the appellant to Dr Smith about her medical history. It should be noted, however, that there were matters concerning her medical condition that the appellant apparently accepted during her consultation with Dr Smith but which she now disputes.

23 Dr Smith noted that the appellant's general practitioner was concerned that the appellant had been previously diagnosed as suffering from schizophrenia and that she had recently reduced her anti-psychotic medication. Dr Smith considered that the diagnosis of schizophrenia was 'valid' based on his review of her case-notes. He concluded that the appellant suffered from paranoid schizophrenia and that her illness had been difficult to manage. He noted that the appellant accepted the diagnosis but that she denied having experienced some of the symptoms that were typical of the illness. He considered that the appellant's condition was stable at the time of the consultation; that her mental illness was in remission and that she possessed testamentary capacity. However, Dr Smith recommended that the appellant continue to be reviewed by the Mead Centre to ensure that her mental state did not deteriorate as a result of the reduction in her medication dosage.

24 Dr Smith recounted in his opinion aspects of the appellant's behaviour in 2008 and 2009 that were recorded in her case notes and which were regarded as manifestations of her illness. He also noted that the appellant had been treated in 2011 by a consultant psychiatrist to the Mead Centre, Dr Hoe, who discharged her into the care of her then general practitioner, Dr Potter, at the end of 2011. Dr Hoe considered that the appellant was compliant with her medication regime and that there were a number of indications that her illness was in remission. The appellant referred to Dr Hoe and Dr Potter in a number of her submissions to the second respondent, the Information Commissioner and this court. It is apparent that she considers that Dr Hoe and Dr Potter misdiagnosed her medical condition.

25 The documents provided to the court indicate that Dr Hoe discharged the appellant to the care of Dr Elliott, a general practitioner in Kelmscott, in March 2014. A referral letter from Dr Hoe stated that the appellant had an established diagnosis of schizophrenia but had been 'keeping well; had been attending TAFE and was coping well with studies in mental health.

She was considering employment as a peer support worker and her symptoms were 'stable with no current evidence of relapse' (IC Document 32). Dr Hoe referred to Dr Smith's opinion and noted that he had concluded that the appellant had testamentary capacity and that her schizophrenia was in remission. Dr Hoe requested that Dr Elliott provide whatever counselling might be necessary to help the appellant deal with 'stresses as they arise'.

26 In July 2014, Dr Elliott referred the appellant back to the Mead Clinic for the purpose of discussing a reduction in the appellant's medication. Dr Elliott described the appellant as 'currently stable, managing well and had no signs or indications of schizophrenia' (IC Document 33). At about the same time, the appellant completed the requirements for a Certificate IV in Mental Health with Polytechnic West. She was also certified as being fit for work (IC Document 35). She was further certified fit to return to work on a full time basis by Dr Hoe on 23 October 2014 (IC Document 37).

27 It appears that the appellant was reviewed by Dr Hoe on about 3 November 2014 (IC Documents 39 and 40). The apparent purpose of the review was to consider whether her medication should be reduced further or ceased. Dr Hoe did not consider that the appellant's medication should be discontinued but noted that this was a matter for Dr Elliott or any other doctor who had appropriate clinical experience.

28 In December 2014 and February 2015 the appellant made various statutory declarations in which she stated that she had never been diagnosed with a permanent disability and that she was fit to work (IC Documents 41 - 43). Further, an Employment Services Assessment Report made by Centrelink Armadale on 27 March 2015 incorporated remarks made by the appellant that summarised her position (IC Document 47). The remarks noted that the appellant had submitted reports indicating that she was fit for full time work and that she provided the following information in the course of an interview:

> She had been involuntarily hospitalised as a result of interactions with a previous employment services provider and had been treated over approximately five years by the Armadale Mental Health Service but had successfully challenged this with the support of the WA Health Consumers Council and the Mental Health Law Centre and with the support of her GP had successfully reduced off all medications and had received a clear statement from both her GP and the previous Treating Psychiatrist that there are no longer any symptoms. Ms Morris contends that the initial diagnosis and subsequent treatments were incorrect (IC Document 47).

The appellant's submissions to the second respondent and to the Information Commissioner

29 The appellant wrote to the FOI Coordinator for the second respondent by letter dated 24 June 2015 in support of her application to have information struck out from her medical records (IC Document 54). With respect, it is not easy to follow the submission but, in summary, the appellant alleged that she had been wrongly diagnosed and ill-treated by various medical/health practitioners and others and that documents and communications concerning her medical history contained false and defamatory statements. Her submission made assertions that were intended to demonstrate that she had been wrongly diagnosed and that statements that had been made about her medical condition were false. In particular, the appellant maintained that she had not suffered psychotic symptoms and the practitioners to whom she had referred in her submission had not identified any symptoms.

30 The appellant's submission to the Information Commissioner dated 7 July 2015 made similar complaints (IC Document 56). The appellant emphasised that she had not experienced symptoms of any medical condition other than tenosynovitis. She elaborated further on those matters in a document dated 5 August 2015 which was submitted to the Information Commissioner (IC Document 59). The appellant submitted other documents to the Information Commissioner that made further allegations about Dr Hoe, Dr Poli, the Public Trustee and Centrelink. The gist of those allegations was that they had either misdiagnosed the appellant and/or held information that was false and defamatory and/or had mistreated the appellant because of that information.

The Commissioner's reasons

31 The Information Commissioner noted in his preliminary decision that the appellant had, in summary, submitted that:

(a) Various false or inaccurate medical diagnoses concerning her health had been made over a period of approximately 20 years. The diagnoses included arthritis, schizophrenia and anxiety.

(b) She had never experienced any symptoms of mental illness. She had suffered tenosynovitis due to working for long periods typing. The condition was physical and had been successfully treated. The appellant was currently in perfect health. She was fit to work.

(c) She had never self-harmed and had never been violent.

(d) The incorrect diagnoses that had been made relating to her health had prevented, and were continuing to prevent, her from obtaining full time work. Various Federal and State agencies held false, defamatory and misleading records about her.

(e) A guardian had been 'falsely' appointed to her. The appointment and consequent infringement on her rights constituted an act of fraud.

(f) Expunging the inaccurate and misleading diagnoses from her medical records did not raise any medical or legal problem; her application only involved a 'records keeping' problem.

(g) She wanted to ensure that proof of her intellectual capacity and sound mind was fully accepted.

32 The Information Commissioner accepted that factual information may be corrected under pt 3 of the FOI Act if other factual information exists to establish that there were inaccuracies in the recorded information. However, he also noted that the obliteration, removal or destruction of a document by an agency was only authorised in the particular circumstances referred to in s 48(3) of the FOI Act. That section recognised the public interest in an agency retaining a complete record of information. The public interest in the preservation of the records of government organisations was also evidenced by s 78(3) of the *State Records Act 2000* (WA). That section makes it an offence for a government organisation employee to destroy a government record unless the destruction is authorised by the record keeping plan of the organisation.

33 The Information Commissioner considered that a medical file generally contained a complete history of a person's medical conditions and illnesses at various points in time. Opinions about a person's medical condition could vary from time to time but a person's medical file was intended to contain a complete record of the individual's various conditions, illnesses, medical events, treatments and hospital admissions. Section 45 of the FOI Act was not directed to rewriting history but rather to whether recorded information was inaccurate, incomplete, out of date or misleading. The fact that information may contain contested opinions did not mean that it was inaccurate or misleading.

The appellant's further submission to the Information Commissioner

34 The appellant responded to the Information Commissioner's preliminary decision by letter dated 16 December 2015. The appellant again asserted that she had not suffered from any symptoms of a medical condition other than tenosynovitis. She maintained that she had been consistently fit for work and had never suffered from any psychiatric or psychological condition; she did not require a guardian or the involvement of the Public Trustee in her affairs and she had been prevented from obtaining employment because of inaccurate statements about her medical history in records maintained by Centrelink (the Public Advocate had been appointed a limited guardian by an order made by the State Administrative Tribunal on 21 May 2009). She further submitted that:

> Expunging the diagnosis is not a problem of medicine nor law. It is only a 'records keeping' problem appears to be correct and is upheld by the playing with words. No one is considering the complete destruction of a document. The fact that MUCH OF THE CURRENT PROBLEM has been caused by refusal in the past to CORRECT FALSE AND MISLEADNG INFORMATION/UPDATE and to prevent the continual and recurrent input of the same incorrect information that has been LONG dealt with and OVERCOME. Surely a COMPLETE RECORD should only include those items which are correct, not invented, surmised nor downright harmful and wrong and once proven wrong should be agreed to be so AND taken out. Is the problem merely that the Hospital wants to maintain the restrictions of the Library Board Act?

35 The appellant concluded her submission by stating that she wanted her name cleared 'after many years of malignment and harm' and that it would be acceptable if on each of her files maintained by the second respondent there appeared a 'large and overarching notice of expungement'.

The FOI Act

36 Section 3 of the FOI Act sets out the objects of the Act: to enable the public to participate more effectively in governing the State and to make persons and bodies that are responsible for State and local government more accountable to the public.

37 Section 45(1) of the FOI Act provides that a person has a right to apply to an agency for amendment of personal information about the person contained in a document of an agency if the information is inaccurate, incomplete, out of date or misleading. The expression 'personal information' is defined by cl 1 of the glossary to the Act to mean:

> [I]nformation or an opinion, whether true or not, and whether recorded in a material form or not, about an individual, whether living or dead -
>
> (a) whose identity is apparent or can reasonably be ascertained from the information or opinion; or
>
> (b) who can be identified by reference to an identification number or other identifying particular such as a fingerprint, retina print or body sample.

38 Section 48(1) provides that an agency may amend personal information by, among other things, striking out or deleting information or inserting a note in relation to information. If the agency inserts a note in relation to information, the note must give details of the matters in relation to which the information is inaccurate, incomplete, out of date or misleading; and if the information is incomplete or out of date, the note must also set out whatever information was required to complete the information or bring it up to date: s 48(2). Section 48(3) provides that:

> The agency is not to amend information under subsection (1) in a manner that -
>
> (a) obliterates or removes the information; or
>
> (b) results in the destruction of a document containing the information,
>
> unless the Commissioner has certified in writing that it is impracticable to retain the information or that, in the opinion of the Commissioner, the prejudice or disadvantage that the continued existence of the information would cause to the person outweighs the public interest in maintaining a complete record of information.

39 Further, s 48(4) provides that:

> Before information is amended under subsection (1) in a manner that -
>
> (a) obliterates or removes the information; or
>
> (b) results in the destruction of a document containing the information,
>
> and that contravenes the *State Records Act 2000*, a record keeping plan made under that Act or the archives keeping plan made under that Act, the Commissioner shall provide the State Records Commission with a copy of the certificate issued by the Commissioner under subsection (3).

40 Section 50 of the FOI Act provides that if the agency decides not to amend the information in accordance with an application, the applicant may, in writing, request the agency to make a notation or attachment to the information giving details of the matters in relation to which the

applicant claims the information is inaccurate, incomplete, out of date or misleading, and if the person claims the information is incomplete or out of date, setting out the information that the person claims is needed to complete the information or bring it up to date.

41 Section 67 of the FOI Act states that:

> (1) The Commissioner may, at any time after receiving a complaint, decide not to deal with the complaint, or to stop dealing with the complaint, because -
>
> (a) it does not relate to a matter the Commissioner has power to deal with; or
>
> (b) it is frivolous, vexatious, misconceived or lacking in substance.
>
> (2) If the Commissioner decides not to deal with the complaint, or to stop dealing with the complaint, the Commissioner has to inform the complainant in writing, of the decision and the reasons for the decision.

42 Section 76 requires the Information Commissioner to give his decisions in writing. The written decision must include the reasons for the decision and the findings on material questions of fact underlying those reasons, referring to the material on which the findings were based.

43 Section 85(4) of the FOI Act provides that an appeal lies to the Supreme Court on any question of law arising out of a decision of the Information Commissioner on a complaint relating to an application for amendment of personal information if the effect of the decision is that information is not to be amended in accordance with the application. However, s 85(5) provides that there is no appeal under s 85(4) in relation to a decision of the Commissioner as to whether or not to deal with a complaint.

44 Neither respondent contended that s 85(5) applied, presumably on the basis that the Information Commissioner had initially chosen to deal with the complaint but had subsequently stopped dealing with the complaint because it was, in his opinion, lacking in substance. That is, the respondents accepted that s 85(4) distinguished between a decision not to deal with a complaint (from which no appeal will lie) and a decision to stop dealing with a complaint (from which an appeal may be taken). It is not entirely clear that s 85(5), read with s 67(1), is to be construed in that way. However, I have not further considered the point as the parties made no submissions concerning the proper construction of s 85(5).

The nature of the appellant's personal information

45 The characterisation of information for the purpose of s 45(1) of the FOI Act - whether it is inaccurate, incomplete, out of date or misleading - may depend on the nature of the information. Information about facts that are capable of being objectively determined may be readily described as accurate or inaccurate or complete or incomplete and so on. Further, the accuracy etc of information about objective facts can be assessed against evidence produced about those facts. An applicant for amendment can present evidence to demonstrate that information recorded about an objective fact is, for example, inaccurate and the relevant agency or the Information Commissioner may determine whether the information ought to be amended by reference to that evidence.

46 However, not all facts can be objectively determined. For example, a person's state of mind is a matter of fact but the existence or otherwise of a particular state of mind can only be inferred from what the person says and does and from the surrounding circumstances. It may be more difficult to characterise information about such facts as accurate or inaccurate etc for the purpose of s 45(1). In many instances, it will be more difficult for an agency or the Information Commissioner to determine whether the information about such facts ought to be amended pursuant to an application made under s 45(1).

47 An application to amend information in the form of an opinion presents even greater difficulties. Opinions are obviously qualitatively different to facts. Opinions are not objectively right or wrong and the fact that experts reach different conclusions about a matter does not mean that one conclusion is accurate and the other is inaccurate or misleading.

48 Accordingly, the characterisation and determination of whether information should be amended will depend significantly on whether the information consists of objective facts or facts that cannot be objectively determined or is a record of opinion.

49 Those distinctions can be readily illustrated by reference to information likely to be recorded in a patient's medical file. The date of a consultation and which doctor the patient consulted are facts that are capable of being objectively determined. Whether the patient experienced a physical sensation is a question of fact but whether the patient actually experienced the sensation is a matter of inference. Whether a physical sensation constituted a symptom of a particular medical condition is a matter of opinion. Whether a doctor made a particular diagnosis and

whether the diagnosis was honestly and reasonably made are questions of fact. The diagnosis is, of course, a matter of opinion.

50 Handley JA (with whom Ipp AJA and Davies AJA agreed) commented on such matters in ***Crewdson v Central Sydney Area Health Service*** [2002] NSWCA 345:

> Even if the Tribunal accepted other experts who had a different opinion that would not make 'incorrect', for the purposes of s 39(c) [of the *Freedom of Information Act 1989* (NSW)], an accurate statement of the opinion held by Drs Roberts and Jagger … The Act is not a vehicle for the determination of disputed questions of expert or other opinion when the recorded opinion was actually held and accurately entered in the official records.
>
> The position might be different if an expert whose opinion had been accurately recorded recognised later that it was incorrect at the time and withdrew it. However the proper course would be to add a notation that the opinion had been withdrawn rather than to remove the original opinion … An amendment in the latter form would falsify the records and attempt to rewrite history … Without the original opinion the records would not tell the whole story, and would be misleading [34] - [35].

51 His Honour also noted that there was some support in the decided cases for the proposition that an accurate statement of an opinion, expert or otherwise, that was genuinely held could be incorrect or misleading if it was based solely or, perhaps, substantially on information that had been shown to be incorrect. However, his Honour considered that it was not necessary to further determine that issue as it had not been established that the opinion in question had been based solely or substantially on information that was incorrect.

52 The difficulties encountered in application to amend information about a person's medical history, including to delete or amend records of diagnoses that were alleged to be wrong, was considered by the Administrative Appeals Tribunal in ***Re Resch and Department of Veterans' Affairs*** (1986) 9 ALD 380. Deputy President A N Hall noted that medical opinions were not shown to be 'incorrect' merely by producing opinions to the contrary and an opinion might not be regarded as inaccurate, incomplete or misleading merely because it was based, in part, on erroneous factual statements.

53 The *Freedom of Information Act 1982* (Cth) contains provisions that deal with problems relating to amending recorded opinions. The Act provides that the Information Commissioner and the Administrative Appeals Tribunal may only amend a record of opinion if satisfied that the

opinion was based on a mistake of fact and/or the author of the opinion was biased, unqualified to form the opinion or acted improperly in conducting the factual enquiries that led to the formation of the opinion: s 55N and s 58AA. There is no equivalent provision in the FOI Act.

54 The provisions of the Commonwealth Act for amending a record of opinion reflect the rights of appeal and review under that Act. An applicant is entitled to complain to the Information Commissioner from a decision of an agency. The Information Commissioner can receive evidence and make enquiries. The Administrative Appeals Tribunal can review the Information Commissioner's decision. The Tribunal conducts a hearing *de novo* and is to make the correct and preferable decision: ***Drake v Minister for Immigration and Ethnic Affairs*** (1979) 46 FLR 409. Accordingly, the Tribunal may receive evidence, including evidence in addition to whatever was before the decision maker (see, in relation to an allegation that medical records were inaccurate or misleading, ***Francis v Department of Defence*** [2012] AATA 838; (2012) 59 AAR 35).

55 However, an appeal from the Administrative Appeals Tribunal is limited to a question of law. Accordingly, the Commonwealth Freedom of Information Act does not expressly confer power on the Federal Court to amend a record of opinion on the grounds referred to s 55N and s 58AA as those grounds are essentially concerned with factual questions.

A question of law

56 What constitutes a question of law was extensively considered by a five member bench of the Full Court of the Federal Court in ***Haritos v Federal Commissioner of Taxation*** [2015] FCAFC 92; (2015) 233 FCR 315. The issue has been considered by the Court of Appeal in a number of decisions: see, for example, ***Western Australian Planning Commission v Questdale Holdings Pty Ltd*** [2016] WASCA 32; (2016) 213 LGERA 81 and ***Paridis v Settlement Agents Supervisory Board*** [2007] WASCA 97; (2007) 33 WAR 361. It is not necessary to explore the concept for the purpose of determining this appeal other than to note that I have had regard to what was said by the Full Court in ***Haritos***, including those aspects that might arguably take a more expansive view of what constitutes a question of law than has been adopted by the Court of Appeal (for example, on the issue of whether a mixed question of fact and law can be a question of law). Accordingly, I have accepted what was said by the court in ***Haritos*** that the issue must be approached as one of substance. The court should consider the notice of appeal, the alleged question or questions of law, the grounds raised, the statutory context and

the decision-maker's reasons and having considered all of those matters, satisfy itself that there is, in fact, a question of law (***Haritos*** [94]).

57 It is, however, uncontroversial that an appeal on a question of law is in the nature of judicial review proceedings and that; the existence of a question of law is not merely a qualifying condition for, or gateway to, an appeal but is the subject of the appeal itself. An appeal on a question of law is not an appeal by way of rehearing so that questions of fact, practice and procedure, policy and discretion can only be reviewed by the court if, and to the extent that, they must necessarily be determined in order to decide the question of law upon which the appeal has been brought.

58 The legislative intention is that the decision-maker is the body or person charged with the responsibility of making administrative decisions on their merits in accordance with the legislation conferring the decision-making power. The court has no jurisdiction to determine administrative matters on their merits; the court's function is confined solely to deciding questions of law. That is not to say that an error in the exercise of a discretion or a process of evaluation cannot answer the description of 'a question of law'. Alleged errors of that kind may reflect a question of law depending on the scope, nature and subject matter of the relevant legislation, the nature of the decision-maker and the nature and effect of the decision: see ***Haritos*** [112] and ***Attorney General (NSW) v X*** [2000] NSWCA 199; (2000) 49 NSWLR 653 [28] (Spigelman CJ).

59 In a passage that has often been cited with approval, Hill J said in ***Sharp Corporation of Australia Pty Ltd v Collector of Customs*** (1995) 59 FCR 6:

> Where the facts found are capable of falling within or without the description used in the statute, the decision which side of the line they fall on will be a decision of fact and not law. Such a decision will generally involve weight being given to one or other element of the facts and so involve matters of degree (16).

60 It follows that the proper construction of a statute is a question of law but the application of the statute to facts that have been found will often involve a factual assessment. It will only be where the facts inferred from the evidence are necessarily within the description of a word or phrase in a statute or necessarily outside that description that a contrary decision will be wrong in law: ***Haritos*** [196]. The Full Federal Court in ***Collector of Customs v Pozzolanic Enterprises Pty Ltd*** (1993) 43 FCR 280 held that the question whether facts fully found fall within the provision of a statutory enactment properly construed is generally a question of law.

However, that proposition was qualified: when a statute uses words according to their ordinary meaning and it is reasonably open to hold the facts of the case fall within those words, the question as to whether they do or not is one of fact (288).

61 Finally, an appeal that alleges that a decision maker was obliged to give reasons and that the reasons provided were inadequate may be on a question of law: ***Civil Aviation Safety Authority v Central Aviation Pty Ltd*** [2009] FCAFC 137; (2009) 179 FCR 554. The question would concern the legal content of the decision maker's obligation having regard to the provisions of the relevant legislation and the nature and effect of the decision in issue.

Conclusion

62 The appellant's primary complaint is that the Information Commissioner did not direct that her medical records be amended by deleting what she alleges to be an 'incorrect and unproven' diagnosis: an 'appeal *for* expungement under the Freedom of Information Act' (emphasis added). Expressed in that way, the appellant seeks to have the court perform what she perceives to be the Information Commissioner's function; for the court to exercise the Information Commissioner's discretion to cause her medical records to be amended. As has been explained, this court does not possess that power. The court's jurisdiction is limited to determining questions of law; it cannot conduct a review of the merits of the Information Commissioner's decision.

63 In my view, the appellant's appeal is not on a question of law however her primary complaint is expressed. The Information Commissioner decided to cease dealing with the complaint as he had concluded that it lacked substance. That conclusion involved a finding that the appellant's allegation that her medical records were inaccurate or incomplete or out of date or misleading lacked substance on the evidence that she had presented and the enquiries that the Information Commissioner had made. The decision involved the application of statutory criteria to the material provided to and gathered by the Information Commissioner; that is, it involved factual assessments. As has been said, in substance the appellant merely seeks to have this court exercise the discretion that was vested in the Information Commissioner.

64 This is not an appeal to which the qualification recognised by Spigelman CJ in ***Attorney-General (NSW) v X*** applies having regard to the limitations on the power to amend information about a person imposed by s 48(3) of the FOI Act, the nature of the information sought to be

amended by the appellant and the fact that the second respondent has added the appellant's application to her medical records.

65 I would add, however, that the documents provided to the court do not establish that the appellant's medical records are inaccurate or incomplete or out of date or misleading. That is especially so having regard to the difficulties in characterising an opinion as inaccurate etc for the purpose of s 45 and s 48 of the FOI Act.

66 The documents submitted to the court do not prove that the appellant has never suffered from schizophrenia or an anxiety disorder. The opinion given by Dr Smith to the Public Trustee provided a comprehensive statement of the appellant's medical condition. He accepted that the diagnosis of schizophrenia was 'valid', albeit that the condition was in remission. The fact that the appellant's condition was in remission does not, of course, mean that her medical records are inaccurate or incomplete or out of date or misleading. The records are intended to document a history. The same observation can be made about the evidence that the appellant has been certified fit to work at various times and that she now lives independently of any hospital or care facility (and has done so for some time).

67 No doubt the appellant would point to the fact that Dr Smith considered that the diagnosis of schizophrenia was valid on a review of the second respondent's case notes as being significant as she contends that the notes contained false and inaccurate information. However, the appellant has not produced evidence that establishes that the symptoms and related matters that were apparently recorded in her case notes and which Dr Smith considered to be relevant were falsely or inaccurately documented; Dr Smith consulted with the appellant as part of the process by which he formed his opinion; according to Dr Smith, the appellant accepted that she had suffered from schizophrenia; and Dr Smith did not apparently note anything in the appellant's medical records that was inconsistent with a diagnosis of schizophrenia.

68 The appeal notice raised other matters. First, the appellant alleged that she had not been given access to documents. That matter was not the subject of the appellant's complaint to the Information Commissioner.

69 Second, the appellant alleged that the Information Commissioner had 'refused to give a reason for refusal'. To the extent that this allegation complained that the Information Commissioner's reasons for not continuing to deal with the appellant's complaint were inadequate, the

Information Commissioner's letter of 7 December 2015 contained a comprehensive statement of his preliminary views. The letter discharged the Information Commissioner's obligation to provide the appellant with a fair opportunity to address his concerns and satisfied the requirements of s 76(5) of the FOI Act having regard to the nature of the Information Commissioner's decision.

70 Finally, the appellant complains that 'no proof of claims against me' had been provided. Putting to one side any question of whether the Information Commissioner or the second respondent was obliged to provide proof that the appellant's medical records were inaccurate or incomplete or out of date or misleading, the appellant has not established that the Information Commissioner failed to undertake appropriate inquiries into her complaint prior to making his decision under s 67(1) of the FOI Act. The documents provided to the court indicate that he did inquire into and give appropriate consideration to the appellant's complaint. Further, as I have indicated the material submitted by the appellant to the Information Commissioner did not establish that her medical records ought to be amended having regard to terms of s 45 and s 48 of the FOI Act.

Notice	Appeal for Expungement under the Freedom of Information Act of Incorrect and Unproven Diagnosis: refusal to give a reason for refusal, no proof of claims against me provided, no access to records (3 application areas tried (Hospital, Commission and Minister), no access to discussion with diagnostician? and full identity not given of such person(s) Attached to this form are these documents in this order – • Final decision letter from Bluemmel referring to appeal to Supreme Court, Preamble to Appeal outlining background, 3 letters outlining duties covered at City of Gosnells (employer at time of needed treatment for severe and spreading inflammation), reading of Xray : no neck injury, referral to Royal Perth Hospital with correct diagnosis of Tenosenovitis by chosen GP, one of a wide variety of incorrect diagnosis discovered made by non-treating GP, two letters from Royal Perth Hospital stating no record of referral, concurring diagnosis of Tenosenovitis advised by the Dentist of 2 brothers sharing a practice, treatment by Dr Fung for the intestinal problem caused by longterm lack of treatment for the invasive inflammation, outline of Business Management subjects undertaken whilst approved and on Newstart Allowance (a Records Management Subject and also a Statistics Quantitative Methods A were also passed during this period), several Sickness Benefits and normal Newstart Allowance notifications of Treatment and Cure by my GP, Notice of the subject product used to gain the complete cure (now more widely advertised on the WEB), 3 pages of typing speed tests 1994/95, 2 of many medical clearances for a wide range of employment duties, the previous 70% impairment listing at DSS Gosnells (including an unlawful addition of a 5% administrative impairment): no pension available without an appropriate diagnosis and thankfully NOT A DISABILITY, response from Medical Board in regard to a participating Commonwealth Doctor (complete with practice address as a PO Box), Letter from Australian Government Health Service/Commonwealth Department of Human Services and Health, letter from Work Cover stating no Worker's Compensation claim laid nor paid, fraudulent claim under strict direction and heavy sedation with bogus reports by both Dr Elizabeth Moore and Nurse Joanne Sheppherd (Sheppherd retracted), initial annotation accepted by Commonwealth FOI, others still awaiting approval; Head Scan reading stating no sign of Schizophrenia, 2 letters from Una Bridson Manager of Armadale Mental Health Services at the time (no actual contact could be made), identity qualifications of Theresa Dewse to whom Una gave complete control over complaints, administration matters and Freedom of Information Applications (nothing would be accepted and apparently nothing had/has been updated during her reign), application for DSP Pension instigated by Heather George, Social Worker at Centrelink (NOTE no diagnosing Doctor and on both complete LACK of information required to gain assistance in the employment gaining area with as yet no manner to update these documents, NOTE ALSO no input from me apart from the fact I corresponded with my Trustee predominantly rather ~~than use the expense of a mobile telephone), ON NO~~ OCCASION WAS ANY INFORMATION IN ~~OCCASION FROM MOAD~~

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than use up an expensive mobile telephone account, NO INFORMATION IN REGARD TO SYMPTOMS NOR ACTUAL DIAGNOSIS WAS GIVEN TO ME BY ANY TREATING STAFF, copy of email from Sylvia de Laroche advising closure of the matter by the FOI Commissioner; a copy of my resume indicating the range of skills, qualifications and employment experience (and the length of time unemployed and being REFUSED REFERRAL TO EMPLOYMENT with no reason given), my response to Sven Bluemmel's discussion letter setting out numerous barriers to Expungement, my letter to the Information Commissioner, statement by Department of Human Services that there is no REPORT by Social Worker Heather George, examples of attempts to gain a copy of the pension application and any reports or details of what I was purportedly diagnosed with and problems in locating/sending such by both RSA.National (apparently a U.S. of A. Company involved with the C.R.S. annotations and records corrections and overriding my applications to the FOI area of Dept. Of Human Services, letter to Human Services after release of Heather George's notes leading up to her referral (no contact with me and no contact with anyone who had had contact with me; incorrect background details; diagnosis apparently provided by the Job Find (Job Network) Manager (non-qualified), statement from Dept. of Human Services that Heather George's referral to a Special Officer who had been dealing with me is not supported by their records, a copy of the order placed on Heather George's statement of her diagnosis and refusal to permit me to be paid Newstart Allowance, Statement of removal of the Order, email from the Mental Health Review Board recording my objection to an ANNONYMOUS STATEMENT which was the ONLY evidence placed by Hoe to the Board Members to place me on a treatment order; Statement that there are no records held by Bentley Health, correction by Armadale Health of any assumption that I had EVER had any kind of unpaid bill or debt, further acceptance of submission as normally not stating the subject matter from Armadale Health, Submission to FOI utilising SOME of the Occupational Therapist's Report that I had 'normal personal capacity' (the statements of WOUNDS of self harm and Senior Health Certificate have been stated by Armadale Health as having not evidence although not prepared to expend time to discover source of these harmful claims), Armadale Health statement against the O.T. statement of being a 'frequent inpatient', Disability Services Commission statement that I have never been identified as a person with any kind of intellectual disability nor autistic spectrum disorder (3 pages), my initial attempt to further annotate the false and misleading diagnostic comments of Dr Elizabeth Moore in her 2000 false diagnosis and I am now advised treatment for a NECK INJURY and MUSCULAR SPASTIC SPASMS which NEVER OCCURRED with my TENDONS which had been treated; the letter of Sound Mind given by a Consulting Psychiatrist who saw me for approximately an hour or less and had never seen me before nor since due to the fact Dr Jane Potter refused to give me a letter of sound mind having been my GP for some 6 years she deferred to Hoe and REPORTED ME to the clinic due to the fact Hoe had seen me perhaps every 3 months for 2 years. Hoe did not write the letter. Potter also REFUSED to refer me to a private psychiatrist whose name I provided along with many side-effects from the medication. I am advised I am entitled BY LAW to see a private

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I certify –

30/12/2015

Time Estimate	Psychiatrist as I am paying, however I cannot refuse an URGENT REPORT TO THE CLINIC. My new GP's referral to reduce my medication, letter from HaDSCO after my complaint, outline of agreement made with the Health Consumer's Council of WA, email asking Dr Potter if she could give a basis for her diagnosis/statement of Schizophrenis (she had declined), apparently the first letter of referral by Hoe has been lost and I had only PARTIALLY been shown it by both Hoe and Potter, letter of acknowledgement to Potter (not my GP) that her referral to the Clinic as per her verbal advice, had worked; letter from Hoe stating fit for fulltime work, letter to my GP who referred for medication reduction; advising new GP (Elliott had left) of progress in my situation and brief background, attempt to gain access to FOI through DSS and in need of a GP to pass on letter (Dr Zhuo Yang not in that day and picked up by Skellan who proposed an expensive and prolongued system of double consultations to KEEP ME PENSIONED. I am not a Socialist in any way and have expended a great amount of time and resources trying to gain EMPLOYMENT and not a PENSION; letter from Minister Morton outlining that my GP is now in control of medication; 2 pages of side-effects, after a medical and form for Centrelink Dr Zhuo Yang provided a letter of fit to work fulltime, Jury Duty Clearance email, copy of clearance from DSP onto full Newstart Compliance; letter from Armadale Health NOW claiming PSYCHOLOGICAL RECORDS with no psychologist ever consulted, a false claim that I had requested that I have SOCIAL COMPETENCIES struck out AND now rejection of my submissions into the medical record against false claims be REASSESSED as CORRESPONDENCE therein leaving it ready to be DESTROYED UNDER THE LIBRARY ACT as noted in the letters from other hospitals therein leaving the false claims in medical diagnosis and such things as SELF HARMING with no statement against it from me; letter of advice from Dr Nathan Gibson, Chief Psychiatrist on how to gain EXPUNGEMENT of information through the Freedom of Information Act, clearance letters from both Commonwealth and State Police, 5 Statutory Declaration which progressed as the situation was legally and lawfully resolved. I estimate that it will take [possibly 20 minutes] to orally present the appellant's case at the hearing of this appeal.
Appellant's address for service	
Firm name	[Ann Mary Morris]
Street Address	[redacted]
Telephone no	(08) [redacted] Fac 08
Email address	[redacted]
Reference	
Signature of appellant or lawyer	..... Appellant / Appellant's lawyer — Date:

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