

**NORTHWEST TERRITORIES
INFORMATION AND PRIVACY COMMISSIONER
Review Report 19-207
Citation: 2019 NTIPC 24**

File: 18-182-4
November 5, 2019

Background

The Applicant made a request for records from the Government of the Northwest Territories (GNWT) Department of Health and Social Services (DHSS) and the Northwest Territories Health and Social Services Authority (NTHSSA). The specific information requested was as follows:

1. Internal communications about racism, cultural bias/racial bias in the healthcare system June 2018 to present.
2. Results and findings of external investigation into a specific individual's death.

In response to the Applicant's request, the Department identified that the external investigation referred to in the second part of the request was a "critical incident investigation", done in accordance with s. 25.3 of the *Hospital Insurance and Health and Social Services Act* (HIHSSA). The Department therefore refused to disclose this report, arguing that HIHSSA and the *Access to Information and Protection of Privacy Act* (ATIPPA) exclude critical incident reports from the scope of ATIPPA and therefore need not be disclosed. Further, the Department refused to provide the critical incident report to the Information and Privacy Commissioner for review. The Applicant sought a review of the Department's decision.

Relevant Sections of the Legislation

Access to Information and Protection of Privacy Act

3. (1) This Act applies to all records in the custody or under the control of a public body, including court administration records, but does not apply to the following:

...

(b.1) personal health information, as defined in subsection 1(1) of the *Health Information Act*, in a record to which that Act applies that is in the custody or under the control of a public body that is a public custodian as defined in subsection 1(1) of that Act;

4. If a provision of this Act is inconsistent with or in conflict with a provision of another Act, the provision of this Act prevails unless the other Act expressly provides that it, or a provision of it, prevails notwithstanding this Act.

32.(1) A review must be conducted in private.

33.(1) On a review of a decision to refuse an applicant access to all or part of a record, the onus is on the head of the public body to establish that the applicant has no right of access to the record or part.

34.(1) Notwithstanding any other Act or any privilege available at law, the Information and Privacy Commissioner may, in conducting a review under this Division, require the production of and examine any

record to which this Act applies that is in the custody or under the control of the public body concerned.

- (2) In conducting a review under this Division, the Information and Privacy Commissioner
- (a) may summon any person as a witness;
 - (b) may require any person to give evidence on oath or affirmation; and
 - (c) has the same power as is vested in a court of record in civil cases
 - (i) to administer oaths and affirmations,
 - (ii) to enforce the attendance of any person as a witness,
 - (iii) to compel any person to give evidence, and
 - (iv) to compel any person to produce any record to which this Act applies that is in the custody or under the control of the public body concerned.

49.4. Notwithstanding any other Act or any privilege available at law, the Information and Privacy Commissioner may, after receiving a request for a review under this Division, require the production of and examine any record to which this Act applies that is in the custody or under the control of the public body concerned.

56.(1) The Information and Privacy Commissioner shall not disclose any information that comes to his or her knowledge in the exercise of the powers or performance of the duties or functions of the Information and Privacy Commissioner under this Act.

Hospital Insurance and Health and Social Services Act

"critical incident" means an unintended event that occurs when health services or social services provided to a patient or client result in a consequence to him or her that

- (a) is serious or undesired, such as
 - (i) death, disability, injury or harm,
 - (ii) an unplanned admission to a health facility or an unusual extension of a stay in a health facility, or
 - (iii) a significant risk of substantial or serious harm to the safety, well-being or health of the patient or client, and
- (b) does not result from an underlying health condition of the patient or client or from a risk inherent in providing the health services or social services to him or her;

25.4.(1) Subject to the regulations, an investigator appointed or assigned under subsection 25.3(2) or (3) to investigate a critical incident shall not provide a notification or report referred to in section 25.3, any information in a notification or report referred to in that section, or any information gathered, or record produced, by or for the investigator in the course of, or for the purpose of, the investigation to any person except

- (a) the person or body that, under subsection 25.3(2) or (3), appointed or assigned the investigator to investigate the critical incident, or a person designated by the person or body;
- (b) the chief executive officer of a person or body referred to in paragraph (a), in the case of an investigator appointed or

assigned under subsection 25.3(2) to investigate the critical incident;

- (c) the Minister, in the case of an investigator appointed or assigned under subsection 25.3(2) or (3) to investigate the critical incident, or a person designated by the Minister;
- (d) the Deputy Minister, in the case of an investigator appointed or assigned under subsection 25.3(2) or (3) to investigate the critical incident, or a person designated by the Deputy Minister;
- (e) the Chief Public Health Officer under the Public Health Act or a person authorized under that Act to make an inspection, investigation or inquiry for the Chief Public Health Officer;
- (f) the Director of Child and Family Services under the Child and Family Services Act, or a person to whom, under section 8 of that Act, information must be provided in respect of a child in need of protection;
- (g) a person or body on order of a court; or
- (h) a prescribed person or body.

(2) Notwithstanding the *Access to Information and Protection of Privacy Act* and the *Health Information Act*, and subject to subsection (3), no person is entitled under those Acts to access to

- (a) a notification or report referred to in section 25.3; or
- (b) any record produced in the course of, or for the purpose of, preparing a notification or report referred to in section 25.3.

(3) Subsection (2) does not apply in respect of recommendations set out in a critical incident investigation report.

Issue

The issue arising out of this request are:

- a) whether the DHSS is required to release the critical incident report to the Information and Privacy Commissioner for review as to whether it was properly withheld from the Applicant pursuant to ATIPPA
- b) whether the public body properly interpreted the legislation in refusing to disclose the report to the Applicant.

Discussion / Recommendations

The Applicant's Submissions

The Applicant submitted that DHSS should release the report on the basis that the public interest outweighs any invasion of privacy.

The Department's Submissions

The Department submitted that when read together, the relevant sections of HIHSSA confirm that, with the exception of any recommendations set out in the critical incident report, no person is entitled to have access to a notification of the Minister of DHSS of a critical incident, a critical incident report that results from the investigation, or to a record produced in relation to the critical incident and that this is so notwithstanding the rights to access set out under ATIPPA or the *Health Information Act (HIA)*. The Department also argued that the wording that "no person" is entitled to this information includes the Information and Privacy Commissioner.

The Department argued that s. 3(1)(b.1) of ATIPPA expressly excludes all information that is the fundamental component of any critical investigation report from the application of ATIPPA. They said that s. 4 of ATIPPA further affirms that the notwithstanding clause in s. 25.4(2) of HIISSA prevails over any inconsistent or conflicting provisions in ATIPPA, including s. 34(1) and (2) of ATIPPA.

The DHSS noted that the Legislative Assembly of the Northwest Territories enacted the s. 25.4(2) notwithstanding clause of HIISSA in 2015. Given that this occurred after the enactment of ATIPPA, the Department argued that s. 25.4(2) was meant to take precedence over s. 34(1) and (2) of ATIPPA because these sections were brought into force prior to the enactment of s. 25.4(2) of HIISSA.

The DHSS provided two cases to support their position: *British Columbia (Information and Privacy Commissioner) v. British Columbia (Police Complaint Commissioner)*, 2015 BSCS 1538, 81 BCLR (5th) 373, and *West Vancouver Police Department v. British Columbia (Information and Privacy Commissioner)*, 2016 BSCS 934, 2016 Carswell BC 1394. The Department argued that these cases found that a clause similar to s. 25.4(2) of HIISSA excluded a record from British Columbia's privacy legislation, and, consequently, from the jurisdiction of the Information and Privacy Commissioner.

Overall, the Department submitted that given the provisions of ATIPPA and HIISSA, s.25.4(2) of HIISSA signaled a clear legislative intention to exclude critical incident reports from the scope of ATIPPA, meaning that DHSS is not required to provide the critical incident report to the Information and Privacy Commissioner for review.

On October 7th of this year, I issued Review Report 19-203 which dealt with the preliminary issue as to whether or not the Department of Health and Social Services was required to provide this office with a copy of the report in question in order to confirm that it met the criteria for a "critical incident report" under HIISSA. I concluded

that the legislation did not prohibit the Department from disclosing the record to this office for the purpose of a review under the ATIPP Act and recommended that the record be provided to this office for the purpose of our review. The public body refused to accept the recommendations made in that report and refused, therefore, to provide our office with a copy of the relevant record.

Before assessing the merits of the Department's reasons for refusing to disclose the record in question to the Applicant, I must express my regret about the Department's refusal to provide the disputed records to me. The Act, and the powers assigned to this office within it, creates a system of independent review established by the Legislature. In order to fulfil this mandate, I must be able to review the disputed records. This is true even when the record at issue is a critical incident report. This statutory goal creates a duty for my office to ensure public bodies are withholding documents only when appropriate in accordance with the legislation. My ability to independently and efficiently verify the government's assertion that the document is in fact a critical incident report, protected from disclosure, maintains public trust and confidence in access to information in the Northwest Territories.

The public body's refusal to co-operate with my office and provide the relevant records for my review ignores the protections afforded by the Act. Where we conduct a review hearing, section 32(1) requires that it be private, which is consistent with section 56, which imposes on my office a duty to keep confidential all information that we acquire in discharging our duties. On completing a review my office does not disclose records that we have recommended be disclosed. That is the role of the public body.

As set out in s. 33(1) of ATIPPA, the public body has the onus to establish that the Applicant has no right of access to the record if it has decided to refuse access. Whether the public body has met this onus depends on the totality of the evidence

before me. For reasons given below, I conclude that the public body has not met its burden.

Turning to the Department's reliance on *British Columbia (Information and Privacy Commissioner) v. British Columbia (Police Complaint Commissioner)*, I am of the opinion that the wording of the legislation in British Columbia is significantly different from the wording in HIHSSA. In that case, the relevant section was section 182 of the BC Police Act:

182. Except as provided by this Act and by section 3(3) of the Freedom of Information and Protection of Privacy Act, that Act does not apply to
- (a) any record of a complaint concerning the conduct of a member that is made, submitted, registered or processed under this Part,
 - (b) any record related to a record described in paragraph (a), including, without limitation, any record related to a public hearing or review on the record in respect of the matter,
 - (c) any information or report in respect of which an investigation is initiated under this Part, or
 - (d) any record related to information or a report described in paragraph (c), including, without limitation, any record related to a public hearing or review on the record in respect of the matter, whether that record, information or report is created on or after a complaint is made, submitted or registered or the investigation is initiated, as the case may be. (emphasis added)

This section states that the privacy legislation does not apply to s. 182 of the Police Act. This is in contrast to s. 25.4(2) of HIHSSA, which I will repeat here for ease of reference:

- 25.4(2) Notwithstanding the *Access to Information and Protection of Privacy Act* and the *Health Information Act*, and subject to subsection (3), no person is entitled under those Acts to access to
- (a) a notification or report referred to in section 25.3; or
 - (b) any record produced in the course of, or for the purpose of, preparing a notification or report referred to in section 25.3.

It is to be noted that this section clearly relates to the right to access to information as set out in Section 1 of the ATIPP Act. This provision says that where the record requested is a critical incident report, an applicant seeking access to such a record under the ATIPP Act is not “entitled” to receive that record. It does not negate the provisions of the ATIPP Act which give the Information and Privacy Commissioner the authority to independently review a public body’s decision to refuse access to such records. Nor does it change those parts of the ATIPP Act which authorize the Information and Privacy Commissioner to require production of records in such cases, in order to allow her to assess whether the claim was properly made.

Furthermore, S. 25.4(2) of HIHSSA is a “notwithstanding clause” as opposed to s. 182, which states that the privacy legislation does not apply. In *British Columbia (Information and Privacy Commissioner) v. British Columbia (Police Complaint Commissioner)*, Cullen J. noted that there is a distinction to be made between sections like s. 182 of the Police Act, to which the privacy legislation does not apply and sections of the privacy legislation that creates exceptions (at para. 112). The distinction is that in the case of exceptions, the application of the Act and the Commissioner is engaged. On the other hand, in the case of exemptions, neither the application of the Act nor the jurisdiction of

the Commissioner are engaged. Here, HIHSSA does not state that ATIPPA does not apply. Rather, s. 25.4(2) is a notwithstanding clause. Had the legislature meant to exclude the application of ATIPPA to critical incident reports, it could have done so in HIHSSA by including a provision that ATIPPA does not apply. This was done in Ontario for example, in the Quality of Care Information Protection Act, 2016. That Act has created the concept of "quality of care" and defines its function as the following:

"quality of care functions", in respect of a quality of care committee, means activities carried on for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of the health care and include conducting reviews of critical incidents; (emphasis added)

The Act goes on to exclude the application of Ontario privacy legislation to quality of care information:

- 3 The Freedom of Information and Protection of Privacy Act does not apply to quality of care information.

"Quality of care information" is defined as follows:

- 2 (2) Subject to subsection (3), in this Act, "quality of care information" means information that,
 - (a) is collected or prepared by or for a quality of care committee for the sole or primary purpose of assisting the committee in carrying out its quality of care functions,
 - (b) relates to the discussions and deliberations of a quality of care committee in carrying out its quality of care functions, or

- (c) relates solely or primarily to any activity that a quality of care committee carries on as part of its quality of care functions, including information contained in records that a quality of care committee creates or maintains related to its quality of care functions.

(3) "Quality of care information" does not include any of the following:

1. Information contained in a patient record.
2. Information contained in a record that is required by law to be created or to be maintained.
3. Information relating to a patient in respect of a critical incident that describes,
 - i. facts of what occurred with respect to the incident,
 - ii. what the quality of care committee or health facility has identified, if anything, as the cause or causes of the incident,
 - iii. the consequences of the critical incident for the patient, as they become known,
 - iv. the actions taken and recommended to be taken to address the consequences of the critical incident for the patient, including any health care or treatment that is advisable, or
 - v. the systemic steps, if any, that a health facility is taking or has taken in order to avoid or reduce the risk of further similar incidents.
4. Information that consists of facts contained in a record of an incident involving the provision of health care to a patient.

5. Information that a regulation specifies is not quality of care information and that a quality of care committee collects or prepares after the day on which that regulation comes into force.

There is no similar provision in HIHSSA stating that ATIPPA does not apply to critical incident information. Furthermore, Ontario amended its Personal Health Information Protection Act to state that:

- 51(1) This Part does not apply to a record that contains,
- A) quality of care information;

There is nothing in the Northwest Territories *Health Information Act* (HIA) or in the *Access to Information and Protection of Privacy Act* that excludes their application to critical incidents. Had it meant to exclude the Information and Privacy Commissioner's jurisdiction to independently assess claims that records fall within the definition of a critical incident report (or related records), the legislature could have amended both ATIPPA and HIA. It did not do so. In conclusion, I find that ATIPPA applies to critical incidents and that the application of ATIPPA remains engaged such that a claim by the Department that a record is a critical incident report as contemplated by the HIHSSA is subject to independent assessment by the Information and Privacy Commissioner.

It is to be noted that despite the inclusion of the provisions in the Ontario legislation, in *Mackenzie Health (Re)*, 2016 CanLII 72690 (ON IPC), at para. 32, it is clear that the Respondent provided the quality of care reports to the Ontario IPC for review. In that case, the IPC largely found that legislation prevented quality of care information from being released to the applicant. However the IPC was afforded the right to review the quality of care information to ensure that the documents did in fact contain quality of care information. Here, despite not having the legislative protections set out in Ontario,

the Department is still refusing to provide my office with the opportunity to review the critical incident reports to allow for an independent review of whether they are in fact critical incident reports.

S. 25.4(2) of HIHSSA states that no person is entitled to access the critical incident report. In my view, in the absence of clear and unequivocal language barring the Information and Privacy Commissioner from reviewing the records, the records should be viewable to permit the Commissioner to fulfill her mandate.

Further, I note section 1 of ATIPPA:

1. The purposes of this Act are to make public bodies more accountable to the public and to protect personal privacy by
 - (a) giving the public a right of access to records held by public bodies;
 - ...
 - (e) providing for an independent review of decisions made under this Act.

In my view, this provision creates a duty for the Information and Privacy Commissioner to ensure public bodies are only withholding documents as outlined in the legislation. This conclusion is supported by the decision in *University of Saskatchewan v Saskatchewan (Information and Privacy Commissioner)*, 2018 SKCA 34, where the Saskatchewan Court of Appeal found that statutory language written as "[n]otwithstanding any other Act or any privilege available at law" – is self-evidently broad. The reference to any privilege available at law is clear and doubtless embraces solicitor-client privilege." (at para. 37). This language is the same as s. 34 of ATIPPA. In that case, the Court of Appeal concluded that the privacy legislation empowers the Commissioner to require the production of records subject to, or said to be subject to,

solicitor-client privilege (at para. 47). I find this case instructive to the current one. Claims of solicitor/client privilege are more sensitive than critical incident reports.

Section 33(1) of the Act provides that, on a review of a public body's decision to refuse access, "the onus is on the head of the public body to establish that the applicant has no right of access to the record or part." This burden on the Department to establish that the record is a "critical incident report" is consistent with the common law burden to establish privilege at law, which rests on the person asserting the privilege. Because I have not been able to review the records, I have only the Department's evidence on the issue. That evidence is contained in two sentences of one paragraph of the Department's submissions as follows:

We confirm that there was an investigation in accordance with section 25.3 of Hospital Insurance and Health and Social Services Administration Act (the "HIHSSA"). This investigation resulted in a Critical Incident Report ("CIR") with recommendations.

This amounts to a statement of opinion on the very issue that is before me for decision. If I were to accept this, without more, I would be improperly delegating my responsibility to adjudicate the application of exceptions to the right of access under the Act to the very departments claiming it. A similar situation was considered in the Federal Court of Canada case of *Environmental Defence Canada v. Canada (Fisheries and Oceans)*. In that case an official with the federal government department claimed solicitor/client privilege over records and deposed in a sworn affidavit that the redacted portions of the document in question "reflected the legal advice obtained from counsel", adding that he "expected these communications between the DOJ counsel and the DFO officials to be and to remain confidential." The Court noted that these statements tracked the wording of the elements of solicitor-client privilege and said this:

[21] Whether solicitor-client privilege is properly claimed is a substantive issue to be determined by the court: *Goodis*. If I were to accept paragraphs four and five of Mr. Ahluwalia's affidavit as conclusive, I would be abdicating my judicial responsibility to determine the substantive issue. That is not to say that Mr. Ahluwalia's evidence is to be disregarded. Rather, it is a question of the weight that ought to be assigned to it.

The Court concluded that the government "has fallen short of this standard and has failed to provide the information required for a proper assessment." (*Environmental Defence Canada v. Canada (Fisheries and Oceans)*, 2009 FC 131 (CanLII), per Layden-Stevenson J., as she then was, at paragraph 24).

The same analysis applies to this case. The onus is on the public body to establish that an exception or exemption applies. My task is to decide whether there is sufficient evidence to establish that the record in question fits the criteria to qualify it as a "critical incident report". With the Department's refusal to allow this office to review the record in question, I am left with nothing more than the statement of opinion provided by the Department that this is the case. This falls far short of establishing that as a fact. I would have needed, at the very least, background information outlining what event occurred, how health services or social services were involved and the consequences of that involvement. Better yet, as outlined above, access to the records themselves would undoubtedly have allowed an assessment as to whether this record amounted to a critical incident report. In the circumstances, however, I have no background information and no way to confirm the Department's opinion with respect to the nature of the report. I have no option, therefore, but to **recommend** that the records be disclosed, in full.

Elaine Keenan Bengts
Information and Privacy Commissioner