OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER
NEWFOUNDLAND AND LABRADOR

Report A-2023-003

January 30, 2023

Department of Health and Community Services

Summary: The Department of Health and Community Services received an access request under the *Access to Information and Protection of Privacy Act, 2015* for records related to adverse patient safety incidents. The Department responded that there were no records responsive to the request. The Complainant filed a complaint with this Office. The Commissioner concluded that the Department had failed in its duty to assist the Complainant by failing to engage with the Complainant to understand the request, and by failing to conduct a reasonable search for records. The Commissioner also concluded that the Department initially failed to satisfy our Office that it does not hold records that might be responsive to the Complainant's request, and that the Department initially refused to provide our Office with records, information about records, or information about the search conducted, to enable our Office to deal with the issues in this complaint. The Commissioner recommended that the Department continue its now ongoing search for and analysis of records, provide a new Final Response to the Complainant, and provide to the Complainant copies of all responsive records located, subject to any applicable exceptions to access or exclusions that may apply.

Statutes Cited: *Access to Information and Protection of Privacy Act, 2015*, SNL 2015, c. A-1.2, sections 7, 13, 43, 46, 97;

Public Inquiries Act, 2006, SNL 2006, c. P-38.1;

Patient Safety Act, SNL 2017, c. P-3.01, sections 7, 8, 9, 10, 18-20.

Authorities Relied On: NL OIPC Reports A-2022-023; A-2022-010.

File # 0005-074-22-076

BACKGROUND

[1] The Complainant made an access request on August 2, 2022 to the Department of Health and Community Services ("HCS" or the "Department") under the *Access to Information and Protection of Privacy Act, 2015 ("ATIPPA, 2015"* or the "*Act*") for:

> *Documentation and communication, written or electronic, regarding adverse patient safety incidents from Jan 1, 2018 to now."*

[2] Email correspondence ensued, from August 2, 2022 to August 17, 2022, between two different staff of the Department and the Complainant, asking the Complainant to clarify what he meant by the request.

[3] On September 13, 2022 the Department sent the Complainant a final response stating that the Department had no responsive records. The Complainant filed a complaint with our Office.

[4] Our notification of the complaint was sent to the parties on September 15, 2022. By agreement, the Department on September 21, 2022 provided our Office with a partial response, copies of the correspondence with the Complainant, with a further response to come. On September 29, 2022 the Department provided our Office with a response to the complaint, referencing the *Patient Safety Act*, the *Evidence Act*, and *ATIPPA, 2015*, Schedule A. No responsive records were provided to our Office by the Department. Note that section 7(2) of *ATIPPA, 2015* in interaction with Schedule A of the *Act* provides that certain sections of certain statutes prevail over *ATIPPA, 2015*. In this case, sections 10 and 15 of the *Patient Safety Act* prevail over *ATIPPA, 2015* to create an exclusion related to "quality assurance information". Excluded information and records are, however, different from non-responsive information and records. This difference has been the crux of considerable difficulty with this request and complaint. It is discussed in greater detail below.

[5] On November 23, 2022 the Department offered to provide the Complainant with information about the numbers of certain reports received by the Minister. The Complainant agreed with such a proposed resolution.

[6] On November 24, 2022 the Department sent the Complainant a letter, containing a table simply stating the total reported in each year. The Complainant refused to accept that as a response to his request.

[7] As informal resolution was unsuccessful, the complaint proceeded to formal investigation on November 4, 2022 in accordance with section 44(4) of *ATIPPA, 2015*.

PUBLIC BODY'S POSITION

[8] The positions taken by the Department on the issues involved in this complaint will be set out and discussed in the following pages.

COMPLAINANT'S POSITION

[9] The Complainant argues that "adverse patient safety incidents" is a well-known concept in health care and there should be no difficulty in understanding his request.

[10] The Complainant provided our Office with a page from an access request response from another health care body that stated there are over 17,000 adverse patient safety incidents in Newfoundland and Labrador per year, at a rate three times the national average. This record was provided to our Office as evidence that such data exists.

[11] The Complainant argues that there should be records responsive to his request that are not excluded from access by the *Patient Safety Act.*

ISSUES

[12] The issues to be addressed in this Report are as follows:

1. Whether the Department has complied with its duty to assist the Applicant under section 13 of the *Act*, including the duty to engage with the applicant and the duty to conduct a reasonable search for records;

2. Whether the Department has correctly understood what constitutes records responsive to the access request;

3. Whether the Department has failed to provide records relevant to the investigation, including records responsive to the access request, to our Office for review.

DECISION

Duty to Assist the Applicant

[13] The emails between the Department and the Complainant cover several weeks, during which the Department repeatedly asked the Complainant to clarify what he was requesting, and what he meant by "adverse patient safety incidents". During that time, the Department also requested – and received – a time extension from our Office.

[14] This request for clarification is puzzling since, as the Complainant repeatedly pointed out to the Department, "adverse patient safety incident" is a well-known concept in health care. While there is some variation in terminology in different jurisdictions, adverse incidents are usually defined in basically the same way as described by the Complainant: "an unplanned event or circumstance which could have resulted or did result in harm to a patient." Such occurrences are usually broken down into several types, such as:

- an incident that reached a patient and caused harm;
- an incident that reached the patient but did not result in harm; and
- a close call or near miss, where an incident happened but did not reach the patient.

These concepts are reflected in similar terms in the *Patient Safety Act* and elsewhere.

[15] Under the *Patient Safety Act,* "adverse health events" are intended to be the subject of detailed quality assurance reviews by the regional health authorities, potentially leading to recommendations for improvement to help prevent such incidents in future. Quality assurance

information, as defined in the *Patient Safety Act,* is considered confidential, is excluded from the operation of *ATIPPA, 2015*, and cannot be entered into evidence in litigation.

[16] The Department repeatedly asked the Complainant for clarification, without ever explaining to him what was unclear, and suggested to the Complainant that he was asking for quality assurance information. The Complainant stated that he was not, and explained that he understood the difference. He repeatedly asked for a phone discussion, but it never took place.

[17] Given the interactions between the Department and the Complainant, we must conclude that the Department failed in its duty to engage with the Complainant to ensure that it understood the nature of the request.

Search for Responsive Records

[18] On September 13, 2022, the Department sent a Final Response to the Complainant, stating: "Please be advised that the Department of Health and Community Services has reviewed this request and has no records responsive to your request."

[19] As the Complainant stated, it was difficult to believe that the Department would not have <u>any</u> records responsive to this request, even after considering that many records may be excluded from *ATIPPA, 2105* by the *Patient Safety Act*. Sections 7 and 8 of the *Patient Safety Act* require the regional health authorities to provide information about adverse health events to the Minister. Furthermore, sections 18-20 of that *Act* require the establishment of a province-wide patient safety advisory committee, including the Deputy Minister of the Department and others appointed by the Minister, with responsibilities as follows:

> *20. The patient safety and quality advisory committee shall*
> *(a) advise on matters relating to patient safety and quality assurance within regional health authorities;*
> *(b) consider and make recommendations to the minister respecting any matter referred by the minister;*
> *(c) measure, monitor and assess patient safety indicators and the quality of health services;*

> *(d) identify effective practices and make recommendations to improve patient safety and the quality of health services;*
> *(e) assist in implementing and evaluating patient safety and quality assurance improvements;*
> *(f) consult and engage with regulatory bodies of health professions where appropriate;*
> *(g) report annually to the minister on its activities; and*
> *(h) undertake other activities as prescribed in the regulations.*

[20] Given the Minister's responsibility for setting policy direction for the provision of health care, and given the above requirements of the *Patient Safety Act*, it was difficult to see how the Department would not have at least **some** records on that subject.

[21] Furthermore, as stated above, during our investigation the Complainant provided our Office with a page from an access request response, received from another health care body, which stated there are over 17,000 adverse patient safety incidents in Newfoundland and Labrador per year, at a rate three times the national average. This record was provided to our Office as evidence that such data exists.

[22] The Complainant's access request was for "documentation and communication . . . regarding adverse patient safety incidents" which is clearly broad enough to encompass information other than what might be excluded under the *Patient Safety Act*. Given the nature of the subject, there could be communications to the Department about such issues from various other sources, even from members of the public. It was not at all clear that all such communications would be covered by the strictures of the *Patient Safety Act*.

[23] Given the responsibilities set out in sections 18-20 of the *Patient Safety Act*, it is reasonable to suppose that a departmental committee or other such body, or at least an individual, would be tasked with dealing with such matters, at least receiving, replying to, and filing such communications. If so, it might be expected that there would be correspondence, notes or other records that would be responsive to the request.

[24] On the Department's own website there is a page describing the "Office of Adverse Health Events". The description goes on to state:

> *The Office of Adverse Health Events provides leadership, strategic advice and adverse health management expertise to the department. It oversees the development, and implementation of the Provincial Adverse Health Event Management Framework and the provincial electronic occurrence reporting system. The office works in collaboration with other divisions of the department, the regional health authorities and other key stakeholders on an array of issues and initiatives affecting quality and patient safety.*

[25] Such an office might be expected to have records, other than records excluded by the *Patient Safety Act*, regarding such leadership, expertise and collaboration.

[26] On November 23, 2022 the Department wrote our Office stating that it does not keep "data" about such matters, but that the Minister receives "reports" under section 7 of the *PSA*. The Department offered to provide the Complainant information about the numbers of such reports, by year. However, as stated above, the Complainant refused to accept what the Department provided, as there was no information included to describe the enumerated reports, who they were from, what the subject-matter might be, or even to show that they were responsive to his request.

[27] In the initial Notification of Complaint letter our Office sent to the Department, we clearly explained that we required the Department to provide details on how it conducted its search, including:

> *(1) the specific steps taken by the Department to identify and locate responsive records;*
> *(2) the scope of the search conducted, including a list of all areas searched (i.e. physical sites, program areas, specific databases, off-site storage areas, etc.);*
> *(3) the steps taken to identify and locate all possible repositories of records relevant to the access request (i.e. keyword searches, records retention and disposition schedules, etc.);*
> *(4) the name of the person who conducted the search, and that person's knowledge and experience with respect to the records;*
> *(5) whether the search was reviewed by the ATIPP coordinator;*
> *(6) why the Department believes no responsive records exist; and*
> *(7) any other information you think appropriate to provide regarding the issue of reasonableness of search.*

[28] Despite repeated requests, the Department responded only that "…a search was conducted based on the clarification of the request the applicant provided…." This was not a complete response to our questions.

[29] We conclude that, at that juncture, the Department had failed to satisfy our Office that it has conducted a reasonable search and does not hold records that might be responsive to the Complainant's request.

Definition of Responsive Records

[30] The Department's first response, dated September 29, 2022, to our notification of the complaint differed from the response provided to the Complainant. Instead of advising that there were no responsive records, the Department **now** stated that "HCS advised the applicant that there was no responsive information *as it was excluded from ATIPPA, 2015, in reliance on [the Patient Safety Act]*." (emphasis added)

[31] That statement is not quite accurate. The Final Response to the Complainant did not mention the *Patient Safety Act*; it simply said that there were no responsive records. There was no explanation for this discrepancy. Second, the Department's rationale, above, appears to represent a fundamental misunderstanding of the meaning of the term "responsive records." A responsive record is simply a record containing information that reasonably fits the description of the information sought in the access request. A public body must **first** understand what is sought by the applicant, and seek clarification if necessary. Second, it must conduct a search to ascertain whether it has custody or control of any such records. If it does, those records are what is responsive to the request. **Only then** does the public body ask whether a record, or any of the information in it, may be excluded from the operation of the *Act,* or withheld under an exception to access. The Department, however, appears to have acted on the premise that a record excluded from the operation of *ATIPPA, 2015* is not a responsive record.

[32] We conclude that, at that juncture, the Department misunderstood what a responsive record is.

Provision of Records to this Office

[33] As mentioned above, some records held by public bodies may be excluded from the operation of *ATIPPA, 2015.* The relevant provisions of section 7 of *ATIPPA, 2025* read as follows*:*

> *7. (1) Where there is a conflict between this Act or a regulation made under this Act and another Act or regulation enacted before or after the coming into force of this Act, this Act or the regulation made under it shall prevail.*
>
> *(2) Notwithstanding subsection (1), where access to a record is prohibited or restricted by, or the right to access a record is provided in a provision designated in Schedule A, that provision shall prevail over this Act or a regulation made under it.*

[34] It is clear that section 10 of the *Patient Safety Act* is such a provision, designated in Schedule A. It reads:

> *The Access to Information and Protection of Privacy Act, 2015 does not apply to the use, collection, disclosure, release, storage or disposition of, or any other dealing with, quality assurance information.*

[35] The question then would be whether any of the information in any records responsive to the Complainant's request falls into the category of "quality assurance information" as defined by the *Patient Safety Act*.

[36] The question of whether a record is excluded from the operation of the *Act* is one that must be decided by the public body, in processing and responding to an access request, subject to review by this Office following a complaint. In order to decide that question, we of course must be provided with copies of the records that the public body asserts are excluded, along with any other information relevant to the issue. In the present case, no records were provided to our Office, or even listed or described.

[37] On December 6, 2022 our Office wrote to the Department asking for responses on two issues. First, we asked for representative samples of the "reports" referred to in the Department's previous letter, in order for our Office to be able to conclude whether they

contained information excluded from the *Act*. The Department failed to respond to the request, except to say that those records would be excluded.

[38] Second, we asked whether or not the Department actually conducted a search for other records. If such a search was conducted and records were located, we asked that the Department forward copies of such records to us, regardless of whether they were deemed at the time to be excluded from the *Act*. The Department advised only that "…a search was conducted based on the clarification of the request the applicant provided."

[39] The inference to be drawn from the Department's response would appear to be that the Department, at that juncture, believed that it was not required to provide such records to our Office, either because it had deemed the records not to be responsive to the Complainant's request, or because it had deemed the records to be excluded from the *Act*. Yet in our December 6, 2022 request, we had explicitly stated that "we make the above requests pursuant to the powers of the Commissioner in subsections 97(1), (2), (3) and (4) of *ATIPPA, 2015*."

[40] The relevant provisions of section 97 of the *Act* read as follows:

> *97. (1) This section and section 98 apply to a record notwithstanding*
>
> *(a) paragraph 5 (1)(c), (d), (e), (f), (g), (h) or (i);*
>
> *(b) subsection 7 (2);*
>
> *(c) another Act or regulation; or*
>
> *(d) a privilege under the law of evidence.*
>
> *(2) The commissioner has the powers, privileges and immunities that are or may be conferred on a commissioner under the Public Inquiries Act, 2006.*
>
> *(3) The commissioner may require any record in the custody or under the control of a public body that the commissioner considers relevant to an investigation to be produced to the commissioner and may examine information in a record, including personal information.*

> *(4) As soon as possible and in any event not later than 10 business days after a request is made by the commissioner, the head of a public body shall produce to the commissioner a record or a copy of a record required under this section.*

Section 97(3) empowers the Commissioner to require a public body to provide to our Office, not merely records that the public body deems responsive to a request, or that the public body considers not to be excluded from the application of the *Act,* but "…any record in the custody or under the control of a public body that the commissioner considers relevant to an investigation…." Although we specifically drew the attention of the Department to that distinction, no records were provided.

Extraordinary Measures

[41] Our Office had almost reached the end of the 65-day statutory period within which a report must be issued, without having a reasonable evidentiary basis for reaching conclusions about the issues in this complaint. The only party in a position to provide such an evidentiary basis was, of course, the Department, but it had failed to do so. On December 12, 2022 our Office therefore issued a Summons to the Department under the *Public Inquiries Act,* pursuant to section 97(2) of *ATIPPA, 2015,* requiring the Department to provide the information we needed.

[42] The Department responded to the Summons with some, but not all, of the required information. It was obvious that more time would be needed. On December 13, 2022 our Office therefore took the unusual step of filing an application with the Supreme Court pursuant to section 46(2) of *ATIPPA, 2015,* for a 30 day extension of the 65 day time limit. On December 15, 2022 the Court granted an extension of 5 business days, with the proviso that with the consent of the Department it would be extended for a further 25 days. With the Department's concurrence, we secured the full 30 business day extension and arranged a meeting on January 11, 2023 to further explain why we need the information we had requested, clear up any misunderstandings, get complete answers to our questions.

[43] During this meeting we made progress toward reaching agreement with the Department on a number of issues, particularly on the interpretation of section 97 of *ATIPPA, 2015*, and on the definition of responsive records. We agreed that the Department was to conduct a further search for responsive records, based on our mutual understanding of what constitutes a reasonable search, and the understanding that "responsive records" in the present case should cover more than just the reports made to the Minister by the RHAs under the *Patient Safety Act*, but should also include emails, other internal and external correspondence, agendas and notes of meetings and any other records dealing with the topic of occurrences, close calls or adverse health events. The Department agreed that it would provide our Office with copies of all records located, and a detailed description of the search conducted.

[44] On January 25, 2023 the Department provided our Office with a further response to our Summons. Included with that response was some additional information on the activities of the provincial patient safety advisory committee, and about the Office of Adverse Health Events.

[45] Also included with that response were packages of records, including emails, minutes of meetings, documents to be discussed at meetings and more, totaling almost 5,000 pages. It is not clear what proportion of those records, if any, the Department considers to be responsive to the access request, nor is it clear whether the Department considers any or all of those records to be excluded from the operation of the *Act.*

[46] Once again, therefore, it has become clear that the Department requires more time to complete its work. While some progress has been made, the work cannot be completed in time for the results to be confirmed and reported, for any records to be processed and, potentially, provided to the Complainant, and for us to attempt to reach an informal resolution of the complaint. Therefore our Office has decided to issue the present Report.

CONCLUSION

[47] It is not clear from the Department's recent correspondence if it is taking the position that all, none or some of the 5,000 pages of the newly located records are responsive to, or

whether they are excluded from, the original request. At first glance, it would appear that many if not all of the records are responsive and at least some are not excluded as they do not appear to contain quality assurance information. We believe that it is not appropriate for the Department to categorically declare that all of these records are either non-responsive or excluded without doing a proper analysis. A detailed analysis of all of these documents to answer that question seems unlikely to have been possible during the two weeks that elapsed between the January 11 meeting and the time in which they were sent to this Office. It is also not possible, with the time remaining, for our Office to properly assess and provide recommendations on whether section 7(2) applies so as to exclude records.

[48] At this juncture, therefore, this Report makes recommendations aimed at completing the process that ought to have been followed in the present case, upholding, though belatedly, the Complainant's right to the assistance of the Department, to a reasonable search for records, and to be provided with the records requested, subject only to limited exceptions to access, and with the right to complain to this Office if not satisfied with the Department's response.

RECOMMENDATIONS

[49] Under the authority of section 47(a) of *ATIPPA, 2015*, I recommend the Department of Health and Community Services, within **10 business days** of receipt of this Report:

1. As set out in section 49(1)(b) of *ATIPPA,* 2015, provide a response to this report to the Complainant and advise regarding its assessment of whether or not it has categorically determined that these newly located ~5,000 pages of records are responsive to the original request, and whether they are excluded from *ATIPPA, 2015* in their entirety.

2. If the Department has made this categorical determination, advise the Complainant that this is a new Final Decision about these newly located documents and advise the Complainant of their right pursuant to section 17 of *ATIPPA, 2015* to complain to our Office or appeal directly to Court.

3. If, in the alternative, the Department has not made this categorical determination and deems that some of these records may be responsive, and not excluded from *ATIPPA, 2015*, assess the records and as soon as possible but within **60 business days** provide the Complainant with the documents subject to any exclusions and exceptions that may apply. In this event, the Department should advise the Complainant that if he is not satisfied with this new Final Decision he has the right to file a new complaint with the Commissioner or appeal directly to the Court pursuant to section 17 of *ATIPPA, 2015.*

[50] Dated at St. John's, in the Province of Newfoundland and Labrador, this 30th day of January, 2023.

Michael Harvey
Information and Privacy Commissioner
Newfoundland and Labrador