Access To Medical Records

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Introduction

This presentation discusses two of TAIC's recent cases which highlighted the challenges of legislative barriers to ascertaining whether medical factors contributed to the accidents under investigation.

A lack of consistency across transport modes and a narrow definition of 'medical practitioner' create an incoherent view of obligations to disclose or provide access to medical records.

We discuss:

- the challenges,
- the legal framework, and
- the cases which highlighted these issues.

The Challenge

Tension between an individual's privacy interests and the public interest in safety

- Awareness and disclosure of medical conditions is an ongoing issue
- There is variation across the modes
- Resistance to disclose because people are unsure about what action may follow such a disclosure
- Lack of awareness of obligations on medical practitioners to disclose

The Challenge

Where does the line between personal privacy and disclosure sit?

- While TAIC has powers to require any information it reasonably considers relevant to an inquiry, it is tempered by the requirement that personal health information should only be included in a report where it is extremely relevant to the causes or circumstances of the occurrence.
- The public needs confidence people performing safety critical roles are fit for service.
- Public interest in the safety system favours the Commission having powers to inspect private health information.

The Challenge

- A medical practitioner has a role to play in ensuring a patient's condition (where that might affect their work) is known. Better recognition of this is needed.
- It is likely, there will always be a tension between the competing interests of:
  - protecting an individual's private medical history, and
  - the need to ensure those in safety critical roles do not put the public in danger as a result of their medical conditions.

The Law

4 relevant Acts:

Privacy Act 1993 and Health Information Privacy Code 1994

- The Privacy Act 1993 controls how agencies collect, use, disclose, store, and give access to personal information. The Privacy Commissioner has the power to issue codes which can be seen as 'flexible' regulation under the Privacy Act. A Health Information Privacy Code 1994 exists in respect of medical information. This code outlines when and how individuals' private health information can be collected, used, disclosed and stored.

The Law

Commissions of Inquiry Act 1908, Transport Accident Investigation Commission Act

- Notwithstanding this privacy framework, it is recognised that other enactments authorise the disclosure of personal health information. The Commission has the powers of a Commission of Inquiry and can request information relevant to an inquiry: s 4C Commissions of Inquiry Act 1908 and related provisions in TAIC Act s 12. It is therefore able to utilise these powers where it considers them relevant to an inquiry.

The Law

Statutory regimes for the relevant modes - a sliding threshold

Aviation: Civil Aviation Act 1990

- A mature regime for disclosure, reporting, and assessment of health conditions.
  - Section 27B- medical certificate required
  - Section 27C- requirement to notify changes in medical condition- applies to pilots and medical doctors
  - But as will be seen, even a mature system can be circumvented (Case study 1)

The Law

Rail: Railways Act 2005

- No prescribed statutory regime for disclosure of health conditions
- All rail licence holders are required to have a safety system with an overarching safety case covering all of the rail activities of all rail participants with whom they have a contractual relationship. The New Zealand Transport Agency is required to approve the safety case of each licence holder.
- Section 30(k)(ii)- safety case must contain a description of the policies in place to ensure that the rail participant's rail personnel are not suffering impairment or incapacity as a result of fatigue, illness, medication, drugs, alcohol, or any other factor.

The Law

- Case study 2 (Parikawa inquiry) shows deficiencies in the system for disclosure.

Maritime: Maritime Transport Act 1994

- No statutory requirements around medical fitness.

Case 1: Mast bump and in-flight break up, Robinson R44,ZK-IPY, Lochy River, Queenstown, February 2015

Circumstances: About the accident

- Helicopter returning to base after a training flight in sub-alpine terrain in New Zealand's South Island.
- A mast bumping event occurred causing the helicopter to break up in-flight.
- The instructor and student on board died.
- It was thought as likely as not the student was flying the helicopter when the mast bumping occurred.
- Weather was generally calm but there was evidence of light to moderate turbulence in the area.
- The helicopter's airspeed was determined to be at least 102 knots at the time of the accident.
- The cause of the mast bumping could not be conclusively determined.

Case 1: Mast bump and in-flight break up, Robinson R44,ZK-IPY, Lochy River Queenstown, February 2015

Circumstances: About the instructor and student

The instructor

- 42 years of age
- Ex British Royal Marines 1998.
- Immigrated to NZ in 2003.
- Rated on R22, R44 & AS350 helicopters.
- Flew helicopters in Papua New Guinea in 2012 before returning to NZ in 2014.
- Held current class 1 medical certificate valid through to February 2015. Medical examination early February for renewal of his medical certificate and assessed as fit. Determined to be fit and healthy on day of accident.

The student

- 18 years of age
- Reported to be in good health

Of Note: Toxicology results for the instructor and student were negative for any performance-impairing substances.

Case 1: Mast bump and in-flight break up, Robinson R44,ZK-IPY, Lochy River, Queenstown, February 2015

TAIC's Report was published August 2016.

September 2016 the Commission re-opened its inquiry after receiving new evidence from the Coroner concerning the mental health of the instructor.

New Evidence –

The instructor had undergone treatment for a mental health condition some months prior to the accident.

February 2014 self-referred to a psychotherapist for counselling.

March 2014 saw GP for problems with sleeping & anxiety. Diagnosed with depression with anxiety component, on medication (not then flying).

August 2014 mental health improved, stopped medication

August 2014 underwent medical examination by regulator-approved medical examiner (not his own doctor) for renewal of medical certificate (which was granted without restriction).

September 2014 recommenced commercial flying.

February 2015 sought renewal of his medical certificate; was assessed and found fit.

Case 1: Mast bump & in-flight break up, Robinson R44,ZK-IPY, Lochy River, Queenstown, February 2015

What wasn't assessed –

- On the medical certificate application forms for the 2 certificate renewals, the instructor:
  - did reveal problems with sleeping, but
  - did not declare medications he had taken or the mental health conditions he had sought medical advice for, as he was required to do.

So was he fit to fly?

On review -

- The Commission engaged a psychiatrist to review the medical evidence. The Commission found it was very unlikely any medical factor contributed to the accident.

The Commission identified 2 additional safety issues:

- The regulator's medical certification process does not provide sufficient assurance that an applicant has no undisclosed health condition.
- There is insufficient awareness amongst medical practitioners of their legal obligation to inform the regulator that a licence holder has a medical condition that may interfere with the licence holder's ability to conduct their duties safely.

Case 1: Mast bump and in-flight break up, Robinson R44,ZK-IPY, Lochy River, Queenstown, February 2015

3 recommendations made-

- To the regulator (the Director of Civil Aviation)
  - that he improve the mechanisms for informing medical practitioners of the requirement to report to the Civil Aviation Authority health issues with a CAA licence holder that may interfere with the licence holder's ability to exercise the privileges of their licence safely; and
  - that he review the medical application process.
- To the Director-General of Health
  - that consideration be given to enhancing the national electronic health record database to identify a person's occupation and to include a mechanism to draw practitioners' attention to their obligations to notify the appropriate transport authority when a person has a health condition, or is on medication, that could pose a threat to public safety given their occupation.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

Circumstances: About the accident

- 2 trains on a single track approaching in opposite directions – T1 heading north, T2 heading south, and on the same line a hi-rail vehicle was authorised to occupy a section of the line in the vicinity of T2 at Pines – the track warrant station.
- Train controller planned to have the 2 trains cross paths at Pines.
- A track warrant was issued to T2 to proceed to Parikawa (before Pines) but the driver took the train beyond the track warrant destination and in the path of the hi-rail vehicle.
- The hi-rail vehicle had completed its task on the track and had moved off thereby avoiding the likelihood of a collision.
- Driver performance was the focus of the investigation.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

Circumstances: About the driver (T2)

- 55 years of age, 36 years driving experience
- Certificated to drive both express passenger trains and freight trains.
- No areas of concern identified during his 2 main-line driving practical assessments in October 2011 and May 2012.
- Driver spoke of having a medical condition causing him pain at work the day before the incident. He sought a medical appointment but the earliest he could be seen by his medical practitioner was 2 days away so he worked the day of the incident, in pain.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

Circumstances: About the driver (T2)

- Driver's medical history:
  - 2002 chest pain reported while driving. Assessed at A&E and discharged 'fit'.
  - 2003 severe lower back pain for non-work related accident.
  - 2005 and 2006 struck rail corridor trespassers.
  - 2006 delayed anxiety and poor sleep following fatal accidents, prescribed antidepressants – employer, at this stage unaware of his medication.
  - 2007 altercation with a customer. Self referral for counselling. Counsellor reported concern at driver's stress levels and medication he was on. Employer, with the permission of the driver, speaks to medical practitioner about driver's medication. Driver assessed as fit for driving duties.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

- 2009 further non-work related accident with spinal involvement, surgery, with residual fluctuating pain.
- 2010 Employer 'triggered' health assessment – assessed fit for driving duties.
- 2012 (May) Comprehensive pain assessment following reporting of constant daytime pain aggravated by walking and sitting, associated with anxiety and panic attacks. While being assessed revealed to the assessor consuming 9 standard alcoholic drinks per day as a coping mechanism. At this point his employer was unaware of his medical assessments for pain, his level of alcohol use or the assessor's report.
- At the time of the incident (August 2012) the driver was on a cocktail of 9 prescribed medications which either singularly or collectively had the potential to adversely affect his performance. This had gone undetected by his employer's health professionals. The drugs prescribed had various side effects including drowsiness, diminished alertness and behavioural changes.
- Driver was alcohol and drug screened after the incident; both negative.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

Issues of concern:

- There is no requirement for general medical practitioners to inform appropriate authorities when medical issues are diagnosed that could affect the performance of people working in safety critical roles in the rail industry.
- Of concern was the driver was able to work over a 2 year period when clearly not fit to do so given the combination of medications and alcohol intake.
- The employer's operating rules require drivers, when prescribed medication, to establish whether those medications would impact on their performance, and if so, inform their manager. This did not happen. The Commission took the view that the onus to establish whether a medication is likely to affect a person's ability to perform in a safety critical role should rest with medical professionals.

Case 2: Train overran limit of track warrant, Parikawa, Main North Line, August 2012

3 recommendations made-

- To Ministry of Transport– that it address the safety issue of there being no requirement for health professionals who provide primary health care to transport industry personnel employed in safety-critical roles to inform authorities when there are concerns regarding fitness for duty.
- To NZ Transport Agency (the Regulator)– that given safety-critical rail workers are not required to declare prescribed medications they are taking when presenting for 'triggered' health assessments, the Agency work with the National Rail System Standards Executive to address the issue in their health assessment standards.
- To KiwiRail (the Operator/Employer) – That KiwiRail introduce a system whereby KiwiRail's medical professionals are automatically granted access to employees' medical records held by private medical practitioners as necessary.

Concluding Remarks – what we have learned from these 2 cases

When looking across the New Zealand transport system the presumption of availability of personal medical records is not consistently supported by the law. The legal framework only entitles certain organisations to request information under certain conditions. Even within that framework, the question still needs to be asked. There is no automatic notification. Outside the framework it is left to operator systems and processes to screen staff fitness to operate in safety critical roles. How effectively that is done can vary as a matter of degree across the transport modes.

Concluding Remarks

From the prevention perspective Regulatory systems are intended to operate a priori, with the health risks identified (and then mitigated) up front. The work of accident investigators, such as TAIC, operates a posteroiri (benefit of hindsight) with the health issues left to be revealed through the investigation process.

This places the onus on investigators to be thorough in their initial interviews and subsequent follow up as the investigation progresses. In NZ's case our experience has revealed weaknesses in both regulators' and operator's disclosure systems. Ordinarily, it is our practice to request the operator's (employers) personnel files where the issue of medical conditions arise from scrutiny of human factors such as a history of fatigue or physical injury.

Concluding Remarks

These are obvious lines of inquiry. However, the 2 case studies revealed underlying conditions that were not captured by the current disclosure systems. Direct access to the General Practitioner records would have invited, in both cases, further questioning as to the fitness of the involved pilot/locomotive engineer to operate in safety critical roles.

Whilst we have amended our investigation processes, so that our investigators are, along with the normal lines of technical and operator inquiry, paying closer attention to health factors as a sub-category of human factors, this may only be an improvement to our processes as opposed to improvement of the safety system.