OFFICE OF THE
INFORMATION & PRIVACY
COMMISSIONER
— for —
British Columbia

Order 03-41

VANCOUVER COASTAL HEALTH AUTHORITY

David Loukidelis, Information and Privacy Commissioner
December 9, 2003

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Summary: The VCHA is not authorized or required to withhold the entirety of some pages of records relating to incident reports by licensed residential community care facilities. The rest of the requested records contain personal information of residents that cannot reasonably be severed under s. 4(2). The VCHA may create a responsive non-identifying record under s. 6. The VCHA is not required to disclose information under s. 25(1).

Key Words: burden of proof – personal information – reasonably be severed – create a record – public interest disclosure.

Statutes Considered: *Freedom of Information and Protection of Privacy Act*, ss. 4(2), 6(2), 15(1), 22(1), 57(1) and (2).

Authorities Considered: B.C.: Order No. 83-1996, [1996] B.C.I.P.C.D. 9; Order No. 261-1998, [1998] B.C.I.P.C.D. 56; Order 01-20, [2001] B.C.I.P.C.D. No. 21; Order 02-38, [2002] B.C.I.P.C.D. No. 38; Order 03-16, [2003] B.C.I.P.C.D. No. 16; Order 03-28, [2003] B.C.I.P.C.D. No. 28. **Alta**: Order 96-019, [1997] A.I.P.C.D. No. 2.

Cases Considered: *Canada (Information Commissioner)* v. *Canada (Solicitor General)*, [1988] 3 F.C. 551 (T.D.).

1.0 INTRODUCTION

[1] This decision stems from a journalist's request to the North Shore Health Region, under the *Freedom of Information and Protection of Privacy Act* ("Act"), for access to records relating to incident reports from licensed community care facilities ("access request").

[2] The North Shore Health Region is now part of the Vancouver Coast Health Authority ("VCHA"), which is responsible for enforcing licensing requirements under the *Community Care Facilities Act* ("CCFA") and regulations. According to the VCHA, there are 231 adult and child residential facilities, including long term care facilities, in its area.

[3] Schedule 1 of the Act defines "personal information" to mean "recorded information about an identifiable individual". This inquiry concerns the issue of providing public access to information about incident reports at residential community care facilities without providing access to identifying information about the health and well-being of facility residents. This inquiry does not concern access by individuals – facility residents, facility workers or their representatives – to their own personal information.

[4] The applicant's access request was drawn from a summary of incident reports from November 1, 2000 to October 31, 2001 that the VCHA had previously provided to the applicant. The request pinpointed the following records in relation to 35 incident reports at 18 facilities, as shown in the summary:

> … full incident reports, confirmation investigation reports, recommendations and other records such as complaints or reports to or from third parties (such as neighbours, police and the coroner).

[5] The VCHA denied access to all of the requested records, in their entirety, citing s. 22(1) of the Act. The reason for its decision was framed as follows:

> After all the reports were pulled and as we started to process your request, we came to realize that all the homes involved have a maximum capacity of 10 people residing at one time. Due to the small number of people, we felt that even if we sever any identifying information, there is still a very high probability that the identities of the residents might be revealed, thereby violating their privacy.

[6] The applicant requested a review of the VCHA's response. She explained why in the following terms:

> …The summary of reports revealed the health authority had confirmed incidents of abuses ranging from medication errors and financial abuses, to sexual abuse, and in three cases death.
>
> The summaries showed the local health authority confirmed that nine out of nine residents at one group home had been victims of neglect, service delivery problems, financial abuse and medication errors. Since these incidents were provided in the form of summaries no explanation of the incidents was provided, nor was there any indication of follow-up procedures implemented to improve conditions and ensure safety of the residents.
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> The clients involved are all vulnerable individuals who are either minors, mentally impaired or both. There is no question that the quality of care which they receive is

> an issue of considerable public interest as it involves public health and safety of residents living in community care residential facilities.
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> After reviewing the summaries I requested full reports for incidents at 18 facilities. These reports are compiled by the local health authority which is charged with investigating reports of serious incidents filed on an essentially voluntary basis by the group homes. The incidents I chose to request either indicated endangerment of residents – sexual abuse, physical abuse, neglect, service delivery problems – or a disturbing pattern of inadequate care and supervision such as frequent reports of clients going missing or wandering.
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> …
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> I am shocked by this [the VCHA's] response. Not only do I disagree with this interpretation of the Act, but so does every other health authority in BC including the branch of the same Vancouver Coastal Health Authority which oversees community care licensing for Vancouver. It is in the process of providing exactly the same records which North Vancouver has denied. I have also already received full reports – with private information such as the names of the clients severed – from several other health authorities.
>
> I can't help but wonder whose privacy the North Vancouver public health officials are protecting, clients or its own investigating officers who are responsible for monitoring quality of care in licensed group homes to ensure the health and safety of residents?

[7] During mediation by this office, the VCHA told the applicant that it had also decided to apply s. 15(1) of the Act to the records. Because the matter did not settle in mediation, a written inquiry was held under Part 5 of the Act.

2.0 ISSUES

[8] The issues are as follows:

1. Can disclosure of information in the records reasonably be expected to identify residents?

2. Can personal information in the records reasonably be severed?

3. Can a responsive non-identifying record be created?

4. Must information be disclosed in the public interest under s. 25(1) of the Act?

[9] Section 57(1) provides that, at an inquiry into a decision to refuse an applicant access to all or part of a record, it is up to the head of the public body to prove that the applicant has no right of access to the record or part. Only if a record or a part to which access is refused contains personal information about a third party does the burden shift, under s. 57(2) of the Act, to the applicant to prove that disclosure of that information "would not be an unreasonable invasion of the third party's personal privacy". The

words just quoted are from s. 22(1) of the Act, which prohibits disclosure of personal information that would be an unreasonable invasion of third party personal privacy.

[10] It is up to a public body to establish whether information in requested records is personal information and whether excepted information can reasonably be severed under s. 4(2) of the Act, as part of its burden to prove that an applicant has no right of access to requested records.

[11] In this case, the burden rests with the VCHA to prove whether information in the requested records is personal information, whether it is excepted from disclosure under s. 15 and whether, if information is excepted from disclosure under s. 15 or s. 22, it can reasonably be severed under s. 4(2). The applicant's burden, under s. 57(2), is the burden of proving that disclosure of information the VCHA establishes is personal information would not be an unreasonable invasion of third-party personal privacy under s. 22.

[12] For s. 25 of the Act, I have applied the approach to burden of proof explained in Order 02-38, [2002] B.C.I.P.C.D. No. 38.

3.0 DISCUSSION

[13] **3.1 Similar Access Requests** – The applicant made similar access requests to other health regions that now form part of the VCHA. She also made similar access requests to the Vancouver Island Health Authority ("VIHA") and Fraser Health Authority ("FHA"), both of which participated in the inquiry as interveners. The VCHA and VIHA made their submissions through the same lawyer, while the FHA delivered its own submission.

[14] Like the VCHA, the VIHA provided the applicant with a facility-specific incident report summary. Unlike the VCHA, the VIHA responded to a further access request from the applicant by disclosing 347 pages of records from which it severed information under ss. 15 and 22 of the Act (para. 9, initial submission). The VIHA filed *in camera* copies of these records, with severing marked, in this inquiry.

[15] The FHA also provided the applicant with a facility-specific incident report summary – which related to 242 incident reports – then responded to a further access request from the applicant by disclosing 1,104 pages of records, from which it severed under s. 22, according to para. 3.0 of the FHA's submission,

> … all personal information …, any information specifically identifying the facility as well as the incident report number … so that the applicant could not match the specific incident to the specific facility and, due to the uniqueness of the incident or individuals involved, link the incident to a specific person.

[16] The FHA did not provide me with copies of these records.

[17] The VCHA agreed to treat the outcome in this case as governing its response "to the applicant's other requests to other health regions within its authority" (para. 6, initial

submission). The VIHA also agreed to follow the outcome of this case; it apparently would disclose further information from severed records the VIHA had already released to the applicant in response to her access request.

[18] **3.2 Description of the Requested Records** – The CCFA and its regulations establish the framework, overseen by the Ministry of Health Services, for the licensing and operation of child and adult community care facilities in British Columbia. Section 14 of the CCFA provides that the medical health officer ("MHO") appointed for each region under the *Health Act* must investigate every complaint of a violation of the CCFA or regulations, including a reported violation of any licence or permit. These investigative functions have, the VCHA says, been delegated within each health region (para. 13, initial submission).

[19] Section 10.6 of the CCFA regulations requires licence-holders to promptly notify, in a required form, the MHO and the licensing authority (the relevant health region) of any "reportable incident". The contact person and primary health care provider of the resident involved in the incident must also be notified.

[20] Schedule 1 of the CCFA regulations defines the term "reportable incident" with reference to 18 separately defined types of incidents: aggressive or unusual behaviour, attempted suicide, death, disease outbreak or occurrence, emergency restraint, emotional abuse, fall, financial abuse, medication error, missing or wandering person, motor vehicle injury, neglect, other injury, physical abuse, poisoning, service delivery problem, sexual abuse, unexpected illness.

[21] The types of reportable incidents cover broad circumstances or events affecting the health and well-being of residents. Some such incidents – such as the definitions of "neglect" and "service delivery problem" – describe what can be termed quality of care matters. Although reportable incidents may trigger formal investigations and compliance actions by licensing authorities, the types of reportable incidents are not defined according to perceived or possible breaches of a licence or other legal requirements.

[22] Schedule 1 of the CCFA regulations also defines "non-reportable incidents" that facilities should maintain in a daily log, which include "minor accidents (not requiring medical attention), behavioural observations and other unexpected events that may need to be shared with parents, next of kin or others".

[23] As noted above, the access request is for records relating to 35 incident reports at 18 facilities that were listed in the summary the VCHA provided to the applicant. A copy of the summary is attached as Exhibit "A" to the applicant's affidavit in this inquiry. Each incident report entry identifies the facility involved by name, address and facility number and provides an incident number and date. It also states the nature – according to the reportable incident categories in Schedule 1 of the CCFA regulations – of the reported incident and the confirmed incident (if it was confirmed), the maximum capacity of the facility involved and the number of residents affected by the incident. The summary covers 606 Reported Incidents, 586 Confirmed Incidents, 33 Reported Abuses and

13 Confirmed Abuses. The VCHA's letter delivering the summary to the applicant stated as follows:

> We would like to point out that a high number of incident reports does not necessarily mean a decrease in standards. Higher numbers may simply reflect better reporting practices. Not all incidents result in injury or loss.

[24] The VCHA describes the 624 pages of requested records as "incident reports and records of investigations" under the CCFA and regulations, and says that, for the year ending March 2002, it received 1,927 incident reports under the CCFA.

[25] I will describe three examples of entries from the summary. Incident No. 1386341 was reported and confirmed as "aggressive/unusual behaviour". It occurred on July 15, 2001 and involved one resident in a facility that had a maximum capacity of six. The next example, Incident No. 1386345, was a reported incident of "sexual abuse" on July 25, 2001, affecting one resident at the same facility. There is no indication whether the incident was confirmed. The third incident, Incident No. 1459934, occurred on June 30, 2001 at a facility with a maximum capacity of five. It was reported as "physical abuse/sexual abuse" and was confirmed as "sexual abuse". One individual was affected.

[26] The incident reports are written on a triplicate form that is identified, in the example given to me, as having been provided by the Ministry of Health and Ministry Responsible for Seniors. Each report specifies the incident number, facility, individual residents and facility workers involved in the incident, the nature of the incident under the CCFA regulations and whether it was confirmed. Residents are identified by first and last name, date of birth and sex. Some of the residents identified are juveniles. Facility workers are usually identified by first and last name. Occasionally, no single resident is identified because all residents are affected (such as by a flu outbreak).

[27] The incident report form includes spaces for a description about investigation of the incident, its cause or contributing factors and immediate action taken. For some reports, these spaces for "facility follow-up" information are completed and for others they are not. The reason for this appears to be that facilities are required to send incident reports to the local health authority immediately, without the "facility follow up" information yet entered. A copy of the "facility follow-up" information is then supposed to be forwarded when it is completed later.

[28] The incident reports also include a hand-written description by facility staff of the incident (with reference to identifiable individuals); particulars about who was notified of the incident (including a family member or guardian, and emergency, health care and licensing officials); and hand-written commentary from a licensing officer about follow-up, corrective measures, recommendations or other actions taken.

[29] The description of the incident in the reports is detailed and contains information about the physical, mental or emotional condition of residents involved. For example, if the incident reported is unusual or aggressive behaviour, the narrative describes specific

resident acts. The sex of a resident is often explicitly or implicitly identified. This is especially true if sexual behaviour is involved. The acts described are sometimes peculiar, or even unique, in nature. Specific verbal or physical behaviour may be described as characteristic of a particular resident when he or she is upset or it may be tied to a disability, such as quadriplegia, that is peculiar to a particular resident. If the incident reported is death, this portion of the form describes the resident's condition and the health care steps taken prior to death. If the incident reported is medication error, the description discloses the specific medication and amount involved. Some of the incidents happened in public places, such as shopping malls, parks or recreation facilities.

[30] The incident reports usually identify, by first and last name, the family member or guardian who was notified of the incident. They are also signed by one or more members of the facility's staff, by a licensing officer and, sometimes, by an investigating officer.

[31] Many incident reports have further information attached to them. For example, with an incident involving a death, there is also a report of death and related mortality documentation that contain details of the deceased's medical and health history, diagnosis before death and cause of death. For a reported incident of financial abuse, a follow-up report on the security of petty cash held for residents is attached to the incident report. In another case, concerning financial abuse and medication error, the incident report incorporates by reference the attached internal investigation report of the facility.

[32] Some reported incidents involve facility workers reporting events or actions of residents, how they were responded to and how they were resolved. Some involve complaints by residents about the conduct of other residents, facility workers or outside parties. Some involve complaints by facility workers about the conduct of co-workers. For example, pages 52-187 of the requested records relate to an incident report concerning alleged physical abuse, the resulting investigation of a facility worker and its outcome. Pages 188-232 relate to an incident report about alleged financial abuse, the resulting investigation of a facility worker and its outcome. Pages 237-251 relate to two incident reports that include allegations of physical abuse by one resident against another; one of the incidents was witnessed by a third resident. Pages 282-418 relate to an incident report about alleged emotional abuse by facility workers, the resulting investigation and its outcome. Pages 433-440 relate to an incident report about a resident's complaint of earlier sexual abuse by a family member.

[33] Some pages of the incident reports are printed over with mirror image text from another page. This appears to be caused by the fact that the report form, when filled out by hand, creates three copies. The result is a mixing of text from two pages, some of it in mirror image, onto one page. In many cases, the over-printed mirror image text is either clearly legible or at least partially legible with effort.

[34] Many of the incident reports are stamped with the word "ENTERED", which suggests that information in them has been stored electronically. This would be in keeping with the fact that the VCHA earlier produced a summary for the applicant and it continues to offer to compile a statistical summary in response to this access request.

[35] **3.3 The Parties' Positions** – The applicant says she is not seeking identifying information about facility residents (pp. 1-5, initial submission). She believes, however, that information in the requested records can be disclosed without identifying residents or, at the very least, without disclosing identifying information that the VCHA has not already disclosed in the summary. She also argues that disclosure is required in the public interest, under s. 25(1) of the Act.

[36] The VCHA blends the issue of identifiability, which is critical to the Act's definition of "personal information", with the s. 4(2) requirement to sever information that is excepted from disclosure under the Act and then disclose the remainder.

[37] As regards identifiability, the VCHA maintains that no information beyond the summary it has already provided can be disclosed without revealing identifying information about residents (para. 5, initial submission) or workers or others involved with the reported incidents (paras. 20-21, initial submission).

[38] The VCHA says disclosure of identifying information about residents, workers or others would be an unreasonable invasion of their personal privacy under s. 22 of the Act (paras. 23-28, initial submission). It also says disclosure of identifying information about individuals who report and witness incidents would create a reasonable expectation of harm to law enforcement under s. 15 of the Act (paras. 18-22, initial submission).

[39] Regarding s. 4(2), the VCHA says that, to the extent the requested records may contain both personal and non-personal information, the personal information cannot reasonably be severed from the remainder of the requested records (paras. 34-37, initial submission).

[40] Finally, the VCHA says it was, and remains, "prepared to compile a statistical summary of incidents and licensing outcomes across VCHA, which could be disclosed to this applicant" (para. 7, initial submission).

[41] I will now discuss the various issues raised in this case.

[42] **3.4 Identifiability of Residents** – I will first address some pages in the requested records that do not contain identifiable information about anyone. They are pp. 36, 64- 97, 137, 152, 176-179, 307-309, 366, 375, 391-392, 394-395, 401-407, 412-413, 514 and 521. These pages consist of blank forms or excerpts from publications. There is no reason, having regard to the disclosure exceptions in s. 22 and s. 15 of the Act, to deny access to these pages. Further, since these pages contain no information that is excepted from disclosure, no severing is needed.

[43] Pages 390, 393, 396 and 414 can also be disclosed. Pages 390, 393 and 396 identify several individuals, who are not residents, but do so exclusively in the context of their roles as available professional resources or authorities in various mental health fields. Page 414 is a chart of the child protection staff teams at the Ministry of Children and Family Development. The individuals, also not residents, are identified exclusively in relation to their positions as government employees. It is clear that no unreasonable

invasion of third-party personal privacy under s. 22, or risk of harm under s. 15, is engaged by disclosure of these pages.

[44] As for the balance of the records, the VCHA stresses the risk of re-identification – the so-called 'mosaic effect' – which arises where disclosure of what might appear to be non-personal information should be treated as a disclosure of personal information because the seemingly non-identifiable information can be combined with information from other sources to re-identify the disclosed information.

[45] My predecessor referred, in Order No. 261-1998, [1998] B.C.I.P.C.D. 56, to the re-identification risk. The VCHA quotes the following passage from p. 8 of Order No. 261-1998:

> Another factor raised by some of the districts as being relevant in favouring non-disclosure concerns the risk of re-identification of students taking Ritalin and stigmatization of those students and/or their schools. The first concern is that the publication of statistics about the number, sex and school of children taking Ritalin could result in the "re-identification" of the student. For example, if in some schools only one child is taking Ritalin then the districts say that it would not be unreasonable to expect that the child could be identified from the release of statistical information about the child's school … . It is customary in statistical work, such as that done by Statistics Canada, to refuse to disclose personal information in cells in a table that contain fewer than five persons, for example. Some Districts raised the issue of not releasing information about one or two students in small schools, or in a specific grade, who might be easily identified by other families in a given school district. I think that this is a practical issue that needs to be addressed. It would also be realistic for a District to choose to obscure identification of specific schools, where rates of Ritalin use are much higher, to avoid stigmatization of a population of students at one school.
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> I have long been interested in group privacy issues, which arise when the release of personal information, even in anonymized form, nevertheless permits the stigmatization, in some manner, of a group of individuals, such as First Nations Canadians, Chinese Canadians, professors, or, in this inquiry, students at a particular school. One School District indicated that its data could unfairly label and attract undue public attention to a school which could have a higher proportion of students receiving Ritalin and also might be a district-wide school for students with special needs. This raises, in principle, the application of section 22(2)(h) of the Act, although its language refers only to the reputation of a person, not a group of persons.

[46] I also acknowledge that the mosaic effect can be relevant in deciding whether seemingly non-personal information is in fact identifying information.

[47] The VCHA has two main concerns about re-identification. First, it says the small number of residents approved for each affected facility means the disclosure of any information from the disputed records would permit the residents and facility workers to be identified. Second, it contends that the applicant has access to other sources of information, and has demonstrated her interest in getting such information, to allow her

to re-identify residents. Both concerns are alluded to in the affidavit of Sally Mastrantonio, who is described as the Information and Privacy Officer of the North Shore Health Region. At para. 3 of her affidavit, she deposed as follows:

> 3. In particular, I was concerned that the small number of individuals involved in each facility or in each incident combined with the summary information which has already been provided to the applicant and other collateral sources of information available to her would result in the re-identification of residents and employees. In my opinion, it was not possible to reasonably sever the personal information from the documents in dispute and still adequately protect the privacy of individuals and I decided not to release the records in their entirety on the basis of the presumptions set out above.

[48] Sally Mastrantonio did not elaborate on the alleged "other collateral sources of information available" to the applicant.

[49] The affidavit of Cathy Yaskow, the VIHA's Regional Manager for Information and Privacy, also speaks, at para. 5, to concern about the applicant being able to obtain information from other sources that could be used to re-identify individuals:

> 5. In July of 2002, I received a telephone call from the applicant requesting further particulars about a death in one of the facilities on the summary list and whether criminal charges had been laid in a specific case. I was advised by Kim MacDonald, the Chief Residential Care Licensing Officer for the South Island, and verily believe that she had received a telephone call from the applicant who had advised her that she had called the coroner's office trying to obtain more information regarding a specific death at a facility. I was also advised by Ellen Brown, Manager, Community Services, South Island and verily believe, that the applicant had contacted one of her front line staff seeking more information regarding a specific death at a facility.

[50] The applicant's response on the issue of re-identification is summarized in para. 17 of her affidavit, as follows:

> 17. Given the information that has already been provided in the Summary, including the names and addresses of the facilities, the number of residents, as well as the date and nature of incidents, I am at a loss to understand what could be contained in the incident reports which would go further towards unreasonably invading the privacy of any group home residents. I am not interested in the names of residents and I have no objection to names being severed. I am also not interested in the medical history or treatment of any resident which is unrelated to the incident in question. The public body has provided no explanation of what information from the reports is of concern, nor any explanation as to why such information could not be severed.

[51] According to para. 15 of the VCHA's initial submission, the maximum capacity of the facilities covered by the access request "is between four and six residents on

average", although not all of them would "be at maximum capacity on any given day". The VCHA's response to the applicant's request mentioned a maximum capacity of 10 residents. The records themselves suggest that, if four to six residents is in fact the maximum facility capacity, some facilities had more than the permitted maximum capacity of residents at the time of some of the incidents. I accept that the facilities involved here had, over the period covered by the access request, no more than 10 residents and that most had considerably fewer than 10 residents.

[52] I find it reasonable to expect that residents (or their families or guardians) and employees in these small facilities who have no access to the requested records would nonetheless be able to identify, from information in the requested records, the other residents and employees who were involved in the incidents.

[53] To give some examples, for an incident report relating to the death of one of six residents of a facility, if the name of the facility and the date of the incident were known, as they are from the summary, then it is reasonably likely that some or all of the people living, working or otherwise regularly attending at the facility would be able to connect the detailed information in the incident report with the death of an identifiable person. The same would apply to incident reports about a suicide attempt by a female youth or a specific action or medical condition of a resident.

[54] The applicant's argument that disclosure of the requested records will not identify individuals any more they have already been identified by the summary is not compelling. On the contrary, the disclosure of more detailed information that matches with the incident numbers, dates and facilities already disclosed in the summary, would make the connecting of incidents to identifiable individuals much more likely.

[55] I do not agree that a reasonable expectation has been established that the applicant has collateral sources of information that would enable her to identify individuals. The VCHA and VIHA submissions on this point are more conjecture than reasonable expectation. I am inclined, however, to attach some credibility to the expectation that residents or workers who are able, from released information, to identify individuals involved in the incidents, could then – even unwittingly – be collateral sources of information enabling the applicant to identify individuals.

[56] With the exception of the pages listed at the beginning of this section, I am satisfied that the VCHA and the interveners are right to be concerned that disclosure of the requested records can reasonably be expected to identify or re-identify residents involved in the reported incidents. The small size of the facilities makes the identification or re-identification of workers as likely as the identification or re-identification of residents. The applicant does not want information that identifies residents, but information is blended in the narrative descriptions of incidents such that information which it is reasonable to expect to identify or re-identify workers or witnesses can also reasonably be expected to identify or re-identify residents.

[57] To be clear, this is not a conclusion that isolated entries or words in the requested records cannot be disclosed without identifying or re-identifying individuals or that

meaningful information cannot be extracted from the requested records for anonymized disclosure to the applicant. Those issues are addressed below.

[58] **3.5 Severing Personal Information** – Section 4(2) requires public bodies to sever information that is excepted from disclosure under the Act, if that can be reasonably done, and give access to the remainder of the requested record.

[59] The VCHA contends that the duty to sever under s. 4(2) does not apply because protected information cannot reasonably be severed from the remainder of the records. It concedes that "the exempt information can be severed with diligence and considerable time and effort", but says it "cannot reasonably be severed from the records because the result is generally meaningless and potentially misleading" (para. 37, initial submission, with original emphasis). It says that "severing is not a practical or reasonable alternative" and the summary already provided to the applicant by the VCHA "should be the extent of disclosure in this instance" (para. 37, initial submission).

[60] The VCHA argues, alternatively, that, if severing is appropriate, it must entail severing of all information of the type that the VIHA severed in its response to the applicant's request as identified in Cathy Yaskow's affidavit. At paras. 6-13 of her affidavit, Cathy Yaskow describes, with reference to the VIHA records requested by the applicant, the extensive amounts of information that were withheld under s. 22 or s. 15 of the Act. The likelihood of disclosure identifying individuals was at the heart of the VIHA's application of both of these exceptions. Information that had already been disclosed in the summary given to the applicant – such as incident report numbers, dates of the incidents and information identifying the facilities involved – was withheld to prevent re-identification through cross-referencing between information in the summary and the requested records:

> 6. …The degree of severing necessary, however, to adequately protect the personal privacy of the residents and employees of the homes under sections 22(3)(a), (b), (d) and (h), and section 15 was extensive, given the small numbers involved and the potential for the applicant to be able to piece together collateral sources of information to re-identify specific employees or residents. The severed documents did not satisfy the applicant and in many instances were not particularly meaningful.
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> 7. For example, we severed the date of birth and sex of the residents because in a small group this information could easily eliminate a number of residents, for example, or where there is only one who is both male and over 40, identify a specific person. We severed dates of incidents and the dates reports were received and posted to make it more difficult for the applicant to identify the specific facility involved and from that, link back to the initial summary sheet, thereby increasing the likelihood of identifying a resident.
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> 8. The address of the [name of facility] was withheld from the listing because it is a home for underage youths and I was advised and verily believe that it is the position of the Ministry of Child and Family Development not to release such addresses.

9. As service type codes appeared on the listing of incidents that was provided to the applicant in response to her first request, we severed service type and program affiliation again to make it more difficult to identify facilities and potentially the residents.

10. We severed information relating to specific actions of clients as well as information about their medical conditions as it represented their personal information and in particular their personal health information. Many of the behaviours described in the reports are associated only with one individual at a specific home.

11. We severed names and contact information of parents and next of kin or legal guardians again in order to protect not only the privacy of those individuals but the privacy of the residents.

12. We severed information concerning actions taken against employees as representing their personal employment history under section 22(3)(d) of the Act. We did not sever the names of employees who were in fact employees of VIHA visiting the home or social workers employed by the Ministry of Children and Families. We also shuffled the incident reports so that all the reports of a particular facility would not be provided to the applicant as one grouping. We severed witness statements on the basis that they were law enforcement records under section 15 of the Act.

13. Having considered the position taken by the VCHA, I believe that the amount of severing required to protect the privacy of residents is so extensive that it rendered many of the records meaningless to the applicant, notwithstanding that it did provide the applicant with process information to address our public body accountability. In light of that, I agree that it would be appropriate to refuse to disclose any of the records in dispute on the basis of sections 15 and 22 concerns and provide only the statistical summary initially sent to the applicant given the small population involved in this access request.

[61] In contending that severing is not required under s. 4(2), the VCHA cites *Canada (Information Commissioner)* v. *Canada (Solicitor General)*, [1988] 3 F.C. 551 (F.C.T.D.), and Alberta Order 96-019, [1997] A.I.P.C.D. No. 2. It cites the following passage from *Canada (Information Commissioner)*, where Jerome A.C.J. said that the federal access and privacy statutes:

> ¶14 ... do not, in my view, mandate a surgical process whereby disconnected phrases which do not, by themselves, contain exempt information are picked out of otherwise exempt material and released. There are two problems with this kind of procedure. First, the resulting document may be meaningless or misleading as the information it contains is taken totally out of context. Second, even if not technically exempt, the remaining information may provide clues to the content of deleted portions. Especially when dealing with personal information, in my opinion, it is preferable to delete an entire passage in order to protect the privacy of the individual rather than disclosing certain non-exempt words or phrases.

> ¶15 Indeed, Parliament seems to have intended severance of exempt and non-exempt portions be attempted only when the result is a reasonable fulfillment of the purposes of these statutes. Section 25 of the federal *Access to Information Act* contains the phrase: "The head of the institution shall disclose any part of the record that ... can reasonably be severed from any part that contains any such information or material."

[62] I recently considered the meaning of s. 4(2), in Order 03-16, [2003] B.C.I.P.C.D. No. 16. That case dealt with the extent of the s. 4(2) duty to sever in the context of an electronic record, but I made the following general observations about s. 4(2):

> [53] Having said this, the Legislature's use of the word "reasonably" in s. 4(2) obviously limits the duty of a public body to sever protected information and disclose the rest. The Ministry refers to the following interpretation of s. 4(2) from the provincial government's *Policy and Procedures Manual* for the Act:
>
> > "Reasonably be severed" means that after the excepted information is removed from a record, the remaining information is both intelligible and responsive to the request.
>
> [54] I agree with this statement. There will be cases where, after protected information is removed, the remainder of the record conveys nothing intelligible. Where the remainder of a severed record consists of disconnected words or snippets of sentences that cannot reasonably be considered intelligible, it is not reasonable to sever under s. 4(2). This view is supported by decisions elsewhere in Canada.

[63] See, also, the court decisions and access to information decisions cited in Order 03-16.

[64] The question under s. 4(2) is not, of course, whether it is possible to sever, but whether it is reasonable to sever. Except for small sections such as the check boxes for the reported and confirmed types of incidents, the requested records are essentially narrative in style. They are framed, by design, around descriptions of facts, events and actions with reference to specific individuals. In this regard, the requested records are quite unlike a statistical summary or a summary prepared under s. 22(5) of the Act, both of which are designed to convey meaningful information without identifying third-party individuals.

[65] The requested records would require very extensive word-by-word, entry-by-entry severing to remove information that can reasonably be expected to identify residents. I do not agree with what appears to be the applicant's impression that information that was provided to her in the summary (such as incident numbers and other information which would enable specific facilities to be identified) may not be withheld in connection with this access request.

[66] I do agree with the intervenors' assessment that, to avoid a reasonable expectation that individuals would be identifiable by matching information already disclosed in a summary with information disclosed in the incident report records, it was necessary for

them to sever from the records a significant amount of information that had already been provided to the applicant in summaries. The same applies to the requested VCHA records.

[67] It is also evident that there are significant differences between this case and the circumstances considered in Order No. 261-1998. In that case, Commissioner Flaherty concluded that records could reasonably be severed to avoid risk of re-identification of school children receiving Ritalin medication. The access request, again from a journalist, was for records disclosing the number, sex and school of children taking Ritalin. For each child, this information had been collected on a one-page "Request for Administration of Medication" form. Commissioner Flaherty concluded that these one-page paper forms could be severed fairly easily to remove identifying information. He required the school districts involved to disclose the paper forms with identifying information removed. I agree with him that severing excepted information from those forms did not amount to creating records under the Act. He also said that, if the school districts chose, they could satisfy the requirement to give access to the severed forms by releasing the same information in a tabular form amounting to a statistical summary.

[68] The information in issue in this inquiry is much more complex and extensive than the information that was collected in the one-page forms that responded to the access request in issue in Order No. 261-1998. Commissioner Flaherty found that the risk of re-identification could be relatively easily addressed in that case, but the same cannot be said for the requested records in this inquiry.

[69] Severing of the requested records, as the VIHA and the FHA did for their records, is possible. However, the remaining snippets of information defy meaningful or accurate interpretation. Because the severing of identifying information about residents from the requested records would leave disconnected words or snippets of sentences that cannot reasonably be considered intelligible, I have concluded after very careful consideration that the requested records cannot reasonably be severed under s. 4(2) of the Act.

[70] It does not follow that no meaningful information beyond the summary that the VCHA has already provided to the applicant can be extracted from the requested records for disclosure in anonymized form. The option of creating a responsive non-identifying record is discussed below.

[71] **3.6 Creating A Non-Identifying Record** – A statistical or other non-identifying summary may be the only way to provide meaningful disclosure when requested records contain extensive third-party personal information that the Act protects from disclosure. The Act recognizes this directly in s. 22(5), which requires public bodies to give applicants summaries of their own personal information under certain conditions, and indirectly in s. 6, which requires public bodies to assist applicants by creating records under certain conditions.

[72] Section 22(5) does not apply here because this applicant is not seeking access to personal information about herself. Section 6 may apply. The VCHA has already provided a summary to the applicant, but it contained little meaningful information about

incident outcomes. For example, it is not possible to distinguish, from the summary, between a confirmed "death" incident involving the death of a resident who was expected to succumb to a serious illness and then did succumb, or one involving an unexpected death that raised concerns about quality of care at a facility. The summary also did not disclose whether incidents resulted in licensing or disciplinary actions.

[73] I am not suggesting that outcome information of this kind ought to have been included in the summary that the VCHA provided to the applicant. It could very well be that residents would be re-identifiable if such outcome details were included in a summary that also specified the facilities and incident dates involved. The VCHA may be able, however, to create a region-wide summary that provides the applicant with more information about incident outcomes, without being specific as to facilities or incident dates involved.

[74] The applicant believes that there is inadequate public scrutiny and government supervision of standards and incidents in residential community care facilities. She wants to create better public awareness of the circumstances of residents whose health, safety and well-being depend upon the standards at these facilities. The VCHA contends that it is not the media's role to provide oversight to licensees under the CCFA and says there is no evidence that the VCHA is not exercising adequate oversight of the community care facilities in its region (para. 5, reply submission).

[75] As I see it, regardless of the VCHA's confidence in the effectiveness of its own operations, the public and the media have legitimate roles to play in ensuring the VCHA's accountability and that of the provincial authorities overseeing the licensing system for community care facilities. The point is to find the balance, under the Act, between the applicant's right of access to information about reported incidents and the important right of individuals, especially residents in the circumstances of this order, to personal privacy.

[76] The parties' submissions do not enable me to fully resolve the question of what non-identifying record can or should be created by the VCHA in response to this access request. My sense is that a non-identifying record can be created that would provide the applicant with more meaningful information about incident outcomes. In other words, the VCHA was on the right track in offering to compile a statistical summary of incidents and licensing outcomes across the region that could be disclosed to the applicant.

[77] I am adjourning this part of the inquiry to permit the applicant to consider whether she wants to pursue creation of a responsive non-identifying record and, if necessary, to receive submissions for the parties on the make-up of that record.

[78] **3.7 Public Interest Disclosure** – Section 25(1) of the Act can apply to both personal and non-personal information. It has been discussed on many occasions, including in Order 01-20, [2001] B.C.I.P.C.D. No. 21, and Order 02-38.

[79] As I said in Order 02-38, at para. 53:

> The s. 25(1) requirement for disclosure "without delay", whether or not there has been an access request, introduces an element of temporal urgency. This element must be understood in conjunction with the threshold circumstances in ss. 25(1)(a) and (b), with the result that, in my view, those circumstances are intended to be of a clear gravity and present significance which compels the need for disclosure without delay.

[80] Paras. 18-20 of the applicant's affidavit summarize why she believes the public interest requires disclosure of the information she has requested:

> 18. … if the reports are not provided, I (and hence the citizens who will be reading my articles on this subject) will be left without a better understanding of the incidents, their handling, the reporting, and follow-up. In short, citizens will have less information upon which to determine whether incidents were handled well and thoroughly with a view to preventing recurrence, or whether they were poorly handled, leaving residents at risk of recurrence.
>
> 19. The need for this information is even more pointed given indications of inadequate supervision, monitoring, inspection, enforcement and public resources devoted to ensuring high standards at group homes. For example:
>
> (a) I am informed by Barbara Hoffman, manager of licensing for several sectors of the Fraser Health Authority, that routine inspections there do not occur more than every 18 months.
> (b) I am informed by Don Bower of the Fraser Valley Health Authority that they have no-one to enforce the self-reporting of the incidents by group homes.
> (c) I am informed by Minister Gordon Hogg that social workers do not inspect group homes and will only investigate one if there is an actual complaint.
> (d) I am informed by Laney Bryenton, executive director of the BC Association for Community Living, that an agency which for the past 8 years inspected group homes, known as the provincial Monitoring Group (PMG) has been discontinued in recent budget cuts, with no apparent replacement;
> (e) While group homes must be licensed, according to the Ministry and regulations, there are no provincial standards concerning the qualifications or licensing of the care workers in the facilities.
> (f) I have discovered through my inspection of public budget materials and my communications with Minister Hogg that despite the apparent lack of resources to oversee group homes, those resources have been reduced even further – by 23 percent for the Ministry as a whole and by 17% for housing and services for the mentally ill.

> 20. The point is that there is inadequate public scrutiny of standards and incidents in group homes, and an apparent lack of governmental commitment to do more. My request is intended to bring some badly needed scrutiny not only [*sic*] the nature and handling of incidents at group homes, but also the supervising government bodies, with a view to creating better public awareness of the circumstances of the mentally disabled or young people whose health, safety and well being depend upon the standards at publicly funded group homes.

[81] Because the applicant also says that she does not want to be able to identify residents, I do not take her to be arguing that the public interest under s. 25(1) requires disclosure of information that can reasonably be expected to identify residents. Given my findings about the identifiability of residents if the requested records (other than the pages indicated above) are disclosed, and about the unintelligibility of the information that would remain if identifying information is severed, what is left would not come close to triggering the requirement for immediate disclosure in the public interest under s. 25(1).

[82] As for information in the requested records that can reasonably be expected to identify residents, the immediate mandatory disclosure of this information is not, in my view, clearly necessary in the interest of the health or safety of the public or a group of people, or in the wider public interest such as for public debate and political participation.

[83] There may be public interest in the creation and disclosure of a responsive non-identifying record, but the necessary element of urgency – compelling need for disclosure without delay – has not been shown to be present.

[84] I find that s. 25(1) does not require the VCHA to disclose information in the requested records.

[85] **3.8 Law Enforcement Information** – Given my findings about the identifiability of residents if the requested records (other than the pages I have indicated) are disclosed, and about the unintelligibility of the information that would remain if identifying information is severed, it is not necessary for me to address the VCHA's and the applicant's submissions about the applicability of s. 15 to information in the requested records.

[86] I will say, however, that I do not agree with the VCHA's claim that all of the requested records relate to "law enforcement" as defined in Schedule 1 of the Act and used in s. 15. As I have indicated, the types of incidents the CCFA regulations requires to be reported are not defined according to perceived or possible breaches of a licence or other legal requirements. Some reported incidents, certainly, may trigger regulatory investigations that may lead to licensing proceedings, or even police investigations that may lead to criminal proceedings. But a law enforcement dimension is not a defining characteristic of a reportable incident and not every reportable incident relates to law enforcement.

[87] Order No. 83-1996, [1996] B.C.I.P.C.D. No. 9, dealt with records of an investigation by community care facility licensing officials of an applicant's complaints about the quality of care that her child received at a licensed daycare facility. Commissioner Flaherty concluded, without elaborating on what quality of care issue was involved, that the particular investigation related to a law enforcement matter.

[88] In contrast, while some of the requested records here relate to complaints and investigations of licensing or other possible violations of the law, many of the reportable incidents, and related records requested by the applicant, do not relate to law enforcement.

4.0 CONCLUSION

[89] I make the following orders under s. 58 of the Act:

1. I find the VCHA is not authorized or required to refuse access to pp. 36, 64-97, 137, 152, 176-179, 307-309, 366, 375, 390-396, 401-407, 412-414, 514 and 521 of the requested records and I require the VCHA to give the applicant access to those pages.

2. I find the balance of the requested records contain personal information of residents of community care facilities that cannot be reasonably severed under s. 4(2) of the Act and confirm the VCHA's decision to refuse access to those records.

3. I find that s. 25(1) of the Act does not require the VCHA to disclose information in the requested records.

[90] As indicated above, I adjourn this inquiry on the issue of the VCHA's creation of a record that is responsive to the applicant's access request without disclosing information that can reasonably be expected to identify individual residents of community care facilities.

December 9, 2003

ORIGINAL SIGNED BY

David Loukidelis
Information and Privacy Commissioner
for British Columbia