OFFICE OF THE
INFORMATION &
PRIVACY COMMISSIONER
FOR BRITISH COLUMBIA

Order F20-57

MINISTRY OF HEALTH

Michael McEvoy
Information and Privacy Commissioner

December 17, 2020

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Summary: Three Indigenous governments had asked the Ministry and several other public bodies to disclose certain information, including personal information, related to COVID-19 and its transmission in their communities. Having had no success, they complained that the Ministry had failed to comply with its duty under section 25(1)(a) of FIPPA to disclose information specified in their complaint. The Commissioner rejected the Ministry's arguments that, during an emergency, the *Public Health Act* overrides the Ministry's duty to comply with the disclosure duty under section 25(1)(a) of the *Freedom of Information and Protection of Privacy Act*. However, although the Commissioner held that COVID-19 creates a risk of significant harm to the public and to the complainants' communities, section 25(1)(a) does not in the circumstances require the Ministry to disclose the information that the complainants argue must be disclosed. He concluded that sufficient information is already available to the complainants and to the public to enable the public, and the complainant governments, to take steps to avoid or mitigate risks connected with COVID-19.

Statutes Considered: *Freedom of Information and Protection of Privacy Act*, ss. 2(1), 25(1)(a), 25(1)(b) 25(2), 57(1), 58(3)(a) and 79. *Public Health Act*, ss. 53(a) and 54(1)(k). *Declaration on the Rights of Indigenous Peoples Act*. *Interpretation Act*.

INTRODUCTION

[1] This decision arises from my investigation, under section 42 of the *Freedom of Information and Protection of Privacy Act* (FIPPA), of a complaint that the Ministry of Health (Ministry) has failed to comply with its duty to disclose information under section 25(1)(a) of FIPPA. The complaint raises the question of whether that provision requires the Ministry to disclose specific information about COVID-19[1] cases to the complainant Indigenous governments. Specifically, does section 25(1)(a) of FIPPA, which requires a public body to, "without delay, disclose to the public, to an affected group of people or to an applicant information about a risk of significant harm to the environment or to the health or safety of the public or a group of people" require the Ministry to disclose COVID-19-related information?

[2] The complaint that prompted this decision was made on September 14, 2020, by Heiltsuk Tribal Council, Tsilhqot'in National Government, and Nuu-chahnulth Tribal Council (complainants). The complainants are, respectively, the Indigenous governments for Heiltsuk Nation, Tsilhqot'in Nation, and the fourteen Nuu-Chah-Nulth First Nations. The complainants argue that the Ministry has failed to comply with its section 25(1)(a) duty by not disclosing to them, despite repeated requests, certain information relating to confirmed and presumptive cases of COVID-19.

ISSUE

[3] My Office issued a hearing notice to the complainants and the Ministry, as the respondent public body, on September 18, 2020. It stated the issue as follows:

> The Commissioner will consider the issue of whether section 25(1)(a) of FIPPA requires the Ministry to disclose to the complainants, without delay, the following information:
>
> > ITEM #1: the location (not the personal identity) of *proximate* [see Item #2] presumptive and confirmed COVID cases;
> >
> > ITEM #2: whether the proximate case involves a person that has travelled to one of the Nations, e.g., a yes or no answer to whether the person has travelled to a particular Nation's territory within the last 14 days; and

[1] COVID-19 is the disease caused by the novel coronavirus known as SARS-CoV-2: paragraph 17 of the October 15, 2020 affidavit of Doctor Bonnie Henry, British Columbia's Provincial Health Officer (Henry affidavit).

> ITEM #3: the name of a person infected by COVID who is a member of one of the Nations, to be used only for the purposes of culturally safe contact-tracing (where the contact tracer is a member of the infected person's Nation, and will need to know the name of the infected person to conduct contact-tracing). [original italics]

[4] The hearing notice also stated that the term "proximate" has the following meanings for each of the complainants:

1. For Heiltsuk Nation, the proximate communities are Port Hardy, Haida Gwaii, Klemtu, Ocean Falls, Denny Island, Nanaimo, Campbell River, Prince George, and the Metro Vancouver Regional District.[2]

2. For Tsilhqot'in Nation and Tsilhqot'in communities, proximate communities are Williams Lake, and Quesnel.

3. For the Nuu-Chah-Nulth First Nations, the proximate communities are Bamfield, Port Alberni, Ucluelet, Tofino, Campbell River, Duncan, Tahsis, Zeballos and Gold River.[3]

[5] In a September 16, 2020 letter to this Office, complainants' counsel confirmed that these are the communities proximate to the Tsilhqot'in Nation and Tsilhqot'in communities. However, the complainants' initial submission further altered the above list by adding Alexis Creek and Tatla Lake as proximate communities.[4]

[6] In a December 9, 2020 letter to this Office, complainant's counsel advised that, due to an error in counsel's September 16, 2020 letter to this Office, the hearing notice listed Prince George as a proximate community for the Heiltsuk Nation when it should have referred to Prince Rupert. The same letter also advised that the Nuu-Chah-Nulth First Nations wish to add Port McNeill as a proximate community, on the basis that it recently came to the attention of the Nuu-Chah-Nulth Tribal Council that Nuu-Chah-Nulth First Nations members travel to Port McNeill for COVID-19 testing.

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[2] In a September 16, 2020 letter to this Office, counsel for the complainants confirmed that these are the communities proximate to the Heiltsuk Nation.
[3] In a September 17, 2020 letter to this Office, counsel to the complainants confirmed that these are the communities proximate to the Nuu-Chah-Nulth First Nations.
[4] Complainants' initial submission, page 1.

[7] The Ministry has not objected to these changes or corrections and I proceed on the basis of the above amendments to the hearing notice.

[8] It should also be noted that, while the complaint uses the term "presumptive case", the Ministry says this term is no longer in use by the BC Centre for Disease Control (BCCDC), which now uses the all-encompassing term "Case".[5] This term covers cases confirmed by a laboratory test and two other kinds of cases, where there is no laboratory confirmation.[6] In reply, the complainants say they seek information on the basis that a "presumptive case" is "synonymous with" the last two categories of case, i.e., "probable epi-linked" cases and "probable-lab cases".[7]

[9] As the hearing notice stated, FIPPA does not allocate the burden of proof respecting section 25(1)(a) to either the Ministry or the complainants, and both the complainants and the Ministry have a practical incentive to provide such evidence as they consider appropriate to support their position in this matter. As has been said previously by this office:

> …[W]here an applicant argues that s. 25(1) applies, it will be in the applicant's interest, as a practical matter, to provide whatever evidence the applicant can that s. 25(1) applies. While there is no statutory burden on the public body to establish that s. 25(1) does *not* apply, it is obliged to respond to the commissioner's inquiry into the issue and it also has a practical incentive to assist with the s. 25(1) determination to the extent it can.[8] [original emphasis]

[10] In a few places below, where I take "notice" of something, I have applied the "official notice" principle in finding a fact. The "official notice" principle permits me to accept "a fact without proof", i.e., "facts which are so notorious as not to be the subject of dispute among reasonable persons", and "facts that are capable of immediate and accurate demonstration by resorting to readily accessible sources of indisputable accuracy".[9]

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[5] Ministry's submission, paragraphs 19-20.

[6] The first of these is where an individual is symptomatic and has had close contact with a laboratory-confirmed case or other risk factors, which is a "probable epi-linked case". The second is where an individual has had a fever or new onset of cough, meets specified exposure criteria, but has had an inconclusive laboratory test, known as "probable-lab case". Ministry's submission, paragraph 19.

[7] Complainants' initial submission, pages 2-3.

[8] *Office of the Premier & Executive Council Operations, Re*, 2002 CanLII 42472 (BC IPC) [*Office of the Premier*], at paragraph 39.

[9] *R. v. Williams*, 1998 CanLII 782 (SCC), at paragraph 54. There is no doubt that I have the authority to apply this principle. In a judicial review decision involving this office, the Supreme Court of British Columbia said, "It is trite law that official notice may be taken by a decision maker on his or her own initiative. Furthermore, the generally accepted modern view is that where official notice is taken of

[11] In a letter dated November 18, 2020 I advised the parties of my intention to take official notice of certain facts, which I described generally, and invited them to provide representations about those facts. The Ministry's response included further argument on the merits. The complainants objected to this, on the basis that the submissions were improper further reply, not representations about the facts of which I intended to take notice. The Ministry then sought an opportunity to respond to the complainants' objection. I advised the parties that it was not necessary to hear further from them. I have not found it necessary to consider the Ministry's further submission, or the complainants' objections to it, as neither party objected to my taking official notice of facts to which my November 18, 2020 letter referred.

[12] In a December 7, 2020 letter, counsel for the complainants brought to my attention the recently released report by Mary Ellen Turpel-Lafond (Aki-Kwe) entitled "In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care" (In Plain Sight).[10] The complainants submitted that the report is "pertinent to matters before the Commissioner". They asked me to take official notice of the report and asked for an opportunity to provide brief submissions. A December 7, 2020 letter from counsel for the Ministry advised that BCCDC intended to publish more geographic information about COVID-19 case locations. I gave the parties an opportunity to make submissions on each other's new material, and an opportunity to respond to each other. I address these matters later.

DISCUSSION

Contextual observations

[13] Before addressing the issue of whether section 25(1)(a) applies, it is important to understand the context of this case. The COVID-19 pandemic is one of the most serious domestic crises British Columbia has faced in generations. It continues to pose a significant public health challenge and demands a great deal from provincial, federal and Indigenous governments and officials.
As discussed further below, it cannot be doubted that, while the pandemic has caused many personal tragedies, its effect on socio-economically disadvantaged, and often geographically isolated, communities can be especially severe. There

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a matter, the official notice is final.…This is because facts which are capable of official notice are so generally known and accepted they cannot be reasonably challenged: *British Columbia (Minister of Water, Land and Air Protection) v. British Columbia (Information and Privacy Commissioner)*, 2002 BCSC 1429, at paragraph 26. That decision was partially overturned on appeal, but not on this point: *Guide Outfitters Assoc. v. British Columbia (Information and Privacy Commissioner)*, 2004 BCCA 210).

[10] https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf (accessed December 14, 2020).

are substantial gaps in health outcomes between Indigenous people and their communities, and others in British Columbia.[11] This has special relevance in the context of COVID-19 where the pandemic's impact is not necessarily limited to the health and safety of individuals; there can also be implications for the cultures and languages of Indigenous communities. This gives Indigenous communities a particular interest in protecting their elders, who are important knowledge keepers and help ensure the continuity of Indigenous cultures and languages.[12] Since COVID-19 is likely to affect elders more seriously than younger people, the pandemic could have significant consequences for the language and culture of Indigenous communities.

[14] The complainants express the desire to have more information about where cases are located so Indigenous governments can take steps to protect their communities. The complainants' position is that the Ministry is legally required to disclose to them the "location" of both confirmed and presumptive COVID-19 cases in areas "proximate" to them.[13] These areas cover large portions of British Columbia's population. For example, the Heiltsuk Nation's description of which communities are "proximate" to its territory would, if accepted, involve requiring the Ministry to disclose the "location" of cases within a population base of at least 2,600,000 people, or some 50% of British Columbia's population.[14] While the scope of the other complainants' position is

[11] The complaint, and the complainants' initial submission, contain extensive government and other public source material attesting to these disparities. So does the Henry affidavit, at paragraphs 27 and 28.

[12] This impact on Indigenous communities is attested to in the complaint, and the complainants' initial submission. For example, paragraph 86 of the complaint describes the importance of elders to the history, culture, and language of the Heiltsuk Nation, Tsilhqot'in Nation, and the fourteen Nuu-Chah-Nulth First Nations. Also see the Henry affidavit, at paragraph 33.

[13] The complainants have not expressly contended that the Ministry must disclose the residential address of individuals who are, as they put it, "presumptive and confirmed" cases. The complaint refers to "the location (not the personal identity) of proximate cases" by reference to communities identified in the complaint. The complaint says, at paragraph 2, that the "term 'proximate' refers to cases located in specific areas near to the rural communities of the Nations, in terms of transportation links, e.g., highway, ferry, or air transport, with which members of the Nations may have significant contact." The complaint then lists "areas" each of the complainants considers "proximate".

[14] This figure is largely driven by the Heiltsuk Nation's position that the Metro Vancouver Regional District is a proximate community. I take notice of the fact that, according to a 2016 Metro Vancouver Regional District bulletin, the 2016 Canadian census determined that the population of the Metro Vancouver Regional District was 2,463,431 that year: http://www.metrovancouver.org/services/regional-planning/PlanningPublications/2016CensusBulletinPopulation.pdf (accessed December 14, 2020). I also take notice of the fact that, according to Statistics Canada, British Columbia's population in 2016 was 4,648,055: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=59&Geo2=PR&Code2=01&SearchText=Canada&SearchType=Begins&SearchPR=01&B1=All&type=0 (accessed December 14, 2020). If

not as great in terms of population, it is clear that they argue for mandatory disclosure in relation to a considerable population base across several regions.

[15] The First Nations Health Authority (FNHA) has been responsible, since 2013, for administering health programs and services to Indigenous communities and individuals, that used to be delivered by the federal government through Health Canada.[15] The FNHA plans, designs, manages and funds the delivery of First Nations health programs and services in BC, but this does not replace the Ministry's or the regional health authorities' role or services.[16] It also collaborates, coordinates and integrates health programs and services.[17] Some health services are delivered to First Nations communities by First Nations health service organizations, which are formed in some communities and employ health professionals. Some services are delivered by the regional health authorities or the FNHA.[18]

[16] Regarding the COVID-19 pandemic, the FNHA provides funding and support for First Nations communities that have cases.[19] This can include "things like hotel or other isolation accommodation (for the Case or for vulnerable non-infected household members like elders), safe medical transportation to care, food and medication delivery".[20] The supports are "based on need and location—the communities and FNHA regional teams collaborate in partnership with regional health authorities."[21] First Nations communities can also contact the FNHA "to access available supports and funding."[22]

[17] A final contextual consideration is the fact that, the Ministry argues, individuals — and sometimes entire communities — have been stigmatized because of perceptions that they are disease carriers. In her evidence in support of the Ministry's case, the Provincial Health Officer (PHO) offered examples of this, notably the shunning of individuals who live in Manitoba's Hutterite colonies, which have had outbreaks, because of fear that they are carrying the disease. This caused Manitoba's chief provincial health officer to stop reporting

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one accounts for the communities covered by the complaint other than the Metro Vancouver Regional District, the figure of 2,600,000 stated above is a reasonable estimate for the population involved. As for the percentage noted above, the population figures will have changed one way or another in the last four years, but it is reasonable to infer that the complainants are asking for information relating to communities in which about half of British Columbia's people live.

[15] Henry affidavit, paragraph 29.
[16] Henry affidavit, paragraph 63.
[17] Henry affidavit, paragraph 65.
[18] Henry affidavit, paragraphs 64 and 65.
[19] Henry affidavit, paragraph 74.
[20] Henry affidavit, paragraph 74.
[21] Henry affidavit, paragraph 74.
[22] Henry affidavit, paragraph 75.

community-level COVID-19 case reports.[23] A related concern, she deposed, is the risk that stigmatization of those who have contracted COVID-19 may dissuade others from reporting their illness to health officials, which could impede effectiveness of public health measures.[24] At the heart of the Ministry's resistance to disclosure of the information in issue is what the Ministry describes as "best public health practices".[25]

[18] Before tackling the issue of what, if anything, the Ministry is required to disclose under section 25(1)(a), I will discuss who has custody or control of information that might be responsive to the complainants' request.

The Ministry as respondent

[19] The complaint says that, over the last summer, the complainants "repeatedly requested" that the Ministry disclose information to them and made the same request to other public bodies, i.e., the BCCDC, Vancouver Coastal Health Authority, Vancouver Island Health Authority, Northern Health Authority and Interior Health Authority. The regional health authorities are public bodies under FIPPA. The BCCDC is operationally housed in the Provincial Health Services Authority, a public body under FIPPA that serves as the "administrative and operational arm" of the PHO's office.[26]

[20] The complainants agreed to suspend their complaint against the regional health authorities and the BCCDC, while reserving the right to revive them or make new ones.[27] Their complaint contended that the information they seek is clearly under the possession or control of the Ministry, an assertion that the Ministry has not disputed.[28] The Ministry is a public body under FIPPA, but the office of the Provincial Health Officer is not. The hearing notice names the Ministry as the respondent public body, and the Ministry has not argued that it is not the appropriate respondent.[29]

[21] In her evidence in support of the Ministry's case, the PHO deposed that she is responsible for, among other things, advising the Minister of Health on public health issues.[30] She also deposed that "[c]ommunicable disease information which is collected pursuant to" the *Public Health Act* (PHA) and

[23] Henry affidavit, paragraph 125.
[24] Ministry's submission, paragraphs 24-28, Henry affidavit, paragraphs 123 and 124.
[25] Ministry's submission, paragraph 67.
[26] Henry affidavit, paragraph 45.
[27] This was set out in their legal counsel's September 16, 2020 letter to this Office.
[28] Complaint, paragraph 17.
[29] To the contrary, at paragraph 8 of the Ministry's submission, there is a reference to "the Ministry, including the Provincial Health Officer".
[30] Henry affidavit, paragraph 2.

regulations "is under my control", and she is "responsible for the policy and governance framework respecting, the collection, storage, use and disclosure of communicable disease information."[31] The PHO further deposed that she does not receive reports of specific persons with communicable diseases — these are made to the BCCDC electronically and the BCCDC is required to collect, store, use and disclose the information in accordance with the PHO's directions, as well as in accordance with applicable legislation.[32]

[22] I infer from this that, if the PHO ordered it to do so, the BCCDC would provide her with such information as may be needed to comply with any order I might make. Nor does the PHO's evidence suggest that this information would not be made available to the Ministry if I were to order disclosure.

[23] For the above reasons I proceed on the basis that the Ministry is the appropriate respondent.

[24] Before turning to the core issue in this matter it is necessary to address some of the parties' arguments about the application and interpretation of FIPPA.

Interpretation of section 25(1)(a)

[25] The parties have raised several points about the interpretation of section 25(1)(a) that are dealt with below. In interpreting that section, I have applied the ordinary rules of statutory interpretation, notably, that the "words of an Act are to be read in their entire context, in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament."[33]

Complainants' arguments about statutory interpretation

[26] The complainants argue that I should interpret section 25(1)(a) in a manner consistent with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). They refer to UNDRIP's implementation through British Columbia's *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) and argue that section 25(1)(a) "must be interpreted in a manner that recognizes Indigenous governments, particularly when they seek access to information

[31] Henry affidavit, paragraph 38.
[32] Henry affidavit, paragraph 50.
[33] The Supreme Court of Canada has approved this rule many times, with the best-known example being *Rizzo & Rizzo Shoes Ltd. (Re)*, 1998 CanLII 837 (SCC), [1998] 1 SCR 27, from which the above quote is taken. I also note that Commissioner Denham applied this approach when interpreting section 25(1) in *Mount Polley* (at page 20). I have also kept in mind section 8 of the *Interpretation Act*: "Every enactment must be construed as being remedial, and must be given such fair, large and liberal construction and interpretation as best ensures the attainment of its objects."

about what they consider to be risks of significant harm to the health or safety of their members."[34]

[27] Citing several UNDRIP provisions, the complainants argue that DRIPA "now obligates Her Majesty the Queen in right of British Columbia (or 'government' under s. 29 of the *Interpretation Act*) to support statutory interpretations that are consistent with UNDRIP."[35] They cite section 3 of DRIPA, which says, "In consultation and cooperation with the Indigenous peoples in British Columbia, the government must take all measures necessary to ensure the laws of British Columbia are consistent with the Declaration." They advance two points to support this position.

[28] They first argue that I ought to recognize that part of the purpose of section 25 "is to facilitate the ability of Indigenous governments, among others, to know about and address risks of significant harm to the health or safety of their members, where information about such risks comes into a public body's possession."[36] Second, they say that, where "disclosure is actively sought by an Indigenous government", I should "give weight to the views of an Indigenous government that has decided — as part of exercising their Nation's right to self-government — what constitutes a risk of significant harm to the health or safety of their members, and whether information is actionable information 'about' such a risk."[37]

[29] They contend that "[a]n evidential burden should accordingly lie on the public body to prove that the factors set out under FIPPA s. 25 that warrant disclosure of information have not been met."[38] They add that this proposed "evidential burden on public bodies to rebut an assessment by an Indigenous government about a risk of significant harm to health or safety would be consistent with" the burden of proof under section 57(1) of FIPPA.

[30] The Ministry argues that DRIPA "has not created a duty on government to support new statutory interpretations or take a retrospectively revised view on the intent of the Legislature", adding that DRIPA also did not alter the *Interpretation Act* or interpretive rules set out in the case law.[39]

[31] In reply, the complainants argue that, where the issue under 25(1)(a) is the Ministry's duties to Indigenous peoples as an affected group of people, "the subject matter of the FIPPA provision overlaps with the subject matter of

[34] Complainants' initial submission, paragraph 40.
[35] Complainants' initial submission, paragraph 39.
[36] Complainants' initial submission, paragraph 42.
[37] Complainants' initial submission, paragraph 42.
[38] Complainants' initial submission, paragraph 42.
[39] Ministry's submission, paragraph 101.

DRIPA".[40] They submit that this requires section 25(1)(a) to be interpreted as a component of a larger statutory scheme, by applying the principle of interpretation that, as the Supreme Court of Canada said in *Bell ExpressVu Limited Partnership v. Rex*, "presumes a harmony, coherence and consistency between statutes dealing with the same subject matter".[41]

[32] I do not agree that DRIPA and FIPPA are components of a larger statutory scheme as contemplated by *BellExpressVu* or the other authorities cited by the complainants. They are not a statutory scheme composed of statutes dealing with the same subject matter.

[33] Nor does FIPPA's language empower me to accept the complainant's position, which would also set a course different from that taken in previous section 25(1) decisions. It would, without statutory foundation in FIPPA, place an evidentiary burden on public bodies to rebut an Indigenous government's assessment about a risk of harm, i.e., to require public bodies to "prove that the factors…that warrant disclosure of information have not been met." Even if I assume for discussion purposes that DRIPA requires me to interpret FIPPA in line with UNDRIP, I do not see how rights to self-government, or Indigenous rights more broadly conceived, would permit me to read into section 25(1)(a) a duty on public bodies to disprove an Indigenous government's assessment of risk or assessment of what information the public body must disclose to fulfil its duty.

[34] If the Legislature were to conclude, through legislative review and renewal processes established under DRIPA, that such an evidentiary burden should exist, it could amend FIPPA to expressly create it.[42] I acknowledge the complainants' point about rights to self-government, and Indigenous rights more generally, and take these matters very seriously, but I cannot read words into FIPPA that create a positive burden on a public body – the Ministry in this case – to disprove what the complainants have said.

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[40] Complainants' reply submission, paragraph 64

[41] *Bell ExpressVu Limited Partnership v. Rex*, 2002 SCC 42 (CanLII), [2002] 2 SCR 559 [*Bell ExpressVu*], at paragraph 27.

[42] The complainants' argument is also not supported by section 57(1) of FIPPA, which they cite. It allocates the burden of proof in inquiries, under Part 5, about a public body's decision to refuse access to records. As noted above, *Office of the Premier* (above, note 8) and other decisions have made it clear that FIPPA does not allocate a burden for section 25(1) matters. While the complainants raised this issue in their September 14, 2020 complaint, which they have adopted in this process, I note they took no issue with the hearing notice's explicit statement about this: "FIPPA does not allocate the burden of proof respecting section 25(1)(a) to either the Ministry or the complainants. As this Office has held before, as a matter of common sense, both the complainants and the Ministry have a practical incentive to provide such evidence as they consider appropriate to support their position in this matter."

Ministry's arguments about statutory interpretation

[35] The Ministry's arguments about the interpretation of section 25(1)(a) are also unpersuasive. It argues that the PHA "establishes a complete code for the management of communicable disease…including the disclosure of information about communicable disease in the public interest."[43] The Ministry contends that section 53(a) of the PHA "explicitly overrides the application of FIPPA in respect of the collection, use or disclosure of personal information."[44] It says that the "decision to disclose information relating to managing the risk of transmission of COVID-19 is ultimately at the discretion of the PHO – she is given the authority, in her role as the senior public health official for the Province, to determine whether disclosure is in the public interest."[45] The Ministry concludes that:

> In light of the commonality of purpose of section 25 of FIPPA and section 66(2) of the PHA it would only be in the unlikely event that there was a disagreement between the minister and the PHO about the existence of, or response to, a health risk to the public or a group of people that a duty to disclose on the part of the minister could arise under section 25. In the current situation, there is no evidence whatsoever of such a disagreement or of any failing on the part of the PHO to fulfil her responsibilities under the PHA.[46]

[36] This suggests that the duty to disclose under section 25(1)(a) arises only where the Minister and the PHO are at loggerheads about a risk, the disclosure of which, the Minister believes, needs to be made. There is no statutory basis for this view.

[37] Nor is the PHA, as the Ministry argues, a "complete code" for the disclosure of information about communicable disease to the public or a group of people. That assertion fails to address section 79 of FIPPA, which reads as follows:

> If a provision of this Act is inconsistent 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, applies despite this Act.

[38] While the Ministry rightly notes that section 53(a) of the PHA contains an explicit FIPPA override, the override is limited in scope and does not affect this

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[43] Ministry's submission, paragraph 78.
[44] Ministry's submission, paragraph 91. The express mention of FIPPA in section 53(a) means that, if there were a conflict or inconsistency, Part 5 of the PHA would prevail, as contemplated by section 79 of FIPPA.
[45] Ministry's submission, paragraph 98.
[46] Ministry's submission, paragraph 99.

case. Section 53(a) states that, during an emergency, Part 5 of the PHA applies despite any provision of the PHA or any other enactment, including "in respect of the collection, use or disclosure of personal information, the *Freedom of Information and Protection of Privacy Act* and the *Personal Information Protection Act*...to the extent there is any inconsistency or conflict with the provision or other enactment" (my underlining).

[39] As noted by my emphasis, this PHA override clearly relates only to personal information, it enables only the provisions of Part 5 of the PHA to override FIPPA, and it does so only in the case of inconsistency or conflict between a Part 5 provision and FIPPA. The only Part 5 provision that relates to, using the words of section 53(a), the "collection, use or disclosure of personal information" is section 54(1)(k). It states that a health officer acting under the PHA "may, in an emergency… collect, use or disclose information, including personal information… that could not otherwise be collected, used or disclosed, or... in a form or manner other than the form or manner required."

[40] This is an empowering provision giving health officers discretionary authority, in an emergency, to collect, use or disclose personal information where they could not otherwise do so. Compliance with the mandatory section 25(1)(a) duty on the head of a public body to disclose information about a risk of significant harm would not entail a conflict or inconsistency with section 54(1)(k).[47] There is, in other words, no conflict or inconsistency between the two, in the sense that compliance with section 54(1)(k) compels what FIPPA forbids, or the other way around. The narrow override in section 53(a) of the PHA does not support the Ministry's "complete code" submission.[48]

[41] I also reject the Ministry's contention that "[a]ny compulsory disclosure under s. 25(1)(a) would have to be consistent with the purposes of FIPPA".[49] The Ministry notes that section 2(1) states that the purposes of FIPPA "are to make public bodies more accountable to the public and to protect personal privacy". It says that the disclosure duty "must be understood in the context of the overarching purposes of the act, which are to hold public bodies to account, and to protect personal privacy."[50] It adds that disclosure of the information in issue here "in a manner that is consistent with the purposes of FIPPA requires an

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[47] On the issue of when there is a "conflict" between statutes, the complainants cite *Saskatchewan (Attorney General) v. Lemare Lake Logging Ltd.*, 2015 SCC 53 (CanLII), [2015] 3 SCR 419, and *Friends of the Oldman River Society v. Canada (Minister of Transport)*, [1992] 1 S.C.R. 3. I also note that Commissioner Loukidelis expressed the same view as I have about what "inconsistency" or "conflict" entail in *Vancouver (City), Re*, 2004 CanLII 34255 (BC IPC).

[48] I have reached the same conclusion about the *Reporting Information Affecting Public Health Regulation*, B.C. Reg. 167/2018, which gives certain public health officials discretionary authority to disclose information, including "personal information".

[49] Ministry's submission, paragraph 72.

[50] Ministry's submission, paragraph 73.

approach that is coordinated with the public health systems in place to control communicable diseases such as COVID-19."[51] Last, the Ministry suggests that "the public interest purposes contemplated in s. 25 and in the overall purposes of FIPPA are addressed by the public health system in responding to COVID-19 under the PHA."[52]

[42] As already stated, the usual rule of statutory interpretation requires me to interpret legislative language "harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament". The Ministry's argument that disclosure under section 25(1)(a) would have to be consistent with the accountability goal of FIPPA would require me to ignore the plain language of section 25(1)(a), which explicitly focuses on risks of significant harm to people's health or safety, or to the environment, not public body accountability. The Ministry's argument would elevate a statement of statutory purpose to a substantive limitation on the clear meaning of section 25(1)(a). Even if one assumes for discussion purposes that section 2(1) exhaustively states FIPPA's purposes, I decline to ignore the "grammatical and ordinary sense" of the actual words of section 25(1)(a), as doing so would result in the duty to disclose arising only where disclosure of information would be "consistent with" making a public body "accountable to the public" or "consistent with" protecting personal privacy.[53]

Applicable principles under section 25(1)(a)

[43] Section 25(1)(a) is triggered only when several factors are present. The information must be about a risk of harm, the harm must be significant, and the harm must be to the environment or to the health or safety of the public or a group of people. Taken together, these elements of section 25(1)(a) indicate the Legislature has set a high threshold, one that is intended to apply only in serious situations, where there is an element of urgency.[54] If these criteria are met, a public body must, "without delay", disclose information about the risk of significant harm.

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[51] Ministry's submission, paragraph 74.
[52] Ministry's submission, paragraph 75.
[53] In any case, I note in passing that a duty to disclose information about a risk of significant harm may well be "consistent with" making public bodies more accountable to the public. The duty may require a public body to disclose information that also reveals a failure to have prevented or mitigated that risk, or at least raises questions that lead to further inquiry or investigation.
[54] The fact that section 25(2) provides that section 25(1) overrides any of the protections otherwise available under Part 2 of FIPPA reinforces the interpretation that section 25(1) applies only in serious situations. This has been accepted in numerous decisions of this Office. See, for example, Investigation Report F16-02, *Clearly in the Public Interest: The Disclosure of Information Related to Water Quality in Spallumcheen*, 2016 BCIPC 36 (CanLII) [*Spallumcheen*], at page 22, and *Ministry of Forests, Lands and Natural Resource Operations (Re)*, 2015 BCIPC 29 (CanLII) [*Ministry of Forests*], at paragraph 29.

Does a "risk of significant harm" to the public or an affected group of people exist?

[44] There is no doubt that, in the present circumstances, a "risk of significant harm" to the public or a group of people exists.

[45] The classes of harm under section 25(1)(a) include a risk from disease. As the Supreme Court of British Columbia observed in interpreting section 25(1)(a), "[s]ignificant risks of disease, pestilence, and contamination obviously would justify disclosure of personal information under s. 25(1)(a)."[55] Neither of the parties in this case have denied that risks from a disease such as COVID-19 qualify as a type of "harm" for present purposes.

[46] It is not disputed that the risk of harm from COVID-19 is a risk of "significant" harm within the meaning of section 25(1)(a). The Ministry acknowledges that the "PHO determined that the emergence of COVID-19 poses an immediate and significant risk to public health throughout a region or the Province".[56] The Ministry's submission also refers to there being a risk of "significant" harm, "within the Complainants' communities", of "human-to-human transmission of the coronavirus SARS-CoV-2 that causes the illness known as COVID-19".[57]

[47] Further, earlier this year the Minister of Public Safety and Solicitor General declared a state of emergency under the *Emergency Program Act*, and the preamble to his order states that "the COVID-19 pandemic poses a significant threat to the health, safety and welfare of the residents of British Columbia, and threatens to disproportionately impact the most vulnerable segments of society."[58]

[48] It also is clear that the virus that causes COVID-19 spreads through airborne respiratory droplets and surface contamination.[59] The spread and seriousness of the virus are attested to by the fact that, as of December 11,

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[55] *Clubb v. Saanich (Corporation of The District)*, 1996 CanLII 8417, at paragraph 30.
[56] Ministry's submission, paragraph 92, supported by paragraph 7 of, and Exhibit "A" to, the Henry affidavit. Exhibit "A" is a copy of the PHO's March 17, 2020 declaration of a regional event under the PHA, effectively declaring a public health emergency.
[57] Ministry's submission, paragraph 64.
[58] Ministerial Order M073, March 18, 2020: https://www.bclaws.ca/civix/document/id/mo/mo/m0073_2020 (accessed December 14, 2020).
[59] The complaint cites World Health Organization sources to this effect. Complainants' submission at paragraphs 59 and 60.

2020, at least 40,797 cases of COVID-19 had been identified across British Columbia, with at least 598 deaths related to the illness.[60]

[49] This significant risk is undoubtedly ongoing, as the materials before me affirm. I mention this because section 25(1)(a) applies to information about risks of future harm, not information about past harm, but this case is not about a past risk of harm.[61] To the contrary, the COVID-19 public health emergency continues as of writing. There is an ongoing "risk of significant harm" from COVID-19 as it develops and shifts in various ways throughout the province, affecting the public generally and affecting groups of people, including people within the complainants' communities. My finding of an ongoing risk of significant harm encompasses a conclusion that the imminence, or temporal urgency, required for section 25(1)(a) to be triggered exists in this case, and that the high threshold that applies, the seriousness that is required, are present. These requirements have been mentioned in numerous decisions of this Office, and I find they are satisfied here.[62]

Must the Ministry disclose information "about" the risk?

[50] The next question concerns what the term "about" means in section 25, because this determines what information must be disclosed to meet the section 25(1)(a) duty.

[51] The meaning of the term was discussed in *Office of the Premier*, where an individual requested briefing notes, emails and the like related to restrictions on smoking in food and beverage establishments. The premier's office severed some information under section 12(1) (Cabinet confidences) and section 13(1) (advice or recommendations), and the applicant contended that section 25(1)(a) and section 25(1)(b) each required disclosure despite those and other access exceptions.[63]

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[60] These figures, of which I take notice, are from the BCCDC's "COVID-19 Dashboard": https://experience.arcgis.com/experience/a6f23959a8b14bfa989e3cda29297ded (accessed December 12, 2020). I refer below to this BCCDC information source as the "COVID-19 Dashboard".

[61] *Ministry of Forests*, at paragraphs 30 and 31.

[62] My finding of an ongoing risk of significant harm encompasses a conclusion that the imminence, or temporal urgency, required for section 25(1)(a) to be triggered exists in this case, and that the high threshold that applies, the seriousness that is required, are present. These requirements have been mentioned in numerous decisions of this Office, and I find they are satisfied here. See, for example, *Mount Polley Mine Tailings Pond Failure (Re)*, 2015 BCIPC 30 (CanLII) [*Mount Polley*], *Spallumcheen*, note 8 above, and *Ministry of Forests*, note 53 above. On the issue of temporal urgency, I note in passing that, in footnote 40 of *Mount Polley*, Commissioner Denham said she could not "dismiss the possibility that there may be cases where temporality is not present, but there is nevertheless risk of significant harm."

[63] *Office of the Premier*. Various other exceptions were applied or withdrawn at various stages by the public bodies in that case but that is not relevant here.

[52] The applicant in that case argued that the word "about" in section 25(1)(a) should be interpreted to mean "on the subject of" or "concerning" the matter, such that a public body must disclose "all relevant information concerning that risk in order to hold the public body accountable" and in order to achieve "a degree of disclosure sufficient to enable recipients of the disclosed information to have as full an understanding of the risk as the public bodies."[64] Commissioner Loukidelis disagreed, noting that such a broad interpretation could conceivably capture any information that is in any way connected with a risk, however remote that connection might be.[65] He then said this:

> It is not a good idea to attempt to lay down any firm and fast rules for what information will be "about" a risk identified in s. 25(1)(a) and I will certainly not try to do so here. The circumstances of each case will necessarily drive the determination, but information "about" a risk of significant harm to the environment or to the health or safety of the public or a group of people may include, but will not necessarily be limited to:
>
> - information that discloses the existence of the risk,
> - information that describes the nature of the risk and the nature and extent of any harm that is anticipated if the risk comes to fruition and harm is caused,
> - information that allows the public to take or understand action necessary or possible to meet the risk or mitigate or avoid harm.[66]

[53] Commissioner Loukidelis concluded that section 25(1)(a) did not require disclosure in the circumstances. The information at issue, he stated, did not "in any immediate sense disclose the existence of risks, describe their nature, describe the extent of anticipated harm, or allow the public to take or understand action necessary or possible to prevent or mitigate risks."[67] Rather, it related to

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[64] *Office of the Premier*, note 8 above, paragraph 54.
[65] *Office of the Premier*, note 8 above, paragraph 55.
[66] *Office of the Premier*, note 8 above, paragraph 56. Commissioner Denham agreed with this statement in *Spallumcheen*, note 53 above, at page 23. Many other investigation reports and decisions of this Office have agreed with this statement: for a recent example, see *Metro Vancouver Regional District (Re)*, 2019 BCIPC 55 (CanLII), at paragraph 11. I will also note here that, in *Office of the Premier*, Commissioner Loukidelis was clearly of the view that section 25(1)(a) requires, as it states, disclosure of "information", not necessarily records. This view was affirmed by Commissioner Denham in *Spallumcheen*, note 53 above, at page 22, where she noted that a public body "must disclose information under s. 25 as soon as practicable and without regard as to how to package, explain, or characterize the information". She also clearly considered that disclosure of a record may suffice, but it will not always be the case that a record must be disclosed, i.e., there may be cases where a public body could conceivably meet its section 25(1)(a) duty by disclosing an accurate summary of information contained in one or more records.
[67] *Office of the Premier*, note 8 above, paragraph 62.

"policy, political or legal aspects of the government's decision to delay implementation of the WCB's environmental tobacco smoke regulation."[68]

[54] It should also be noted that in some cases a public body will be required to disclose part, or all, of the information specified by an applicant or complainant. In others, the duty will be satisfied by disclosing information that is "about" the risk although it is not the exact information identified by the applicant or complainant. This is because the head of a public body's duty to determine necessary disclosures must not be fettered by someone else's view on what information is "about" the risk.

[55] Citing *Office of the Premier*,[69] the complainants emphasize that section 25(1)(a) contemplates disclosure of information that allows the public to take or understand action necessary or possible to meet the risk or mitigate or avoid harm.[70] They argue that information is about a risk "if it is actionable information that would allow the public or a group of people to safeguard itself, independent of the acts of government."[71] They add that the information they seek about proximate cases is important to them because it would "allow them to decide whether COVID occurrences in a particular proximate community are low enough (based on an absence of information) to warrant their allowing different levels of trade, travel, and safeguards."[72]

[56] They explain the links each of their communities has with proximate communities. They say people travel between those communities for a range of reasons, such as for work or for social reasons (such as funerals), to buy goods or obtain services (including medical services), or trade in harvested fish.[73] They also note that tourists may enter their communities and they cite challenges some Indigenous communities have experienced with those who visit even though the community is closed to visitors.[74] With these considerations in mind, the complainants say this:

> Knowledge of a significant number of COVID cases in proximate communities would allow the Nations to assess risks relating to their continuing to allow members to travel to (or through) proximate communities; to allow travellers from proximate communities; or use

[68] *Office of the Premier*, note 8 above, paragraph 62.
[69] *Office of the Premier*, note 8 above.
[70] Complaint, paragraph 51.
[71] Complaint, paragraph 52.
[72] Complaint, paragraph 54.
[73] Complaint, paragraph 91.
[74] Complaint, paragraphs 91, 93 and 94.

particular kinds of common carriers (e.g., ferries or planes) connected to particular communities.[75]

[57] The complainants submit "they cannot effectively govern without knowing about proximate COVID cases, so that they may tailor measures to address specific risks".[76] They argue that, in order to manage the risks posed by infections in Indigenous communities, they need information about proximate cases so they can make better decisions about the following:

- if curfews are necessary;
- if stay-at-home orders are necessary;
- if elders and others with medical issues must isolate, and the community must provide essential services to them (e.g., food, medication, and other necessities);
- if prohibitions on travel through their territories or their reserves are necessary (e.g., prohibiting the entry of vessels or passengers from ferries);
- if prohibitions on local businesses which attract tourists are necessary (e.g., vacation businesses including fishing or hunting lodges);
- if testing or contact tracing should be conducted (and in the case of First Nations, culturally-safe contact tracing that will need to be conducted where there are presumptive or confirmed cases to ensure accessibility to and responsiveness by community members);
- if families need separate lodgings while isolating (given their possible contact with a member who has recently travelled in an affected community, or who is infected); and
- if requests from other nearby communities for the sharing of resources (food, fuel, and pharmaceuticals) can be met and how (as this is a common request for rural communities).[77]

[58] The complainants also argue that the Ministry's failure to disclose information to them undermines their rights, as Indigenous peoples, to self-government in matters relating to their internal and local affairs, including the "right to be actively involved in developing, determining, and administering through their own institutions, health programs that affect them".[78]

[75] Complaint, paragraph 95.
[76] Complaint, paragraph 103.
[77] Complaint, paragraph 102.
[78] Ibid, paragraph 104.

[59] The complainants argue that In Plain Sight, the report by Mary Ellen Turpel-Lafond (Aki-Kwe) to which I referred earlier,[79] supports their section 25(1)(a) case. They say it is "pertinent because it makes findings about the impact of the Ministry's current policy of withholding information about proximate COVID cases from Indigenous governments", and also "provides valuable guidance about the nature and role of rights recognized under UNDRIP and DRIPA."[80]

[60] They note that the terms of reference for In Plain Sight included making findings of fact about Indigenous-specific systemic racism in B.C.'s health care system, and contend that the report "effectively finds the Ministry's current policy of withholding information about proximate COVID cases from Indigenous governments contributes to systemic barriers to the health system upholding minimum standards for the survival, dignity and well-being of Indigenous peoples, including their right of self-determination."[81] They contend that the "findings and conclusions of the Independent Reviewer in the Report are factors the Commissioner may and should consider when interpreting and applying FIPPA s. 25(1)(a)."[82]

[61] Consistent with my own earlier acknowledgement of the disproportionate impact of COVID-19 on Indigenous people and their communities, In Plain Sight says this:

> The disproportionate impacts of the twin public health emergencies on the health and wellness of Indigenous peoples – including physical disease, mental health and death – are evident. Yet, Indigenous governments are not recognized as full partners in the response, and proper data sharing, information systems and system governance does not promote routine collaborative work with Indigenous peoples' governments and representatives. While it is evident that Indigenous health leaders and political leaders can provide for the unique and pressing needs of their citizens, whether the system does more than hear them out, is a major concern. Urgent action is required given that these public health emergencies are currently worsening and are part of our reality for the foreseeable future. [83]

[62] In Plain Sight further records observations about existing legislative and policy frameworks not properly recognizing the roles and authorities of

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[79] Note 10 above.
[80] Complainants' December 10, 2020 submission, page 2.
[81] Complainants' December 10, 2020 submission, page 3.
[82] Complainants' December 10, 2020 submission, page 3.
[83] Report, note 10 above, at page 81.

Indigenous governments, which are said to lead to jurisdictional confusion among governments and, in health emergencies, creation of "systemic barriers to Indigenous governments in protecting the health and safety of their citizens".[84]

[63] The report describes, as "reported by key informants", the "lack of timely and complete data sharing" about COVID-19 cases. It also mentions informants' reports of "dissatisfaction and lack of clarity about the process by which critical information is disseminated (or not) to impacted communities."[85] It says there is reported frustration that information is mostly held and acted on by regional health authorities and the FNHA, not Indigenous governments, and says that, although there have been ongoing discussions and problem-solving efforts, no systemic solution has been identified.[86] I acknowledge that the investigator gathered these observations.

[64] The complainants submit that In Plain Sight "effectively finds the Ministry's current policy of withholding information about proximate COVID cases from Indigenous governments contributes to systemic barriers to the health system upholding minimum standards for the survival, dignity and well-being of Indigenous peoples, including their right of self-determination."[87] The report does not discuss, or make any finding about, any Ministry policy of withholding information "about proximate COVID cases from Indigenous governments". It records, as just outlined, an informants' observations to the investigator about information sharing. It also includes the investigator's views about the need for reform on, among other matters, information sharing. Neither bears on the issue at hand, which is whether section 25(1)(a) imposes a duty on the Ministry to disclose information about the risks presented by COVID-19.

[65] For its part, the Ministry acknowledges that the parties "share a common interest in protecting the health of the members of the communities represented by the Complainants, particularly in respect of limiting the transmission of COVID-19."[88] It refers to ongoing discussions with the complainants and other First Nations governments and organizations about a variety of COVID-19-related matters. These discussions have included dialogue with the complainants about what the Ministry says are the "limits of information about 'proximate Cases' in managing the risk of COVID-19 and the limited information that is currently collected respecting travel of Cases."[89] On this point, the Ministry stated that the intention of the PHO:

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[84] Report, note 10 above, at page 86.
[85] Report, note 10 above, at page 86.
[86] Report, note 10 above, at pages 86-87.
[87] Complainants' December 10, 2020 submission, page 3.
[88] Ministry's submission, paragraph 8.
[89] Ministry's submission, paragraph 16.

> …is to remain committed to continue to work with the Complainants in the spirit of cooperation and mutual respect to provide them with information that will enhance the protection of First Nations communities from COVID-19. The PHO specifically offered to share information about proximate cases with the complainants subject to conditions including to protect the confidentiality of individuals.[90]

[66] Regarding the complainants' request for the "location" of "proximate" cases, the Ministry says this information "is not currently available in the database used by" BCCDC, though BCCDC "has the capacity to enable that data to be produced."[91] I infer this means that the BCCDC database contains information that could be processed to create location data, as opposed to there being no data about specific case locations.[92]

[67] The Ministry says that disclosure of the location of proximate cases "raises a risk of revealing the identity of the Case", creating the "potential to compromise patient confidentiality", which "would be detrimental to the purpose of limiting the transmission of the virus."[93] It argues that information about the location of cases, "particularly in small communities, could reasonably be expected to expose the identity of a Case through the mosaic effect if the information is disclosed within a time interval that could allow the identification of specific individuals."[94] The Ministry says that, for this reason, "any disclosure of proximity information will have to be subject to an information sharing agreement that protects the personal information of Cases."[95]

[68] The Ministry also cites the PHA's confidentiality requirements, arguing that the "protection of personal information is integral to the broad powers for mandatory reporting of infection" under the PHA.[96] It says what matters is the

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[90] Ibid, paragraph 17, and paragraph 188 of the Henry affidavit. In the light of this and other indications in the submissions that discussions were ongoing, on October 15, 2020 I wrote to the parties, giving them until November 25, 2020 to advise whether they had resolved the issues at hand. They did not manage to do so.

[91] Ibid, paragraph 21. At paragraph 22, the Ministry, supported by the Henry affidavit, refers to there being "no mechanized way to flag Cases who reside in the specified ["proximate"] areas, and all cases are reported daily at the level of" the regional health authorities, but "ways in which this information may be obtained, and pathways for sharing that information with appropriate privacy protections in place" are being explored.

[92] This inference is supported by other aspects of the Ministry's evidence and argument, including the statement, at paragraph 23 of its submission, that "data on proximity is not normally produced in relation to specific communities", particularly "small communities", because it could reasonably be expected to expose the identity of individuals "through the mosaic effect if the information is disclosed within a time interval that could allow the identification of specific individuals."

[93] Ministry's submission, paragraph 67.

[94] Ibid, paragraph 23.

[95] *Ibid*, paragraph 67.

[96] Ibid, paragraphs 82-83.

PHO's decision to disclose information, and that disclosing the information at issue "outside of the coordinated and collaborative practices established under the *Public Health Act* can reasonably be expected to be detrimental to the goal of limiting the transmission of COVID-19 in the province generally and specifically in the Complainants' communities."[97]

[69] The complainants reply that the Ministry has not established that identifying the community where an infected individual is located could disclose the individual's identity. In general, they argue it is mere speculation that the mosaic effect, referenced by the Ministry, could be realistically used to identify individuals.[98]

[70] Because I have decided, as explained below, that section 25(1)(a) does not require the Ministry to disclose further information, it is not necessary to address the Ministry argument that individuals could be identified if case locations were revealed.[99]

[71] Before dealing with the question of whether the Ministry is duty-bound to disclose information in the circumstances of this case, it is useful to consider whether section 25(1)(a) requires a public body to disclose information that it has previously released, or that is otherwise already publicly available, "about" the risk and thus is already known to the public. Put another way, must a public body in the Ministry's position disclose information "about" a risk even if information that meets the requirements of section 25(1)(a) "about" that risk is already available?

[72] In my view, the Legislature did not intend to require a public body to disclose information about a risk where the information has already been disclosed by the public body or by other public bodies and that other information satisfies the duty under section 25(1)(a).

[73] This point was addressed in *Spallumcheen*,[100] where an access applicant argued that the section required the Ministry of Environment to release

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[97] *Ibid* at paragraph 103. I also note that the PHO deposed, at paragraph 112 of her affidavit, that she is "mindful that public reporting of Cases at too great a level of detail (for example, by community name) could leave members of the public to believe that in the absence of an identified case and that community public health measures could be relaxed" and "given the mobility of BC residents, relaxation of public health measures in a specific community could lead to an increase in transmission of COVID-19 in BC as it only takes one individual to transmit the virus."

[98] The mosaic effect has been described as referring "to circumstances where the disputed information, if disclosed, can be linked with other available sources of information to yield additional meaningful information". In the present case, that would mean to reveal someone's identity: Order F19-13, *Vancouver (City) (Re)*, 2019 BCIPC 15 (CanLII), paragraph 17.

[99] Nor is it necessary to decide here whether FIPPA authorizes or requires the Ministry to refuse to disclose case location because doing so would permit individuals to be identified.

[100] Note 53 above.

information disclosing health risks to residents who consumed water that had unsafe nitrate levels. The local waterworks, a public body under FIPPA, had already issued a water quality advisory, a newsletter and a mailout, and the issue had been discussed at its annual general meeting. The local health authority had also issued an advisory.

[74] These disclosures warned residents that their drinking water exceeded safe nitrate levels, and advised that pregnant women, babies under six months of age, the elderly, and individuals with weakened immune systems, or chronic heart, lung and blood conditions should use an alternative source of water until nitrate levels decreased to safe levels. The health authority advisory had also provided internet addresses that linked to more information about the health risks associated with high nitrate levels in drinking water.

[75] Commissioner Denham concluded that these disclosures "would inform the public about the existence of that risk, the nature and extent of the risk, and would allow the public to take action necessary to mitigate that risk or to avoid harm", and "the disclosure of that information meets the threshold for disclosure pursuant to s. 25(1)(a)".[101] She went on to say the following:

> The Ministry, the Health Authority, and the Waterworks are all public bodies under FIPPA and each have the same obligation under s. 25 to disclose information about a risk of significant harm. In a situation such as this where multiple public bodies have essentially the same information about a health risk, the obligation to disclose that information need only be discharged by one of the public bodies.[102]

[76] She went on to conclude that there was no requirement that the Ministry also inform the public of the risk, since the requirement under s. 25(1)(a) of FIPPA to notify the public had already been met by the public notification undertaken by the Waterworks and the Interior Health Authority.[103]

[77] I agree with this view of section 25(1)(a). The Legislature did not intend to require mechanical, *pro forma* or repetitive disclosures of information where information "about" a risk that meets the duty is already publicly available. Of course, any public body that believes its section 25(1)(a) duty may already have been satisfied in this way must carefully assess whether that is so.

[78] It should also be noted that merely stating that a risk exists may not be enough for a public body to discharge its section 25 duties. As *Office of the Premier* illustrates, section 25(1)(a) may require more from a public body even

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[101] *Spallumcheen*, note 53 above, at page 25.
[102] *Spallumcheen*, note 53 above, at page 25.
[103] *Spallumcheen*, note 53 above, at page 26.

though the fact that a risk exists is publicly known. It may require the public body to disclose information that describes the nature and extent of any harm that is anticipated if the risk comes about. It may also require the public body to disclose information that allows the public to understand what action may be necessary or possible to meet the risk or mitigate or avoid harm. If the information already available merely reveals that the risk exists and the public body decides not to disclose further information about the harm that may flow from the risk's realization, or how to avoid or mitigate harm, the public body could, in the right circumstances, find itself in breach of section 25(1)(a).

[79] This is not the case here because I have concluded that information already available to the complainants and the public satisfies the section 25(1)(a) disclosure duty. I will now explain why.

[80] The complainants referred in their complaint to the "publicly-available British Columbia COVID-19 Dashboard".[104] That resource, which appears to be updated daily, contains the following information:

- Daily number of new cases provincially,
- Total cases reported by each regional health authority,
- New cases reported by each regional health authority,
- Active cases reported by each regional health authority,
- For each regional health authority, the number of laboratory diagnosed cases and the number of epi-linked cases,
- For each regional health authority, the number of individuals currently hospitalized and the number currently admitted to ICU,
- Distribution of infections by age and by sex.

[81] The Ministry's evidence, through the Henry affidavit, disclosed that, through the BCCDC's website, maps are available showing the geographic distribution of COVID-19 cases by health service delivery area of case residence.[105] This information is updated and made available weekly.[106] It discloses case rates per 100,000 of population by health service delivery area, not actual cases. I noted, as an example, the map of geographic distribution, by health service delivery area, of COVID-19 cases reported November 6-19, 2020,

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[104] The Henry affidavit also links to this resource, at paragraph 106(a). As indicated earlier, at note 60, I accessed the dashboard on December 14, 2020. I also note that Exhibit "J" to the Henry affidavit is a copy of a chart of the "Geographic Distribution of COVID-19 by Health Service Delivery Area of Case Residence". Exhibit "G" to that affidavit is a chart of the "Geographic Distribution of COVID-19 by Local Health Area of Case Residence".
[105] This information source is attested to at paragraph 106(b) of the Henry affidavit.
[106] Henry affidavit, paragraph 106(b).

showing case rates within each of the three health service delivery areas on Vancouver Island.[107] The same map had an insert for the Greater Vancouver area, showing case numbers for Vancouver, Richmond, Fraser South, Fraser North and North Shore-Coast Garibaldi, which are local health areas within the health service delivery areas. In addition, the BCCDC has published a map showing the case rates by population by local health area during January to October 2020. This information is updated monthly.[108] In its December 10, 2020 submission, the Ministry advised that, with the guidance of the Public Health Leadership Committee, it has been decided that more frequent and more granular case information is to be published.

[82] First, the number of actual COVID-19 cases within the past seven days will be updated weekly on the BCCDC website for each local health area: these have in the past only been published on a monthly basis.[109] Second, the daily average of the case rate per 100,000 people will be updated weekly for each local health area: in the past, this was published on the basis of the larger health service delivery areas.[110]

[83] The Ministry says that this practice will continue until it is decided "that this ongoing disclosure is no longer desirable for managing the pandemic."[111]

[84] The BCCDC also makes some information available about "exposure events", providing specific location information for certain school exposures and certain exposures at worksites, restaurants and bars, and transportation services. In each case, the notice names the facility or establishment, and in the case of facilities or establishments gives the street address and the date of the exposure. This information is made available, according to the Ministry, where not every contact of an infected person can be reached, suggesting that these disclosures are not made in every case of exposure.[112]

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[107] http://www.bccdc.ca/Health-Info-Site/PublishingImages/health-info/diseases-conditions/covid-19/case-counts-press-statements/covid19_hsda_cumulative_14days_20201119.png (accessed December 14, 2020).

[108] This source is described in the Henry affidavit, paragraph 106(c), and is found at: http://www.bccdc.ca/Health-Info-Site/PublishingImages/health-info/diseases-conditions/covid-19/case-counts-press-statements/covid19_lha_cumulative_20201031.png (accessed December 14, 2020). The Ministry says this information is provided monthly "to maintain confidentiality" because if this were reported daily at the local health area level "it may be possible to identify who a new Case is based on a person's activity or appearance in the community" (Henry affidavit, paragraph 107).

[109] Ministry's December 10, 2020 submission, page 3. (This applies to 86 local health areas, with three low-population local health areas being aggregated into one for disclosure purposes.)

[110] Ministry's December 10, 2020 submission, page 3.

[111] Ministry's December 10, 2020 submission, page 3.

[112] This source is described in the Henry affidavit, paragraph 106(e), and is found at: http://www.bccdc.ca/health-info/diseases-conditions/covid-19/public-exposures (accessed December 14, 2020).

[85] The PHO's office has conducted regular town halls, along with medical health officers and executives from the health authorities, to respond to questions from the public.[113] Further, the FNHA has also held regular town hall sessions to respond to public questions.[114]

[86] The FNHA publishes community situation reports, which link COVID-19 case data from the BCCDC with First Nations Client File data.[115] The FNHA's November 19, 2020 community situation report highlights changes from the previous situation report and provides details about First Nations community outbreaks as of November 16, 2020.[116] For example, it discloses that, as of November 16, 2020, there were "zero active cases in or near the Witset First Nation community", with "a total of 20 First Nation COVID-19 cases diagnosed in or near the Witset First Nation community" and "a number of cases outside of the community, totalling more than 40 cases." The same report discloses "First Nation COVID-19 active cases in Vancouver Centre North which contains the Downtown East Side."[117] I also note that this report discloses the number of "active First Nations COVID-19 cases residing in or near community", for the province as a whole.[118]

[87] More generally, the report discloses the total number of First Nations COVID-19 cases provincially as of November 16, 2020, breaking these down into lab diagnosed cases and epi-linked cases. It states the number of active First Nations COVID-19 cases in BC, while noting how many "were in or near community as of November 16, 2020. It breaks down the total case numbers by FNHA area. It also sets out the "cumulative percentage positivity" for First Nations cases, which was 3.46% as of November 16, 2020, and gives the positivity rates for each FNHA region.

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[113] Henry affidavit, paragraph 108.
[114] Henry affidavit, paragraph 109.
[115] Henry affidavit, paragraph 109.
[116] https://www.fnha.ca/Documents/FNHA-COVID-19-Public-Health-Response-Community-Situation-Report-November-20-2020.pdf (accessed December 14, 2020).
[117] The report also contains case information for the Skwah First Nation.
[118] Similarly, the August 7, 2020 community situation report gave First Nations-community-specific case information, stating that "24 confirmed cases have been recorded in Haida Gwaii, of these two new cases were confirmed as of Friday, August 7. Of these, five cases were considered active; no individuals were hospitalized or in ICU; 21 individuals have fully recovered; and 13 individuals are in isolation." https://www.fnha.ca/Documents/FNHA-COVID-19-Public-Health-Response-Community-Situation-Report-August-7-2020.pdf (accessed December 14, 2020). Another example of a community situation report, as of December 10, 2020, is found here: https://www.fnha.ca/Documents/FNHA-COVID-19-Public-Health-Response-Community-Situation-Report-December-10-2020.pdf (accessed December 14, 2020).

[88] In addition, the FNHA's November 19, 2020 community situation report discloses in some detail the FNHA's work with its partners, including the following:

- Maintaining communications and regular telephone updates with the Regional Health Authorities, Emergency Management of BC, Ministry of Health, First Nations Leadership Council, and Indigenous Services Canada.
- FNHA continues to work with its partners, and First Nations communities to identify needs and develop plans at both the provincial, and regional level for the Rural, Remote and Indigenous Framework.
- Continues to maintain essential services to support First Nations communities during this pandemic.
- Supporting First Nations communities in refreshing their Pandemic Plans, and provide COVID-19 resources for medical transportation, isolation and quarantine.
- "*First Nations Virtual Doctor of the Day*" is up and running in all five regions, which is to close this gap by providing virtual access of physicians to First Nations communities.
- The First Nations Virtual Substance Use and Psychiatry Service launched on August 25, 2020.
- Distributed guidelines for eligible COVID-19 items for BC First Nations Communities, including details on reimbursement specific to Community COVID-19 Public Health Check-points, on September 25, 2020. (See updated COVID-19 Community Support Guide in FNHA Resources section below).
- FNHA continues to maintain operations team availability to respond to isolation requests through the weekends during business hours.
- Site selection, training and deployment of Point of Care Testing for COVID-19 is underway.
- Supporting First Nations communities with the re-opening of their health centres.
- FNHA and First Nations Leadership calls on March 26, April 9, April 23, May 7, May 27 and June 4.
- FNHA and First Nations Health Directors calls on April 3, April 17, May 1, May 15 and May29.
- FNHA and First Nations Leadership and Health Directors calls on June 18, July 9, July 16, July 23, July 30, August 20 and September 17.[119]

[119] Similar information is found in other FNHA community situation reports, such as the August 7, 2020 report referred to above. The report also provides an extensive list of information resources, including guidance for individuals, about COVID-19 and the pandemic.

[89] The report also notes that the "FNHA has published an updated Communicable Disease Emergency Response (CDER) plan template – a living document that is user friendly, easy to follow and adaptable to each community's needs and strengths", and the report provides a link to that template. In addition, the report states that the "FNHA's Communicable Disease Emergency (CDE) team is available to support communities, including support updating/creating a Communicable Disease Emergency Response (CDER) plan, scenario/exercise discussions and full FNHA Response FNHA Resources".

[90] Further, I take notice of the information that the FNHA publishes about COVID-19 and the pandemic, under the headings Information for Community Leaders,[120] Information for BC First Nations Individuals, Resources for Health Professionals, and Latest News, all of which are available through the First Nations Health Authority's "COVID-19 (Novel Coronavirus)" page.[121]

[91] Another resource, available through the FNHA's website, is the COVID-19 Notice and Follow-up Process for a Confirmed Case in a First Nations Community.[122] This May 6, 2020 FNHA guideline states the following:

> Pathway for disclosure in the event of a positive laboratory COVID-19 case in a First Nations community.
>
> - The Medical Health Officer (MHO) of the Regional Health Authority (RHA) is informed of the positive test result directly by the provincial lab. The RHA MHO has the legal authority and responsibility for receiving Communicable Disease (CD) lab reports, making case determinations, and directing the appropriate CD management.
> - Concurrently, the MHO from the RHA will notify the FNHA's Chief Medical Officer (CMO) of the positive test result, or the positive case would be identified through the FNHA's First Nations COVID-19 surveillance data linkage. The client is informed of the positive test results by the CD nurse from the RHA, primary health care provider, CHN, or health care provider who ordered the COVID-19 test.
> - The RHA CD team will work directly with the First Nations community's nursing staff to support and provide CD follow-up for community member, in collaboration with the RHA and in accordance with staffing levels and capacity.

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[120] This includes the resources for COVID-19 response at the community level.

[121] That page is found here: https://www.fnha.ca/what-we-do/communicable-disease-control/coronavirus (accessed December 14, 2020).

[122] https://www.fnha.ca/Documents/FNHA-COVID-19-Pathway-for-Confirmed-Cases.pdf (accessed December 14, 2020). This resource is available through the November 16, 2020 community situation report outlined above.

- The FNHA CMO notifies the FNHA's Communicable Disease Control (CDC) team of the positive case. The FNHA CDC team may be engaged by the RHA CDC team. The FNHA CDC team collaborate and liaise within the FNHA and with RHA colleagues to support CD follow-up within communities as requested.
- The FNHA CMO will notify the Regional Executive Director (RED) and the RED will notify the Chief and the community health director to inform them of a positive case in their community, emphasizing that no names or personal information will be provided.
- The circle of care (regulated health care professionals) and circle of support (community leaders, health directors) have information only on a need-to-know basis and should not disclose personal information of a positive case.

Privacy and confidentiality of personal health information will be upheld within the circle of care. Personal information will not be disclosed by any employees or leaders without the express consent of the individual, unless the disclosure is permitted by law.

[92] A further resource for First Nations communities is the FNHA's Community COVID-19 Safety Planning Guide, which offers information on community readiness assessments, on developing a community safety action plan, and on conducting a community job hazard assessment.[123]

[93] Last, WorkSafeBC has been publishing health and safety information about COVID-19 in the workplace, including guidance so that various sectors—such as the tourism, community social services, forestry, retail small business, transit and transportation, accommodation, and childcare sectors—may operate safely.[124]

[94] As the above outline of information and resources already available to the complainants and their communities illustrates, the BCCDC, the Ministry, health authorities including the FNHA and other public bodies, have been publishing information that is available to Indigenous governments and communities, to assess risk and respond to it. This includes information about the location of COVID-19 cases, which is updated periodically. Further, the five regional health authorities publish exposure location information when not all potential contacts could be identified.

[123] https://www.fnha.ca/Documents/FNHA-Community-COVID-19-Safety-Planning-Guide.PDF (accessed December 14, 2020).
[124] Note 121 above, paragraphs 87 and 88.

[95] There is, accordingly, a great deal of publicly available information about the nature of the risk, including information about the infectiousness of the virus and how it is transmitted. The available information enables the public, at the government, community, public agency and individual levels, to understand what action is necessary to avoid or reduce the risk. For instance, the information includes a great deal of guidance on steps that governments, communities, public agencies and individuals can and should take to avoid or reduce the risk.

[96] In the light of the above, I conclude that the information that is already publicly available meets the section 25(1)(a) requirement for disclosure of information "about a risk of significant harm to the…health or safety of the public or a group of people", including the people who reside in the First Nations communities that the complainants represent. Section 25(1)(a) places no duty on the Ministry in this case to disclose information "about" that risk, since the section 25(1)(a) requirement has been met through other means.

CONCLUSION

[97] For the reasons given above, I find that section 25(1)(a) does not require the Ministry to disclose information, including the information that the complainants have specified, and conclude that no order is necessary under section 58(3)(a).

[98] Finally, and further to contextual observations made at the outset of this order, I observe in passing—and not as part of my decision—the following passage from In Plain Sight:

> …First Nations representatives clearly told the Review that they are concerned about barriers to information-sharing and public health and safety, and note that FNHA cannot make arrangements for data, inspection, or other similar matters on their behalf without some form of structured authorization from the Nation. The public health emergencies have magnified the structural problems and the need to ground the work more solidly for the future. The absence of a clear mandate, structure and arrangements has been a point of friction at a time when clear steps are needed.[125]

[125] Report, note 10 above, at pages 136-137.

[99] Whether Indigenous governments and public institutions, like the Ministry and the FNHA, fashion such governance mandates, structures, and arrangements are matters within their purview. It is, however, beyond the scope of my investigative and adjudicative duties and functions under FIPPA.

December 17, 2020

ORIGINAL SIGNED BY

Michael McEvoy
Information and Privacy Commissioner

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